Heal th Financia	al Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS	8-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	ire to report can re	sult in all interim	FORM APPROVI	ED
payments made	since the beginning of the cost	reporting period being of	deemed overpayments	(42 USC 1395g).	OMB NO. 0938	8-0050
	OSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 151315 Period: Wor ND SETTLEMENT SUMMARY To 09/30/2015 Date: 9/6/2016 PART I - COST REPORT STATUS Provider 1. [X] Electronically filed cost report Date: 9/6/2016				Worksheet S Parts I-III Date/Time P 9/6/2016 3:	
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed co	st report		Date: 9/6/201	6 Time:	3:18 pm
use only	2. [ ] Manually submitted cost	report				
	3. [ 1 ] If this is an amended r 4. [ F ] Medicare Utilization. E			r resubmitted this co	ost report	
Contractor use only	(1) Ås Submitted 7. (2) Settled without Audit 8.	Date Received: Contractor No. [ N ]Initial Report for [ N ]Final Report for t	1 this Provider CCN 1	0.NPR Date: 1.Contractor's Vendo 2.[0]Ifline 5, cc number of tim	olumn 1 is 4:	
PART II - CERT	I FI CATI ON					
MISREPRESENTAT	ION OR FAISIFICATION OF ANY INFO	ORMATION CONTAINED IN TH	S COST REPORT MAY B	E PUNISHABLE BY CRIM		

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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY (151315) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 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.



```
Officer or Administrator of Provider(s)
```

Title

Date

			Title	XVIII			
	Cost Center Description	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	656, 849	20, 015	0	-318, 202	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	132, 144	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		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	788, 993	20, 015	0	-318, 202	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

1105111	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		MEMORIAL C	1	r CCN:		Period: From 10/01.	/2014	Workshe Part I	et S-2	
							To 09/30.		Date/Ti 9/6/201	me Pre 6 3:17	pared: _pm
	1.00		00	3.	00			4.00			
1.00	Hospital and Hospital Health Care Co Street: 416 E MAUMEE STREET	PO Box:									1.00
2.00	City: ANGOLA	State: I	N Zi	p Code:	47803-	Count	y: STEUBEN				2.00
		Component Na		CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	
			Nu	mber I	Number	Туре	Certified		0, or		
		1.00			2.00	4.00	F 00	V	XVIII		
	Hospital and Hospital-Based Componer	1.00		. 00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	CAMERON MEMORIAL		1315	99915	1	02/01/2003	N	0	Р	3.00
		COMMUNI TY									
4.00	Subprovider - IPF										4.00
5.00 6.00	Subprovider - IRF Subprovider - (Other)										5.00 6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL	15	Z315	99915		02/01/2003	N	0	N	7.00
7.00		COMMUNI TY	15	2010	///15		02/01/2000				/.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00 12.00	Hospital-Based OLTC Hospital-Based HHA	CAMERON HOME HEAL	тн 15	7117	99915		04/01/1984	N	P	N	11.00
12.00		CARE		,,,,,,	///15				'		12.00
13.00	Separately Certified ASC										13.00
	Hospi tal -Based Hospi ce	CAMERON HOSPICE	15	1561	99915		05/01/1997	'			14.00
	Hospital-Based Health Clinic - RHC										15.00
16.00 17.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16.00
17.00	Renal Dialysis										18.00
	Other										19.00
		·					From		То		
00.00							1.00		2.0		00.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						10/01/2	2014	09/30/	2015	20.00
21.00	Inpatient PPS Information						2				21.00
22.00	Does this facility qualify and is it	currently receiv	ing paymen	ts for c	li spropo	ortionate	N		N		22.00
	share hospital adjustment, in accord	ance with 42 CFR	§412.106?	In colu	ımn 1, e	enter "Y"					
	for yes or "N" for no. Is this facil				106(c)(	(2) (Pi ckl e	9				
22.01	amendment hospital?) In column 2, en Did this hospital receive interim un				cost ro	porting	N		N		22.01
22.01	period? Enter in column 1, "Y" for y						i N				22.01
	reporting period occurring prior to										
	for no for the portion of the cost r	eporting period o	ccurring or	n or aft	er Octo	ber 1.					
22.02	(see instructions)	noguinoo final u	ncomponent	-	novmont	o to bo	N		Ν		22.02
22.02	Is this a newly merged hospital that determined at cost report settlement								IN		22.02
	or "N" for no, for the portion of th	e cost reporting	period priv	or to Oc	tober 1	. Enter	,				
	in column 2, "Y" for yes or "N" for						ו				
~~ ~~	or after October 1.										
22. 03	Did this hospital receive a geograph of the OMB standards for delineating						t N		N		22.03
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no			unted ir	accord	lance with	ר				
23 00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	dicaid days on li	nes 24 and	/or 25 h	elow? I	n column		2	Ν		23.00
20.00								-			20100
	1, enter 1 if date of admission, 2 i	1 0011343 44y3, 01		~~ ·	from th	e method					
	method of identifying the days in th	is cost reporting								ther	
		is cost reporting	<u>enter "Y</u>	" for ye	<u>s or "N</u>	l" for no.			0 h	LI GI	
	method of identifying the days in th	is cost reporting			es or "N te 0u		Out-of !	Medicai HMO day		li cai d	
	method of identifying the days in th	is cost reporting	<u>enter "Y</u> In-State	" for ye In-Sta	es or "N te Ou id S	<u>l" for no.</u> ut-of tate dicaid M	Out-of I State I Nedicaid		/s Mec		
	method of identifying the days in th	is cost reporting	enter "Y' In-State Medicaid	" for ye In-Sta Medica eligib unpai	e <u>s or "M</u> te Ou id S le Mea d pai	U for no. ut-of tate dicaid M d days e	Out-of I State I Medicaid Sigible		/s Mec	li cai d	
	method of identifying the days in th	is cost reporting	, enter "Y' In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	U for no. Ut-of Itate dicaid M d days e	Out-of I State I Medicaid eligible unpaid	HMO day	/s Mec	li cai d lays	
24.00	method of identifying the days in th used in the prior cost reporting per	is cost reporting iod? In column 2	In-State Medicaid paid days	" for ye In-Sta Medica eligib unpai	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00		/s Mec	li cai d lays	24.00
24.00	method of identifying the days in th used in the prior cost reporting per	is cost reporting iod? In column 2 , enter the	, enter "Y' In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	U for no. Ut-of Itate dicaid M d days e	Out-of I State I Medicaid eligible unpaid	HMO day	/s Mec	li cai d lays	24.00
24. 00	method of identifying the days in th used in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2,	In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00	HMO day	/s Mec	li cai d lays	24.00
24. 00	method of identifying the days in th used in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3,	In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00	HMO day	/s Mec	li cai d lays	24.00
24. 00	method of identifying the days in th used in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in co out-of-state Medicaid paid days in co out-of-state Medicaid paid days in co	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column	In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00	HMO day	/s Mec	li cai d lays	24.00
24.00	method of identifying the days in th used in the prior cost reporting per in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00	HMO day	/s Mec	li cai d lays	24.00
	method of identifying the days in th used in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in co out-of-state Medicaid paid days in co out-of-state Medicaid paid days in co	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	In-State Medicaid paid days	for ye In-Sta Medica eligib unpai days	es or "N te Ou id S le Meo d pai	l" for no. ut-of tate dicaid M d days e 3.00	Out-of State Medicaid eligible unpaid 4.00	HMO day	/s Mec	li cai d lays	24. 00
	method of identifying the days in the used in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	e, enter "Y" In-State Medicaid paid days 1.00 0	for ye In-Sta Medica eligib unpai days	es or "N te Ou i d S l e Mee d pai	I" for no. ut-of tate di cai d M d days e 3.00 0	Out-of     I       State     I       Medicaid     I       eligible     I       unpaid     I       4.00     I       0     I	HMO day	/s Mec c c	li cai d lays	
	method of identifying the days in the used in the prior cost reporting per lif this provider is an IPPS hospital in-state Medicaid paid days in colur Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2,	e, enter "Y" In-State Medicaid paid days 1.00 0	for ye In-Sta Medica eligib unpai days	es or "N te Ou i d S l e Mee d pai	I" for no. ut-of tate di cai d M d days e 3.00 0	Out-of     I       State     I       Medicaid     I       eligible     I       unpaid     I       4.00     I       0     I	HMO day	/s Mec c c	li cai d lays	
	method of identifying the days in the used in the prior cost reporting per lif this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	e, enter "Y" In-State Medicaid paid days 1.00 0	for ye In-Sta Medica eligib unpai days	es or "N te Ou i d S l e Mee d pai	I" for no. ut-of tate di cai d M d days e 3.00 0	Out-of     I       State     I       Medicaid     I       eligible     I       unpaid     I       4.00     I       0     I	HMO day	/s Mec c c	li cai d lays	
	method of identifying the days in the used in the prior cost reporting per lif this provider is an IPPS hospital in-state Medicaid paid days in colur Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in lf this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	e, enter "Y" In-State Medicaid paid days 1.00 0	for ye In-Sta Medica eligib unpai days	es or "N te Ou i d S l e Mee d pai	I" for no. ut-of tate di cai d M d days e 3.00 0	Out-of     I       State     I       Medicaid     I       eligible     I       unpaid     I       4.00     I       0     I	HMO day	/s Mec c c	li cai d lays	

	PITAL HEALTH CARE COMPLEX IDENTIFICA		<u>COMMUNITY</u> Provider (		eriod: com 10/01/2014		2 epared:
				I		Date of Geogr	
cost repor	standard geographic classification ting period. Enter "1" for urban or	"2" for rural.			1.00	2.00	26.00
reporting enter the	standard geographic classification period. Enter in column 1, "1" for u effective date of the geographic rec	rban or "2" for lassification i	rural. If ap n column 2.	plicable,	2	2	27.00
	a sole community hospital (SCH), en the cost reporting period.	ter the number	of periods SC	H status in	(		35.00
					Begi nni ng: 1. 00	Endi ng: 2.00	-
	icable beginning and ending dates of		ıbscript line	36 for number	1.00	2.00	36.00
37.00 If this is is in effe	in excess of one and enter subseque a Medicare dependent hospital (MDH) ct in the cost reporting period.	, enter the num			(	D	37.00
	spital a former MDH that is eligible with FY 2016 OPPS final rule? Enter ns)				Ν		37. 01
38.00 If line 37 greater th	is 1, enter the beginning and endin an 1, subscript this line for the nu equent dates.	9					38.00
					Y/N 1.00	Y/N 2.00	-
hospi tal s	facility qualify for the inpatient h in accordance with 42 CFR §412.101(b no. Does the facility meet the mile	)(2)(ii)? Enter	in column 1	"Y" for yes	N	N	39.00
40.00 Is this ho "N" for no	1(b)(2)(ii)? Enter in column 2 "Y" f spital subject to the HAC program re in column 1, for discharges prior t	duction adjustm o October 1. Er	nent? Enter "Y nter "Y" for y	" for yes or	Ν	N	40.00
	mn 2, for discharges on or after Oct	ober 1. (see in	istructions)		V 1.0	XVIII XIX 0 2.00 3.00	
5.00 Does this	e Payment System (PPS)-Capital facility qualify and receive Capital R Section §412.320? (see instruction		sproporti onat	e share in acc	ordance N	N N	45.00
6.00 Is this fa	cility eligible for additional payme o 42 CFR §412.348(f)? If yes, comple	nt exception fo				N N	46.00
17.00 Is this a	new hospital under 42 CFR §412.300 P ility electing full federal capital ospitals				0. N N	N N N N	47.00 48.00
	hospital involved in training reside	nts in approved	I GME programs	? Enter "Y" f	or yes N		56.00
57.00 If line 56 GME progra is "Y" did for yes or	is yes, is this the first cost repo ms trained at this facility? Enter residents start training in the fir "N" for no in column 2. If column ete Wkst. D, Parts III & IV and D-2,	"Y" for yes or st month of thi 2 is "Y", compl	"N" for no in s cost report ete Worksheet	column 1. If ing period? E	column 1 nter "Y"		57.00
58.00  fline 56	is yes, did this facility elect cos CMS Pub. 15-1, chapter 21, §2148? I	t reimbursement	: for physicia	ns' services a	s N		58.00
59.00 Are costs	claimed on line 100 of Worksheet A? aiming nursing school and/or allied	If yes, comple	ete Wkst. D-2,		N		59.00 60.00
provi der-o	perated criteria under §413.85? Ent	er "Y" for yes Y/N	or "N" for no IME	. (see instruc Direct GME	tions) IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	-
section 55	ospital receive FTE slots under ACA 03? Enter "Y" for yes or "N" for no (see instructions)	N			0.00		0 61.00
51.01 Enter the FTEs from ending and	average number of unweighted primary the hospital's 3 most recent cost re submitted before March 23, 2010. (s	ports	0.00	0.00			61.01
FTE count and primar	current year total unweighted primar (excluding OB/GYN, general surgery F y care FTEs added under section 5503	TEs,	0.00	0.00			61. 02
01.03 Enter the and/or gen determinin	instructions) base line FTE count for primary care eral surgery residents, which is use g compliance with the 75% test. (see	d for	0.00	0.00			61.03
surgery al	number of unweighted primary care/or lopathic and/or osteopathic FTEs in	the	0. 00	0.00			61.04
	st reporting period.(see instruction difference between the baseline prim eral surgery FTEs and the current ye	ary	0.00	0.00			61.05

OSPI	TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA				eriod: com 10/01/2014 o 09/30/2015	Worksheet S-2 Part I Date/Time Prep 9/6/2016 3:17	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61. C
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
. 20	5	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.2
	¥			1			1.00	
. 00	ACA Provisions Affecting the Hea Enter the number of FTE resident				. ,	od for which	0.00	62
. 00	your hospital received HRSA PCRE Enter the number of FTE resident	funding (see instructs that rotated from a	ti ons) Teachi	ng Health Cent	er (THC) into			62.
. 00	during in this cost reporting per Teaching Hospitals that Claim Re Has your facility trained reside	sidents in Nonprovide	er Setti	ngs		eriod? Enter	N	63.
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	te line	<u>s 64-67. (see</u>	instructions) Unweighted	Unweighted	Ratio (col. 1/	
					FTEs Nonprovi der Si te		(col. 1 + col. 2))	
					1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J				his base year	is your cost r	eporting	
. 00	· · · · · · · · · · · · · · · · · · ·	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	y trair -primar all nor non-pr columr	ed residents y care provider imary care 3 the ratio	0. 00	0. 00	0. 000000	64.0
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te		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	45
	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				0.00	0.00		

Heal th	Financial Systems	CAMERON	MEMORIAL CC	MMUNI TY		l i	n Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ТА	Provi der	1	Period: From 10/01/ To 09/30/		Workshe Part I Date/Ti 9/6/201	me Prep	
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi ta	n al	Ratio (c (col. 1 2))	ol. 1/ + col. )	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovide	er Setting	1.00 sEffective 1	2.00 For cost re		<u>3.0</u> ng perio		
	beginning on or after July 1, 20	10	•				·			
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	i ngs. dent	0.0		0.00	0.	000000	66.00
		Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n	Ratio (c (col. 3 4))	+ col .	
(7.00		1.00	2.0	00	3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0	0.00	0.	000000	67.00
					·					
	Inpatient Psychiatric Facility F	PS					1.00	2.00	3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or doe	s it cont	ain an IPF sub	provi der?	N			70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Institut and population Encilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	DO4? Enter lity train (D)? Enter	"Y" for y residents "Y" for y	es or "N" for in a new teac es or "N" for	no. (see chi ng no.			0	71.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF), or	does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	oproved GME ember 15, 20 new teachin for no. Col	teaching   04? Enter g program umn 3: If	program in the "Y" for yes c in accordance column 2 is Y	or "N" for e with 42 7,			0	76.00
								1.0	0	
	Long Term Care Hospital PPS								5	
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? En	nter	N N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excluded un				no.	N		85. 00 86. 00
87.00	Is this hospital a "subclause (I	I)" LTCH classified u	under sectio	n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N		87.00
	for yes or "N" for no.					V		XIX	<	
	Title V and VIX Services					1.00		2.0		
90.00	Title V and XIX Services Does this facility have title V		hospital se	rvi ces? E	nter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th				N		N		91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicab	le column				N		92.00
	instructions) Enter "Y" for yes	or"N" for no in the	appl i cabl e	column.						
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of t	itle V and	a XIX? Enter	N		N		93.00
94.00	Does title V or XIX reduce capit applicable column.		or yes, and	"N" for n	o in the	N		N		94.00

Health Financial Systems CAMERON MEMORIA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		F	Period: From 10/01/2 To 09/30/2	2014	<u>of For</u> Workshe Part I Date/Ti	et S-2 me Pre	2 epared:
			V		9/6/201 XI X		/ pm
			1.00		2.0		1
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N		0.0 N	0	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of payment	Y N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see insti	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	1	Respira 4.0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		4.0 Y		109.00
10.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for		1.0 N	0	110.00
			_	1.00	2.00	3.00	-
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 i it for long te	is "E", enter rm care (inclu	in column des	N		0	115. 00
Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insur no.			"N" for	N Y			116. 00 117. 00
18.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	if the policy	is	1			118.00
		Premiums	Losses	;	Insura	ance	
		1.00	2.00		3.0		_
18.01 List amounts of malpractice premiums and paid losses:		195, 27		0			0 118. 0 <sup>-</sup>
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1.00 N		2.0	0	118.0
19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for th	" for yes or he Outpatient	N		Ν		119.00
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y				121. 0
22.00 Does the cost report contain state health or similar taxes?	Enter "Y" for	yes or "N"	N				122. 00
for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.	e Worksheet A	TThe number					
for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo			N				125. 0
for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N" ter the certin	for no. If	N				
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> </ul>	or yes and "N" ter the certin  er the certifi	for no. If fication date ication date	N				126. 0 127. 0
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> </ul>	r yes and "N" ter the certif er the certifi  er the certifi 	for no. If fication date ication date ication date					126.00 127.00 128.00
<ul> <li>for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2</li> </ul>	r yes and "N" ter the certif er the certifi er the certifi er the certifi er the certifi enter the cer	for no. If fication date ication date ication date cation date in					126.00 127.00 128.00 129.00
for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	r yes and "N" ter the certifi er the certifi er the certifi tr the certifi enter the certifi umn 2. , enter the cer umn 2.	for no. If fication date ication date ication date cation date in tification ertification					125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	CAMERON MEMORI / X IDENTIFICATION DATA			In Lie Period: From 10/01/2014 To 09/30/2015	Date/Time Pre	pared:
					9/6/2016 3:17	pm
				1.00	2.00	
133.00 If this is a Medicare certified of			cation date			133.00
in column 1 and termination date, 134.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter th		n column 1			134.00
Al I Provi ders					1	1
140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If	yes, and home	office costs	Y		140.00
	2.0			3.00	1	
If this facility is part of a chai	n organization, enter on l	ines 141 throu			of the	
home office and enter the home offi 141.00Name:	Contractor name and co	ontractor numbe		or's Number:		141.00
142.00 Street:	PO Box:			J 3 Number .		142.00
143. 00 Ci ty:	State:		Zip Code:			143.00
					1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet A	12			1.00 Y	144.00
				1.00	2.00	
<ul> <li>145.00 If costs for renal services are cl inpatient services only? Enter "V" no, does the dialysis facility in period? Enter "V" for yes or "N"</li> <li>146.00 Has the cost allocation methodoloc</li> </ul>	for yes or "N" for no in lude Medicare utilization for no in column 2.	column 1. If c for this cost	column 1 is reporting	N		145.00
Enter 'Y" for yes or "N" for no ir yes, enter the approval date (mm/c	column 1. (See CMS Pub. 1				1.00	
147.00 Was there a change in the statisti	cal basis? Enter "V" for y	les or "N" for	<u>no</u>		1.00 N	147.00
148.00 Was there a change in the order of					N	148.00
149.00 Was there a change to the simplifi				no.	N	149.00
		Part A	Part B	Title V	Title XIX	-
Does this facility contain a provi	der that qualifies for an	1.00 exemption from	2.00	3.00	4.00	
or charges? Enter "Y" for yes or '						
155.00Hospi tal		N	N	N	N	155.00
156.00 Subprovider - IPF 157.00 Subprovider - IRF		N N	N N	N N	N N	156.00 157.00
158. 00 SUBPROVI DER		IN	IN IN	IN	IN IN	158.00
159. 00 SNF		N	N	N	N	159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	1
Multicampus						
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has one	e or more campu	ises in differ	ent CBSAs?	N	165.00
	Name	County		Code CBSA	FTE/Campus	
	0	1.00	2.00 3	3.00 4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0. 00	166. 00
					1.00	-
Health Information Technology (HI	) incentive in the America	an Recovery and	d Reinvestmen	t Act	1.00	
167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter "Y 5 is "Y") and is a meaning	(" for yes or " gful user (line	N" for no.		Y (	167.00 168.00
168.01 If this provider is a CAH and is r			qualify for	a hardship		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful of transition factor. (see instruction	'Enter "Y" for yes or "N" user (line 167 is "Y") and	for no. (see i	nstructions)		0.00	169. 00

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNI TY	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151315 Period: Wo From 10/01/2014 Pa					
	From 10/01/2014 To 09/30/2015		narod.			
			10 09/30/2013	9/6/2016 3: 17		
			Begi nni ng	Endi ng		
			1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginni period respectively (mm/dd/yyyy)	ng date and ending date	for the reporting	10/01/2014	09/30/2015	170.00	
				1.00		
171.00 If line 167 is "Y", does this provider h Medicare cost plans reported on Wkst. S-				N	171.00	
(see instructions)						

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet S- Part II Date/Time Pr 9/6/2016 3:1	epared:
				Y/N 1.00	 2.00	-
	General Instruction: Enter Y for all YES responses. Enter N f	or all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the b reporting period? If yes, enter the date of the change in col			N		1.0
	Treporting period: IT yes, enter the date of the change in cor	unii 2. (3ee	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Proyes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home off or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ices, drug or its the board	Y			3. 0
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00 . 00	Column 1: Were the financial statements prepared by a Certif Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differe	Compiled, able in	Y	A		4.0
	those on the filed financial statements? If yes, submit recon					_
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: I the legal operator of the program?	5	ne provider i			6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing school and/or allied health programs approved an cost reporting period? If yes, see instructions.		l during the	N N		7.0
. 00	Are costs claimed for Interns and Residents in an approved gr		al education	Ν		9.0
0. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	Ν		10. 0
1.00	Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an App	proved	N		11. C
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pol period? If yes, submit copy.			ost reporting	Y N	12. C 13. C
4.00	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement		<b>4</b>		N	14.0
5.00	Did total beds available change from the prior cost reporting	Par	rt A	Par		15.0
		Y/N 1.00	Date	Y/N 2,00	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	12/30/2015	Y	12/30/2015	16. C
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	Ν		Ν		17.0
8. 00	in columns 2 and 4. (see instructions) 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	Ν		N		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		N		19. (

	Financial Systems CAMERON MEMOR AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 151315	Period: From 10/01/2014 To 09/30/2015		5-2 Prepared:		
		Descr	i pti on	Y/N	Y/N	., pii		
			0	1.00	3.00			
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		-	N	N	20.00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3.00	4.00			
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)					
	Capital Related Cost							
2.00 3.00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N N	22. 0 23. 0		
4. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost re	porting period?	Y	24. 0		
5. 00	If yes, see instructions Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see	Y	25.00		
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? I	f yes, see	N	26.00		
7.00	Has the provider's capitalization policy changed during th copy.	e cost reportin	ng period? If	yes, submit	N	27.00		
8. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into du	ing the cost	reporting	Y	28.00		
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	•	ebt Service R	eserve Fund)	Y	29.00		
0. 00	Has existing debt been replaced prior to its scheduled mat instructions.	, see	N	30.00				
1. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	, see	Ν	31.00		
2. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ntractual	Y	32.00		
3. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	Y	33.00		
	Provi der-Based Physi ci ans							
4.00	Are services furnished at the provider facility under an a	irrangement with	n provider-ba	sed physi ci ans?	Y	34.0		
5.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	Y	35.0		
	physicians during the cost reporting period? If yes, see i	nstructions.						
				Y/N	Date			
				1.00	2.00	-		
4 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.0		
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?			37.0		
8. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en					38.0		
9. 00	If line 36 is yes, did the provider render services to oth see instructions.	er chain compor	nents? If yes	1		39. 0		
0.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see			40.0		
	1.00 2.							
1. 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,	KYLE		SMI TH		41.00		
2.00	respectively. Enter the employer/company name of the cost report	BLUE & CO				42.00		
3.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00		

Heal th	Financial Systems CAMERON	MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	I RE	Provi der	CCN: 151315	Peri od:	Worksheet S-2	
					From 10/01/2014 To 09/30/2015		pared: _pm
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/positi	on I	MANAGER				41.00
	held by the cost report preparer in columns 1, 2, ar	nd 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.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	CAMERON MEMORI			CCN: 151315	De	ri od:	u of Form CMS Worksheet S-		52-10
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	P	rovider	CCN: 151315		om 10/01/2014	Part I	3	
						To		Date/Time Pr	epa	ared:
								9/6/2016 3:1		om
								I/P Days / O/		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	<u>Visits / Trip</u> Title V	5	
	component	Line Number	NO. C	n beus	Avai I abl e		CAILIDULS	nue v		
		1.00	2	. 00	3.00		4.00	5.00	+	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		23		95	78, 936.00		ol	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, 3	95	78, 936. 00		0	7.00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT	31.00		2	7.	30	4, 320.00		0	8.00
9.00	CORONARY CARE UNI T									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00								12.00
13.00	NURSERY	43.00		0.5	0.4	0.5	00.05/.00			13.00
14.00	Total (see instructions)			25	9, 1	25	83, 256. 00			14.00
15.00	CAH visits									15.00
16.00	SUBPROVIDER - IPF									16.00 17.00
17.00 18.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVIDER SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
20.00	OTHER LONG TERM CARE									20.00
21.00	HOME HEALTH AGENCY	101.00								22.00
22.00	AMBULATORY SURGICAL CENTER (D. P. )	101.00							- 1 -	22.00
24.00	HOSPI CE	116.00		0		0				24.00
24.10	HOSPICE (non-distinct part)	30.00	1	0		Ŭ				24.10
25.00	CMHC - CMHC	00100								25.00
26.00	RURAL HEALTH CLINIC	88.00								26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00								26.25
27.00	Total (sum of lines 14-26)			25						27.00
28.00	Observation Bed Days									28.00
29.00	Ambulance Trips									29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)			0		0				32.00
32.01	Total ancillary labor & delivery room			-						32.01
	outpatient days (see instructions)									
33 00	LTCH non-covered days									33.00

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	CAMERON MEMORIA AL DATA		F	Period: From 10/01/2014 Fo 09/30/2015		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	1, 171	108				1.00
2.00	HMO and other (see instructions)	634	467				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	303	0	303	3		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	380	D		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 474	108				7.00
8.00	INTENSIVE CARE UNIT	69	26	180	D		8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		34	434	1		13.00
14.00	Total (see instructions)	1, 543	168	4, 586	5 0.00	321.13	14.00
15.00	CAH visits	0	0	(	D		15.00
16.00	SUBPROVI DER – I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2, 030	1, 857	7, 393	3 0.00	9.09	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0	0	0	0.00	2.45	24.00
24.10	HOSPICE (non-distinct part)	0	0	(	D		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	(	0.00	0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	332.67	27.00
28.00	Observation Bed Days		103	735	5		28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0	D		30.00
31.00	Employee discount days - IRF			0	D		31.00
32.00	Labor & delivery days (see instructions)	О	0	(	D		32.00
32.01	Total ancillary labor & delivery room	-	-	(	D		32.01
	outpatient days (see instructions)						
22 00	LTCH non-covered days	0		1	1	1	33.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part I Date/Time Pre 9/6/2016 3:17	pared
		Full Time Equivalents		Dis	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4	51 55	1, 306	1.
00	HMO and other (see instructions)			2	26 197		2.
00	HMO I PF Subprovider				0		3.
00	HMO IRF Subprovider				0		4.
00	Hospital Adults & Peds. Swing Bed SNF						5
00	Hospital Adults & Peds. Swing Bed NF						6
00	Total Adults and Peds. (exclude observation						7
00	beds) (see instructions)						
00 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						8
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	0. 00	0	4	51 55	1, 306	14
. 00	CAH visits						15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00					21
. 00 . 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23
. 00	HOSPI CE	0.00					24
I. 10	HOSPICE (non-distinct part)	01.00					24
5.00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	0. 00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
3. 00	Observation Bed Days						28
9.00	Ambul ance Trips						29
0.00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00 2.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32 32
3.00	outpatient days (see instructions) LTCH non-covered days						33

HOLE HLAL IF AGENCY STATISTICAL DATA         Provider COX 19131         Percent Component COX 197131         Description (Component COX 197131         Description (Cox 2072012)         Description (Cox 2072012) <th>Heal th</th> <th>Financial Systems</th> <th>CAMERON MEMORI</th> <th>AL COMMUNITY</th> <th></th> <th>In Lie</th> <th>eu of Form CMS-</th> <th>2552-10</th>	Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-	2552-10
Home Head In         PPS           0.0         County         1.00         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.00	HOME F	IEALTH AGENCY STATI STI CAL DATA				From 10/01/2014	Date/Time Pre	pared:
0.00         County         Title V         Title V         Title V         Title VX         Other         Total         0.00           1.00         2.00         3.00         0.00         2.00         1.00         2.00         0.00         0.00         0.00         0.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         3.00         1.00         2.00         3.00         1.00         2.00         3.00         1.00         2.00         3.00         1.00         2.00         3.00         1.00         1.00         0.00         1.00         2.00         3.00         1.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>Home Health</td> <td></td> <td>pm</td>						Home Health		pm
IDENT PROFILE         County         STUEEN         0.00           0.00         County         11 file v         11 file v         11 file v         0 other         0 other         1 fatal           0.00         Development         1.00         2.00         3.00         4.00         5.00           2.00         Under infant         All in Statistical DATA         0.00         0						Agency I		
HILE V         TITLE V         TITLE V         TITLE XX         Other         Total           100         LOB         2.00         3.00         4.00         5.00         1.00           2.00         Unspected Census Count (see instructions)         0.00         1.00         0.00		1					00	-
NOME         HEALTH AGENCY STATISTICAL DATA         1.00         2.00         3.00         4.00         5.00           1.00         Index institution         0	0.00	County					Tatal	0.00
1.00         Iheme Heal th Alide Hours         0								
2.00         Undupi Lated Census Count (see Instructions)         0.00         101.00         0								
Image: Internet the number of Employees (Full Time Equivalent)         Image: Internet the number of Employees (Full Time Equivalent)           3.00         Addition is trater und Assistant (Addition Strater(s))         0         1.00         2.00         3.00           4.00         Director(s) and Assistant (Interctor(s))         0         0.00         0.00         0.00         3.00           5.00         Director(s) and Assistant (Interctor(s))         40.00         0.00         0.00         3.00         0.00         3.00           6.00         Director(s) and Assistant Director(s)         40.00         0.00         0.00         3.00         0.00         3.00         0.00         3.00         0.00         3.00         0.00         3.00         0.00         0.00         0.00         0.00         3.00         0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
Jour normal work week								
Jour normal work week								
Jour normal work week							r	
OWDER HALTN AGENCY - MUNRER OF FUPLOYFES         0         1.00         2.00         3.00           Admin Instrator and Assistant Director(s) 0.00         Admin Instrator and Assistant Director(s) 0.00         40.00         0.00         0.00         1.00         2.00         3.00           Admin Instrator and Assistant Director(s) 0.00         Director(s) 3.00         3.00         0.00         0.00         0.00         1.00         2.00         3.02           0.00         Director(s) 3.01         Admin Instrative Personnel         3.02         0.00         0.00         0.00         0.00         0.00         3.72         0.00         3.72         0.00					Staff	Contract	Total	
Home HALTH ACTINY - NUMERO F EMPLOYES			your norman	WOLK WEEK				
Home HALTH ACTINY - NUMERO F EMPLOYES								
3.00         Admin istrator and Assistant Administrator(s)         40.00         0.00         0.00         0.00         0.00         0.00         40.00           40.0         Director(s) and Assistant Director(s)         3.03         0.00         3.03         0.00         4.00           5.00         Other Administrative Personnel         3.03         0.00         3.03         0.00         3.03         6.00           0.01         Prestical Therapy Service         2.11         0.00			C	)	1.00	2.00	3.00	
4.00         Director(s) and Assistant Director(s)         1.00         0.00         1.00         0.00         1.00         4.00           5.00         Other Administrative Personnel         3.03         0.00         3.72         0.00         3.72         0.00         3.72         0.00         3.72         0.00         3.72         0.00         3.72         0.00         3.72         0.00         3.72         0.00	2 00			40.00			0.00	1 2 00
5.00 0.00 0.00 7.00 Nursing Supervisor         3.03 5.00 0.00 0.00 0.00 0.00 0.00 0.00				40. UL				
7.00         Nursing SuperVisor         0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
8.00         Physical Therapy Service         2.11         0.00         2.11         8.00           9.00         Physical Therapy Supervisor         0.39         0.00         0.00         0.00           10.00         Occupational Therapy Supervisor         0.39         0.00         0.00         0.00           10.00         Speech Pathology Service         0.04         0.00         0.00         1.00           12.00         Speech Pathology Service         0.04         0.00         0.00         1.00           13.00         Speech Pathology Service         0.012         0.00         0.00         1.10           14.00         Medical Social Service Supervisor         0.00         0.00         0.00         1.71         0.00         1.71           10.00         Other (specify)         0.00         0.00         0.00         0.00         1.70           10.00         Enter in column 1 the number of CBAs where reporting period.         99915         20.01         10.00         20.00         1.00         20.00         3.00         4.00         5.00         1.00         20.01         10.00         20.01         20.01         10.00         2.00         3.00         4.00         20.01         20.01         20.01								
10.00         Occupational Thérapy Service         0.39         0.00         0.39         10.00           10.00         Occupational Thérapy Syervisor         0.04         0.00         0.00         11.00           12.00         Speech Pathology Service         0.04         0.00         0.00         0.00         11.00           13.00         Speech Pathology Service         0.04         0.00         0.00         12.00         0.00         17.00         0.00         0.00         0.00         0.00         0.00         17.00         0.00         0.00         0.00         17.00         0.00         17.00         0.00         17.00         0.00         17.00         0.00         17.00         0.00         17.00         0.00         17.00         17.00         17.00         17.00         17.00         17.00         0.00         17.00         17.00         17.00         17.00         17.00         1		Physical Therapy Service			1			8.00
11.00       Occupational Therapy Supervisor       0.00       0.00       0.00       11.00         12.00       Speech Pathol ogy Supervisor       0.00       0.00       0.00       0.00       12.00         13.00       Speech Pathol ogy Supervisor       0.00       0.00       0.00       0.00       12.00         13.00       Speech Pathol ogy Supervisor       0.00       0.00       0.00       0.00       11.10         14.00       Medical Social Service Supervisor       0.00       0.00       0.00       17.11       0.00       17.11       0.00       17.11       0.00       17.11       0.00       17.10       0.00       17.10       0.00       17.10       0.00       17.10       0.00       17.10       0.00       17.10       0.00       17.00       18.00       18.00       18.00       18.00       19.00       19.00       19.00       19.00       19.00       19.00       19.00       19.00       19.00       10.00       11.00       10.00		5 15 1			1			1
13.00       Speech Pathology Supervisor       0.00       0.00       0.00       0.00       13.00         14.00       Medical Social Service Supervisor       0.00       0.00       0.00       13.00         16.00       Home Healt h Aide       0.00       0.00       0.00       0.00       17.00         16.00       Home Healt h Aide       0.00       0.00       0.00       0.00       17.01         18.00       Other (Specify)       0.00       0.00       0.00       0.00       0.00       17.00         18.00       Other (Specify)       0.00       0.00       0.00       0.00       0.00       18.00         19.00       Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       99915       20.00       18.00         20.01       Enter in column 1 serviced during this cost reporting period (line 20 contains the first code).       50031       20.00       20.00         20.01       Enter in column 1 serviced during this cost reporting period.       1.00       2.00       3.00       4.00       5.00         20.01       Skilled Nursing Visits       27       0       75       6       908       21.00         21.00       Skilled Nursing Visits       22.00       3.00					1			
14.00       Medical Social Service Supervisor       0.12       0.00       0.12       14.00         15.00       Medical Social Service Supervisor       0.00       0.00       0.00       0.00       0.00       17.10         16.00       Medical Social Service Supervisor       1.71       0.00       0.00       0.00       0.00       0.00       17.00         18.00       Other (specify)       0.00       0.00       0.00       0.00       0.00       18.00         19.00       Enter In column 1 the number of CBSAs where you provided services during the cost reporting period.       99915       20.00       19.00         20.00       List those CBSA code(s) in column 1 serviced during this cost reporting period.       99915       50031       20.01         Fer Activitry DATA         10.00       Skilled Nursing Visits       277       0       75       6       806       21.00         2.00       Skilled Nursing Visit Charges       135,690       0       14.00       82.20       22.00         20.00       Skilled Nursing Visit Charges       164,332       0       2,653       169,159       24.00         20.00       Systical Therapy Visit S       89       0       1       0       92.40					1			
15:00         Medical Social Service Supervisor         0.00         0.00         0.00         0.00         0.00         17:00           16:00         Home Health Aide         Supervisor         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         17:00         17:00         0.00         0.00         0.00         17:00         18:00         18:00         10:01         10:01         10:01         10:01         10:01         20:01         10:01         20:01         10:01         20:01         10:01         20:01         10:01								1
17.00       Home Heal th Ai de Supervisor       0.00       0.00       0.00       0.00       17.00         18.00       Obter (specify)       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       18.00         19.00       Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       99915       20.00       19.00       20.00								
Base of other (specify)         Output								
HOVE HEALTH AGENCY CBSA CODES           19.00         Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.         2         2         19.00           20.01         Exter in column 1 the number of CBSAs where you provided services during the cost reporting period.         99915         20.00           20.01         Exter in column 1 serviced during this cost reporting period (line 20 contains the first code).         50031         20.01           20.01         Full Episodes         Episodes         PEP Only Episodes         Total (cols. 1-4)           21.00         Skilled Nursing Visit Charges         135,690         0         3.00         4.00         5.00           21.00         Skilled Nursing Visit Charges         135,690         0         13.608         1.166         150,464         22.00           23.00         Physical Therapy Visit S         800         0         14         10         824.00           25.00         Cocupational Therapy Visit S         164,232         0         2,874         2,053         169,159         24.00           26.00         Cocupational Therapy Visit S         89         0         1         0         9025         25.00           28.00         Speech Pathology Visit Charges         16,64220         3<		· · ·						
you provided services during the cost perfing period.         you provided services during the cost List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).         20.00         50031         20.01           20.01         EVITE PISOdes         50031         20.01 <td></td> <td>HOME HEALTH AGENCY CBSA CODES</td> <td>1</td> <td></td> <td>1</td> <td></td> <td></td> <td></td>		HOME HEALTH AGENCY CBSA CODES	1		1			
Peporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).         Period         20.00           20.01         Full Epi sodes         99915         20.01           Full Epi sodes         Full Epi sodes         PEP Only Episodes         Total (cols. 1-4)           20.00         Without With Outliers         UPA Episodes         1-4)           20.01         Without With Outliers         UPA Episodes         1-4)           20.02         Skilled Nursing Visits         727         0         75         6         808         1.00           20.03         Physical Therapy Visits         800         0         14         10         824         23.00           21.00         Physical Therapy Visits         800         14         10         824         23.00           22.00         Skilled Nursing Visit Charges         156,690         0         13.608         1,166         150,464         22.00           23.00         Physical Therapy Visits         890         1         0         92.50         25.00           24.00         Speech Pathology Visit Charges         17,674         0         199         0         17,873         26.00         25.00         25.00         25.00 </td <td>19.00</td> <td></td> <td></td> <td></td> <td></td> <td>2</td> <td></td> <td>19.00</td>	19.00					2		19.00
20. 01         Full Episodes Mithout Outliers         Soo31         Zoo         Total (cols.           20. 01         Full Episodes Mithout Outliers         With Outliers UluPA Episodes         PEP Only Episodes         Total (cols.         20. 01           PPS ACTIVITY DATA           21.00         Skilled Nursing Visits         727         0         75         6         808         21. 00           20.00         136,608         1,166         150,464         22. 00           20.00         3.00         4.00         5.00           20.01           PPS ACTIVITY DATA           21.00         Skilled Nursing Visits         727         0         75         6         808         21. 00           24.00         Physical Therapy Visits         800         0         14         10         824 23. 00           24.00         2.874         2.053         169,159         24. 00           0         0         17,674         0         199         0         17,873         26. 00           24.00         3         0         25         0         0         15         0         0         15		reporting period.						
contains the first code).         20.01         50031         20.01           Full Episodes         PEP Only Episodes         20.01           Full Episodes         PEP Only Episodes         Total (cols.           0         3.00         3.00         4.00         5.0031         20.01           PEP Colspan="2">Total (cols.           0         Total (cols.         20.01           PEP Only Episodes         Total (cols.           PEP Only Episodes         Total (cols.           0         3.00         4.00         Saturity PATA           Colspan="2">Total Cols         Total (cols.           2.00         Skilled Nursing Visits         Total (cols.           Colspan="2">Total Nursing Visits         Total (cols           Colspan="2">Total Nursing Visit Charges         2.00           Saturity PATA           Colspan="2">Total Nursing Visit Charges         135.690         0           Colspan= To	20.00				99915			20.00
Full Episodes         Full Episodes         PEP Only         Total (cols.           0utliers         0utliers         0utliers         0utliers         0utliers         0utliers           1.00         2.00         3.00         4.00         5.00           21.00         Skilled Nursing Visits         727         0         75         6         808         21.00           22.00         Skilled Nursing Visits         727         0         75         6         808         21.00           23.00         Physical Therapy Visits         800         0         14         10         824         23.00           24.00         Physical Therapy Visit Charges         164,232         0         2,874         2,053         169,159         24.00           25.00         Occupational Therapy Visit S         89         0         1         0         90         25.00           26.00         Speech Pathology Visit Charges         17,674         199         0         17,873         26.00           29.00         Speech Pathology Visit Charges         3,699         0         0         3,268         0.00         3,268         0.00         3,269         0         3,269         0.00         3,269								
Without Outliers         With Outliers LUPA Episodes         PEP only Episodes         Total (cols. 1-4)           PPS ACTIVITY DATA         1.00         2.00         3.00         4.00         5.00           21.00         Skilled Nursing Visits         727         0         75         6         808         21.00           22.00         Skilled Nursing Visit Charges         135.690         0         13.608         1,166         150.464         22.00           24.00         Physical Therapy Visits         800         0         14         10         824         23.00           25.00         Occupational Therapy Visit Charges         164,232         0         2,874         2,053         169,159         24.00           26.00         Speech Pathology Visit Charges         17,674         0         199         0         17,873         26.00           27.00         Speech Pathology Visit Charges         3,699         0         0         25.00         0         28.00         3,699         0         15         29.00         3.00         25.00         27.00         28.00         3,699         0         0         0         3.00         25.00         0.00         3.00         3.00         3.00         3.00	20.01		Eull En	vi sodos	50031			20.01
Dutliers         Episodes         1-4)           1.00         2.00         3.00         4.00         5.00           21.00         Skilled Nursing Visits         727         0         75         6         808         21.00           22.00         Skilled Nursing Visit         Charges         135,690         0         13,608         1,166         150,464         22.00           23.00         Physical Therapy Visit         Storeapy Visit         800         0         14         10         824.23.00           24.00         Physical Therapy Visit Charges         164,232         0         2,874         2,053         169,159         24.00           25.00         Occupational Therapy Visit Charges         17,674         0         199         0         17,873         26.00           27.00         Speech Pathol ogy Visit Charges         4,369         596         0         4,965         28.00         29.00         3         0         25.27.00         29.00         3         26.80         29.00         3         699         0         15.29.00         3.00         15.29.00         3.00         26.80         3.699         0         0         3.699         0         0         3.699 <td< td=""><td></td><td></td><td></td><td></td><td>LUPA Epi sode</td><td>es PEP Only</td><td>Total (cols.</td><td></td></td<>					LUPA Epi sode	es PEP Only	Total (cols.	
PPS ACTI VI TY DATA         727         0         75         6         808         21.00           21.00         Skilled Nursing Visits         727         0         75         6         808         21.00           22.00         Skilled Nursing Visit Charges         135,690         0         13,608         1,166         150,464         22.00           23.00         Physical Therapy Visit Charges         800         0         14         10         824         23.00           24.00         Physical Therapy Visit Charges         164,232         0         2,874         2,053         169,159         24.00           25.00         Occupational Therapy Visit Charges         17,674         0         199         0         17,873         26.00           27.00         Speech Pathology Visit Charges         4,369         0         596         0         4,965         28.00           29.00         Medical Social Service Visits         15         0         0         0         1529,00           30.00         Medical Social Service Visits         265         0         0         3,699         30.00           30.00         Home Heal th Aide Visit Charges         13,928         0         0         158			Outliers			Epi sodes		
21.00       Skilled Nursing Visits       727       0       75       6       808       21.00         22.00       Skilled Nursing Visit Charges       135,690       0       13,608       1,166       150,464       22.00         23.00       Physical Therapy Visit Charges       164,232       0       2,874       2,053       169,159       24.00         24.00       Physical Therapy Visit Charges       164,232       0       2,874       2,053       169,159       24.00         25.00       Occupational Therapy Visit Charges       17,674       0       199       0       17,873       26.00         27.00       Speech Pathology Visit Charges       17,674       0       199       0       25.00       27.00         28.00       Speech Pathology Visit Charges       4,369       0       596       0       4,955       28.00         29.00       Medical Social Service Visits       15       0       0       0       3.00       29.80         30.00       Medical Social Service Visits       265       0       0       3.268       31.00         31.00       Home Heal th Aide Visits Charges       13,928       0       0       158       14,086       32.00		PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	-
23.00       Physical Therapy Visits       800       0       14       10       824       23.00         24.00       Physical Therapy Visit Charges       164,232       0       2,874       2,053       169,159       24.00         25.00       Occupational Therapy Visit Charges       89       0       1       0       90       25.00         26.00       Occupational Therapy Visit Charges       89       0       1       0       90       25.00         27.00       Speech Pathology Visit Charges       17,674       0       199       0       17,873       26.00         28.00       Speech Pathology Visit Charges       4,369       0       596       0       4,965       28.00         29.00       Medical Social Service Visits       15       0       0       0       15       29.00         30.00       Medical Social Service Visit Charges       3,699       0       0       3.268       31.00         31.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         32.00       Total visits (sum of Lines 21, 23, 25, 27, 29, 27, 29, and 31)       1,918       9       0       0       0       0       0       3		Skilled Nursing Visits						
24.00       Physical Therapy Visit Charges       164,232       0       2,874       2,053       169,159       24.00         25.00       Occupational Therapy Visits       89       0       1       0       90       25.00         26.00       Occupational Therapy Visit Charges       17,674       0       199       0       17,873       26.00         27.00       Speech Pathology Visit Charges       17,674       0       199       0       17,873       26.00         28.00       Speech Pathology Visit Charges       4,369       0       596       0       4,965       28.00         29.00       Medical Social Service Visits       15       0       0       0       15       29.00         30.00       Medical Social Service Visit Charges       3,699       0       0       3       268       31.00         31.00       Home Heal th Aide Visits       265       0       0       3       268       32.00         32.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total Visits (sum of Lines 21, 23, 25, 27, 1,918       0       0       0       0       0       34.00       34.00								
26.00       Occupational Therapy Visit Charges       17,674       0       199       0       17,873       26.00         27.00       Speech Pathology Visits       22       0       3       0       25       27.00         28.00       Speech Pathology Visit Charges       4,369       0       596       0       4,965       28.00         29.00       Medical Social Service Visits       15       0       0       0       15       29.00         30.00       Medical Social Service Visit S       15       0       0       0       3.699       30.00         31.00       Home Heal th Aide Visit S       265       0       0       3.268       31.00         32.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total visits (sum of lines 21, 23, 25, 27, 1,918       0       93       19       2,030       33.00         29, and 31)       0       Other Charges       0       0       0       0       34.00       34.00         35.00       Total Charges (sum of lines 22, 24, 26, 28, 339, 592       0       17,277       3,377       360,246       35.00         30, 32, and 34)       0 </td <td>24.00</td> <td>Physical Therapy Visit Charges</td> <td>164, 232</td> <td>C</td> <td></td> <td></td> <td>169, 159</td> <td>24.00</td>	24.00	Physical Therapy Visit Charges	164, 232	C			169, 159	24.00
27.00       Speech Pathology Visits       22       0       3       0       25       27.00         28.00       Speech Pathology Visit Charges       4,369       0       596       0       4,965       28.00         29.00       Medical Social Service Visits       15       0       0       0       15       29.00         30.00       Medical Social Service Visits       15       0       0       0       3,699       30.00         31.00       Home Heal th Aide Visits       265       0       0       32.00       158       14,086       32.00         32.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total visits (sum of lines 21, 23, 25, 27, 1,918       0       93       19       2,030       33.00         29, and 31)       0       0       0       0       0       34.00       32, 20       37.00       33.77       360, 246       35.00         30, 32, and 34)       0       0       0       0       0       0       0       36.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146       36.00 <td></td> <td>1 13</td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td>		1 13			1			
29.00       Medical Social Service Visits       15       0       0       0       15       29.00         30.00       Medical Social Service Visit Charges       3,699       0       0       0       3,699       30.00         31.00       Home Heal th Aide Visits       265       0       0       3       268       31.00         32.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total visits (sum of Lines 21, 23, 25, 27, 1,918       0       93       19       2,030       33.00         29, and 31)       34.00       Other Charges       0       0       0       0       34.00         35.00       Total Charges (sum of Lines 22, 24, 26, 28, 339, 592       0       17,277       3,377       360,246       35.00         30, 32, and 34)       36.00       Total Number of Episodes (standard/non ottlier)       112       32       2       146       36.00         37.00       Total Number of Outlier Episodes       0       0       0       0       0       37.00						3 0		1
30.00       Medical Social Service Visit Charges       3,699       0       0       0       3,699       30.00         31.00       Home Heal th Aide Visits       265       0       0       3       268       31.00         32.00       Home Heal th Aide Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total visits (sum of Lines 21, 23, 25, 27, 29, and 31)       1,918       0       93       19       2,030       33.00         34.00       Other Charges (sum of Lines 22, 24, 26, 28, 339, 592       0       17,277       3,377       360,246       35.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146       36.00         37.00       Total Number of Outlier Episodes       0       0       0       0       0       37.00					5	96 0		
31.00       Home Heal th Ai de Visits       265       0       0       3       268       31.00         32.00       Home Heal th Ai de Visit Charges       13,928       0       0       158       14,086       32.00         33.00       Total visits (sum of lines 21, 23, 25, 27, 29, and 31)       1,918       0       93       19       2,030       33.00         34.00       Other Charges       0       0       0       0       0       34.00         35.00       Total Charges (sum of lines 22, 24, 26, 28, 339, 592       0       17,277       3,377       360,246       35.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146       36.00         37.00       Total Number of Outlier Episodes       0       0       0       0       0       37.00						0 0		
33.00       Total visits (sum of lines 21, 23, 25, 27, 29, 1, 918 29, and 31)       0       93       19       2,030       33.00         34.00       Other Charges       0       0       0       0       0       34.00         35.00       Total Charges (sum of lines 22, 24, 26, 28, 339, 592 30, 32, and 34)       0       17,277       3,377       360, 246 35.00       35.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146 36.00         37.00       Total Number of Outlier Episodes       0       0       0       0       37.00	31.00	Home Health Aide Visits	265	C		0 3	268	31.00
29, and 31)       0ther Charges       0       0       0       0       0       34.00         34.00       Other Charges       0       0       0       0       0       34.00         35.00       Total Charges (sum of Lines 22, 24, 26, 28, 339, 592       0       17, 277       3, 377       360, 246       35.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146       36.00         37.00       Total Number of Outlier Episodes       0       0       0       0       37.00		5						1
35.00       Total Charges (sum of lines 22, 24, 26, 28, 339, 592 30, 32, and 34)       0       17, 277 3, 377 360, 246 35.00         36.00       Total Number of Episodes (standard/non outlier)       112 32 2       146 36.00         37.00       Total Number of Outlier Episodes       0       0       0       37.00		29, and 31)						
30, 32, and 34)       32       2       146       36.00         36.00       Total Number of Episodes (standard/non outlier)       112       32       2       146       36.00         37.00       Total Number of Outlier Episodes       0       0       0       37.00		Other Charges	-	-		0 0 77 77		1
outlier) 37.00Total Number of Outlier Episodes0037.00	33.00		559, 592		17,2	3,377	300, 240	35.00
37.00         Total Number of Outlier Episodes         0         0         37.00	36.00		112			32 2	146	36.00
38. 00   Total Non-Routi ne Medical Supply Charges         18, 359         0         1, 599         76         20, 034         38. 00	37.00			С		0		37.00
	38.00	Total Non-Routine Medical Supply Charges	18, 359	C	1, 5	99  76	20, 034	38.00

Heal th	n Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lieu of Form CMS-2552-			
HOSPI	TAL IDENTIFICATION DATA			Provi der	CCN: 151315	Period:	Worksheet S-9		
						From 10/01/2014			
				Component	CCN: 151561	To 09/30/2015			
						Hospi ce I	9/6/2016 3:17	pm	
		Unduplicated				HUSPICE I			
		Days							
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of		
				Skilled	Nursing	All other	col s. 1, 2 &		
				Nursing	Facility		5)		
				Facility	l		0)		
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0		0 0	0	1.00	
2.00	Routine Home Care	3, 017	14	404		0 160	3, 191	2.00	
3.00	Inpatient Respite Care	5	0	0		0 0	5	3.00	
4.00	General Inpatient Care	0	0	0		0 0	0	4.00	
5.00	Total Hospice Days	3, 022	14	404		0 160	3, 196	5.00	
	Part II - CENSUS DATA								
6.00	Number of Patients Receiving	80	1	16		0 6	87	6.00	
	Hospi ce Care								
7.00	Total Number of Unduplicated	0.00		0.00				7.00	
	Continuous Care Hours Billable								
	to Medicare								
8.00	Average Length of Stay (line	37. 78	14.00	25.25	0.0	26.67	36.74	8.00	
	5/line 6)								
9.00	Unduplicated Census Count	75	1	16		0 6	82	9.00	

Heal th	Financial Systems CAMERON MEMORIAL CC	MMUNI TY		In Li€	eu of Form CMS	-2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151315	Period:	Worksheet S	-10
				From 10/01/2014 To 09/30/2015		
					9/6/2016 3:	17 pm
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 columr	18)	0. 4178	5 1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 544, 20	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicaid	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			-87, 78	3 5.00
6.00	Medi cai d charges				7, 652, 63	6.00
7.00	Medicaid cost (line 1 times line 6)				3, 197, 69	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lir	nes 2 and 5; if	1, 741, 27	6 8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructi	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP					0 9.00
10.00	Stand-alone SCHIP charges					0 10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)					0 11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (	(line 11 m	inus line 9;	if < zero then		0 12.00
	enter zero)					_
10.00	Other state or local government indigent care program (see instr					0 13.00
13.00 14.00	Net revenue from state or local indigent care program (Not inclu Charges for patients covered under state or local indigent care					0 13.00
14.00	10)	program (	Not included	In Thes 6 of		0 14.00
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 indi		nrogram (Lir	ne 15 minus line		0 16.00
10.00	13; if < zero then enter zero)	gent ouro	program (iii			0 10.00
	Uncompensated care (see instructions for each line)				1	
17.00	Private grants, donations, or endowment income restricted to fur	nding char	ity care			0 17.00
18.00	Government grants, appropriations or transfers for support of he	ospital op	erations			0 18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local	i ndi gent	care program	ns (sum of lines	1, 741, 23	6 19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col.	1
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (		1, 000, 94	48, 135	1, 049, 08	30 20.00
21 00	charges excluding non-reimbursable cost centers) for the entire		410 0	0 20 112	420.24	3 21.00
21.00	Cost of initial obligation of patients approved for charity care times line 20)		418, 25	50 20, 113	438, 36	5 21.00
22.00	Partial payment by patients approved for charity care			0 0		0 22.00
	Cost of charity care (line 21 minus line 22)		418, 25	0	438, 36	
23.00			410, 20	20,113	430, 30	5 25.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient	days bevo	nd a length o	of stav limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p					
25.00	If line 24 is "yes," charges for patient days beyond an indiger		ogram's lengt	h of stay limit		0 25.00
	Total bad debt expense for the entire hospital complex (see inst		- 5	2	4, 917, 19	6 26.00
	Medicare bad debts for the entire hospital complex (see instruct				369, 3	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lir		s line 27)		4, 547, 82	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe			e 28)	1, 900, 33	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	-			2, 338, 69	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			4, 079, 9	0 31.00

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period:	Worksheet A	
					rom 10/01/2014 o 09/30/2015	Date/Time Pre 9/6/2016 3:17	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	OFNERAL CERVICE COST OFNITERS	1.00	2.00	3.00	4.00	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		3, 164, 807	3, 164, 807	-196, 860	2, 967, 947	1 1.
00	00200 CAP REL COSTS-BEDG & TTXT		1, 510, 716			2, 907, 947	2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 395, 180			5, 395, 180	
00	00500 ADMI NI STRATI VE & GENERAL	3, 676, 064	4, 309, 713			8, 401, 759	
00	00700 OPERATION OF PLANT	505, 778	2, 036, 056			2, 550, 783	
00	00800 LAUNDRY & LINEN SERVICE	0	143, 167			143, 167	8
00	00900 HOUSEKEEPING	583, 751	276, 954			860, 705	9
. 00	01000 DI ETARY 01100 CAFETERI A	406, 889 0	412, 697 0	819, 586 C		91, 201 688, 029	
. 00	01300 NURSI NG ADMI NI STRATI ON	746, 641	31, 593			778, 234	
. 00	01400 CENTRAL SERVICES & SUPPLY	149, 869	-34, 824			115, 045	
. 00	01500 PHARMACY	402, 635	1, 679, 101	2, 081, 736		2, 081, 736	
. 00	01600 MEDICAL RECORDS & LIBRARY	319, 570	242, 460	562, 030	0 0	562, 030	16
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
. 00	03000 ADULTS & PEDIATRICS	1, 508, 360	1, 247, 813			3, 120, 987	30
. 00	03100 I NTENSI VE CARE UNI T	0	0			118, 069	31
. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		52, 056	52, 056	43
. 00	05000 OPERATING ROOM	1, 598, 160	1, 624, 658	3, 222, 818	-650, 704	2, 572, 114	50
. 00	05100 RECOVERY ROOM	0	0 1,021,000	0,222,010		650, 704	
. 00	05200 DELIVERY ROOM & LABOR ROOM	697, 701	93, 881	791, 582		256, 643	
. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 357, 421	463, 639	1, 821, 060	0 0	1, 821, 060	54
. 00	06000 LABORATORY	870, 045	1, 532, 920	2, 402, 965	5 0	2, 402, 965	
. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0 0	0	64
. 00	06500 RESPIRATORY THERAPY	41, 665	824, 845	866, 510		659, 893	
. 01 . 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	631, 697	0 41, 284	0 672, 981		195, 648 672, 981	65 66
. 00	06900 ELECTROCARDI OLOGY	031,097	275, 431	275, 431		286, 400	
. 01	06901 CARDI AC REHAB	61, 450	49, 795			111, 245	
. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	1, 506, 085			1, 123, 705	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	382, 380	382, 380	72
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	-	0	73
. 00	03020 CHEMI CAL DEPENDENCY	28, 122	2, 445			30, 567	76
. 01	03480 ONCOLOGY	0	1, 877, 122	1, 877, 122	2 0	1, 877, 122	76
. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0 0	0	88
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89
. 00	09000 CLINIC	128, 407	26, 904			155, 311	90
. 00	09100 EMERGENCY	1, 477, 624	479, 483			1, 957, 107	91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS						
1.00	10100 HOME HEALTH AGENCY	668, 162	97, 359	765, 521	-96, 321	669, 200	101
<u> </u>	SPECIAL PURPOSE COST CENTERS	1	1 107 (07	1 107 (07		0	1112
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	0	1, 127, 627 0				113 114
	11600 HOSPI CE	132, 265	37, 839				
3. OC 3. OC		15, 992, 276	30, 476, 750			46, 830, 106	
	NONREI MBURSABLE COST CENTERS	10/ //2/2/0	00/1/0//00	10/ 10// 020		10/ 000/ 100	1.10
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190
1. 00	07950 DAYCARE-I NFANT/TODDLER	0	0	c	0 0	0	194
	07951 MOB	0	9, 604			655	
	07952 COMMUNI TY HEALTH	81, 127	7,469			88, 596	
	07953 ASSI STED LI VI NG/CAMERON WOODS	0	0	(	-		194
		85, 369	54, 421	139, 790		24, 747	
	07955 MARKETI NG	157, 018	479, 203			502, 726 40, 356	
	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	0	0		40, 356		194
	07957 OUTSTDE LAUNDRY	0	0				194
	07959 URGENT CARE	1,071,234	317, 602	1, 388, 836	-143, 949	1, 244, 887	
	1 I = = =	., ., .,	31, 345, 049			48, 732, 073	

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Prov	'i der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet A Date/Time Pr 9/6/2016 3:1	
	Cost Center Description	Adjustments	Net Expe For Alloc			I.,	77072010 3.1	
		(See A-8) 6.00	7.00		-			
	GENERAL SERVICE COST CENTERS	0.00	1.00		1			
00	00100 CAP REL COSTS-BLDG & FIXT	-697,026	2,27	0, 921				1.0
00	00200 CAP REL COSTS-MVBLE EQUIP	-317,645	2, 59	7, 609				2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-194, 356	5, 20	0, 824				4. (
00	00500 ADMINI STRATI VE & GENERAL	-490, 410	7, 91	1, 349				5.0
00	00700 OPERATION OF PLANT	-3, 300		7, 483				7.0
00	00800 LAUNDRY & LINEN SERVICE	0		3, 167	1			8.0
00	00900 HOUSEKEEPI NG	0	86	0, 705				9. (
). 00	01000 DI ETARY	-14, 471	7	6, 730				10.0
. 00	01100 CAFETERI A	-290, 092		7, 937				11. (
3. 00	01300 NURSING ADMINISTRATION	0		8, 234				13. (
I. 00	01400 CENTRAL SERVICES & SUPPLY	0		5, 045	1			14.0
5.00	01500 PHARMACY	-103, 498		8, 238	1			15.0
	01600 MEDI CAL RECORDS & LI BRARY	-338		1, 692	1			16.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			., ., 2				
). 00	03000 ADULTS & PEDIATRICS	-703, 518	2.41	7,469				30.
. 00	03100 I NTENSI VE CARE UNI T	0		8,069	1			31.
3.00	04300 NURSERY	0		2, 056	1			43.
. 00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	2,000	1			
). 00	05000 OPERATING ROOM	-1, 034, 165	1 53	7, 949				50.
. 00	05100 RECOVERY ROOM	0		0, 704	1			51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	-20, 760		5, 883	1			52.
. 00	05400 RADI OLOGY-DI AGNOSTI C	20,700		1, 060				54.
. 00	06000 LABORATORY	-10, 750		1, 000 2, 215	•			60.
. 00	06400 INTRAVENOUS THERAPY	-10,730	2, 37	2, 213	1			64.
5.00	06500 RESPI RATORY THERAPY	0	65	9, 893	•			65.
5.00	06501 SLEEP LAB	0		7, 073 5, 648	1			65.
5.00	06600 PHYSI CAL THERAPY	0		2, 981				66.
9.00	06900 ELECTROCARDI OLOGY	0		2, 901 6, 400				69.
9.00 9.01	06901 CARDI AC REHAB	0		0, 400 1, 245	1			69.
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1, 245 3, 705	1			71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			1			72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0	30	2, 380 0	1			73.
		-						
b. 00	03020 CHEMI CAL DEPENDENCY	0		0,567	1			76.
o. 01	03480 ONCOLOGY	0	1,87	7, 122				76.
00	OUTPATIENT SERVICE COST CENTERS	0	1					
8.00	08800 RURAL HEALTH CLINIC	0		0				88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		0				89.
. 00		0		5,311	1			90.
. 00	09100 EMERGENCY	-421	1, 95	6, 686				91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.
4 00	OTHER REIMBURSABLE COST CENTERS	-		0 000	1			-101
1.00	10100 HOME HEALTH AGENCY	0	66	9, 200	1			101.
0 0 0	SPECIAL PURPOSE COST CENTERS		1		1			1110
	11300 INTEREST EXPENSE	0		0				113.
	11400 UTI LI ZATI ON REVI EW-SNF	0		0				114.
	11600 HOSPI CE	0		2, 879	1			116.
8.00		-3, 880, 750	42, 94	9, 356				118.
	NONREI MBURSABLE COST CENTERS	-	1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0				190.
	07950 DAYCARE-I NFANT/TODDLER	0		0	•			194.
	07951 MOB	0		655	1			194.
	07952 COMMUNI TY HEALTH	0	8	8, 596				194.
	07953 ASSISTED LIVING/CAMERON WOODS	0		0				194.
4.04	07954 EDUCATI ON	0	2	4, 747				194.
4. 05	07955 MARKETI NG	0	50	2, 726	1			194.
	07956 GUEST MEALS	0		0, 356	1			194.
	07957 OUTSI DE LAUNDRY	0		0				194.
	07958 CANCER CENTER	0		0				194.
		0	1 24	4, 887				194.
	07959 URGENT CARE	0	1,27	4,007				

Heal th	Financial Systems		CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet A-6 Date/Time Prepared:
		Increases					9/6/2016 3: 17 pm
	Cost Center	Li ne #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	425, 613	57, 270			1.00
2.00	NURSERY	<u>43.</u> 00	4 <u>5, 882</u> 471, 495	<u>6, 174</u> <u>63, 444</u>			2.00
	B - PROPERTY INSURANCE		471,493	03, 444			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	68, 650			1.00
	0		0	68, 650			
	C – CAFETERIA	44.00	0.11 577				
1.00 2.00	CAFETERIA GUEST MEALS	11.00 194.06	341, 577 20, 035	346, 452 20, 321			1.00
2.00	<u>GUEST MEALS</u>	194.00	361, 612	<u>20, 321</u> 366, 773			2.00
	D - INTEREST EXPENSE		001, 012	000, 110			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 048, 885			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7 <u>8, 7</u> 42			2.00
			0	1, 127, 627			
1.00	E - DEPRECIATION EXPENSE CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 325, 796			1.00
1.00	0		— — — <del>0</del>	1, 325, 796			1.00
	F - ICU		0	1,020,770			
1.00	INTENSIVE_CARE_UNIT	31.00	65, 391	52, 678			1.00
	0		65, 391	52, 678			
	G - ADVERTISING COST		25 (22	10/ 11/			
1.00	ADMI NI STRATI VE & GENERAL	5.00	2 <u>5, 698</u> 25, 698	<u>196, 416</u> 196, 416			1.00
	H - PROPERTY TAX		25, 070	190, 410			
1.00	CAP_REL_COSTS_BLDG_&_FIXT	1.00	0	11, 401			1.00
	0			11, 401			
	I - EDUCATION COSTS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	85, 369 85, 369	2 <u>9, 674</u> 29, 674			1.00
	J - SLEEP LAB		80, 309	29,074			
1.00	SLEEP LAB	65.01	0	195, 648			1.00
2.00	ELECTROCARDI OLOGY	69.00	0	10, 969			2.00
	0		0	206, 617			
4 00	K - UTILITIES	7 00		0.040			
1.00	OPERATION_OF_PLANT		•	<u> </u>			1.00
	L - PUBLIC RELATIONS		U	0, 747			
1.00	MARKETING	194.05	0	88, 619			1.00
	0		0	88, 619			
	M - MSW	101.00	7.005	-			
1.00	HOME HEALTH AGENCY	1 <u>01.00</u>	<u>7, 225</u> 7, 225	0			1.00
	N - RECOVERY ROOM		7,225	0			
1.00	RECOVERY ROOM	51.00	650, 704	0			1.00
	0		650, 704	ō			
	O - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO	72.00	0	382, 380			1.00
	PATI ENTS	+					
	P - HOME HEALTH		J	302, 300			
1.00	ADMI NI STRATI VE & GENERAL	5.00	103, 546	0			1.00
	0		103, 546	<u>0</u>			
	Q - URGENT CARE						
1.00	ADMI NI STRATI VE & GENERAL	5.00	143,949				1.00
500 00	0 Grand Total: Increases		143, 949 1, 914, 989	3, 929, 024			500.00
555.00		I	1, 714, 707	5, 727, 024			1 500.00

th Financial Systems ASSIFICATIONS		CAMERON MEMORIA		CCN: 151315	In Lieu of Form Period: Worksheet From 10/01/2014	
					To 09/30/2015 Date/Time 9/6/2016	e Prepare 3:17 pm
	Decreases					
Cost Center	Line #	Salary		Wkst. A-7 Rei	f.	
6.00	7.00	8.00	9.00	10.00		
A - LABOR AND DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	471, 495	62 444	1	0	1
D DELIVERY ROOM & LABOR ROOM	0.00	471, 495	63, 444		0	1.
		471, 495	63, 444			2.
B - PROPERTY INSURANCE	I	471, 475	00, 444	L		
ADMI NI STRATI VE & GENERAL	5.00	0	68, 650		12	1
		0	68,650		-	
C – CAFETERIA		· · · ·	· · ·			
DI ETARY	10.00	361, 612	366, 773		0	1.
)	0.00	0	0		0	2.
0		361, 612	366, 773			
D - INTEREST EXPENSE				1		
INTEREST EXPENSE	113.00	0	1, 127, 627		11	1.
	0.00	0	0		11	2
		0	1, 127, 627			
E - DEPRECIATION EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	1, 325, 796		0	1.
CAP REL CUSTS-BLDG & FIXT		<u>o</u>	<u>1, 325, 796</u> 1, 325, 796		9	'.
F - ICU		0	1, 323, 790			
ADULTS & PEDIATRICS	30.00	65, 391	52, 678		0	1.
		65, 391	<u>52,678</u>			
G - ADVERTISING COST		00/07/	02,070			
MARKETING	194.05	25, 698	196, 416		0	1.
		25, 698	196, 416		-	
H - PROPERTY TAX				L.		
ADMI NI STRATI VE & GENERAL	5.00	0	11, 401		13	1.
0		0	11, 401			
I - EDUCATION COSTS						
DEDUCATION	<u>194.</u> 04	8 <u>5, 3</u> 69	2 <u>9,674</u>		Q	1.
0		85, 369	29, 674			
J - SLEEP LAB	(5.00			1		
RESPIRATORY THERAPY	65.00	0	206, 617		0	1.
	0.00	<u>0</u>	206, 617		<u>0</u>	2.
K – UTILITIES		0	200, 017			
MOB	194.01	0	8, 949		0	1.
			<u>8, 949</u>			
L - PUBLIC RELATIONS			0, ,+,	1	1	
ADMI NI STRATI VE & GENERAL	5.00	0	88, 619		0	1.
	<u> </u>	0	88, 619		<u> </u>	
M - MSW						
HOSPICE	116.00	7, 225	0		0	1.
0		7, 225	0			
N - RECOVERY ROOM				1	-1	
O OPERATING ROOM	50.00	650, 704	0	<u> </u>	0	1.
		650, 704	0			
0 - IMPLANTABLE DEVICES	71 00	<u>ما</u>	202.202			
MEDICAL SUPPLIES CHARGED TO	71.00	0	382, 380		0	1.
PATI ENT	+			├─ ─ ─	-	
P - HOME HEALTH		0	502, 500	I		
HOME HEALTH AGENCY	101.00	103, 546	0		0	1
		103, 546	Ö	$\vdash$	-	
Q - URGENT CARE	<b>_</b>		0	1		
URGENT CARE	194.09	143, 949	0		0	1.
		143, 949			1	
00 Grand Total: Decreases		1, 914, 989	3, 929, 024			500.

Heal th	Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015		pared:
				Acqui si ti ons	5		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	750, 190	567, 678		0 567, 678	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	55, 488, 169	9, 448, 483		0 9, 448, 483	12, 504, 950	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	18, 170, 884	6, 078, 234		0 6, 078, 234	8, 949, 322	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74, 409, 243	16, 094, 395		0 16, 094, 395	21, 454, 272	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	74, 409, 243	16, 094, 395		0 16, 094, 395	21, 454, 272	10.00
		Ending Balance	Fully				
		3	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		•			
1.00	Land	1, 317, 868	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	52, 431, 702	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15, 299, 796	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	69, 049, 366	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	69, 049, 366	0				10.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151315	Period:	Worksheet A-7	
					From 10/01/2014 To 09/30/2015		narod
					10 0773072013	9/6/2016 3: 17	pm
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	11.00		instructions)	
	DADT IL DECONCLULATION OF ANOUNTS FROM WOR	9.00	10.00	<u>11.00</u>	12.00	13.00	
1 00	PART 11 - RECONCILIATION OF AMOUNTS FROM WORK		N Z, LINES I A	na z		0	1 00
1.00	CAP REL COSTS-BLDG & FIXT	3, 164, 807	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 164, 807	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 164, 807				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 510, 716	1, 510, 716				2.00
3.00	Total (sum of lines 1-2)	1, 510, 716	4, 675, 523				3.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2014 To 09/30/2015		pared:
	COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		_				
1.00 CAP REL COSTS-BLDG & FIXT	53, 749, 570		53, 749, 57			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	15, 299, 796	0	15, 299, 79			2.00
3.00 Total (sum of lines 1-2)	69, 049, 366		69, 049, 36			3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 1, 809, 152		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 1, 151, 344		2.00
3.00 Total (sum of lines 1-2)	0	9		0 2, 960, 496	0	3.00
		Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			1 .	-1		
1.00 CAP REL COSTS-BLDG & FIXT	381, 718				2/2/0//2/	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	-64, 451			0 1, 510, 716		2.00
3.00  Total (sum of lines 1-2)	317, 267	68, 650	11, 40	1 1, 510, 716	4, 868, 530	3.00

	Financial Systems MENTS TO EXPENSES		CAMERON MEMORI	AL COMMUNITY Provider CCN: 151315	Peri od:	u of Form CMS-2 Worksheet A-8	
00001					From 10/01/2014 To 09/30/2015		
						9/6/2016 3: 17	
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00		4.00	5.00	1.0
. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-667, 167	CAP REL COSTS-BLDG & FIXT	1.00	11	1.0
. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-50, 086	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.0
. 00	Investment income - other		C		0.00	0	3.0
. 00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.0
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.0
	expenses (chapter 8)	_				_	
. 00	Rental of provider space by suppliers (chapter 8)	В	-18, 468	CAP REL COSTS-MVBLE EQUIP	2.00	9	6.0
. 00	Telephone services (pay stations excluded) (chapter		C		0.00	0	7.0
	21)						
. 00	Television and radio service (chapter 21)		C		0.00	0	8.0
. 00 0. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	C -1, 769, 193		0.00	0	
	adjustment	A-0-2	-1,709,193			_	
1.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.0
2.00	Related organization	A-8-1	-356, 313	3		0	12.0
3. 00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.0
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee		-262, 687	CAFETERIA	11.00 0.00		
	and others						
6. 00	Sale of medical and surgical supplies to other than		C		0.00	0	16.0
7.00	patients Sale of drugs to other than	В	-103 409	PHARMACY	15.00	0	17.0
	patients						
8. 00	Sale of medical records and abstracts	В	-338	MEDICAL RECORDS & LIBRARY	16.00	0	18.0
9.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.0
0. 00	Vending machines	В	-21, 285	CAFETERI A	11.00	0	
1.00	Income from imposition of interest, finance or penalty		C		0.00	0	21.0
2.00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.0
2.00	overpayments and borrowings to		C		0.00	0	22.0
3.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.0
	therapy costs in excess of						
4.00	limitation (chapter 14) Adjustment for physical	A-8-3	C	PHYSICAL THERAPY	66.00		24.0
	therapy costs in excess of limitation (chapter 14)						
5.00	Utilization review -		C	UTILIZATION REVIEW-SNF	114.00		25. C
	physicians' compensation (chapter 21)						
6. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
7.00	Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.0
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	C	) *** Cost Center Deleted ***	0.00		29. C 30. C
0.00	therapy costs in excess of	A 0-0	C		07.00		30.0
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 9
1.00	instructions) Adjustment for speech	A-8-3		*** Cost Center Deleted ***			31.0
1.00	pathology costs in excess of	H-0-3	L		08.00		31.0
2.00	limitation (chapter 14) CAH HIT Adjustment for	А	-33.481	CAP REL COSTS-MVBLE EQUIP	2.00	9	32. C
	Depreciation and Interest						
3.00 3.01	LOBBYING EXPENSES EMPLOYEE CHRISTMAS PARTY	A A		ADMI NI STRATI VE & GENERAL	5.00 5.00		33.0 33.0

Health Financial Systems		CAMERON MEMORI	AL COMMUNI TY	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
			Expense Classification or	Worksheet A	77072010 3.17	
			To/From Which the Amount is			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33. 02 PHYSI CI AN RECRUI TMENT	A	-44, 185	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03 MEALS ON WHEELS	В	-14, 211	DI ETARY	10.00	0	33.03
33.04 BREAKFAST CART	В	-260	DIETARY	10.00	0	33.04
33.05 REIMBURSEMENT FOUNDATION	В	-72, 587	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
DEVELOPMENT						
33.06 RENTAL INCOME OFFSET - CANCE	R B	-29, 859	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
CENTER						
33.07 ATM SURCHARGE REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00		33.07
33.08 OP EDUCATION	В		EMPLOYEE BENEFITS DEPARTMEN			33.08
33. 09 EMS	В		EMERGENCY	91.00		33.09
33.10 DIETICIAN CONSULTATIONS	В		CAFETERIA	11.00	0	33.10
33.11 HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33. 11
33.12 RENT EXPENSE OFFSET	A		CAP REL COSTS-MVBLE EQUIP	2.00	11	33.12
50.00 TOTAL (sum of lines 1 thru 4	9)	-3, 880, 750				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	CAMERON MEMOR	IAL COMMUNITY	In Li€	eu of Form CMS-:	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period: From 10/01/2014	Worksheet A-8	-1
OFFICE	COSTS			To 09/30/2015		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	193, 367	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	37, 143	2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3, 300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	393, 839	516, 342	4.00
5.00	0		0	393, 839	750, 152	5.00

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

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

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

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

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

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

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

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

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

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

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

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

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNI TY	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM REL OFFICE COSTS	LATED ORGANIZATIONS AND HOME	Provider CCN: 151315	Period: From 10/01/2014	Worksheet A-8-1
			To 09/30/2015	Date/Time Prepared:

			9/6/2016 3:17	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-193, 367	0		1.00
2.00	-37, 143	0		2.00
3.00	-3, 300	0		3.00
4.00	-122, 503	9		4.00
5.00	-356, 313			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

110	13 1101	been posted to worksheet A,		the anount		be mulcated i	this part.	
		Related Organization(s)						
		and/or Home Office						
		Type of Business						
		51						
		6, 00						
-								
		B. INTERRELATIONSHIP TO RELATIONSHIP	TED_ORGANIZATION(S)	AND/OR HOME	OFFICE:			

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

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

6.00 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 00 9. 00 10. 00 <u>100. 00</u>	100.00

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

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

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

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

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

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

Heal th	Financial Syste	ems	CAMERON MEMOR	IAL COMMUNITY		Inlie	eu of Form CMS-	2552-10
	R BASED PHYSIC		of merior		r CCN: 151315	Peri od:	Worksheet A-8	
						From 10/01/2014 To 09/30/2015		epared: pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00		LABORATORY	18,000					1.00
2.00		ADULTS & PEDIATRICS	707, 318				-	
3.00		OPERATING ROOM	1, 054, 165				0	
4.00	30.00	ADULTS & PEDIATRICS	32, 700	32, 70	о О	0 0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	20, 760	20, 76	D I	0 0	0	5.00
6.00	0.00		0		C	0 0	0	6.00
7.00	0.00		0		C	0 0	0	7.00
8.00	0.00		0		-	0 0	0	
9.00	0.00		0		C	0 0	0	
10.00	0.00		0		0	0 0	0	
200.00			1, 832, 943				0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of	Provi der	Physician Cost of Malpractice	
		I denti ri er		Limit	E Memberships & Continuing	Component Share of col.	Insurance	
					Educati on	12	i iisui ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		LABORATORY	0			0 0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0		C	0 0	0	2.00
3.00	50.00	OPERATING ROOM	0		C	0 0	0	3.00
4.00		ADULTS & PEDIATRICS	0		-	0 0	0	
5.00		DELIVERY ROOM & LABOR ROOM	0		-	0 0	0	
6.00	0.00		0		C	0 0	0	
7.00	0.00		0		0	0 0	0	
8.00	0.00		0		-	0 0	0	
9.00	0. 00 0. 00		0			0 0	0	
10. 00 200. 00	0.00		0		-		0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A EINC #	I denti fi er	Component	Limit	Di sal I owance	Aujustilient		
			Share of col.	2	broarronanco			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		LABORATORY	0		-	0 10, 750		1.00
2.00		ADULTS & PEDIATRICS	0			670, 818		2.00
3.00		OPERATING ROOM	0		-	1, 034, 165		3.00
4.00		ADULTS & PEDIATRICS	0		-	32, 700		4.00
5.00		DELIVERY ROOM & LABOR ROOM	0		-	20, 760		5.00
6.00 7.00	0. 00 0. 00		0		-		1	6.00
7.00 8.00	0.00							7.00 8.00
8.00 9.00	0.00				-			9, 00
10.00	0.00		0		-			10.00
200.00	0.00		0		-	1, 769, 193		200.00
	•	1		1	I	, , ,	1	

	DE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8- Parts I-VI Date/Time Prep 9/6/2016 3:17	pared:
					Respi ratory Therapy	Cost	
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide:	s) (see instruct	ions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week	<i>,</i> ,				780	2.00
3.00 4.00	Number of unduplicated days in which supervision Number of unduplicated days in which therapy					365 0	3.00 4.00
	nor therapist was on provider site (see inst	ructions)			Super Viser		
5.00 5.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				w therapy	0	5.00 6.00
51 00	assistant and on which supervisor and/or the					Ĵ	
7.00	instructions) Standard travel expense rate					3. 25	7.00
3.00	Optional travel expense rate per mile					0.00	
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	2, 082. 50	20, 384. 74	0.0	0.00	0.00	
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	62. 88 31. 44	62.88 31.44	0. 0 0. 0		0.00	10.00 11.00
11.00	one-half of column 2, line 10; column 3,	01.11	01.11	0.0			
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12.00
12.01	Number of travel hours (offsite)						12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
10.01		II					10.0
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,					130, 948	
15.00 16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					1, 281, 792 0	15.00 16.00
17.00	Subtotal allowance amount (sum of lines 14 and		atory therapy	or lines 14-	16 for all	1, 412, 740	
18.00	others) Aides (column 4, line 9 times column 4, line	10)				о	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					1, 412, 740	20.00
	occupational therapy, line 9, is greater than						
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by sur	n of columns	1 and 2 line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)			0.00	
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 time	s line 21)			0 1, 412, 740	
20.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - PRO	VIDER SITE	1, 112, 710	20.00
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					11 474	
	Assistants (line 4 times column 3, line 11)						1 24 00
25.00							
26.00							25.00 26.00
					and 4 for all	11, 476 0 11, 476 1, 186	25.00 26.00
26.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respiratory	therapy or su	um of lines 3		0 11, 476	25.00 26.00 27.00
26. 00 27. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense	therapy or su at the provide	um of lines 3		0 11, 476 1, 186	25.00 26.00 27.00 28.00
26.00 27.00 28.00 29.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum	for respiratory travel expense Expense of columns 1 and	therapy or su at the provide	um of lines 3		0 11, 476 1, 186 12, 662	25. 00 26. 00 27. 00 28. 00 29. 00
26. 00 27. 00 28. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense of columns 1 and line 12)	therapy or si at the provide 2, line 12)	um of lines 3 er site (sum		0 11, 476 1, 186 12, 662	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
26.00 27.00 28.00 29.00 30.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29	therapy or su at the provide 2, line 12 ) and 30 for al	um of lines 3 er site (sum	of lines 26 and	0 11, 476 1, 186 12, 662 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
26.00 27.00 28.00 29.00 30.00 31.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line	therapy or si at the provide 2, line 12) and 30 for al 13 for respira	um of lines 3 er site (sum	of lines 26 and	0 11, 476 1, 186 12, 662 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
<ol> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> </ol>	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respire 28) f lines 27 and	um of lines 3 er site (sum l others) atory therapy d 31)	of lines 26 and	0 11, 476 1, 186 12, 662 0 0 0 0 0 0 12, 662 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
<ol> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> </ol>	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and ptional travel allowance and optional travel allowance and optional travel allowance and optional travel allowance and ptional tr	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or su at the provide 2, line 12) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 0 12, 662 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SI TE	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
<ol> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> <li>35. 00</li> <li>36. 00</li> </ol>	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SI TE	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SI TE	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SI TE 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37)	for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SI TE 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 37. 00 38. 00 39. 00
<ul> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> <li>35. 00</li> <li>36. 00</li> <li>37. 00</li> <li>38. 00</li> <li>39. 00</li> <li>40. 00</li> <li>41. 00</li> </ul>	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 4 Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 0 VI DER_SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NNCE AND TRAVEL n of lines 5 and Expense 01 times column n 3, line 10)	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT 6) 2, line 10)	um of lines 3 er site (sum l others) atory therapy d 31) d 32)	oflines 26 and	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 VI DER_SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
<ul> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> <li>35. 00</li> <li>36. 00</li> <li>37. 00</li> <li>38. 00</li> <li>39. 00</li> <li>40. 00</li> <li>41. 00</li> <li>42. 00</li> </ul>	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 4 Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o expense (sum o NACE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-3	therapy or su at the provide 2, line 12 ) and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU 6) 2, line 10) , line 13.01)	um of lines 3 er site (sum l others) atory therapy d 31) d 32) FATION - SERV	of lines 26 and / or sum of /ICES OUTSIDE PRC	0 11, 476 1, 186 12, 662 0 0 12, 662 0 0 12, 662 0 0 0 VI DER_SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015		pared:
					Respi ratory Therapy	Cost	
						1.00	
15.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	nd 42 - see ir	nstructions)	0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	521. 25	0.00	0.0	0.00	521.25	47.00
B. 00	Overtime rate (see instructions)	94.32	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	49, 164. 30	0.00	0.0	0.00		49.00
0. 00	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100. 00	0.00	0.0	0.00	100. 00	50.00
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	2, 080. 00	0.00	0.0	00 0.00	2, 080. 00	51.00
2.00	Adjusted hourly salary equivalency amount	62.88	0.00	0.0	0.00		52.00
8. 00	(see instructions) Overtime cost limitation (line 51 times line	130, 790	0		0 0		53.00
1. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	49, 164	0		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	32, 776	0		0 0		55.00
6.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	16, 388	0		0 0	16, 388	56.00
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
7.00 3.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site					1, 412, 740 12, 662	
9.00 ).00	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	es (from lines	44, 45, or 46	)		0 16, 388	59.00
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					1, 441, 790	
	Total cost of outside supplier services (from	, , , , , , , , , , , , , , , , , , ,				537, 637	64.00 65.00
. 00	00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION						
0.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		11, 476	100.00
00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27							100. 01 100. 02
01 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	und 4 for all	others	1 186	101.00
01. 01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					0	101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
	13 for all others Line 35 = sum of lines 31 and 32	, ,	5 15				102. 02

Cost Center Description         Net Expenses for Cost Al location (from Wkst A col. 7)         BLDG & FIXT         MVBLE EQUIP         EMPLOYEE BENEFITS DEPARTMENT         Subtotal           0         0.1.00         2.00         4.00         4A           0         0.1.00         2.00         4.00         4A           0         0.1.00         2.00         4.00         4A           0         0.00100 [CAP REL COSTS-BLDG & FIXT         2.270,921         2.597,609         2.597,609           2.00         0.00200 [CAP REL COSTS-WIDE EQUIP         2.597,609         2.597,609         1.212,752         9,409,           5.00         00500 [ADMINI STRATI VE & GENERAL         7,911,349         107,285         177,906         1.212,752         9,409,           9.00         00900 [OUSEKEPINS         860,705         7,334         7,164         152,029         3,190,           8.00         00500 [DUSEKEPINS         860,705         7,334         7,164         175,467         1,050,           10.00         01000 [DETARY         115,045         68,016         64,38         45,048         249,1038,           11.00         01100 [CAFTERIA         397,937         43,329         22,323         102,673         586,           10.00	e Prepared: 3: 17 pm 1 1 1 1 1 1 1 0 2 0 4 0 2 0 4 0 0 2 0 4 0 0 2 0 4 0 0 2 0 4 0 0 4 0 0 0 4 0 0 0 4 0 0 0 4 0 0 0 0 4 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0
Cost Center Description         Net Expenses for Cost Al location (from Wkst A col. 7)         BLDG & FIXT NVBLE EQUIP         EMPLOYEE BENEFITS DEPARTMENT         Subtotal           0         0.0         2.00         4.00         4A           0         0.00         2.00         4.00         4A           0         0.00         2.00         4.00         4A           0         0.00         0.00         4.00         4A         4A           0         0.00         0.00         0.00         4.00         4A           0         0.0000         ADMINI STRATIVE & GENERAL         7.911, 349         107, 285         177, 906         1.212, 752         9, 409,           0.00         00000 DUSEKEPINS         860, 705         7.33         7.164         175, 467         1.050,           10.00         01000 CAFFTER NA         397, 937         43, 329         42, 323         102, 673         586,           113.00         01300 ANRSIN & DMINI	3: 17 pm 11 1.00 2.00 4.00 5.00 0,292 5.00 0,180 7.00 8,991 8.00 0,670 9.00 0,572 10.00 0,262 11.00
Cost Center Description         Net Expenses for Cost Al location (from Wkst A col. 7)         MVBLE EQUIP BLDG & FIXT         EMPLOYEE BENEFITS DEPARTMENT         Subtotal BENEFITS DEPARTMENT           1.00         00100 [CAP REL COST CENTERS         0         1.00         2.00         4.00         4A           0         00100 [CAP REL COSTS-BLDG & FIXT         2.270,921         2.597,609         2.597,609         4.00         4A           0         00400 EMPLOYEE BENEFITS DEPARTMENT         5.200,824         12.879         12.580         5.226,283           5.00         00500 ADMINI STRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           9.00         00900 [OUSEKEPING         860,705         7,334         1.2643         0         188,           9.00         00900 [DUSEKEPING         860,705         7,334         7,164         175,467         1.050,           10.00         1300 [DUSEKEPING         76,730         85,609         83,623         13,610         259,           11.00         01300 [NURSING ADMINISTRATION         778,234         18,292         17,867         224,429         1,038,           13.00         01300 [NURSING ADMINISTRATION         778,234         16,265         121,026         2,149,	1.00 2.00 4.00 0,292 5.00 0,180 7.00 8,991 8.00 0,670 9.00 0,572 10.00 0,262 11.00
GENERAL SERVICE COST CENTERS         0         1.00         2.00         4.00         4A           1.00         00100 (CAP REL COSTS-BLDG & FIXT         2,270,921         2,270,921         2,597,609         4.00         4A           2.00         00200 (CAP REL COSTS-BUDG & FIXT         2,597,609         2,597,609         2,597,609         4.00         4A           3.00         00400 EMPLOYEE BENEFI TS DEPARTMENT         5,200,824         12,879         12,580         5,226,283         5.00         00500 ADMINI STRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           0.00         00500 ADMINI STRATI ON OF PLANT         2,547,483         225,920         264,748         152,029,3190         188,           9.00         00900 HOUSEKEEPI NG         960,705         7,334         7,164         175,467         1,050,           0.00         01000 DI ETARY         76,730         85,609         83,623         13,610         259,           1.00         01000 DI ETARY         115,045         64,318         42,429         1,038,           1.00         01300 NURSI NG ADMINI STRATI ON         778,234         82,922         17,867         224,429         1,038,             1.00         01400 CENTRAL S	1.00 2.00 4.00 0,292 5.00 0,180 7.00 8,991 8.00 0,670 9.00 0,572 10.00 0,262 11.00
Al I ocation (from Wkst A col 7)         DEPARTMENT           0         1.00         2.00         4.00         4A           1.00         00100         CAP REL COSTS CENTERS         0         1.00         2.00         4.00         4A           2.00         00200         CAP REL COSTS-BLDG & FIXT         2.270,921         2.270,921         2.597,609         2.597,609         2.597,609         2.597,609         1.00         2.000         4.00         4A         0         4A           2.00         00200         CAP REL COSTS-MVBLE EQUIP         2.577,609         2.597,609         2.597,609         1.212,752         9.409,         0.00         0.00         00500         AMIN ISTRATI VE & GENERAL         7.911,349         107,285         177,906         1.212,752         9.409,         1.900         0.00         00800         AUNPY         1.050,00         1.88,         9.00         00800         AUNPY         1.050,01         1.00         0.164A         175,467         1.050,01         1.050,01         1.00         0.160A         44         1.934,	2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00
Image: constraint of the service cost centers         (from Wkst A col . 7)         (col . 7)         (col . 7)           0         0         1.00         2.00         4.00         4A           0         00100 CAP REL COST CENTERS	2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00
0         1.00         2.00         4.00         4A           GENERAL SERVICE COST CENTES           0.00         00100         CAP REL COSTS-BLDG & FIXT         2,270,921         2,270,921         2,597,609         2,597,609         2,597,609         2,597,609         2,597,609         2,597,609         2,597,609         2,597,609         5,226,283         5,226,283         5,226,283         5,00         00500         ADMIN ISTRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           8.00         00500         ADMIN ISTRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           8.00         00500         ADMIN ISTRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           8.00         00500         ADMIN ISTRATI VE & GENERAL         7,911,349         107,343         7,164         175,467         1,050,         10.00         10300         NURSING ADMINISTRATI ON         178,234         18,292         17,867         224,429         1,038,           10.00         01300         NURSING ADMINISTRATI ON         778,234         18,292         17,867         224,429         1,038,           11.00 </td <td>2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00</td>	2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00
GENERAL SERVICE COST CENTERS           1.00         001001 CAP REL COSTS-BLDG & FIXT         2, 270, 921         2, 270, 921         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         2, 597, 609         12, 275, 200, 824         12, 879         12, 580         5, 226, 283         5, 00         00500, ADMI NI STRATI VE & GENERAL         7, 911, 349         107, 285         177, 906         1, 212, 752         9, 409, 3, 190, 3, 800         00800         LAUNDRY & LI NEN SERVICE         143, 167         23, 181         22, 643         0         188         9, 00         00900         HOUSEKEEPI NG         860, 705         7, 334         7, 164         175, 467         1, 050, 100         0, 25, 609         83, 623         13, 610         259, 256         13, 00         01000         DETARY         76, 730         85, 609         83, 623         13, 610         259, 737         13, 329         14, 20, 673         186, 202         17, 867         224, 429         1, 038, 102, 673         586, 016         66, 438         45, 048         294, 15. 00         1500         01400         CENTRAL SERVICES & SUPPLY         115, 045         68, 016 <td>2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00</td>	2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00
2.00         00200         CAP_REL_COSTS-MVBLE_EQUIP         2,597,609         2,597,609           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         5,200,824         12,879         12,580         5,226,283           5.00         00500         ADMI NISTRATI VE & GENERAL         7,911,349         107,285         177,906         1,212,752         9,409,           7.00         00700         OPERATI ON OF_PLANT         2,547,483         225,920         264,748         152,029         3,190,           8.00         00800         LAUNDRY & LINEN SERVICE         143,167         23,181         22,643         0         188,           9.00         00900         HOUSEKEEPI NG         76,730         85,609         83,623         13,610         259,           11.00         01100         CAFETERI A         397,937         43,329         42,323         102,673         586,           13.00         01300         NURSI NG ADMI NI STRATI ON         778,234         18,292         17,867         224,429         1,038,           14.00         O1400         CENTRAL SERVI CES & SUPPLY         115,045         68,016         66,438         45,048         294,           15.00         01500         PLARMACY         1,978,238 </td <td>2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00</td>	2.00 4.00 5.292 5.00 7.180 7.00 8.991 8.00 0.670 9.00 0.572 10.00 0.262 11.00
4.00       00400       EMPLOYEE BENEFITS DEPARTMENT       5, 200, 824       12, 879       12, 580       5, 226, 283         5.00       00500       ADMI NI STRATI VE & GENERAL       7, 911, 349       107, 285       177, 906       1, 212, 752       9, 409,         7.00       00700       OPERATI ON OF PLANT       2, 547, 483       225, 920       264, 748       152, 029       3190,         8.00       00800       LAUNDRY & LINEN SERVI CE       143, 167       23, 181       22, 643       0       188,         9.00       00900       HOUSEKEEPI NG       860, 705       7, 334       7, 164       175, 467       1, 050,         10.00       01000       DI ETARY       76, 730       85, 609       83, 623       13, 610       259,         13.00       01300       NURSI NG ADMI NI STRATI ON       778, 234       18, 292       17, 867       224, 429       1, 038,         14.00       01400       CENTRAL SERVI CES & SUPPLY       115, 045       68, 016       66, 438       45, 048       294,         15.00       01500       PHARMACY       1, 978, 238       25, 211       24, 626       121, 026       2, 149,         10.00       03000       ADULTS & PEDI ATRI CS       2, 417, 469       336, 152	4.00           9,292         5.00           180         7.00           8,991         8.00           6,670         9.00           5,572         10.00           2,622         11.00
7.00         00700         OPERATI ON OF PLANT         2, 547, 483         225, 920         264, 748         152, 029         3, 190,           8.00         00800         LAUNDRY & LINEN SERVICE         143, 167         23, 181         22, 643         0         188,           9.00         00900         HOUSEKEEPING         860, 705         7, 334         7, 164         175, 467         1, 050,           10.00         DI ETARY         76, 730         85, 609         83, 623         13, 610         259,           11.00         CAFETERIA         397, 937         43, 329         42, 323         102, 673         586,           13.00         O1400         CENTRAL SERVICES & SUPPLY         115, 045         68, 016         66, 438         45, 048         294,           15.00         O1600         PHARMACY         1, 978, 238         25, 211         24, 626         121, 026         2, 149,           16.00         O1600         MEDI CAL RECORDS & LI BRARY         561, 692         0         23, 603         96, 058         681,           1NPATI ENT ROUTI NE SERVI CE COST CENTERS         2, 417, 469         336, 152         328, 348         561, 668         3, 643,           30.00         030000         AUULTS & PEDI ATRI CS	0, 1807. 003, 9918. 000, 6709. 000, 57210. 000, 26211. 00
8.00         00800         LAUNDRY & LINEN SERVICE         143, 167         23, 181         22, 643         0         188,           9.00         00900         HOUSEKEEPING         860, 705         7, 334         7, 164         175, 467         1, 050,           10.00         D1000         D1 ETARY         76, 730         85, 609         83, 623         13, 610         259,           11.00         O1100         CAFETERI A         397, 937         43, 329         42, 323         102, 673         586,           13.00         O1300         NURSI NG ADMI NI STRATI ON         778, 234         18, 292         17, 867         224, 429         1, 038,           14.00         D1400         CENTRAL SERVI CES & SUPPLY         115, 045         68, 016         66, 438         45, 048         294,           15.00         D1500         PHARMACY         1, 978, 238         25, 211         24, 626         121, 026         2, 149,           16.00         O1600 MEDI CAL RECORDS & LI BRARY         561, 692         0         23, 603         96, 058         681,           1.01         03000 ADULTS & PEDI ATRI CS         2, 417, 469         336, 152         328, 348         561, 668         3, 643,           3.00         03000 OLARE C	8, 9918. 009, 6709. 009, 57210. 009, 26211. 00
9.00         00900         HOUSEKEEPING         860,705         7,334         7,164         175,467         1,050,           10.00         01000         DI ETARY         76,730         85,609         83,623         13,610         259,           11.00         01100         CAFETERIA         397,937         43,329         42,323         102,673         586,           13.00         01300         NURSI NG ADMI NI STRATI ON         778,234         18,292         17,867         224,429         1,038,           14.00         O1400         CENTRAL SERVI CES & SUPPLY         115,045         68,016         66,438         45,048         294,           15.00         01500         PHARMACY         1,978,238         25,211         24,626         121,026         2,149,           16.00         01600         MEDI CAL RECORDS & LI BRARY         561,692         0         23,603         96,058         681,           18.00         03000         ADULTS & PEDI ATRI CS         2,417,469         336,152         328,348         561,668         3,643,           31.00         03100         INTENSI VE CARE UNI T         118,069         25,757         25,159         19,656         188,           43.00         04300, NURSERY	0, 6709. 000, 57210. 000, 26211. 00
11.00       01100       CAFETERIA       397,937       43,329       42,323       102,673       586,         13.00       01300       NURSI NG ADMI NI STRATI ON       778,234       18,292       17,867       224,429       1,038,         14.00       01400       CENTRAL SERVI CES & SUPPLY       115,045       68,016       66,438       45,048       294,         15.00       01500       PHARMACY       1,978,238       25,211       24,626       121,026       2,149,         16.00       01600       MEDI CAL RECORDS & LI BRARY       561,692       0       23,603       96,058       681,         10.00       03000       ADULTS & PEDI ATRI CS       2,417,469       336,152       328,348       561,668       3,643,         31.00       03100       INTENSI VE CARE UNI T       118,069       25,757       25,159       19,656       188,         43.00       04300       NURSERY       52,056       9,168       8,955       13,791       83,         43.00       05100       REATI NG ROOM       1,537,949       237,271       231,764       284,791       2,291,         51.00       05100       REATI NG ROOM       1,537,949       237,271       231,764       284,791       2,29	, 262 11. 00
13.00       01300       NURSI NG ADMI NI STRATI ON       778, 234       18, 292       17, 867       224, 429       1, 038,         14.00       01400       CENTRAL SERVI CES & SUPPLY       115, 045       68, 016       66, 438       45, 048       294,         15.00       01500       PHARMACY       1, 978, 238       25, 211       24, 626       121, 026       2, 149,         16.00       01600       MEDI CAL RECORDS & LI BRARY       561, 692       0       23, 603       96, 058       681,         INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00       03000       ADULTS & PEDI ATRI CS       2, 417, 469       336, 152       328, 348       561, 668       3, 643,         31.00       03100       INTENSI VE CARE UNI T       118, 069       25, 757       25, 159       19, 656       188,         43.00       04300       NURSERY       52, 056       9, 168       8, 955       13, 791       83,         41.00       05100       PERVI CE COST CENTERS       52, 056       9, 168       8, 955       13, 791       83,         52.00       05000       OPERATI NG ROOM       1, 537, 949       237, 271       231, 764       284, 791       2, 291,         52.00       <	
15.00         01500         PHARMACY         1,978,238         25,211         24,626         121,026         2,149,           16.00         MEDI CAL RECORDS & LI BRARY         561,692         0         23,603         96,058         681,           INPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000         ADULTS & PEDI ATRI CS         2,417,469         336,152         328,348         561,668         3,643,           31.00         03100         INTENSI VE CARE UNI T         118,069         25,757         25,159         19,656         188,           43.00         NURSERY         52,056         9,168         8,955         13,791         83,           ANCI LLARY SERVI CE COST CENTERS           50.00         05000         OPERATI NG ROOM         1,537,949         237,271         231,764         284,791         2,291,           51.00         05100         RECOVERY ROOM         650,704         155,132         151,531         195,592         1,152,           52.00         05200         DELI VERY ROOM & LABOR ROOM         235,883         71,399         69,742         67,994         445,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1,821,060	
16.00         01600         MEDI CAL RECORDS & LI BRARY         561,692         0         23,603         96,058         681,           1NPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00         ADULTS & PEDI ATRI CS         2,417,469         336,152         328,348         561,668         3,643,           31.00         03000         ADULTS & PEDI ATRI CS         2,417,469         336,152         328,348         561,668         3,643,           43.00         04300         INTENSI VE CARE UNI T         118,069         25,757         25,159         19,656         188,           43.00         04300         NURSERY         52,056         9,168         8,955         13,791         83,           ANCI LLARY SERVI CE COST CENTERS         50.00         OPERATI NG ROOM         1,537,949         237,271         231,764         284,791         2,291,           51.00         05000         OPERATI NG ROOM         650,704         155,132         151,531         195,592         1,52,           52.00         05200         DELI VERY ROOM & LABOR ROOM         235,883         71,399         69,742         67,994         445,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1,821,060         166,635         162,768         408,020 <td>, 547 14. 00</td>	, 547 14. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         2, 417, 469         336, 152         328, 348         561, 668         3, 643,           31. 00         03100 I NTENSI VE CARE UNI T         118, 069         25, 757         25, 159         19, 656         188,           43. 00         04300 NURSERY         52, 056         9, 168         8, 955         13, 701         83,           ANCI LLARY SERVI CE COST CENTERS         50. 00         05000 OPERATI NG ROOM         1, 537, 949         237, 271         231, 764         284, 791         2, 291,           51. 00         05100 RECOVERY ROOM         650, 704         155, 132         151, 531         195, 592         1, 152,           52. 00         05200 DELI VERY ROOM         235, 883         71, 399         69, 742         67, 994         445,           54. 00         05400 RADI OLOGY-DI AGNOSTI C         1, 821, 060         166, 635         162, 768         408, 020         2, 558,           60. 00         06000 LABORATORY         2, 392, 215         60, 551         59, 146         261, 522         2, 773,	
31.00         03100         INTENSI VE CARE UNI T         118,069         25,757         25,159         19,656         188,           43.00         04300         NURSERY         52,056         9,168         8,955         13,791         83,           ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         1,537,949         237,271         231,764         284,791         2,291,           51.00         05100         RECOVERY ROOM         650,704         155,132         151,531         195,592         1,152,           52.00         05200         DELI VERY ROOM & LABOR ROOM         235,883         71,399         69,742         67,994         445,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1,821,060         166,635         162,768         408,020         2,558,           60.00         06000         LABORATORY         2,392,215         60,551         59,146         261,522         2,773,	, 333 10.00
43. 00         04300         NURSERY         52,056         9,168         8,955         13,791         83, ANCI LLARY SERVICE COST CENTERS           50. 00         05000         0PERATI NG ROOM         1,537,949         237,271         231,764         284,791         2,291, 2,291,           51. 00         05100         RECOVERY ROOM         650,704         155,132         151,531         195,592         1,152, 2,52.00         05200         DELI VERY ROOM & LABOR ROOM         235,883         71,399         69,742         67,994         445, 445, 54.00         05400         RADI OLOGY-DI AGNOSTI C         1,821,060         166,635         162,768         408,020         2,558, 60.00         2,392,215         60,551         59,146         261,522         2,773,	
ANCI LLARY         SERVI CE         COST         CENTERS           50. 00         05000         OPERATI NG         ROOM         1, 537, 949         237, 271         231, 764         284, 791         2, 291,           51. 00         05100         RECOVERY         ROOM         650, 704         155, 132         151, 531         195, 592         1, 152,           52. 00         05200         DELI VERY         ROOM & LABOR ROOM         235, 883         71, 399         69, 742         67, 994         445,           54. 00         05400         RADI OLOGY-DI AGNOSTI C         1, 821, 060         166, 635         162, 768         408, 020         2, 558,           60. 00         06000         LABORATORY         2, 392, 215         60, 551         59, 146         261, 522         2, 773,	3, 64131.003, 97043.00
51.0005100RECOVERY ROOM650, 704155, 132151, 531195, 5921, 152,52.0005200DELI VERY ROOM & LABOR ROOM235, 88371, 39969, 74267, 994445,54.0005400RADI OLOGY-DI AGNOSTI C1, 821, 060166, 635162, 768408, 0202, 558,60.0006000LABORATORY2, 392, 21560, 55159, 146261, 5222, 773,	
52. 00         05200         DELI VERY ROOM & LABOR ROOM         235, 883         71, 399         69, 742         67, 994         445,           54. 00         05400         RADI OLOGY-DI AGNOSTI C         1, 821, 060         166, 635         162, 768         408, 020         2, 558,           60. 00         06000         LABORATORY         2, 392, 215         60, 551         59, 146         261, 522         2, 773,	
60. 00         O6000         LABORATORY         2, 392, 215         60, 551         59, 146         261, 522         2, 773,	6,018 52.00
	· · · · · · · · · · · · · · · · · · ·
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0	60.00 0 64.00
	6, 642 65. 00
	, 084 65. 01
66. 00         06600         PHYSI CAL         THERAPY         672, 981         121, 931         119, 101         189, 879         1, 103, 000           69. 00         06900         ELECTROCARDI OLOGY         286, 400         3, 121         3, 049         0         292, 292, 202, 202, 202, 202, 202, 202,	8, 892 66. 00 2, 570 69. 00
69. 01         O6901         CARDI AC         REHAB         111, 245         26, 543         25, 927         18, 471         182,	2, 186 69. 01
71. 00         07100         MEDI CAL         SUPPLI ES         CHARGED TO PATI ENT         1, 123, 705         0         0         1, 123, 705           72. 00         07200         IMPL.         DEV.         CHARGED TO PATI ENTS         382, 380         0         0         0         382, 382	8, 705 71.00 2, 380 72.00
72. 00 07200 TMLE. DEV. CHARGED TO PATIENTS 0 0 0 0 0	0 73.00
	7,826 76.00
76. 01 03480 0NC0L0GY 1, 877, 122 242, 291 236, 668 0 2, 356, 0UTPATI ENT SERVICE COST CENTERS	<u>, 081</u> 76. 01
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0	0 88.00
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0	0 89.00
	, 879 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 92.00
OTHER REI MBURSABLE COST CENTERS           101. 00         10100         HOME HEALTH AGENCY         669, 200         0         31, 321         171, 887         872,	2, 408 101. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVIEW-SNF	113.00 114.00
	, 882 116.00
	2, 146 118. 00
NONREI MBURSABLE COST CENTERS           190. 00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         12, 660         12, 366         0         25,	026 190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0	0 194.00
194. 01 07951 MOB 655 0 0 0	655 194.01
194. 02         07952         COMMUNI TY HEALTH         88, 596         0         0         24, 386         112,           194. 03         07953         ASSI STED         LI VI NG/CAMERON WOODS         0 <td>2, 982 194. 02 0 194. 03</td>	2, 982 194. 02 0 194. 03
194. 04 07954 EDUCATI ON 24, 747 0 0 0 24,	, 747 194. 04
	0, 146 194. 05 0, 378 194. 06
194. 00 07950 G0E3T MEALS 40, 350 0 0 0, 022 40, 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0	0 194.07
194. 08 07958 CANCER CENTER 0 0 0 0	0 194.08
194. 09         07959         URGENT CARE         1, 244, 887         0         136, 628         278, 728         1, 660,           200. 00         Cross Foot Adjustments         1	
201.00 Negative Cost Centers 0 0 0	), 243 194. 09
202. 00         TOTAL (sum lines 118-201)         44, 851, 323         2, 270, 921         2, 597, 609         5, 226, 283         44, 851,	0, 243 194. 09 0 200. 00 0 201. 00

	Financial Systems	CAMERON MEMORI		0000 454045		u of Form CMS-2	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS			F	Period: From 10/01/2014 Fo 09/30/2015	Worksheet B Part I Date/Time Pre 9/6/2016 3:17	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 409, 292					5.00
7.00	00700 OPERATION OF PLANT	846, 942	4, 037, 122				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	50, 174	42, 669				8.00
9.00	00900 HOUSEKEEPI NG	278, 936	13, 500				9.00
10.00	01000 DI ETARY	68, 912	157, 580			497, 642	10.00
11.00		155, 643	79, 754			0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	275, 791	33, 669		-	0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	78, 198 570, 552	125, 196 46, 406			0	14.00
16.00	01600 MEDICAL RECORDS & LI BRARY	180, 888	40, 400			0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100,000	44,477		, <u> </u>	0	10.00
30.00	03000 ADULTS & PEDIATRICS	967, 326	618, 746	58, 380	430, 422	471, 817	30.00
31.00	03100 I NTENSI VE CARE UNI T	50, 081	47, 410			25, 825	31.00
43.00	04300 NURSERY	22, 293	16, 875			0	43.00
	ANCI LLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	608, 430				0	50.00
51.00	05100 RECOVERY ROOM	306, 092	285, 548			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	118, 145	131, 423			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	679, 236	306, 722			0	54.00
60.00		736, 302	111, 455			0	60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 187, 337	0 30, 937	-	-	0	64.00 65.00
65.00	06501 SLEEP LAB	66, 659	104, 464			0	65.00
66.00	06600 PHYSI CAL THERAPY	293, 066	224, 436			0	66.00
69.00	06900 ELECTROCARDI OLOGY	77,673	5, 746			0	69.00
69.01	06901 CARDI AC REHAB	48, 367	48, 857			0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	298, 326	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	101, 516	0	C	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C		0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	12, 697	16, 594			0	76.00
76. 01	03480 ONCOLOGY	625, 502	445, 980	C	0 0	0	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS	1					
88.00	08800 RURAL HEALTH CLINIC	0	0			0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	59, 177	27,000	-	-	0	89.00 90.00
90.00 91.00	09100 EMERGENCY	716, 244	27,000		, o	0	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	710,244	270,000	52,741	177, 507	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	231, 610	59, 022	219	6, 219	0	101.00
	SPECIAL PURPOSE COST CENTERS	•					
113.00	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11600 HOSPI CE	54, 924			0 0		116.00
118.00		8, 767, 039	3, 749, 887	281, 296	1, 336, 429	497, 642	118.00
100.00	NONREI MBURSABLE COST CENTERS		00.000				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 644	23, 303				190.00
	07950 DAYCARE-INFANT/TODDLER 07951 MOB	174		538			194.00 194.01
	207952 COMMUNI TY HEALTH	29, 995		030			194.01
	07953 ASSI STED LI VI NG/CAMERON WOODS	27, 793	0				194.02
	07954 EDUCATI ON	6, 570	0		0 0		194.04
	07955 MARKETI NG	145, 789	6, 469	c	0		194.05
194.06	07956 GUEST MEALS	12, 313	0	C	0		194.06
	07957 OUTSI DE LAUNDRY	0	0	C	0		194.07
10/ 00	07958 CANCER CENTER	0	0	0	0 0		194. 08
	07959 URGENT CARE	440, 768	257, 463	0	76, 265	0	194.09
194.09							
194.09 200.00	Cross Foot Adjustments						200.00
194.09	Cross Foot Adjustments Negative Cost Centers	0 9, 409, 292	0	C 281, 834	0 0 1, 412, 694		201.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	CAMERON MEMORI		CCN: 151315	In Lie Period:	u of Form CMS- Worksheet B	2552-10
GENERAL SERVICE CUSIS				Period: From 10/01/2014 To 09/30/2015	Worksheet B Part I Date/Time Pre 9/6/2016 3:17	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						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 CAFETERIA	896, 676					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	44, 999					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	19, 551					14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	22, 999					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	57,00			0 0	743, 047	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	171, 381	533, 389	21, 94	7 0	11, 596	30.00
31.00 03100 INTENSIVE CARE UNIT	6, 487			0 0		1
43. 00 04300 NURSERY	3, 039	9, 497		0 0	2, 161	43.00
ANCI LLARY SERVI CE COST CENTERS	- 1	1	1	1		
50. 00 05000 OPERATI NG ROOM	68, 452					
51.00 O5100 RECOVERY ROOM	46, 451			0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	15,060					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	99, 616 89, 364				209, 083 289, 529	
64. 00 06400 I NTRAVENOUS THERAPY	07, 302			0 0	207, 327	
65. 00 06500 RESPI RATORY THERAPY	1, 814	-		-		
65. 01 06501 SLEEP LAB				0 0	0	
66. 00 06600 PHYSI CAL THERAPY	49, 490	0	1, 44	0 0	89, 622	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	00		50, 523	69.00
69. 01 06901 CARDI AC REHAB	4,672		=0		32, 324	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	-			0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CHEMICAL DEPENDENCY	3, 810	-		0 2, 804, 994 3 0	0 2, 302	
76. 01 03480 ONCOLOGY	3,010					
OUTPATIENT SERVICE COST CENTERS		<u>,                                    </u>	1 10	0 0	0	1 / 0. 01
88.00 08800 RURAL HEALTH CLINIC	(	0 0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	11, 703				40, 126	
91.00 09100 EMERGENCY	125, 018	389, 202	22, 71	5 0	161, 802	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART						92.00
OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY	41, 234	0	1, 69	2 0	0	101.00
SPECIAL PURPOSE COST CENTERS	41,23		1,07	2 0	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116. 00 11600 HOSPI CE	11, 114	0	39	5 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	873, 315	1, 393, 281	536, 55	8 2, 804, 994	943, 849	118.00
NONREI MBURSABLE COST CENTERS		1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190.00
194. 00 07950  DAYCARE - I NFANT/TODDLER 194. 01 07951  MOB		-		0 0 1 0		194.00 194.01
194. 02 07952 COMMUNI TY HEALTH	6, 260	-				194.01
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS	0,200			0 0		194.02
194. 04 07954 EDUCATI ON	(	0		0 0		194.04
194. 05 07955 MARKETI NG	13, 790	0	23			194.05
194.0607956 GUEST MEALS	3, 311			0 0	0	194.06
194. 07 07957 OUTSI DE LAUNDRY	0	-		0 0		194.07
194. 08 07958 CANCER CENTER	0	-		0 0		194.08
194. 09 07959 URGENT_CARE	0	0	3, 83	9 0	0	194.09
200.00 Cross Foot Adjustments	· · ·					200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	896 676	-		0 0 9 2, 804, 994		201.00
202.00   10TAL (SUM TIMES 110-201)	896, 676	ין ו, גאס, 201	541, 25	2, 004, 994	943, 649	1202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	CAMERON MEMORI		CCN: 15131			u of Form CMS Worksheet B Part I	
						9/30/2015	Date/Time Pi 9/6/2016 3:	
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			<u>, , , , , , , , , , , , , , , , , , , </u>	
	1	24.00	25.00	26.00				
1 00	GENERAL SERVICE COST CENTERS		1					1 1 0
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY							1. 0 2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 14. 0
16.00	01600 MEDI CAL RECORDS & LI BRARY							16.0
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	6, 928, 641	(	6, 928	641			30.0
31.00	03100 I NTENSI VE CARE UNI T	359, 450			, 450			31. 0
43.00	04300 NURSERY	235, 374	. (	235	, 374			43.0
50.00	ANCI LLARY SERVI CE COST CENTERS	3, 909, 577	· (	3, 909	. 577			50.0
51.00	05100 RECOVERY ROOM	1, 948, 934	. (	1, 948	, 934			51.0
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM	792, 447			, 447			52.0 54.0
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	3, 998, 728 4, 215, 047						60.0
64.00	06400 I NTRAVENOUS THERAPY	0		D	0			64.0
65.00	06500 RESPIRATORY THERAPY	977, 255			, 255			65.0
65.01 66.00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	441, 697 1, 844, 121			, 697 , 121			65. 0 66. 0
69.00	06900 ELECTROCARDI OLOGY	427,012	. (	427	, 012			69.0
69.01	06901 CARDI AC REHAB	317, 362		1	, 362			69.0
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 626, 219		.,	, 219 , 860			71.0
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 804, 994	. (	2, 804	, 994			73.0
76.00	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	87,814			, 814			76.0
76. 01	OUTPATIENT SERVICE COST CENTERS	3, 427, 669	<u>/</u>	3, 427	, 009			76.0
88.00	08800 RURAL HEALTH CLINIC	(			0			88. 0
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	400, 221			0 , 221			89.0 90.0
	09100 EMERGENCY	4, 621, 558		400				90.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			D				92.0
101 00	OTHER REIMBURSABLE COST CENTERS	1, 212, 404		1, 212	404			101.0
101.00	SPECIAL PURPOSE COST CENTERS	1,212,402		1,212	, 404			
	11300 INTEREST EXPENSE							113.0
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	285, 409		285	, 409			114. 0 116. 0
118.00		41, 397, 793		41, 397				118.0
	NONREI MBURSABLE COST CENTERS		1		070			1.00.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	54, 973		54	, 973 0			190. 0 194. 0
194.01	07951 MOB	1, 478		1 1	, 478			194.0
	07952 COMMUNITY HEALTH	149, 750		149	, 750			194.0
	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION	31, 317		) ) 31	0 , 317			194.0 194.0
194.05	07955 MARKETI NG	715, 432	2 (	715	, 432			194. 0
		62,002		62	, 002			194.0
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER				0 0			194. 0 194. 0
194.09	07959 URGENT CARE	2, 438, 578		2,438	, 578			194. 0
200.00				D D	0			200.0
201.00	INEGALIVE COST CENTERS		л (	ע	U			201.0

	inancial Systems	CAMERON MEMORI				u of Form CMS-	2552-10
ALLOCATI	ON OF CAPITAL RELATED COSTS		Provi der	F	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Pre 9/6/2016 3:17	pared:
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ENERAL SERVICE COST CENTERS			1	T		
$\begin{array}{cccc} 2.\ 00 & 0 \\ 4.\ 00 & 0 \\ 5.\ 00 & 0 \\ 7.\ 00 & 0 \\ 8.\ 00 & 0 \\ 9.\ 00 & 0 \\ 10.\ 00 & 0 \\ 11.\ 00 & 0 \\ 13.\ 00 & 0 \\ 14.\ 00 & 0 \end{array}$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY		107, 285 225, 920 23, 181 7, 334 85, 609 43, 329 18, 292	177, 906 264, 748 22, 643 7, 164 83, 623 42, 322 17, 865 66, 438	285, 191 490, 668 45, 824 14, 498 169, 232 85, 652 36, 159 134, 454	5, 912 740 0 855 66 500 1, 093 219	5.00 7.00 8.00 9.00 10.00 11.00 13.00
		0					
	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	0	0	23, 603	3 23, 603	468	16.00
	3000 ADULTS & PEDIATRICS	0	336, 152	328, 348	664, 500	2, 736	30.00
	3100 INTENSIVE CARE UNIT	0				96	
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	9, 168	8, 955	5 18, 123	67	43.00
	5000 OPERATING ROOM	0	237, 271	231, 764	469, 035	1, 387	50.00
	5100 RECOVERY ROOM	0	155, 132	151, 531	306, 663	953	
	5200 DELIVERY ROOM & LABOR ROOM	0	,			331	1
	5400 RADI OLOGY-DI AGNOSTI C 6000 LABORATORY	0	166, 635 60, 551			1, 987 1, 274	
	6400 I NTRAVENOUS THERAPY	0	00, 551	59, 140		0	1
	6500 RESPI RATORY THERAPY	0	16, 808		-	61	65.00
	6501 SLEEP LAB	0	0	55, 436	55, 436	0	65.01
	6600 PHYSI CAL THERAPY	0	121, 931			925	
	6900 ELECTROCARDI OLOGY 6901 CARDI AC REHAB	0	3, 121 26, 543			0 90	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20, 343				
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	, e	0	
	3020 CHEMI CAL DEPENDENCY	0		8, 806			76.00
	3480 ONCOLOGY UTPATI ENT SERVI CE COST CENTERS	0	242, 291	236, 668	478, 959	0	76.01
	8800 RURAL HEALTH CLINIC	0	0	(	0 0	0	88.00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	· · · ·	0	89.00
	9000 CLINIC	0					90.00
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART	0	150, 264	146, 777	297, 041 0	2, 163	91.00 92.00
	THER REIMBURSABLE COST CENTERS		I	1	0		72.00
101.001	0100 HOME HEALTH AGENCY	0	0	31, 321	31, 321	837	101.00
	PECIAL PURPOSE COST CENTERS		[	1			1
	1300 INTEREST EXPENSE 1400 UTI LI ZATI ON REVIEW-SNF						113.00 114.00
	1600 HOSPI CE	0	0	6, 418	6, 418	183	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0					118.00
	ONREIMBURSABLE COST CENTERS		1				
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 660	12, 366	25, 026		190.00
	7950 DAYCARE-INFANT/TODDLER 7951 MOB	0					194.00 194.01
	7952 COMMUNI TY HEALTH	0	0		0 0		194.02
194.030	7953 ASSISTED LIVING/CAMERON WOODS	0	0	C C	0	0	194.03
	7954 EDUCATI ON	0	0	) ()	0		194.04
	7955 MARKETING 7956 GUEST MEALS	0	3, 514	3, 433	6,947		194.05 194.06
	7950 GUEST MEALS 7957 OUTSI DE LAUNDRY						194.06
	7958 CANCER CENTER	0	0		0		194.08
194.090	7959 URGENT CARE	0	0	136, 628	136, 628		194.09
200.00	Cross Foot Adjustments		_		0	-	200.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118–201)	0	0 2, 270, 921	2, 597, 609	0 0 4, 868, 530		201.00 202.00
202.00	TUTAL (SUII TITIES TIO-201)	1 0	2,210,921	2, 377, 009	4,000,030	Z0, 409	1202. UU

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS	_		F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet B Part II Date/Time Pre 9/6/2016 3:17	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 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 ADMI NI STRATI VE & GENERAL	291, 103					5.00
7.00	00700 OPERATION OF PLANT	26, 201					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 552	5, 471	52, 847			8.00
9.00	00900 HOUSEKEEPI NG	8, 629	1, 731	13, 048	38, 761		9.00
10.00	01000 DI ETARY	2, 132				192, 233	
11.00	01100 CAFETERI A	4, 815					•
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 532				0	
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 419				0	
15.00	01500 PHARMACY	17,651			-	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 596	5, 703	C	0	0	16.00
30.00	03000 ADULTS & PEDIATRICS	29, 944	79, 326	10, 947	11, 808	182, 257	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 549				9,976	
43.00	04300 NURSERY	690		1	2, 344	0	•
101.00	ANCI LLARY SERVICE COST CENTERS	0,0	2,101		2,011		
50.00	05000 OPERATI NG ROOM	18, 822	55, 995	7, 667	4, 347	0	50.00
51.00	05100 RECOVERY ROOM	9, 469				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 655	16, 850	667	665	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 013	39, 326	4, 370	3, 170	0	54.00
60.00	06000 LABORATORY	22, 778	14, 290	95	2, 003	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	-	-	-	0	64.00
65.00	06500 RESPI RATORY THERAPY	5, 795				0	
65.01	06501 SLEEP LAB	2,062				0	
66.00	06600 PHYSI CAL THERAPY	9,066				0	
69.00	06900 ELECTROCARDI OLOGY	2,403			-	0	•
69. 01 71. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 496				0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 229 3, 140				0	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 140				0	
76.00	03020 CHEMI CAL DEPENDENCY	393	-		-	0	•
76.01	03480 ONCOLOGY	19, 350				0	
	OUTPATIENT SERVICE COST CENTERS			-	-		
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	c c	0	0	89.00
90.00	09000 CLI NI C	1, 831	3, 462	C	0	0	90.00
91.00	09100 EMERGENCY	22, 158	35, 462	9, 889	4, 921	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	7, 165	7, 567	41	171	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS						1112 00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.00 114.00
	11600 HOSPICE	1, 699	1, 551		0	0	116.00
118.00		271, 234			36, 668		
110.00	NONREI MBURSABLE COST CENTERS	271,201	100,702	02,710	00,000	172,200	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	206	2, 988	C	0	0	190.00
	07950 DAYCARE-INFANT/TODDLER	0		C			194.00
194.01	07951 MOB	5	0	101	0	0	194.01
194.02	07952 COMMUNI TY HEALTH	928	0	C	0	0	194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	-	-	0		194.03
	07954 EDUCATI ON	203		-	0		194.04
	07955 MARKETI NG	4, 510			0		194.05
	07956 GUEST MEALS	381		C	0		194.06
	07957 OUTSI DE LAUNDRY	0	-	C	0		194.07
	07958 CANCER CENTER	0	-		0		194.08
	07959 URGENT CARE	13, 636	33, 010	n c	2, 093	0	194.09
200.00		_	_	_	_	_	200.00
201.00 202.00		0	-	E2 047	0		201.00
202.00	TOTAL (sum lines 118-201)	291, 103	517, 609	52, 847	38, 761	192,233	1202. UU

Health Financial Systems CAMERON MEMORIAL CO	MMUNI TY		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der		eriod: rom 10/01/2014	Worksheet B Part II	
		Te		Date/Time Pre 9/6/2016 3:17	epared:
Cost Center Description CAFETERIA N	JRSI NG	CENTRAL	PHARMACY	MEDI CAL	
ADMI N	II 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 & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP					1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 103, 627	EE 201				11.00
13. 00         01300         NURSI NG ADMI NI STRATI ON         5, 200           14. 00         01400         CENTRAL SERVI CES & SUPPLY         2, 259	55, 301 C				13.00
15. 00 01500 PHARMACY 2, 658	0		77, 693		15.00
16.00 01600 MEDI CAL_RECORDS & LI BRARY 4, 283	0	20	0	39, 673	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS         19, 808	21, 171	6, 329	0	487	30.00
31. 00 03100   NTENSI VE CARE UNI T 750	801		0	60	
43. 00 04300 NURSERY 351	377	0	0	91	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 7, 911	8, 459	18, 827	o	1, 112	50.00
51. 00 05100 RECOVERY ROOM 5, 368	5, 739		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM 1,740	1, 859	2, 363	0	0	
54. 00         05400         RADI OLOGY-DI AGNOSTI C         11, 512           60. 00         06000         LABORATORY         10, 328	0		0	8, 788	
60. 00         06000         LABORATORY         10, 328           64. 00         06400         I NTRAVENOUS THERAPY         0	0		0	12, 170 0	
65. 00 06500 RESPI RATORY THERAPY 210	0	1, 318	0	1, 130	
65. 01 06501 SLEEP LAB 0	0		0	0	
66. 00 06600 PHYSI CAL THERAPY 5, 719 69. 00 06900 ELECTROCARDI OLOGY 0	0		0	3, 767 2, 124	
69. 01 06901 CARDI AC REHAB 540	0		0	1, 359	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0	0	00,002	0	0	
72. 00         07200         I MPL.         DEV.         CHARGED TO PATIENTS         0           73. 00         07300         DRUGS         CHARGED TO PATIENTS         0	0		0 77, 693	0	
76. 00 03020 CHEMI CAL DEPENDENCY 440	0		0	97	
76. 01 03480 ONCOLOGY 0	C	31	0	0	76.01
			0	0	
88. 00 08800 RURAL HEALTH CLINIC 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	0		0	0	
90. 00 09000 CLINIC 1, 353	1, 447		0	1, 687	
91.00 09100 EMERGENCY 14,448	15, 448	6, 551	0	6, 801	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS					92.00
101.00 10100 HOME HEALTH AGENCY 4, 765	0	488	0	0	101.00
SPECIAL PURPOSE COST CENTERS					1
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF					113.00 114.00
116. 00 11600 HOSPI CE 1, 284	C	114	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 100,927	55, 301	154, 732	77, 693	39, 673	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0		0	0	0	190.00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 0 194. 00 07950 DAYCARE-I NFANT/TODDLER 0	0		0		190.00
194. 01 07951 MOB 0	0	32	0	0	194. 01
194. 02 07952 COMMUNITY HEALTH 723	0		0		194.02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 194. 04 07954 EDUCATI ON 0	0	0	0		194. 03 194. 04
194. 05 07955 MARKETI NG 1, 594	0	69	Ö		194.05
194. 06 07956 GUEST MEALS 383	0	0	0		194.06
194. 07 07957 OUTSI DE LAUNDRY 0 194. 08 07958 CANCER CENTER 0	0	0	0		194. 07 194. 08
194. 09 07939 CARCER CENTER 0	0	1, 107	0		194.08
200.00 Cross Foot Adjustments					200.00
201.00         Negative Cost Centers         0           202.00         TOTAL (sum lines 118-201)         103,627	0 55, 301	0	0 77, 693		201. 00 202. 00
202.00   TOTAL (sum lines 118-201)   103,627	55, 501	156, 088	11,093	37, 073	1202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	CAMERON MEMORI	Provi der	CCN:	151315	Peri od:	worksheet B	2002-
LLLOON				00111	101010	From 10/01/2014 To 09/30/2015	Part II	epared 7 pm
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		Total		<u>, , , , , , , , , , , , , , , , , , , </u>	
		24.00	25.00		26.00			
	GENERAL SERVICE COST CENTERS	1	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP							2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.0
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT							5.0
7.00 8.00	00800 LAUNDRY & LINEN SERVICE							8.0
9.00	00900 HOUSEKEEPING							9.0
10.00	01000 DI ETARY							10.0
11.00	01100 CAFETERIA							11. (
13.00	01300 NURSING ADMINISTRATION			1				13. (
14.00	01400 CENTRAL SERVICES & SUPPLY							14. (
15.00	01500 PHARMACY							15.0
16.00	01600 MEDICAL RECORDS & LIBRARY							16. (
	INPATIENT ROUTINE SERVICE COST CENTERS		1					
	03000 ADULTS & PEDIATRICS	1, 029, 313			1,029,3	13		30.0
	03100 I NTENSI VE CARE UNI T	70, 984			70, 9			31. (
13.00	04300 NURSERY	26, 478	C		26, 4	78		43.0
	ANCI LLARY SERVICE COST CENTERS	500 540	1		500 5	( ol		1 5 0 1
60.00	05000 OPERATING ROOM	593, 562		1	593, 5			50.0
1.00	05100 RECOVERY ROOM	365, 618			365,6			51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	169, 271			169, 2			52.
4.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	421, 512 223, 431			421, 5 223, 4			54. 60.
4.00	06400 I NTRAVENOUS THERAPY	223, 431		1	223, 4	0		64.
5.00	06500 RESPI RATORY THERAPY	46, 273	-		46, 2	-		65.0
5. 01	06501 SLEEP LAB	72, 084		1	72, 0			65.0
56.00	06600 PHYSI CAL THERAPY	293,006			293, 0			66. (
9.00	06900 ELECTROCARDI OLOGY	11, 578			11, 5			69. (
9. 01	06901 CARDI AC REHAB	62, 424	C		62,4	24		69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 111	C		68, 1	11		71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 125	c C		18, 1	25		72.0
	07300 DRUGS CHARGED TO PATIENTS	77, 693			77,6			73.
76.00	03020 CHEMI CAL DEPENDENCY	12, 032			12, 0			76.0
76. 01	O3480 ONCOLOGY	555, 520	C	0	555, 5	20		76.0
	OUTPATIENT SERVICE COST CENTERS							
38.00	08800 RURAL HEALTH CLINIC					0		88.
9.00 9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	39, 784		()	39, 7	-		89. 90.
	09100 EMERGENCY	414, 882		Ś.	414, 8			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	414,002	C		414,0	02		92.
2.00	OTHER REIMBURSABLE COST CENTERS			1				_ /2.
01.00	10100 HOME HEALTH AGENCY	52, 355	C		52, 3	55		101.0
	SPECIAL PURPOSE COST CENTERS							
13.00	11300 INTEREST EXPENSE							113. (
	11400 UTI LI ZATI ON REVI EW-SNF							114. (
	11600 HOSPI CE	11, 249			11, 2	49		116. (
18.00		4, 635, 285	C		4, 635, 2	85		
	NONREI MBURSABLE COST CENTERS		1			20		4-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28, 220			28, 2			190.
	07950 DAYCARE - I NFANT/TODDLER	100				0		194.
		138				38		194. 194.
	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS	1, 918			1, 9	0		194.
	07953 ASSISTED LIVING/CAMERON WOODS	203		í l	n	03		194.
	07955 MARKETI NG	14, 141		Ś	∠ 14, 1			194.
	07956 GUEST MEALS	793				93		194.
	07957 OUTSI DE LAUNDRY	/ / / 3			1	0		194.
	07958 CANCER CENTER	r				0		194.
	07959 URGENT CARE	187, 832			187, 8	32		194.
200.00		(0,002			, 0	0		200.
			) C			0		201.
201.00								

	Financial Systems ALLOCATION - STATISTICAL BASIS	CAMERON MEMORI			eri od:	worksheet B-1	2552-1
				F	rom 10/01/2014 o 09/30/2015	Date/Time Pre	
		CAPITAL REI	ATED COSTS			9/6/2016 3:17	pm
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5.00	
1 00	GENERAL SERVICE COST CENTERS	104 027		1	1		1 1 0
1.00 2.00 4.00 5.00 7.00 3.00 9.00 10.00 11.00 13.00 14.00 15.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	104, 037 590 4, 915 10, 350 1, 062 336 3, 922 1, 985 838 3, 116 1, 155	121, 831 590 8, 344 12, 417 1, 062 336 3, 922 1, 985 838 3, 116 1, 155	4, 034, 626 505, 778 C 583, 751 45, 277 341, 577 746, 641 149, 869	-9, 409, 292 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 190, 180 188, 991 1, 050, 670 259, 572 586, 262 1, 038, 822 294, 547	8.00 9.00 10.00 11.00 13.00 14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 107	319, 570	0	681, 353	16.00
30. 00 31. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS O3000  ADULTS & PEDI ATRI CS O3100  I NTENSI VE CARE UNI T O4300  NURSERY ANCI LLARY SERVI CE COST CENTERS	15, 400 1, 180 420	15, 400 1, 180 420	65, 391	0	188, 641	30. 00 31. 00 43. 00
50.00 51.00 52.00 54.00 60.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI 0LOGY-DI AGNOSTI C 06000 LABORATORY	10, 870 7, 107 3, 271 7, 634 2, 774	10, 870 7, 107 3, 271 7, 634 2, 774	650, 704 226, 206 1, 357, 421 870, 045		2, 558, 483 2, 773, 434	51.00 52.00 54.00 60.00
54.00 55.00 55.01 56.00 59.00 59.01	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 069001 CARDI AC REHAB	0 770 0 5, 586 143 1, 216	0 770 2, 600 5, 586 143 1, 216	631, 697 C		705, 642	65.0 <sup>°</sup> 66.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY 03480 ONCOLOGY	0 0 0 11, 100	0 0 0 413	C C C 28, 122		1, 123, 705 382, 380 0 47, 826	71.0 72.0 73.0 76.0
91.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 672 6, 884	0 0 672 6, 884	128, 407	0	0 222, 904	90.0
101.00	OTHER REIMBURSABLE COST CENTERS	0	1, 469	571, 841	0	872, 408	101. 0
114.00		0 103, 296	301 114, 682	125, 040 16, 227, 257		206, 882	
194.00 194.01	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-I NFANT/TODDLER 07951 MOB	580 0 0	580 0 0	C C	0	0 655	194. 0 194. 0
194.03 194.04 194.05 194.06	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY	0 0 0 161 0 0	0 0 0 161 0 0	81, 127 C C 131, 320 20, 035 C		0 24, 747 549, 146 46, 378	194. 0 194. 0 194. 0
194. 09 200. 00 201. 00	Negative Cost Centers	0	0 6, 408			1, 660, 243	200. 0 201. 0
202.00 203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	2, 270, 921 21. 828013				9, 409, 292 0. 265484 291, 103	203. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)			0. 001464		0. 008213	

	ancial Systems	CAMERON MEMORI				u of Form CMS-	
COST ALLOC	CATION - STATISTICAL BASIS		Provi der		eriod: rom 10/01/2014	Worksheet B-1	
				T	o 09/30/2015	Date/Time Pre 9/6/2016 3:17	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	
		7.00	8.00	9.00	10.00	11.00	
	ERAL SERVICE COST CENTERS 00 CAP REL COSTS-BLDG & FIXT						1.00
	00 CAP REL COSTS-MVBLE EQUIP						2.00
	00 EMPLOYEE BENEFITS DEPARTMENT						4.00
	OO ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT	100, 480					5.00 7.00
	00 LAUNDRY & LINEN SERVICE	1, 062					8.00
	00 HOUSEKEEPI NG	336					9.00
	00 DI ETARY	3, 922					10.00
		1, 985				19, 767	1
	00 NURSI NG ADMI NI STRATI ON 00 CENTRAL SERVI CES & SUPPLY	838				992 431	1
	00 PHARMACY	1, 155				507	
	00 MEDICAL RECORDS & LIBRARY	1, 107		C	0	817	16.00
	ATIENT ROUTINE SERVICE COST CENTERS	15 400	0.000	1 015	12.2/4	0.770	1 20 00
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT	15, 400 1, 180				3, 778 143	1
	00 NURSERY	420				67	43.00
	ILLARY SERVICE COST CENTERS						1
	OO OPERATING ROOM	10, 870				1, 509	
	OO RECOVERY ROOM OO DELIVERY ROOM & LABOR ROOM	7, 107	450 568			1, 024 332	1
	00 RADI OLOGY-DI AGNOSTI C	7,634				2, 196	1
	00 LABORATORY	2, 774				1, 970	1
	00 INTRAVENOUS THERAPY	0	0		-	0	
	00 RESPI RATORY THERAPY	770				40	1
	01 SLEEP LAB 00 PHYSI CAL THERAPY	2, 600 5, 586				0 1, 091	1
	00 ELECTROCARDI OLOGY	143				0	1
	01 CARDI AC REHAB	1, 216	112	C	0	103	1
	00 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	-		0	0	1
	00 I MPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	0	0			0	
	20 CHEMI CAL DEPENDENCY	413	-			84	
	80 ONCOLOGY	11, 100	0	C	0	0	76.01
	PATIENT SERVICE COST CENTERS	0	0		ol	0	
	00 FEDERALLY QUALIFIED HEALTH CENTER		-		-	0	
	OO CLINIC	672	0	C		258	1
	00 EMERGENCY	6, 884	8, 427	548	0	2, 756	
	00 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	ER REIMBURSABLE COST CENTERS	1, 469	35	19	0	909	101.00
	CIAL PURPOSE COST CENTERS	1,10,		1		,,,,	
	00 INTEREST EXPENSE						113.00
	00 UTI LI ZATI ON REVI EW-SNF	201				245	114.00
116.00116 118.00	SUBTOTALS (SUM OF LINES 1-117)	301 93, 331					116.00 118.00
	REIMBURSABLE COST CENTERS	70,001	11, 710	1,000		17,202	
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580					190.00
	50 DAYCARE - I NFANT/TODDLER	0			-		194.00
194.01079	51 MOB 52 COMMUNITY HEALTH	0	86		0		194. 01 194. 02
	53 ASSI STED LI VI NG/CAMERON WOODS	0	0	C	0		194.03
194.04 079	54 EDUCATI ON	0	0	C	0		194.04
	55 MARKETI NG	161	0	C			194.05
	56 GUEST MEALS 57 OUTSI DE LAUNDRY	0					194.06 194.07
	58 CANCER CENTER	0	0	c c	-		194.08
194.09079	59 URGENT CARE	6, 408	0	233	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	4, 037, 122	281, 834	1, 412, 694	497, 642	896, 676	201.00
202.00	Part I)	4,037,122	201,034	1, 412, 094	477,042	070,070	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	40. 178364				45.362270	
204.00	Cost to be allocated (per Wkst. B,	517, 609	52, 847	38, 761	192, 233	103, 627	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	5. 151363	1. 173543	8. 980769	13. 740743	5. 242424	205, 00
	11)				101.107.10	0. 2 12 12 7	

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	CAMERON MEMORIA		CCN: 151315	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
CUST ALLOCATION - STATISTICAL DASIS		Provider	1	From 10/01/2014	Date/Time Prepared:
Cost Costor Description					9/6/2016 3: 17 pm
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY	
	(DI RECT NRSI NG HR)	(COSTED REQUI S. )		(TIME SPENT)	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	
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 5. 00 00500 ADMINISTRATIVE & GENERAL					4.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING					8.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	205, 243	3, 179, 634			13.00
15. 00 01500 PHARMACY	0	12, 857		D	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	414	(	87, 337	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	78, 573	128, 925		1,073	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 972	120, 723		132	31.00
43.00 04300 NURSERY	1, 399	0	(	200	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	31, 395	383, 514		2,449	50.00
51. 00 05100 RECOVERY ROOM	21, 300	000,011		0 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 899	48, 126		0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	39, 587 831, 036		0 19, 347 0 26, 791	54.00 60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	031,030		0 0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	26, 850		2, 488	65.00
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	0	0 8, 462		-	65. 01 66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 936		0, 293 0, 4, 675	69.00
69. 01 06901 CARDI AC REHAB	0	1, 500			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 199, 503 305, 263			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	305, 203			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	18		213	76.00
76. 01 03480 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	0	624	(	0 0	76. 01
88.00 08800 RURAL HEALTH CLINIC	0	0	(	0 0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	89.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	5, 372 57, 333	16, 701 133, 439		0 3, 713 0 14, 972	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	07,000	100, 107		, , , , , , , , , , , , , , , , , , , ,	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	9, 937		0 0	101.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		2 222			114.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	205, 243	2, 322 3, 152, 014		87,337	116. 00 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	
194. 00 07950  DAYCARE-INFANT/TODDLER 194. 01 07951  MOB	0	0 655			194. 00 194. 01
194. 02 07952 COMMUNI TY HEALTH	0	3, 015		0 0	194. 02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS	0	0	(	0	194.03
194. 04 07954  EDUCATI ON 194. 05 07955  MARKETI NG	0	0 1, 397			194. 04 194. 05
194. 06 07956 GUEST MEALS	0	0		0 0	194.06
194. 07 07957 OUTSI DE LAUNDRY	0	0	(	0 0	194.07
194. 08 07958  CANCER CENTER 194. 09 07959  URGENT CARE	0	0 22, 553		ס וכ ה וכ	194. 08 194. 09
200.00 Cross Foot Adjustments		22,000			200.00
201.00 Negative Cost Centers	4 000 000	<b>-</b> · · ·	0.001		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 393, 281	541, 259	2, 804, 994	4 943, 849	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 788446	0. 170227	28, 049. 94000	10. 806978	203.00
	55, 301	156, 088			204.00
204.00 Cost to be allocated (per Wkst. B,	55, 501	100,000			
204.00Cost to be allocated (per Wkst. B, Part II)205.00Unit cost multiplier (Wkst. B, Part	0. 269442	0. 049090			

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151315	Peri od:	Worksheet C	
				From 10/01/2014	Part I	norod.
				To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
		Ti †I	e XVIII	Hospi tal	Cost	pin
				Costs	0001	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.	-				
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	6, 928, 641		6, 928, 64		0	
31. 00 03100 I NTENSI VE CARE UNI T	359, 450		359, 45		0	31.00
43. 00 04300 NURSERY	235, 374		235, 37	74 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1	I	1			-
50. 00 05000 OPERATI NG ROOM	3, 909, 577		3, 909, 57		0	50.00
51.00 05100 RECOVERY ROOM	1, 948, 934		1, 948, 93		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	792, 447		792, 44		0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 998, 728		3, 998, 72		0	54.00
60. 00 06000 LABORATORY	4, 215, 047		4, 215, 04		0	
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	977, 255		,=		0	65.00
65.01 06501 SLEEP LAB	441, 697	0	441, 69		0	65.01
66. 00 06600 PHYSI CAL THERAPY	1, 844, 121	0	1, 844, 12		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	427,012		427, 01		0	69.00
69. 01 06901 CARDI AC REHAB	317, 362		317, 36		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 626, 219		1, 626, 21		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	535, 860		535, 86		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 804, 994		2, 804, 99		0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	87, 814		87, 81		0	76.00
76. 01 03480 ONCOLOGY	3, 427, 669		3, 427, 66	59 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90. 00 09000 CLI NI C	400, 221		400, 22	21 0	0	
91. 00 09100 EMERGENCY	4, 621, 558		4, 621, 55		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 168, 591		1, 168, 59	91	0	92.00
OTHER REIMBURSABLE COST CENTERS	-i					
101.0010100HOME HEALTH AGENCY	1, 212, 404		1, 212, 40	)4	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116. 00 11600 HOSPI CE	285, 409		285, 40			116.00
200.00 Subtotal (see instructions)	42, 566, 384		,,			200.00
201.00 Less Observation Beds	1, 168, 591		1, 168, 59			201.00
202.00  Total (see instructions)	41, 397, 793	0	41, 397, 79	93 0	0	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	CAMERON MEMORIA		CCN: 151315	Peri od:	u of Form CMS- Worksheet C	2002 1
SUMPORTION OF RATIO OF COSTS TO CHARGES		TTOVIDEI	CON. 131313	From 10/01/2014 To 09/30/2015	Part I Date/Time Pre	pared:
					9/6/2016 3:17	pm
			e XVIII	Hospi tal	Cost	
		Charges			TEEDA	
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other Ratio	TEFRA Inpatient	
			+ col. 7)	Ratio	Ratio	
	6.00	7.00	8.00	9,00	10.00	-
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	5, 910, 589		5, 910, 58	39		30.00
31. 00 03100 I NTENSI VE CARE UNI T	422, 562		422, 56			31.00
43. 00 04300 NURSERY	361, 120		361, 12			43.00
ANCI LLARY SERVI CE COST CENTERS	0017120		001,12			1
50. 00 05000 0PERATI NG ROOM	1, 469, 869	7, 460, 614	8, 930, 48	0. 437779	0. 000000	50.00
51.00 05100 RECOVERY ROOM	293, 845	1, 633, 975			0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	342, 370	479, 183			0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 300, 707	25, 500, 833			0.000000	
60. 00 06000 LABORATORY	2, 130, 767	11, 806, 970			0.000000	
54.00 06400 INTRAVENOUS THERAPY	0	0		0 0.000000	0. 000000	64.0
65. 00 06500 RESPI RATORY THERAPY	1,000,900	572, 922	1, 573, 82	0. 620944	0. 000000	65.0
65. 01 06501 SLEEP LAB	0	837, 343	837, 34	0. 527498	0. 000000	65. 0 <sup>4</sup>
66. 00 06600 PHYSI CAL THERAPY	733, 511	2, 218, 370	2, 951, 88	0. 624727	0. 000000	66.00
59. 00 06900 ELECTROCARDI OLOGY	107, 174	1, 207, 313	1, 314, 48	0. 324851	0. 000000	69.0
69. 01 06901 CARDI AC REHAB	17, 772	310, 593			0. 000000	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	769, 350	1, 663, 296	2, 432, 64	0. 668498	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	393, 524	518, 690	912, 21	4 0. 587428	0.000000	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 264, 530	5, 145, 331	6, 409, 86	0. 437606	0.000000	73.0
76. 00 03020 CHEMI CAL DEPENDENCY	0	24, 399	24, 39	3. 599082	0. 000000	76.0
76. 01 03480 ONCOLOGY	2, 698	7, 604, 940	7, 607, 63	0. 450556	0. 000000	76.0
OUTPATIENT SERVICE COST CENTERS	· · · ·					1
38.00 08800 RURAL HEALTH CLINIC	0	0		0		88. 0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
90. 00 09000 CLINIC	78	473, 632	473, 71	0 0.844865	0. 000000	90.0
91. 00 09100 EMERGENCY	540, 605	11, 949, 625	12, 490, 23	0. 370014	0. 000000	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	233, 339	786, 878	1, 020, 21	7 1.145434	0. 000000	92.0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 110, 825	1, 110, 82	25		101. 0
SPECIAL PURPOSE COST CENTERS	_		-			
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.0
116. 00 11600 H0SPI CE	0	471, 051				116.0
200.00 Subtotal (see instructions)	17, 295, 310	81, 776, 783	99, 072, 09	93		200. 0
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	17, 295, 310	81, 776, 783	99, 072, 09	93		202.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prep 9/6/2016 3:17	pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	- F				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	_				
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
65. 01 06501 SLEEP LAB	0. 000000				65.01
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHAB	0. 000000				69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 107200 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000				76.00
76. 01 03480 0NC0L0GY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS	0.000000				76.01
					88.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00 09000 CLINIC	0. 000000				89.00 90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000				92.00
OTHER REI MBURSABLE COST CENTERS					101 00
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE					112 00
					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
116.00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)				I	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 151315         Period: Tro 10/9730/2015         Period: Part I (20)         Provider CCN: 151315         Period: Tro 10/9730/2015         Period: Part I (20)         Provider CCN: 151315         Period: Part I (20)         Period: Part I (20)	Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
To         09/30/2015         Date/Time Prepared Vol/2016 3.17 pm           Cost Center Description         Title XIX         Hospital         PPS           Cost Center Description         Total Cost (from Wkst. B) Part 1, col. 20         Therapy Limit Adj.         Total Costs         RCE D is all owance         Total Costs           1000         03000 ADULTS & PEDIATRICS         6, 928, 641         6, 928, 641         0         6, 928, 641         30.00           30.00         04300 AURES & PEDIATRICS         6, 928, 641         0, 928, 945         0         30.00         4.00         5.00           30.00         04300 INTERSI VE CASE UNIT         359, 450         359, 450         0         235, 374         0         225, 374         0         225, 374         43.00           30.00         05000 OPERATING ROOM         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         1, 948, 934         0         1, 928, 947         55.00           52.00         05000 DELIVERY ROM         1, 948, 934         1, 944, 934         1, 944, 934         1, 944, 934         1, 944, 934         1, 947, 651         0         907, 255         0         977, 255         0 <td< td=""><td>COMPUTATION OF RATIO OF COSTS TO CHARGES</td><td></td><td>Provi der</td><td>CCN: 151315</td><td></td><td></td><td></td></td<>	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151315			
Cost Center Description         Total Cost (from Wist, B, Part I, col.         Therapy Lim t Adj.         Therapy Lim t Adj.         Hospital Total Costs         PPS           0.00         03000 ADULTS & PEDIATRICS         0.00         3.00         4.00         5.00           30.00         03000 ADULTS & PEDIATRICS         6.928, 641         0.6928, 641         0.6928, 641         30.00           30.00         03000 INTERSIVE COST CENTERS         5.928, 641         359, 450         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.399, 577         0.00         0.998, 728         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00         0.999, 577         0.00 <td></td> <td></td> <td></td> <td></td> <td>From 10/01/2014</td> <td>Part I</td> <td></td>					From 10/01/2014	Part I	
Image: Cost Center Description         Total Cost (from Wist. B, Part I, col. 200         Total Cost Center Description         Total Cost (from Wist. B, Part I, col. 200         RCE         Total Cost S           0.00         03000 ADULTS & PEDIATRICS         0.928,641         0.928,641         0.928,641         0.00         5.00           1.00         2.00         3.00         4.00         5.00         1.00         3.00         4.00         5.00           0.00         03000 ADULTS & PEDIATRICS         0.928,641         0.60,928,641         0.00         0.00         2.35,374         0.253,374         0.253,374         3.00           0.43.00 NURSERV         2.35,374         2.35,374         0.253,374         0.253,374         3.00         2.45,374         3.00           0.43.00 NURSERV         2.35,374         1.948,934         0.948,934					10 09/30/2015	Date/lime Pre	pared:
Cost Center Description         Total Cost (Prom Wkst. B, Part I, col. 26)         Therapy Linit Adj.         Therapy Linit Adj.         Total Costs Total Costs         Total Costs Disal Iowance         Total Costs           1000         200         3.00         4.00         5.00           30.00         03000 NUTSE RVICE COST CENTERS         6,928,641         0,6,928,641         0,6,928,641         0,6,928,641         30,00           31.00         03100 INTERSIVE CARE UNIT         359,450         359,450         359,450         359,450         31,00           30.00         05100 INTERSIVE CARE UNIT         359,450         3,909,577         0         3,909,577         50,00           51.00         05100 RECOVERY ROM         1,948,934         1,948,934         1,948,934         1,948,934         51,00           52.00         05200 DELIVERY ROMA         1,399,7728         3,909,577         0,00         60,00         60,00           50.00         05400 RADI CLOSY-DI AGNORTIC         3,998,728         3,998,728         3,998,728         50,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         60,00         <			Ti t		Hosni tal		piii
Cost Center Description         Total Cost (from Wkst, B Part I, col., 20         Therapy Limit Adj.         Total Costs Adj.         RCE Disal I owance         Total Costs           30:00         03000 ADULTS & PEDIATRICS         6,928,641         6,928,641         6,928,641         0         6,928,641         30,00           30:00         04300 NUBSERY         235,374         235,374         0         235,374         30,00           43:00         04300 NUBSERY         235,374         235,374         0         235,374         43.00           50:00         05000 PERATING ROOM         1,948,934         1,948,934         1,948,934         50.00           51:00         05100 DELIVERY NOM & LABOR ROOM         1,948,934         1,948,934         1,948,934         50.00           52:00         05200 DELIVERY NOM & LABOR ROOM         1,948,934         1,948,121         0         1,844,121         1,844,121<			110			115	
Impart ext         Error West. B, 26, 20         Adj.         Disal I owance           1         100         2.00         3.00         4.00         5.00           30         00         03000 ADULTS & PEDIATRICS         6.928,641         0.6928,641         30.00           31.00         03100 INTENSIVE CARE UNIT         359,450         359,450         359,450         31.00           43.00         04300 MUSTS & PEDIATRICS         6.928,641         3.999,577         0         3,999,577         0         3,999,577         0         3,999,577         50.00         05000 DELOYERY ROOM         1,948,934         1,948,934         1,948,934         1,948,934         51.00         52.00         52.00         05000 DELOYERY ROOM         1,948,934         1,948,934         51.00         52.00         52.00         06000 RADIOTS & PEDIATRICS         3,999,577         0         3,999,572         50.00         52.0	Cost Center Description	Total Cost	Therapy limit	Total Costs		Total Costs	
Part I, col.         Part I, col.         Aug         Aug           1000         2:00         3:00         4:00         5:00           30:00         03000 ADULTS & PEDIATRICS         6:928,641         6:928,641         0         6:928,641         0         6:928,641         0         6:928,641         0         0         3:00         0         0:000 (DULTS & PEDIATRICS         6:928,641         0         0         3:00         3:00         3:00         3:00         3:00         3:00         3:00         3:00         3:00         5:00         5:000         0:5000 (DELINERY ROCAR LUNI T         3:909,577         0         3:909,577         0         3:909,577         0         3:909,577         0         1:92,447         5:00           5:00         0:5000 (DELINERY ROOM & LABOR ROOM         1:948,934         1:948,934         1:948,934         1:944,52.047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         4:215,047         6:00         6:00         6:00         6:00         6:00         6:00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>iotal oboto</td> <td></td>						iotal oboto	
26)         20         3.00         4.00         5.00           IMPATI ENT ROUTI NE SERVICE COST CENTERS         -							
INPATI ENT ROUTINE SERVICE COST CENTERS         0							
30:00       03000       ADULTS & PEDIATRICS       6.928, 641       0, 6.928, 641       0, 6.928, 641       30.00         31:00       03100       INTERSIVE CARE UNIT       359, 450       359, 450       0       359, 450       31.00         ANGLLARY SERVICE COST CENTERS       235, 374       235, 374       0       235, 374       43.00         ANGLLARY SERVICE COST CENTERS       0       235, 374       0       3, 909, 577       0       3, 909, 577       50.00         51:00       05100 RECOVERY ROM       1, 948, 934       1, 948, 934       0       1, 948, 934       51.00         52:00       05200 DELIVERY ROM & LABOR ROM       722, 447       0       722, 447       0       722, 447       0       722, 447       0       722, 447       0       726, 447       0			2.00	3.00	4.00	5.00	
31.00       O3100       INTENSIVE CARE UNIT       359, 450       359, 450       359, 450       31.00         A3.00       O4300 UNESERY       235, 374       235, 374       0       235, 374       43.00         ANCILLARY SERVICE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS			•			
43:00       04300       ANCILLARY SERVICE COST CENTERS       43.00         ANCILLARY SERVICE COST CENTERS       50.00       05000       0FRATING ROOM       3,909,577       3,909,577       0       3,909,577       50.00         51.00       05000       0FRATING ROOM       1,948,934       1,948,934       0       1,948,934       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       792,447       0       792,447       0       792,447       62.00       56.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00       64.00       66.00       65.00       65.00       65.00       65.00       65.00       65.01       95.55       977,255       0       977,255       60.077,255       60.077,255       60.077,255       60.077,255       60.01       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.01       66.01       66.01       66.01       66.01       66.01       66.01       66.01       66.00       66.00       66.00       66.00       66.00       66.00       65.06       65.06       65.06       65.06       65.06       65.06       65.06       65.06	30. 00 03000 ADULTS & PEDI ATRI CS	6, 928, 641		6, 928, 64	11 0	6, 928, 641	30.00
43.00         0         235, 374         235, 374         235, 374         0         235, 374         0         235, 374         0         235, 374         0         235, 374         0         235, 374         0         235, 374         0         235, 374         0         235, 374         0         3, 909, 577         0         3, 909, 577         0         3, 909, 577         50, 00         64, 00         64, 00         64, 00         64, 00         64, 00         64, 00         64, 00         64, 00         64, 00         64, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 01         66, 01         64, 01         64, 10         64, 01         64, 00         66, 01         66, 01         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 00         66, 01         60, 01         60, 01<	31.00 03100 INTENSIVE CARE UNIT	359, 450		359, 45	50 0	359, 450	31.00
50.00       05000       0PERATINC ROOM       3, 909, 577       3, 909, 577       0       3, 909, 577       51.00         51.00       05100       RECOVERY ROOM       1, 948, 934       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       1, 948, 934       0       792, 447       0       792, 447       0       792, 447       0       792, 447       0       792, 447       0	43. 00 04300 NURSERY	235, 374				235, 374	43.00
51.00       05100       RECOVERY ROOM       1,948,934       1,948,934       1,948,934       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       792,447       0       3,998,728       3,998,728       3,998,728       0       3,998,728       0       0       0       0       0       44,215,047       0       4,215,047       0       4,00       0       60.00       60.00       65.00       65.01       0       65.00       65.01       0       66.00       60.01       73.02       73.02       73.02       73.02       73.02       73.02       73.02       73.02       73.02<	ANCI LLARY SERVI CE COST CENTERS	<u>.</u>	•	•			
52.00       05200       DELIVERY ROOM & LABOR ROOM       792,447       792,447       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       3,998,728       3,998,728       0       3,998,728       4,215,047       0       4,215,047       0       4,215,047       0       4,215,047       0	50.00 05000 OPERATI NG ROOM	3, 909, 577		3, 909, 57	77 0	3, 909, 577	50.00
54.00       05400       RADI OLOGY - DI AGNOSTI C       3, 998, 728       3, 998, 728       4, 215, 047       4, 215, 047       0       4, 215, 047       0       4, 215, 047       0       0.00       0 <td< td=""><td>51.00 05100 RECOVERY ROOM</td><td>1, 948, 934</td><td></td><td>1, 948, 93</td><td>34 0</td><td>1, 948, 934</td><td>51.00</td></td<>	51.00 05100 RECOVERY ROOM	1, 948, 934		1, 948, 93	34 0	1, 948, 934	51.00
60.00       06000       LABORATORY       4, 215, 047       0       4, 215, 047       0       60.00         64.00       06400       INTRAVENUUS THERAPY       0       0       0       60.00         65.00       06500       RESPIRATORY THERAPY       977, 255       0       977, 255       0       977, 255       50.01         65.01       06501       SLEEP LAB       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       441, 697       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       42, 200       0       0       0       0       0       0       0       0       0       0       0       0 </td <td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td> <td>792, 447</td> <td></td> <td>792, 44</td> <td>17 0</td> <td>792, 447</td> <td>52.00</td>	52.00 05200 DELIVERY ROOM & LABOR ROOM	792, 447		792, 44	17 0	792, 447	52.00
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       977, 255       0	54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 998, 728		3, 998, 72	28 0	3, 998, 728	54.00
65.00       06500       RESPIRATORY THERAPY       977, 255       0       977, 255       0       977, 255       65.00         66.01       06501       SLEEP LAB       441, 697       0       441, 697       0       441, 697       0       441, 697       0       65.01         66.00       0600       PHYSICAL THERAPY       1.844, 121       0       1.844, 121       0       1.844, 121       0       427, 012       427, 012       60.00         69.01       06901       CARDIA CA EHAB       317, 362       317, 362       0       317, 362       0       71.00       71.00       CALS SUPPLIES CHARGED TO PATIENT       1.626, 219       1.626, 219       1.626, 219       1.626, 219       72.00       72.00       73.00       DT300       DRUGS CHARGED TO PATIENTS       2.804, 994       2.804, 994       0       2.804, 994       73.00         76.00       03202       CHEMICAL DEPENDENCY       87.814       87.814       0       87.814       0       87.814       76.01         03480       ONCOLOGY       3.427, 669       3.427, 669       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	60. 00 06000 LABORATORY	4, 215, 047		4, 215, 04	17 0	4, 215, 047	60.00
65.01       06501       SLEEP LAB       441, 697       0       441, 697       0       441, 697       65.01         66.00       06600       PHYSI CAL THERAPY       1, 844, 121       0       1, 844, 121       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       427, 012       0       71, 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       1, 626, 219       1, 626, 219       1, 626, 219       1, 626, 219       1, 626, 219       0       535, 860       0       535, 860       0       535, 860       0       330       00       0       0       0       3427, 669       0       3, 427, 669       0       3, 427, 669       0       3, 427, 669       0 <td< td=""><td>64.00 06400 INTRAVENOUS THERAPY</td><td>0</td><td></td><td></td><td>0 0</td><td>0</td><td>64.00</td></td<>	64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
66.00       06600       PHYSI CAL THERAPY       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       0.900       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       1,844,121       0       427,012       0       427,012       0       427,012       0       0       0       0       0       0       0       1,626,219	65. 00 06500 RESPI RATORY THERAPY	977, 255	0	977, 25	55 0	977, 255	65.00
69.00       66900       ELECTROCARDIOLOGY       427,012       427,012       0       427,012       69.00         69.00       06901       CARDIAC REHAB       317,362       317,362       0       317,362       69.01         71.00       OT100       MEDICAL SUPPLIES CHARGED TO PATIENT       1,626,219       1,626,219       0       1,626,219       71.00         72.00       O7200       IMPL. DEV. CHARGED TO PATIENTS       535,860       535,860       0       535,860       72.00         73.00       O7300       DRUGS CHARGED TO PATIENTS       2,804,994       2,804,994       0       2,804,994       73.00         76.00       03202       CHEMICAL DEPENDENCY       87,814       87,814       0       87,814       76.00         03480       ONCOLOGY       3,427,669       0       3,427,669       0       88.00         99.00       08900       FDERALLY QUALIFIED HEALTH CENTER       0       0       0       89.00         90.00       090000       CLINIC       400,221       400,221       0       400,221       90.00         91.00       09100       EMERGENCY       4,621,558       0       4,621,558       91.00       91.00       91.00       92.00       0BSE	65.01 06501 SLEEP LAB	441, 697	0	441, 69	97 0	441, 697	65.01
69.01       06901       CARDI AC REHAB       317, 362       317, 362       0       317, 362       69.01         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       1, 626, 219       1, 626, 219       0       1, 626, 219       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535, 860       535, 860       0       535, 860       72.00         73.00       ORUGS CHARGED TO PATIENTS       2, 804, 994       2, 804, 994       0       2, 804, 994       0       2, 804, 994       73.00       73.00       87, 814       87, 814       87, 814       0       87, 814       76.00       76.01       03480       00.000 (OCU OGY       3, 427, 669       0       3, 427, 669       76.01       0       88.00       88.00       88.00       88.00       88.00       88.00       88.00       88.00       88.00       89.00       0       0       0       0       0       89.00       89.00       90.00       0	66. 00 06600 PHYSI CAL THERAPY	1, 844, 121	0	1, 844, 12	21 0	1, 844, 121	66.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       1, 626, 219       1, 626, 219       0       1, 626, 219       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535, 860       535, 860       0       535, 860       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2, 804, 994       2, 804, 994       0       2, 804, 994       0       87, 814       0       87, 814       0       87, 814       0       87, 814       0       87, 814       0       87, 814       0       3, 427, 669       76.01         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       0       88.00       88.00       88.00       88.00       8900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89.00	69. 00 06900 ELECTROCARDI OLOGY	427, 012		427, 01	0	427, 012	69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535,860       535,860       0       535,860       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,804,994       2,804,994       0       2,804,994       73.00         76.00       03020       CHEMI CAL DEPENDENCY       87,814       87,814       0       87,814       76.00       0       0       0       0       0       0       0       0       0       0       0       87,809       88.00       89.00       89.00       0       99.00       0       00       0       0       90.00       210,00       0       90.00       210,00       90.00       2110	69. 01 06901 CARDI AC REHAB	317, 362		317, 36	52 0	317, 362	69.01
73.00       07300       DRUGS CHARGED TO PATIENTS       2,804,994       2,804,994       0       2,804,994       73.00         76.00       03020       CHEMICAL DEPENDENCY       87,814       87,814       0       87,814       76.00         76.01       03480       ONCOLOGY       3,427,669       0       3,427,669       0       3,427,669       76.01         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       0       88.00       0800       RURAL HEALTH CLINIC       0       0       0       0       89.00       9900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89.00       99000       CLINIC       400,221       400,221       0       400,221       90.00       99.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       92.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 626, 219		1, 626, 21	0 0	1, 626, 219	71.00
76.00       03020       CHEMI CAL DEPENDENCY       87,814       87,814       0       87,814       76.00         76.01       03480       ONCOLOGY       3,427,669       0       3,427,669       0       3,427,669       76.01         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       88.00       08800       RURAL HEALTH CLINIC       0       0       0       88.00       89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       89.00       00       90.00 <td< td=""><td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td><td>535, 860</td><td></td><td>535, 86</td><td>50 0</td><td>535, 860</td><td>72.00</td></td<>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	535, 860		535, 86	50 0	535, 860	72.00
76. 01       03480       ONCOLOGY       3, 427, 669       0       3, 427, 669       0       3, 427, 669       76. 01         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       88.00         88.00       08900       RURAL HEALTH CLINIC       0       0       0       0       88.00         90.00       09000       CLINIC       400, 221       0       400, 221       0       400, 221       90.00         90.00       09100       EMERGENCY       4, 621, 558       4, 621, 558       0       4, 621, 558       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       1, 168, 591       1, 168, 591       1, 168, 591       92.00         0THER REI MBURSABLE COST CENTERS       0       1, 212, 404       1, 212, 404       1, 212, 404       101.00         101.00       10100       HOME HEALTH AGENCY       1, 212, 404       1, 212, 404       113.00       113.00         113.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00       114.00       285, 409       285, 409       285, 409       114.00         200.00       Subtotal (see instructions)       42, 566, 384       0       42, 566, 384       0       42, 566, 384       <		2, 804, 994		2, 804, 99	94 0	2, 804, 994	73.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         09000         CLINIC         400,221         400,221         0         400,221         90.00           91.00         09100         EMERGENCY         4,621,558         0         4,621,558         91.00           92.00         09200         DOBSERVATI ON BEDS (NON-DI STINCT PART         1,168,591         1,168,591         92.00           0THER REIMBURSABLE COST CENTERS         0         1,212,404         1,212,404         1,212,404         101.00           01000         HOME HEALTH AGENCY         1,212,404         1,212,404         1,212,404         101.00           113.00         1NTEREST EXPENSE         113.00         1NTEREST EXPENSE         113.00         114.00         114.00         114.00         124,566,384         0         42,566,384         0         42,566,384         0         42,566,384         0         42,566,384         0         42,566,384         0         42,566,384         0         0.00         0.00         0.00	76.00 03020 CHEMI CAL DEPENDENCY	87, 814		87, 81	4 0	87, 814	76.00
88.00       08800       RURAL HEALTH CLINIC       0       0       0       0       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89.00         90.00       09000       CLINIC       400,221       400,221       0       400,221       90.00         91.00       09100       EMERGENCY       4,621,558       0       4,621,558       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       1,168,591       1,168,591       92.00         0THER REIMBURSABLE COST CENTERS       0       1,212,404       1,212,404       1,212,404       101.00         101.00       HOME HEALTH AGENCY       1,212,404       1,212,404       1,212,404       101.00         SPECIAL PURPOSE COST CENTERS       113.00       114.00       11400 UTI LI ZATI ON REVI EW-SNF       114.00       114.00       114.00       114.00       285,409       285,409       285,409       285,409       285,409       114.00       106.00       1060       042,566,384       0       42,566,384       0       42,566,384       0       42,566,384       0       42,566,384       00.00       1,168,591       11.00         100       Less Observati on Beds<	76. 01 03480 ONCOLOGY	3, 427, 669		3, 427, 66	59 0	3, 427, 669	76.01
89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       89.00         90.00       09000       CLINIC       400,221       400,221       0       400,221       90.00         91.00       09100       EMERGENCY       4,621,558       4,621,558       0       4,621,558       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       1,168,591       1,168,591       92.00         0THER       REI MBURSABLE COST CENTERS       0       1,212,404       1,212,404       1,212,404       101.00         01000       HOME HEALTH AGENCY       1,212,404       1,212,404       1,212,404       113.00         113.00       11300       INTEREST EXPENSE       113.00       11300       114.00       114.00       114.00       285,409       285,409       114.00         116.00       I1600       HOSPI CE       285,409       285,409       285,409       116.00         200.00       Subtotal (see instructions)       42,566,384       0       42,566,384       0       42,566,384       0       42,566,384       200.00         201.00       Less Observation Beds       1,168,591       1,168,591       1,168,591       201.00	OUTPATIENT SERVICE COST CENTERS						
90.00       09000       CLINIC       400,221       400,221       0       400,221       90.00         91.00       09100       EMERGENCY       4,621,558       4,621,558       0       4,621,558       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DISTINCT PART       1,168,591       1,168,591       92.00         0THER       REI MBURSABLE       COST CENTERS       1,212,404       1,212,404       1,212,404       101.00         101.00       1000       HOME HEALTH       AGENCY       1,212,404       1,212,404       101.00         SPECIAL PURPOSE COST CENTERS         113.00       11300       INTEREST EXPENSE       113.00         114.00       11400       UTILIZATION REVIEW-SNF       114.00       285,409       285,409       114.00         200.00       Subtotal (see instructions)       42,566,384       0       42,566,384       0       42,566,384       200.00         201.00       Less Observation Beds       1,168,591       1,168,591       1,168,591       201.00		0			0 0	0	88.00
91. 00       09100       EMERGENCY       4, 621, 558       0       4, 621, 558       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       1, 168, 591       1, 168, 591       1, 168, 591       92. 00         07HER       REI MBURSABLE       COST CENTERS       1       1, 168, 591       1, 168, 591       92. 00         101. 00       10100       HOME       HEALTH       AGENCY       1, 212, 404       1, 212, 404       1, 212, 404       101. 00         SPECIAL PURPOSE COST CENTERS         113. 00       11300       INTEREST EXPENSE       113. 00       114.00       114.01 LI ZATI ON REVI EW-SNF       114. 00       116. 00       1060       285, 409       285, 409       285, 409       114. 00         200. 00       Subtotal (see instructions)       42, 566, 384       0       42, 566, 384       0       42, 566, 384       00. 00         201. 00       Less Observation Beds       1, 168, 591       1, 168, 591       1, 168, 591       1, 168, 591       201. 00		0				0	89.00
92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       1, 168, 591       1, 168, 591       92.00         0THER REIMBURSABLE COST CENTERS         101.00       10100       HOME HEALTH AGENCY       1, 212, 404       1, 212, 404       101.00         SPECIAL PURPOSE COST CENTERS         113.00       11300       INTEREST EXPENSE       113.00       114.00       114.00       114.00       114.00       1160, FOP (285, 409)       114.00       116.00       1160, OP (285, 409)       116		400, 221		400, 22	21 0	400, 221	90.00
OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY         1, 212, 404         1, 212, 404         1, 212, 404         101.00           SPECIAL         PURPOSE         COST         CENTERS         113.00         1NTEREST         113.00         1NTEREST         113.00         114.00         114.00         114.00         114.00         114.00         116.00         11600         11600         11600         116.00         1160.00         1160.00         1285, 409         285, 409         285, 409         114.00         114.00         114.00         114.00         114.00         116.00         1000         1160.00         1000         285, 409         285, 409         114.00		4, 621, 558		4, 621, 55	58 0	4, 621, 558	91.00
101.00       10100       HOME HEALTH AGENCY       1, 212, 404       1, 212, 404       1, 212, 404       101.00         SPECIAL PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00       113.00       113.00       114.00       114.00       114.00       114.00       116.00       1060       285, 409       285, 409       114.00       285, 409       114.00       285, 409       114.00       114.00       116.00       100.00       285, 409       114.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 168, 591		1, 168, 59	91	1, 168, 591	92.00
SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE           114.00         11400         UTI LI ZATI ON REVIEW-SNF           116.00         11600         HOSPI CE           200.00         Subtotal (see instructions)         42, 566, 384         0         42, 566, 384         0         42, 566, 384         0         42, 566, 384         200.00           201.00         Less Observation Beds         1, 168, 591         1, 168, 591         1, 168, 591         201.00							
113.00       11300       INTEREST EXPENSE       113.00         114.00       11400       UTI LI ZATI ON REVI EW-SNF       114.00         116.00       11600       HOSPI CE       285,409       285,409         200.00       Subtotal (see instructions)       42,566,384       0       42,566,384       0         201.00       Less Observation Beds       1,168,591       1,168,591       1,168,591       201.00	101.0010100 HOME HEALTH AGENCY	1, 212, 404		1, 212, 40	04	1, 212, 404	101.00
114.00       11400       UTI LI ZATI ON REVIEW-SNF       114.00         116.00       11600       HOSPI CE       285,409         200.00       Subtotal (see instructions)       42,566,384       0       42,566,384       0         201.00       Less Observation Beds       1,168,591       1,168,591       1,168,591       201.00							
116.0011600HOSPI CE285, 409285, 409285, 409116.00200.00Subtotal (see instructions)42, 566, 384042, 566, 384042, 566, 384200.00201.00Less Observation Beds1, 168, 5911, 168, 5911, 168, 591201.00							
200.00         Subtotal (see instructions)         42, 566, 384         0         42, 566, 384         0         42, 566, 384         0         42, 566, 384         200.00           201.00         Less Observation Beds         1, 168, 591         1, 168, 591         1, 168, 591         1, 168, 591         201.00							
201.00         Less Observation Beds         1, 168, 591         1, 168, 591         1, 168, 591         201.00		285, 409			)9		
			-	,,			
202.00           Total (see instructions)           41, 397, 793         0  41, 397, 793         0  41, 397, 793         202.00				1, 168, 59	91		
	202.00  Total (see instructions)	41, 397, 793	0	41, 397, 79	93 0	41, 397, 793	202.00

Health Financial Systems	CAMERON MEMORIA		CCN: 151315	Peri od:	u of Form CMS- Worksheet C	2002 .
		11 OVI del		From 10/01/2014	Part I	
				To 09/30/2015	Date/Time Pre 9/6/2016 3:17	epared:
		Ti t	le XIX	Hospi tal	PPS	рш
		Charges		incopri cui		
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
•		·	+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	5 010 500		5 010 50			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 910, 589		5, 910, 58			30.00
31. 00 03100 I NTENSI VE CARE UNI T	422, 562		422, 56			31.00
43. 00 04300 NURSERY	361, 120		361, 12	20		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1, 469, 869	7, 460, 614	8, 930, 48	0. 437779	0. 000000	50.00
51.00 05100 RECOVERY ROOM	293, 845	1, 633, 975			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	342, 370	479, 183			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 300, 707	25, 500, 833			0. 000000	
50. 00 06000 LABORATORY	2, 130, 767	11, 806, 970			0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	2,100,707	0	10, 707, 70	0 0.000000	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	1,000,900	572, 922	1, 573, 82		0.000000	
65. 01 06501 SLEEP LAB	0	837, 343			0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	733, 511	2, 218, 370	2, 951, 88	0. 624727	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	107, 174	1, 207, 313	1, 314, 48	0. 324851	0.000000	69.00
69. 01 06901 CARDI AC REHAB	17, 772	310, 593	328, 36	0. 966492	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	769, 350	1, 663, 296	2, 432, 64	6 0. 668498	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	393, 524	518, 690			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 264, 530	5, 145, 331			0.00000	
76. 00 03020 CHEMI CAL DEPENDENCY	0	24, 399			0.00000	
76. 01 03480 ONCOLOGY	2, 698	7, 604, 940	7, 607, 63	0. 450556	0. 000000	76.0
OUTPATIENT SERVICE COST CENTERS	-	-	1			1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0.00000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.00000	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	78	473, 632			0. 000000	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	540, 605 233, 339	11, 949, 625 786, 878			0.000000	
OTHER REIMBURSABLE COST CENTERS	233, 339	/00,0/0	1, 020, 21	1.140434	0.00000	92.00
101.00 10100 HOME HEALTH AGENCY	0	1, 110, 825	1, 110, 82	5		101.00
SPECIAL PURPOSE COST CENTERS	0	1, 110, 023	1, 110, 02	.5		
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
116. 00 11600 HOSPI CE	0	471,051	471, 05	51		116.00
200.00 Subtotal (see instructions)	17, 295, 310	81, 776, 783				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	17, 295, 310	81, 776, 783	99, 072, 09	3		202.00

alth Financial Systems MPUTATION OF RATIO OF COSTS TO CHARGES	CAMERON MEMORIAL	Provider CCN: 151315	Peri od:	u of Form CMS-2552- Worksheet C
			From 10/01/2014	Part I
			To 09/30/2015	Date/Time Prepared 9/6/2016 3:17 pm
			11	
Cost Conton Description	DDC Innationt	Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio			
	11,00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDIATRICS				30.
1. 00 03100 INTENSIVE CARE UNIT				31.
3. 00 04300 NURSERY				43.
ANCI LLARY SERVICE COST CENTERS				43.
0. 00 05000 OPERATING ROOM	0, 437779			50.
. 00 05100 RECOVERY ROOM	1. 010952			51.
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 964572			52.
. 00 05200 BEELVERT ROOM & EABOR ROOM	0. 149198			54.
0. 00 06000 LABORATORY	0. 302420			60.
4. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.
5. 00 06500 RESPIRATORY THERAPY	0. 620944			65.
0 00 00500 RESPIRATORY THERAPY	0. 527498			65.
0.00 06600 PHYSICAL THERAPY	0. 527498			65. 66.
	0. 324851			69.
2. 00 06900 ELECTROCARDI OLOGY 2. 01 06901 CARDI AC REHAB	0. 324851			
	0. 668498			69. 71.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 587428			71.
3. 00 07200 TMPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 437606			72.
	3. 599082			76.
0.01 03480 ONCOLOGY	0. 450556			76.
OUTPATIENT SERVICE COST CENTERS	0.000000			88.
B. OO  08800  RURAL HEALTH CLINIC P. OO  08900  FEDERALLY QUALIFIED HEALTH CENTER	0.000000			88. 89.
0. 00 009000 FEDERALLY QUALIFIED HEALTH CENTER	0. 844865			89. 90.
. 00 09100 EMERGENCY	0. 370014			
	1. 145434			91. 92.
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	1. 145434			92.
D1. 0010100 HOME HEALTH AGENCY				101.
SPECIAL PURPOSE COST CENTERS				101.
3. 00 11300 I NTEREST EXPENSE				113.
4. 00 11400 UTI LI ZATI ON REVI EW-SNF				113.
16. 00 11600 HOSPI CE				114.
00.00 Subtotal (see instructions)				200.
01.00 Less Observation Beds				200. 201.
02.00 Total (see instructions)				201.
J2. UU   IULAI (SEE HISTIUCTIONS)	I I			202.

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY         Provider CCN: 151315         Period From 10/01/2014 To 09/30/2015         Worksheet C Provider CN: 151315         Worksheet C From 10/01/2014 Provider CN: 151315         Worksheet C From 10/01/2014 Provider CN: 151315         Worksheet C Provider CN: 1	Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
Cost Center Description         Total Cost (Wkst. B, Part (Wkst. B, Part Net of Capital n. col. 26)         Hospital Cost Col. 2         Hospital Reduction         PPS           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         3.909,577         593,562         3.316,015         0         0         50.00           51.00         05100 RECOVERY ROOM         1.948,934         365,618         1.583,316         0         55.00           52.00         05200 DELIVERY ROOM         1.948,934         365,618         1.583,316         0         0         55.00           64.00         05200 DELIVERY ROOM         1.948,934         34,21,512         3.77,216         0         0         52.00           64.00         06400 INTRAVENUS THERAPY         0         0         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         66.01         67.01         66.01         67.01 <td></td> <td>ATIOS NET OF</td> <td>Provi der</td> <td>CCN: 151315</td> <td>From 10/01/2014</td> <td>Part II Date/Time Pre</td> <td>pared:</td>		ATIOS NET OF	Provi der	CCN: 151315	From 10/01/2014	Part II Date/Time Pre	pared:
Image: Constraint of the second sec			Ti t	le XIX	Hospi tal	PPS	
Image: Constraint of the second sec	Cost Center Description	Total Cost	Capital Cost	Operating Co	st Capital	Operating Cost	
Image: Service cost centers         1.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATI NG ROOM         3,909,577         593,562         3,316,015         0         0         50.00           50.00         DECOVERY ROOM         1,948,934         365,618         1,583,316         0         0         50.00           52.00         DELUVERY ROM         1,948,934         365,618         1,583,316         0         0         52.00           52.00         DELUVERY ROM         4,245,1047         223,431         3,991,616         0         52.00         0         0         0         64.00         64.00         65.00         0         65.00         0.00         0         0         0         0         0         0         0         0         0         66.00         1.51.15         0         0         66.00         66.00         66.00         67.01         72.00		(Wkst. B, Part	(Wkst. B, Part	Net of Capit	al Reduction		
I         1         00         2.00         3.00         4.00         5.00           50.00         05000         OPERATI NG ROOM         3,909,577         593,562         3,316,015         0         0         50.00           51.00         05100         RECOVERY ROOM         1,948,934         365,618         1,583,316         0         0         51.00           52.00         05200         DELV EERY ROOM & LABOR ROOM         792,447         169,271         623,176         0         0         52.00           54.00         Ob5400         RADI OLOGY-DI AGNOSTI C         3,998,728         421,512         3,577,216         0         0         60.00         60.00         66.00         64.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         69.01         0         66.00         69.01         66.00         69.01         66.01         66.01         66.00         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
ANCL LLARY SERVICE COST CENTERS         Image: Cost of Centers           MACK LLARY SERVICE COST CENTERS         3, 909, 577         593, 562         3, 316, 015         0         0         50.00           05000 (DECOVERY ROOM         1, 948, 934         365, 618         1, 583, 316         0         0         51.00           52.00         DSLUVERY ROOM         1, 948, 934         365, 618         1, 583, 316         0         0         52.00           54.00         DSGOO (PAD LOLOGV-DI AGNOSTI C         3, 982, 728         421, 512         3, 577, 216         0         0         0         0         0         0         66.00           64.00         D6400 (LABORATORY         4, 215, 047         223, 431         3, 991, 616         0         66.00         69.00         67.00         67.01         67.111         1, 55.81.018         0         0         71.00				col. 2)			
50:00       05000       05000       05100       0500       05000       05000       05000       05000       05000       05000       05000       05000       05000       05000       05000       05111       05101       0511		1.00	2.00	3.00	4.00	5.00	
51.00       05100       RECOVERY ROOM       1,948,934       365,618       1,583,316       0       0       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       792,447       169,271       623,176       0       0       54.00         54.00       05400       RADO RADI OLCGY-DI AGNOSTI C       3,998,728       421,512       3,577,216       0       0       60.00       60.00       60.00       1NTRAVENUOSI THERAPY       0       0       0       66.00       67.01       66.00       66.00       67.01       66.00       67.01       66.00       67.01       66.00       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.00       67.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52.00       05200       DELIVERY ROOM & LABOR ROOM       792,447       160,271       623,176       0       0       52.00         54.00       05400       RADIOLOCY-DIAGNOSTIC       3,998,728       421,512       3,577,216       0       0       54.00       0       60.00       0       60.00       0		3, 909, 577	593, 562	3, 316, 0		0	
54.00       RADI OLOGY-DI AGNOSTI C       3,998,728       421,512       3,577,216       0       54.00         60.00       06000       LABORATORY       4,215,047       223,431       3,991,616       0       0       64.00         64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       64.00         65.01       06500       RESPI RATORY THERAPY       977,255       46,273       930,982       0       0       65.00         65.01       06600       PHYSI CAL THERAPY       977,255       46,273       930,982       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       1,844,121       293,006       1,551,115       0       0       66.00         69.01       06901       CARDI AC REHAB       317,362       62,424       254,938       0       0       69.00         71.00       07100       IMDL AC REHAB       317,352       60       72.00       73.00       7300       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00		1, 948, 934	365, 618	1, 583, 3	16 0	0	51.00
60.00       06000       LABDRATORY       4, 215, 047       223, 431       3, 991, 616       0       60.00       64.00       0       64.00       0       0       0       0       0       0       0       66.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.01       65.00       65.00       65.01       65.00       67.01       69.01       77.01       0       77.00       73.00       73.00       73.00 <t< td=""><td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td><td>792, 447</td><td>169, 271</td><td>623, 1</td><td>76 0</td><td>0</td><td>52.00</td></t<>	52.00 05200 DELIVERY ROOM & LABOR ROOM	792, 447	169, 271	623, 1	76 0	0	52.00
64.00       06400       INTRAVENOUS THERAPY       0       0       0       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       977, 255       46, 273       930, 982       0       65.01         65.01       06500       RESPI RATORY THERAPY       977, 255       46, 273       930, 982       0       65.01         66.00       06600       PHYSI CAL THERAPY       1, 844, 121       293, 006       1, 551, 115       0       66.00         69.01       06900       ELCTROCARDI OLOCY       427, 012       11, 578       415, 434       0       69, 01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       1, 626, 219       68, 111       1, 558, 108       0       71.00         72.00       07200       INPL. DEV.       CHARGED TO PATI ENTS       535, 860       18, 125       517, 735       0       72, 00         76.00       03020       CHEMI CAL DEPENDENCY       87, 814       12, 032       75, 782       0       76.00         76.01       03480       RUCLOGY       3, 427, 669       555, 520       2, 872, 149       0       0       76.00         70.00       03000       RLBAL HEALTH CLINIC       0       0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 998, 728	421, 512	3, 577, 2	16 0	0	54.00
65.00         06500         RESPI RATORY THERAPY         977, 255         46, 273         930, 982         0         0         65.00           66.01         06501         SLEEP LAB         441, 697         72, 084         369, 613         0         0         65.00           67.01         06900         ELECTROCARDIOLOGY         427, 012         11, 578         415, 434         0         0         69.00           69.01         ORPIO CAL THERAPY         1, 844, 121         293, 006         1, 551, 115         0         0         69.00           69.01         ORPIO CAL THERAPY         1, 844, 121         293, 006         1, 551, 115         0         0         69.00           0         06901         CARDI AC REHAB         317, 362         62, 424         254, 938         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         535, 860         18, 125         517, 735         0         0         73.00           76.00         03020         CHARGED TO PATI ENTS         2, 804, 994         77, 693         2, 727, 301         0         0         76.00           76.00         03020         CHARGED TO PATI ENTS         2, 804, 994         75, 520         2,	60. 00 06000 LABORATORY	4, 215, 047	223, 431	3, 991, 6	16 0	0	60.00
65.01       06501       SLEEP LAB       441,697       72,084       369,613       0       65.01         66.00       06600       PHYSI CAL THERAPY       1,844,121       293,006       1,551,115       0       0       66.00         69.00       06900       LECTROCARDI OLOGY       427,012       11,578       4115,434       0       0       69.01         69.01       06901       CARDI AC REHAB       317,362       62,424       254,938       0       0       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       1,626,219       68,111       1,558,108       0       0       71.00         72.00       07200       DPL. DEV. CHARGED TO PATIENTS       2,804,994       77,693       2,727,301       0       73.00       73.00         76.01       03480       ORCOGY       3,427,669       555,520       2,872,149       0       76.00         71.00       09000       CLENIC COST CENTERS       400,221       39,784       360,437       0       99.00       99.00         89.00       08900       FUBERALLY QUALIFIED HEALTH CENTER       0       0       0       99.00       99.00       99.00       99.00       99.00       99.00       99.00 </td <td>64.00 06400 INTRAVENOUS THERAPY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>64.00</td>	64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
66.00       06600       PHYSI CAL THERAPY       1,844,121       293,006       1,551,115       0       0600       66.00         69.01       06900       ELECTROCARDI OLOGY       427,012       11,578       415,434       0       0       69.00         69.01       0ARDI AC REHAB       317,362       62,424       254,938       0       0       71.00       0       0       71.00       0       72.00       0       72.00       0       72.00       72.00       72.00       72.00       72.00       72.00       73.00       73.00       73.00       73.00       73.00       73.00       75.52       0       75.782       0       0       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01	65. 00 06500 RESPI RATORY THERAPY	977, 255	46, 273	930, 9	82 0	0	65.00
69.00       06900       ELECTROCARDI OLOGY       427,012       11,578       415,434       0       0       69.00         69.01       06901       CARDI AC REHAB       317,362       62,424       254,938       0       0       69.00         71.00       07200       IMPL. DEV. CHARGED TO PATI ENT       1,626,219       68,111       1,558,108       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       2,804,994       77,693       2,727,301       0       0       73.00         76.01       03480       ONCOLOGY       87,814       12,032       75,782       0       0       76.00         004700       MERCLEC COST CENTERS       0       0       0       0       88.00       0800       RURAL HEALTH CLINIC       0       0       0       88.00       0       88.00       0       99.00       0       99.00       99.00       0       99.00       0       0       0       0       0       90.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.00       99.	65.01 06501 SLEEP LAB	441, 697	72, 084	369, 6	13 0	0	65.01
69.01       06901       CARDI AC REHAB       317, 362       62, 424       254, 938       0       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       1, 626, 219       68, 111       1, 558, 108       0       71.00         72.00       07300       DRUGS CHARGED TO PATIENTS       535, 860       18, 125       517, 735       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2, 804, 994       77, 693       2, 727, 301       0       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       73.00       0       0       73.00       0       0       76.00       76	66. 00 06600 PHYSI CAL THERAPY	1, 844, 121	293, 006	1, 551, 1	15 0	0	66.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       1,626,219       68,111       1,558,108       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535,860       18,125       517,735       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,804,994       77,693       2,727,301       0       0       73.00         76.00       03202       CHEMI CAL DEPENDENCY       87,814       12,032       75,782       0       0       76.00         0UTPATIENT SERVICE COST CENTERS       87,814       12,032       75,782       0       0       76.00         88.00       0800       RURAL HEALTH CLINIC       0       0       0       0       76.00         90.00       09000       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       99.00         91.00       09000       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       99.00       99.00         92.00       09200       DESERVATION BEDS (NON-DI STINCT PART       1,168,591       173,605       994,986       0       0       91.00         92.00       DTHER REI MBURSABLE COST CENTERS       113.00       114.00	69. 00 06900 ELECTROCARDI OLOGY	427, 012	11, 578	415, 4	34 0	0	69.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       1,626,219       68,111       1,558,108       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535,860       18,125       517,735       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,804,994       77,693       2,727,301       0       0       73.00         76.01       03480       ONCOLOGY       3,427,669       555,520       2,872,149       0       0       76.01         0UTPATIENT SERVICE COST CENTERS       88.00       0800       RURAL HEALTH CLINIC       0       0       0       0       88.00       88.00       9900       6900       9200       0       0       0       92.00       99.00       0       99.00       99.	69. 01 06901 CARDI AC REHAB	317, 362	62, 424	254, 9	38 0	0	69.01
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       535,860       18,125       517,735       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       2,804,994       77,693       2,727,301       0       0       73.00         76.00       0340       ORCOLOGY       87,814       12,032       75,782       0       0       76.00         0UTPATIENT SERVICE COST CENTERS       0       0       76.00       0       0       0       76.00         00000       FEDERALLY QUALIFIED HEALTH CLINIC       0       0       0       0       0       88.00         88.00       0800       RURAL HEALTH CLINIC       0       0       0       0       88.00       89.00         90.00       09000       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       0       0       90.00         91.00       O9100       EMERGENCY       4,621,558       414,882       4,206,676       0       0       92.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       1,212,404       52,355       1,160,049       0       0       101.00         91.00       IHMERSABLE COST CENTERS       113.00       113.00       114.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 626, 219	68, 111	1, 558, 1	08 0	0	71.00
76.00       03020       CHEMI CAL DEPENDENCY       87,814       12,032       75,782       0       0       76.00         03480       ONCOLOGY       3,427,669       555,520       2,872,149       0       0       76.01         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       0       76.01         88.00       08900       FDERALLY QUALI FIED HEALTH CENTER       0       0       0       0       88.00         90.00       09000       CLINIC       400,221       39,784       360,437       0       0       90.00         91.00       OP100       EMERGENCY       4,621,558       414,882       4,206,676       0       91.00       92.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       1,168,591       173,605       994,986       0       0       0       92.00         01100       HOME HEALTH AGENCY       1,212,404       52,355       1,160,049       0       0       101.00         SPECI AL PURPOSE COST CENTERS       113.00       11300       11400       11400       0       114.00       114.00       114.00       114.00       0       0       0       0       0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					0	72.00
76.00       03020       CHEMI CAL DEPENDENCY       87,814       12,032       75,782       0       0       76.00         76.01       03480       ONCOLOGY       3,427,669       555,520       2,872,149       0       0       76.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       88.00         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       88.00         90.00       09000       CLINIC       400,221       39,784       360,437       0       90.00       90.00       91.00       92.00       920.00	73.00 07300 DRUGS CHARGED TO PATIENTS	2, 804, 994	77, 693	2, 727, 3	01 0	0	73.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0	76.00 03020 CHEMI CAL DEPENDENCY	87, 814	12,032			0	76.00
OUTPATIENT SERVICE COST CENTERS           88.00         OB800 RURAL HEALTH CLINIC         0         0         0         0         88.00           89.00         O8900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         89.00           90.00         09000 CLINIC         400,221         39,784         360,437         0         0         90.00           91.00         09100 EMERGENCY         4,621,558         414,882         4,206,676         0         0         91.00           92.00         09200 (DSERVATION BEDS (NON-DISTINCT PART         1,168,591         173,605         994,986         0         0         92.00           0THER REIMBURSABLE COST CENTERS         113.00         11300         INTEREST EXPENSE         113.00         11300         11400         114.00 REVIEW-SNF         114.00         114.00         114.00         114.00         114.00         0         0         0         0         200.00         0         0         200.00         0         0         0         0         114.00         114.00         114.00         114.00         114.00         114.00         0         0         0         0         0         0         114.00         0 <td< td=""><td>76. 01 03480 ONCOLOGY</td><td>3, 427, 669</td><td>555, 520</td><td>2, 872, 1</td><td>49 0</td><td>0</td><td>76.01</td></td<>	76. 01 03480 ONCOLOGY	3, 427, 669	555, 520	2, 872, 1	49 0	0	76.01
88.00         08800         RURAL         HEALTH         CLINIC         0         0         0         0         0         88.00           89.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER         0         0         0         0         0         89.00           90.00         09000         CLINIC         400,221         39,784         360,437         0         0         90.00           91.00         09100         EMERGENCY         4,621,558         414,882         4,206,676         0         0         91.00           92.00         OBSERVATION BEDS (NON-DISTINCT PART         1,168,591         173,605         994,986         0         0         92.00           0THER         REI MBURSABLE         COST CENTERS         111.00         101.00         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td>1</td></t<>						-	1
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00         90.00         90.00         CLINIC         400,221         39,784         360,437         0         0         90.00		0	C	)	0 0	0	88.00
91.00       09100       EMERGENCY       4, 621, 558       414, 882       4, 206, 676       0       0       91.00         92.00       09200       0BSERVATION       BEDS (NON-DISTINCT PART       1, 168, 591       173, 605       994, 986       0       0       92.00         0THER       REI MBURSABLE       COST CENTERS       1, 212, 404       52, 355       1, 160, 049       0       0       0       101.00         SPECIAL       PURPOSE       COST CENTERS       113.00       11400       UTI LIZATION REVIEW-SNF       114.00       114.00       114.00       114.00       0       0       0       0       116.00       0       0       116.00       0       0       0       0       0       0       116.00       0       0       0       0       0       114.00       0       114.00       0       0       0       0       114.00       0       0       0       0       0       0       0       0       101.60       0       0       0       0       0       0       114.00       0       0       0       0       0       0       0       116.00       0       0       0       0       0       0       0	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			0	89.00
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         1,168,591         173,605         994,986         0         0         92.00           OTHER REIMBURSABLE COST CENTERS         0         114.00         114.00         114.00         0         0         0         0         0         114.00         0         114.00         0         0         0         0         0         10         0         0         0	90. 00 09000 CLINIC	400, 221	39, 784	360, 4	37 0	0	90.00
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         1,168,591         173,605         994,986         0         0         92.00           OTHER REIMBURSABLE COST CENTERS         0         114.00         114.00         114.00         0         0         0         0         0         114.00         0         114.00         0         0         0         0         0         10         0         0         0	91. 00 09100 EMERGENCY	4, 621, 558	414, 882	4, 206, 6	76 0	0	91.00
OTHER REI MBURSABLE COST CENTERS           101.00         OTHER REI MBURSABLE COST CENTERS           101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         101.00         SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         114.00         114.00         114.00         0         0         0         0         113.00         113.00           114.00         285, 409         11, 249         274, 160         0         0         0         200.00         200.00         200.00         200.00						0	92.00
101.00         10100         HOME         HEALTH         AGENCY         1, 212, 404         52, 355         1, 160, 049         0         0         0         101.00           SPECIAL         PURPOSE         COST         CENTERS         113.00         11300         INTEREST         EXPENSE         113.00         114.00         114.00         114.00         UTI LIZATION         REVIEW-SNF         114.00         114.00         10600         HOSPICE         285, 409         11, 249         274, 160         0         0         114.00           116.00         HOSPICE         285, 409         11, 249         274, 160         0         0         200.00         Subtotal         (sum of Lines 50 thru 199)         35, 042, 919         3, 682, 115         31, 360, 804         0         0         200.00         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00         0         201.00							
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           114.00         11400           114.00         11400           116.00         HOSPICE           200.00         Subtotal (sum of lines 50 thru 199)           35,042,919         3,682,115           31,360,804         0           00         0           201.00         Less Observation Beds		1, 212, 404	52,355	1, 160, 0	49 0	0	1101.00
113.00       11300       INTEREST EXPENSE       113.00         114.00       11400       UTI LI ZATI ON REVIEW-SNF       114.00         116.00       11600       HOSPI CE       285,409       11,249       274,160       0       0       116.00         200.00       Subtotal (sum of lines 50 thru 199)       35,042,919       3,682,115       31,360,804       0       0       200.00         201.00       Less Observation Beds       1,168,591       173,605       994,986       0       0       201.00							
114.00       114.00       UTI LI ZATI ON REVIEW-SNF       114.00         116.00       11600       HOSPI CE       285,409       11,249       274,160       0       0       116.00         200.00       Subtotal (sum of lines 50 thru 199)       35,042,919       3,682,115       31,360,804       0       0       200.00         201.00       Less Observation Beds       1,168,591       173,605       994,986       0       0       201.00							113.00
116.0011600HOSPICE285,40911,249274,16000116.00200.00Subtotal (sum of lines 50 thru 199)35,042,9193,682,11531,360,80400200.00201.00Less Observation Beds1,168,591173,605994,98600201.00							
200.00Subtotal (sum of lines 50 thru 199)35,042,9193,682,11531,360,804000200.00201.00Less Observation Beds1,168,591173,605994,986000201.00		285, 409	11, 249	274.1	60 0	0	
201.00         Less Observation Beds         1, 168, 591         173, 605         994, 986         0         0         0 201.00							
	202.00 Total (line 200 minus line 201)	33, 874, 328					

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF		CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Date/Time Prepar 9/6/2016 3:17 pm
			le XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,			
		Part I, column		6	
	Reduction	8)	/ col . 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	3, 909, 577	0.000.400	0. 4377	70	50
	1, 948, 934 792, 447				5
					5.
4. 00  05400  RADI OLOGY-DI AGNOSTI C 0. 00  06000  LABORATORY	3, 998, 728				6
4. 00 06400 INTRAVENOUS THERAPY	4, 215, 047		1		6
5. 00 06500 RESPIRATORY THERAPY	-	-			6
5. 01 06500 RESPIRATORY THERAPY 5. 01 06501 SLEEP LAB	977, 255				6
6. 00 06600 PHYSI CAL THERAPY	441, 697 1, 844, 121				6
9. 00 06900 ELECTROCARDI OLOGY	427,012				6
9. 01 06900 ELECTROCARDI OLOGY 9. 01 06901 CARDI AC REHAB					6
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	317, 362				7
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	535, 860				7
3. 00 07300 DRUGS CHARGED TO PATIENTS	2, 804, 994				7.
6. 00 03020 CHEMICAL DEPENDENCY	2, 804, 994				7
6. 01 03480 ONCOLOGY	3, 427, 669				70
OUTPATIENT SERVICE COST CENTERS	5, 427, 009	1,007,030	0.4505	50	/
8. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	00	8
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					8
0. 00 09000 CLINIC	400, 221	-			91
1. 00 09100 EMERGENCY	4, 621, 558				9
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 168, 591				9
OTHER REIMBURSABLE COST CENTERS	1, 100, 391	1,020,217	1. 1434	54	9.
01.00 10100 HOME HEALTH AGENCY	1, 212, 404	1, 110, 825	1.0914	15	10
SPECIAL PURPOSE COST CENTERS	1, 212, 404	1, 110, 825	1.0914	40	10
13. 00 11300 I NTEREST EXPENSE					11:
14. 00 11400 UTI LI ZATI ON REVI EW-SNF					11.
16. 00 11600 H0SPI CE	285, 409	471, 051	0, 6058	98	110
00.00 Subtotal (sum of lines 50 thru 199)	35, 042, 919			/0	200
01.00 Less Observation Beds	1, 168, 591		1		20
02.00 Total (line 200 minus line 201)	33, 874, 328				20

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 10/01/2014 To 09/30/2015	9/6/2016 3:17	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	-	1		
50. 00 05000 OPERATI NG ROOM	593, 562					
51.00 05100 RECOVERY ROOM	365, 618					
52.00 05200 DELIVERY ROOM & LABOR ROOM	169, 271	821, 553	0. 20603	3, 103	639	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	421, 512	26, 801, 540	0. 01572	458, 042	7, 204	54.00
60. 00 06000 LABORATORY	223, 431	13, 937, 737	0. 01603	81 828, 892	13, 288	
64.00 06400 I NTRAVENOUS THERAPY	0	0			0	64.00
65. 00 06500 RESPI RATORY THERAPY	46, 273	1, 573, 822			12, 166	65.00
65. 01 06501 SLEEP LAB	72, 084				0	65.01
66. 00 06600 PHYSI CAL THERAPY	293, 006	2, 951, 881	0. 09926	174, 405	17, 312	66.00
69. 00 06900 ELECTROCARDI OLOGY	11, 578	1, 314, 487	0. 00880	08 47, 116	415	69.00
69. 01 06901 CARDI AC REHAB	62, 424	328, 365	0. 19010	06 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 111	2, 432, 646	0. 02799	282, 476	7, 909	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 125	912, 214	0. 01986	9 132, 469	2, 632	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 693	6, 409, 861	0. 01212	464, 738	5, 633	73.00
76.00 03020 CHEMI CAL DEPENDENCY	12, 032	24, 399	0. 49313	35 0	0	76.00
76. 01 03480 ONCOLOGY	555, 520	7, 607, 638	0. 07302	21 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	39, 784	473, 710	0. 08398	34 74	6	90.00
91. 00 09100 EMERGENCY	414, 882	12, 490, 230				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	173, 605	1, 020, 217	0. 17016	5 211, 053		
200.00   Total (lines 50-199)	3, 618, 511	90, 795, 946		3, 522, 860	146, 490	200.00

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 151315	Period:	Worksheet D		
THROUGH COSTS				From 10/01/2014			
				To 09/30/2015			
		Titl	e XVIII	Hospi tal	9/6/2016 3:17 Cost	pili	
Cost Center Description	Non Physician				Total Cost		
	Anestheti st	J		Medi cal	(sum of col 1		
	Cost			Education Cost	through col.		
					4)		
	1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
65. 01 06501 SLEEP LAB	0	0		0 0	0	65.01	
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 REHAB	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 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76.00	
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00	
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
91.00 09100 EMERGENCY	0	0		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0		
200.00  Total (lines 50-199)	0	0		0 0	0	200. 00	

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	narad
				10 09/30/2015	9/6/2016 3: 17	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			I npati ent	
		(from Wkst. C,		Ratio of Cost		
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATING ROOM	0	8, 930, 483				
51.00 05100 RECOVERY ROOM	0	1, 927, 820				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	821, 553				
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	26, 801, 540				54.00
60. 00 06000 LABORATORY	0	13, 937, 737				60.00
64.00 06400 I NTRAVENOUS THERAPY	0	C	0.0000			64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 573, 822				65.00
65.01 06501 SLEEP LAB	0	837, 343				65. 01
66. 00 06600 PHYSI CAL THERAPY	0	2, 951, 881				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 314, 487				69.00
69. 01 06901 CARDI AC REHAB	0	328, 365				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 432, 646	0.0000	0.00000	282, 476	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	912, 214	0.0000	0.00000	132, 469	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 409, 861	0.0000	0.00000	464, 738	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	24, 399	0.0000	0.00000	0	76.00
76. 01 03480 ONCOLOGY	0	7,607,638	0.0000	0.00000	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0.00000	0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.0000			89.00
90. 00 09000 CLINIC	0	473, 710	0.0000	0.00000	74	90.00
91.00 09100 EMERGENCY	0	12, 490, 230	0.0000	0.00000	5, 920	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 020, 217	0.0000	0.00000	211, 053	92.00
200.00 Total (lines 50-199)	0	90, 795, 946			3, 522, 860	200. 00

Health Financial Systems	CAMERON MEMORIA	L COMMUNITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CCN: 151315	Period: From 10/01/2014 To 09/30/2015	9/6/2016 3:17	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10)</u> 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Through Costs (col. <u>x col. 12)</u> 13.00			
ANCI LLARY SERVI CE COST CENTERS						
ANOTELEXTICE         Outwick           50.00         05000         OPERATING ROOM           51.00         05100         RECOVERY ROOM           52.00         05200         DELIVERY ROOM & LABOR ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           60.00         06000         LABORATORY           64.00         06400         INTRAVENOUS THERAPY           65.01         06500         RESPI RATORY THERAPY           69.00         06600         PHYSI CAL THERAPY           69.01         06900         ELECTROCARDI OLOGY           69.01         06901         CARDI AC REHAB           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS           73.00         07300         DRUGS CHARGED TO PATI ENTS           76.01         03480         ONCOLOGY				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		50.00 51.00 52.00 54.00 60.00 64.00 65.01 65.01 65.01 66.00 69.00 69.01 71.00 72.00 73.00 76.00 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00       08800       RURAL HEALTH CLINIC         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER         90.00       09000       CLINIC         91.00       09100       EMERGENCY         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART         200.00       Total (lines 50-199)	0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		88.00 89.00 90.00 91.00 92.00 200.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pre 9/6/2016 3:17	
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To			
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 437779				0	
51.00 05100 RECOVERY ROOM	1. 010952		337, 2	32 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 964572			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 149198		5, 939, 1		0	54.00
60. 00 06000 LABORATORY	0. 302420		3, 456, 6	73 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 620944	0	386, 2	32 0	0	65.00
65. 01 06501 SLEEP LAB	0. 527498	0	2, 9	81 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 624727	0	749, 5	74 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 324851	0	359, 9	39 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 966492	0	108, 0	12 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 668498	0	367, 2	78 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 587428	0	147, 8	64 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 437606	0	1, 564, 5	53 5, 733	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	3. 599082	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 450556	0	1, 605, 8	69 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 844865	0	240, 2	0 0	0	90.00
91.00 09100 EMERGENCY	0. 370014	0	2, 504, 9	72 2, 022	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 145434	0	482, 2	73 2, 359	0	92.00
200.00 Subtotal (see instructions)		0	20, 099, 4	01 10, 114	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	20, 099, 4	01 10, 114	0	202.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prep 9/6/2016 3:17	pared:
		Ti tl	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	808, 398					50.00
51.00 05100 RECOVERY ROOM	340, 925	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	886, 110					54.00
60. 00 06000 LABORATORY	1,045,367	0				60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	239, 828					65.00
65. 01 06501 SLEEP LAB	1, 572					65.01
66. 00 06600 PHYSI CAL THERAPY	468, 279					66.00
69. 00 06900 ELECTROCARDI OLOGY	116, 927					69.00
69. 01 06901 CARDI AC REHAB	104, 393					69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	245, 525					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86, 859					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	684, 658	2, 509				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0				76.00
76.01 03480 ONCOLOGY	723, 534	0	)			76.01
OUTPATIENT SERVICE COST CENTERS	1	-	1			
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	e e e e e e e e e e e e e e e e e e e				89.00
90. 00 09000 CLINIC	202, 942					90.00
91.00 09100 EMERGENCY	926, 875					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	552, 412					92.00
200.00 Subtotal (see instructions)	7, 434, 604	5, 959				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	7, 434, 604	5, 959	'			202.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151315	Peri od:	Worksheet D	
		Component	CCN: 15Z315	From 10/01/2014 To 09/30/2015		nared
		component	0011. 102010	10 07/30/2013	9/6/2016 3: 17	
		Titl	e XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins (see inst.)	. Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 437779	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	1. 010952	0		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 964572	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 149198	0		0 0	0	
60. 00 06000 LABORATORY	0. 302420	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 620944	0		0 0	0	65.00
65.01 06501 SLEEP LAB	0. 527498	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 624727	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 324851	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 966492	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 668498	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 587428	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 437606	0		0 0	0	
76. 00 03020 CHEMI CAL DEPENDENCY	3. 599082			0 0	0	
76. 01 03480 ONCOLOGY	0. 450556	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	T			1		-
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	0. 844865	0		0 0	0	
91.00 09100 EMERGENCY	0. 370014	0		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1. 145434	0		0 0	0	121.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges 202.00 Net Charges (line 200 +/- line 201)		_		0 0	0	202.00
202.00   INEL CHAIGES (ITTHE 200 +/ - ITTHE 201)	I	0	l	0	0	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST         Provider CCN: 151315 Component CCN: 152315         Period: To 09/30/2015         Worksheet D Perepret: 09/30/2015           Cost         Cost Center Description         Cost Reinbursed Services Subject To Ded. & Coins. (see inst.)         Swing Beds - SNF         Cost           MACILLARY SERVICE COST CENTERS         6.00         7.00         50.00         51.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         65.01	Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2552-10
Component CCN: 15Z315         To         09/30/2015         Date/Time Prepared: 96/2016         97/2016         3:17 pm           Cost	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151315		
ANCI LLARY SERVICE COST CENTERS         O         O         Source			0	L CON 157015		
Cost Center Description         Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)         Swing Beds - SNF         Cost           ANCILLARY SERVICE COST CENTERS         Cost Subject To Ded. & Coins. (see inst.)         Services Subject To Ded. & Coins. (see inst.)         Services Subject To Ded. & Coins. (see inst.)         Services Subject To Ded. & Coins. (see inst.)           50.00         OSCOOD OPERATING: ROOM         0         0         0         50.00           50.00         OSCOOD OPERATING: ROOM         0         0         0         50.00         50.00           50.00         OSCOOD OPERATING: ROOM         0         0         0         50.00         50.00           50.00         OSCOOD RECOVERY ROOM         0         0         0         51.00         52.00           50.00         OSCOOD RADIOLOGY-DIAGNOSTIC         0         0         0         54.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         71.00         72.00         72.00         72.00         73.00         71.00         72.00         73.00         73.00         73.00			Component	L CCN: 152315	10 09/30/2015	9/6/2016 3 17 pm
Cost Center Description         Cost Reinbursed Subject To Ded. & Coins.         Cost Reinbursed Services Subject To Ded. & Coins.           ANCILLARY SERVICE COST CENTERS         Subject To Ded. & Coins.         Subject To Ded. & Coins.         Subject To Ded. & Coins.           ANCILLARY SERVICE COST CENTERS         Subject To Ded. & Coins.         Services Subject To Ded. & Coins.         Solo           ANCILLARY SERVICE COST CENTERS         Solo 05000 (Secontery Room Solo 05000 (Secontery Room Solo 05000 Rabit Room Solo 05000 (Secontery Room Solo 05000 Rabit Room Solo 05100 (Secontery Room Solo 05000 Rabit Room Solo 0510 (Secontery Room Solo 05100 Rabit Room Solo 0520 (Secontery Room Solo 0510 Solo 0515 (Secontery Room Solo 051 Secontery Herapy Solo 05200 RESPI RATORY THERAPY Solo 05200 RESPI RATORY THERAPY Solo 05200 RESPI RATORY THERAPY Solo 05200 RESPI RATORY THERAPY Solo 05400 (Secontery Room Stepi Room Solo 05500 (Secontery Therapy Solo 05500 RESPI RATORY THERAPY Solo 05500 RABIT RATERY Solo 05500 RABIT RATERY			Ti tl	e XVIII	Swing Beds - SNF	
Reimbursed Services         Reimbursed Services         Services Not Subject To Ded. & Coins.           ANCILLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000         PERATING ROOM         0           50.00         05000         DED.         4.001           50.00         05000         PERATING ROOM         0         0           50.00         05000         DELIVER WOM & LABOR ROOM         0         0           50.00         05000         DELIVER WOM & LABOR ROOM         0         0           50.00         05000         DELIVER WOM & LABOR ROOM         0         0           51.00         05000         DELIVER WOM & LABOR ROOM         0         0           60.00         06000         LABORATORY         0         0         0           61.00         DEGOU LABORATORY         0         0         0         65.00           65.01         06501         SEPI RATORY THERAPY         0         0         0         65.00           66.00         06000         PHYSI CAL THERAPY         0         0         0         65.00           69.00         06000         ELECTROCARDI LOGY         0         0         0         72.00 <td></td> <td>Cos</td> <td>sts</td> <td></td> <td></td> <td></td>		Cos	sts			
Anci LLARY SERVICE COST CENTERS         Services Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)           6.00         05000 (PERATING ROOM         0         0         7.00           50.00         05000 (PERATING ROOM         0         0         50.00           51.00         05000 (PERATING ROOM         0         0         50.00           52.00         05400 RADIOLOGY-DI AGNOSTIC         0         0         52.00           60.00         05400 RADIOLOGY-DI AGNOSTIC         0         0         64.00           60.00         06500 RADIOLOGY-DI AGNOSTIC         0         0         66.00           60.00         06500 RADIOLOGY-DI AGNOSTIC         0         0         66.00           66.00         06500 RESPI RATORY THERAPY         0         0         66.00           66.01         154.00         0         0         65.01           66.01         06500 RESPI RATORY THERAPY         0         0         65.01           66.01         0         0         0         65.01           66.01         0         0         0         0           67.01         0         0         0         0         0	Cost Center Description	Cost	Cost			
ANCI LLARY SERVICE COST CENTERS         Subject To Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)           6.00         7.00           ANCI LLARY SERVICE COST CENTERS         0           50.00         05000 OPERATING ROOM           51.00         05100 RECOVERY ROOM           60.00         0           52.00         05200 DELI VERY ROOM & LABOR ROOM           60.00         0           54.00         05400 RADIOLOGY-DIARNOSTIC           0         0           65.00         0           66.00         0           66.00         0           65.00         66500 RESPI RATORY THERAPY           0         0           65.01         06501 RESPI RATORY THERAPY           0         0           66.00         0           66.00         0           66.01         0           65.01         06501 SLEEP LAB           0         0           69.00         6900 LECERCARDI OLOGY           0         0           71.00         72.00           73.00         OT200 IMPL. DEV. CHARGED TO PATI ENT           0         0           72.00         0		Reimbursed	Reimbursed			
Ded, & Coins. (see inst.)         Ded, & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS           0.00         05000 (PERATING ROOM         0         0         50.00           51.00         05100 RECOVERY ROOM         0         0         0         51.00           52.00         05200 DELIVERY ROOM & LABOR ROOM         0         0         0         52.00           54.00         05400 RAD ILOGV-DI AKNOSTI C         0         0         0         64.00           65.00         06500 INTRAVENUS THERAPY         0         0         0         64.00           65.01         06500 RESPI RATORY THERAPY         0         0         0         65.00           66.00         06600 INTRAVENUS THERAPY         0         0         0         66.00           66.00         66501 SLEEP LAB         0         0         0         66.00           66.00         06600 INTRAVENUS THERAPY         0         0         0         69.01           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENT         0         0         0         72.00           72.00         07200 INPL. DEV. CHARGED TO PATIENTS         0         0         72.00         73.00         73.00         73.00						
ANCI LLARY SERVICE COST CENTERS         (see inst.)         (see inst.)         7.00         7.00           50.00         05000         OPERATING ROOM         0         0         50.00         50.00         50.00         51.00         50.00         51.00         50.00         51.00         50.00         51.00         50.00         51.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         54.00         0         0         0         0         52.00         52.00         54.00         0.00         60.00         60.00         60.00         60.00         64.00         64.00         64.00         64.00         64.00         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         66.00         66.00         66.00         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         69.01         71.00         71.00         71.00         72.00         72.00         72.00         72.00         72.00         73.00         73.00<						
ANCI LLARY SERVICE COST CENTERS           6.00         7.00           ANCI LLARY SERVICE COST CENTERS         50.00           50.00         05000 (DPERATING ROOM         0           51.00         5200 (DEL) CENTERY ROOM         0           52.00         05200 (DEL) CENTERY ROOM         0           64.00         06400 (INTRAVENUS) THERAPY         0         0           65.00         06500 (ESPI RATORY THERAPY         0         0           66.00         06600 (INTRAVENUS) THERAPY         0         0           66.00         06600 (PHYSICAL THERAPY         0         0           66.01         06600 (PHYSICAL THERAPY         0         0           67.01         06600 (PHYSICAL THERAPY         0         0           68.00         06600 (PHYSICAL THERAPY         0         0           69.01         06400 (INTRAVENUS) THERAPY         0         0           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENT         0         0           72.00         07200 (IMPL) DEV. CHARGED TO PATIENTS         0         0           73.00         07300 DRUGS CHARGED TO PATIENTS         0         0           74.00         0320 CHEMI CAL DEPENDENCY         0         0						
ANCI LLARY SERVICE COST CENTERS         0         0           50.00         05000 DPERATI NG ROOM         0         0         50.00         51.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         52.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         64.00         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.01         66.00         66.00         69.00         69.01         67.00         69.00         69.01         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         72.00         72.00         72.00         72.00         73.00         73.00         74.00         73.00         76.01						
50.00       05000       0PERATING ROM       0       0       50.00         51.00       05100       RECOVERY ROM & LABOR ROM       0       0       51.00         52.00       05200       DELIVERY ROM & LABOR ROM       0       0       54.00         64.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0         64.00       06400       INTRAVENOUS THERAPY       0       0       0         65.01       06500       RESPI RATORY THERAPY       0       0       0         65.01       06501       SLEEP LAB       0       0       65.00         66.00       06900       ELECTROCARDI OLOGY       0       0       65.01         66.01       06900       CARDI AC REHAB       0       0       65.01         67.00       06900       ELECTROCARDI OLOGY       0       0       69.00         69.01       06900       CARDI AC REHAB       0       0       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         76.00       03200       CHEMI CAL DE		6.00	7.00			
51.00       05100       RECOVERY ROOM       0       0       51.00         52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       52.00         54.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       52.00         64.00       06400       LABORATORY       0       0       60.00         64.00       06400       INTRAVENOUS THERAPY       0       0       64.00         65.00       06500       RESPIRATORY THERAPY       0       0       65.00       65.01         65.01       06500       RESPIRATORY THERAPY       0       0       65.01       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       66.00       69.01         67.00       06900       ELECTROCARDI OLOGY       0       0       69.01       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       76.01       76.01       76.01       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.00       76.01       76.		-	-			
52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0         54.00       05400       RADIOLOGY-DIAGNOSTI C       0       0         60.00       L6000       LABORATORY       0       0         64.00       06400       INTRAVENOUS THERAPY       0       0         65.01       06500       RESPI RATORY THERAPY       0       0         65.01       06501       SLEEP LAB       0       0         66.00       06900       LECTROCARDIOLOGY       0       65.01         67.01       06900       CARDIA C REHAB       0       0         69.01       06901       CARDIA C REHAB       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0         73.00       07300       DRUSS CHARGED TO PATIENTS       0       0         74.00       03202       CHEMI CAL DEPENDENCY       0       0         74.00       03202       CHEMI CAL DEPENDENCY       0       0         75.00       03202       CHEMI CAL DEPENDENCY       0       0         00       00       0		0				
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0         60.00       06000       LABORATORY       0       0         64.00       06400       INTRAVENOUS THERAPY       0       0         65.00       06500       RESPI RATORY THERAPY       0       0         65.01       06500       RESPI RATORY THERAPY       0       0         66.00       06600       PHYSI CAL THERAPY       0       0         66.00       06000       ELECTROCARDI OLOGY       0       0         67.00       06000       ELECTROCARDI OLOGY       0       0         69.01       06900       ELECTROCARDI OLOGY       0       0         69.01       06900       ELECTROCARDI OLOGY       0       0         71.00       07100       IMPL.       DEV. CHARGED TO PATI ENT       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       74.00         74.00       03480       ONCAL ECOST CENTERS       76.00       76.00       76.00         70.00       08900       REAL HEALTH CLINIC       0		0	C C			
60.00       CABORATORY       0       0       60.00         64.00       O6400       INTRAVENOUS THERAPY       0       0         65.00       RESPI RATORY THERAPY       0       0       65.00         65.01       SLEEP LAB       0       0       65.01         66.00       O6600       PHYSI CAL THERAPY       0       0       65.01         66.00       O6600       PHYSI CAL THERAPY       0       0       66.00         69.01       O6901       CARDI AC REHAB       0       0       69.01         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       69.01         72.00       O7200   IMPL.       DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       O7300 DRUGS CHARGED TO PATI ENTS       0       0       73.00       73.00         74.01       DAGDOLOGY       0       0       0       74.00       74.00       74.00         75.00       O3202 CHEMI CAL DEPENDENCY       0       0       0       76.01       74.00       76.01       76.01         004000       DIRAL HEALTH CLINIC       0       0       0       90.00       90.00       90.00       90.0		0	C			
64.00       06400       INTRAVENOUS THERAPY       0       0       64.00         65.00       06500       RESPI RATORY THERAPY       0       0       65.00         65.01       06501       SLEEP LAB       0       0       65.01         66.00       06600       PHSI CAL THERAPY       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       69.00         69.01       06901       CARDI AC REHAB       0       0       69.01         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00         72.00       07200 I MPL.       DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       73.00         74.00       03202 CHEMI CAL DEPENDENCY       0       0       76.00         74.01       03480       ONCOLOGY       0       0       76.00         75.00       03202 CHEMI CAL DEPENDENCY       0       0       76.00       76.00         76.01       03480       ONCOLOGY       0       0       90.00       90.00       90.00         89.00       <		0	C C			
65.00       06500       RESPI RATORY THERAPY       0       0       65.00         65.01       06501       SLEEP LAB       0       0       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       69.00         69.01       06901       CARDI AC REHAB       0       0       69.01         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       76.00         74.00       03480       ONCOLOGY       0       0       76.00         76.01       03480       ONCOLOGY       0       0       76.01         76.01       03480       ONCOLOGY       0       0       99.00         78.00       08800       RURAL HEALTH CENTER       0       0       99.00         79.00       09000       FEDERALLY QUALI FIED HEALTH CENTER       0       0       90.00         79.00       090000       OPO000		0	C C			
65.01       06501       SLEEP LAB       0       0       65.01         66.00       06600       PHYSI CAL THERAPY       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       69.01         69.01       06901       CARDI AC REHAB       0       0       69.01         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       73.00         76.00       03020       CHEMI CAL DEPENDENCY       0       0       76.01         0UTPATI ENT SERVI CE COST CENTERS       0       0       76.01       76.01         00.00       FEDERALLY QUALI FIED HEALTH CENTER       0       0       88.00       9900       FEDERALLY QUALI FIED HEALTH CENTER       90.00		0	C			
66.00       06600       PHYSI CAL THERAPY       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       69.00         69.01       06900       CARDI AC REHAB       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       72.00       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       73.00       73.00         76.00       03202       CHEMI CAL DEPENDENCY       0       0       0       76.01         03480       INCOLOGY       0       0       0       76.01       78.00       78.00         76.01       03480       INCOLOGY       0       0       0       76.01         77.00       08800       RURAL HEALTH CLINIC       0       0       99.00       99.00         79.00       09000       CLINIC       0       0       0       91.00       91.00         91.00       09100       EMERGENCY       0       0       0       91.00       92.00 <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td>		0	C			
69.00       06900       ELECTROCARDIOLOGY       0       0       0         69.01       06901       CARDIAC REHAB       0       0       0         71.00       OT100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00       73.00         76.00       03020       CHEMICAL DEPENDENCY       0       0       0       76.00         76.01       03480       ONCOLOGY       0       0       0       76.01         04800       RURAL HEALTH CLINIC       0       0       0       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       90.00         90.00       09000       CLINIC       0       0       90.00       90.00         91.00       09100       EMERGENCY       0       0       91.00       92.00         92.00       09200       OSESERVATION BEDS (NON-DI STINCT PART       0       0       20.00       200.00         201.00       Less PBP Clinic Lab. Services-		0	C			
69.01       06901       CARDI AC REHAB       0       0       69.01         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       73.00         76.00       03020       CHEMI CAL DEPENDENCY       0       0       76.00         76.01       03480       ONCOLOGY       0       0       76.01         004TPATI ENT SERVICE COST CENTERS       0       0       0       76.01         004TPATI ENT SERVICE COST CENTERS       0       0       0       76.01         004TPATI ENT SERVICE COST CENTERS       0       0       0       88.00         89.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0       0       90.00         90.00       09000       CLI NI C       0       0       90.00       90.00       91.00         91.00       09100       EMERGENCY       0       0       0       91.00       92.00         920.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       200.00 </td <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td>		0	C			
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         76.00       03202       CHEMICAL DEPENDENCY       0       0       76.00         0017041       ENT SERVICE COST CENTERS       0       0       76.01         0017041       ENT SERVICE COST CENTERS       0       0       76.01         0017041       ENT SERVICE COST CENTERS       0       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       89.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00<		0	C			
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       73.00         76.00       03200       CHEMI CAL DEPENDENCY       0       0       0       76.00         00       03480       ONCOLOGY       0       0       0       0       76.00         00       04800       RURAL HEALTH CLINIC       0       0       0       0       76.00         00       08900       RURAL HEALTH CLINIC       0       0       0       88.00       89.00       99.00       99000       CLINIC       90.00       99.00       99000       99000       CLINIC       90.00       99.00       99000       99000       SUBTORY       0       0       99.00       99.00       99000       99000       SUBTORY       0       0       99.00       99.00       99000       99000       SUBTORY       0       0       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td></td><td></td></t<>		0	C			
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         76.00       03020       CHEMI CAL DEPENDENCY       0       0       0       76.00         76.01       03480       ONCOLOGY       0       0       0       76.01         0UTPATIENT SERVICE COST CENTERS       0       0       0       76.01       76.01         0UTPATIENT SERVICE COST CENTERS       0       0       0       88.00       88.00       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       89.00       90.00       9000       90.00 <t< td=""><td></td><td>0</td><td>C</td><td></td><td></td><td></td></t<>		0	C			
76.00         03020         CHEMI CAL         DEPENDENCY         0         0         76.00         76.00         76.01         70.01         70.01 <t< td=""><td></td><td>0</td><td>C</td><td></td><td></td><td></td></t<>		0	C			
76.01         03480         ONCOLOGY         0         0         76.01           OUTPATI ENT SERVICE COST CENTERS         0         0         0         88.00         88.00         88.00         88.00         88.00         88.00         88.00         89.00         0         0         0         88.00         89.00         90.00         0         90.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00 <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td>		0	C			
OUTPATIENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0           90.00         09000         CLINIC         0         0         90.00           91.00         09100         EMERGENCY         0         0         91.00           92.00         09200         DSERVATION BEDS (NON-DISTINCT PART         0         0         92.00           200.00         Subtotal (see instructions)         0         0         200.00         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00         201.00		0		•		
88.00       08800       RURAL HEALTH CLINIC       0       0       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       89.00         90.00       09000       CLINIC       0       0       90.00         91.00       09100       EMERGENCY       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       92.00         200.00       Subtotal (see instructions)       0       0       200.00       200.00         201.00       Less PBP Clinic Lab. Services-Program       0       0       201.00       201.00		0	0			76. 01
89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       89.00         90.00       09000       CLINIC       0       0       90.00         91.00       09100       EMERGENCY       0       0       91.00         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART       0       0       92.00         200.00       Subtotal (see instructions)       0       0       200.00       200.00         201.00       Less PBP Clinic Lab. Services-Program       0       0       201.00       201.00		1	1	1		
90.00         09000         CLINIC         0         0         90.00           91.00         09100         EMERGENCY         0         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0         0         92.00           200.00         Subtotal (see instructions)         0         0         200.00         200.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00		0	-	•		
91.0009100EMERGENCY0092.0009200OBSERVATI ON BEDS (NON-DI STINCT PART00200.00Subtotal (see instructions)00201.00Less PBP Clinic Lab. Services-Program0201.000nl y Charges00201.00		0	0			
92.00092000BSERVATI ON BEDS (NON-DI STINCT PART00200.00Subtotal (see instructions)00201.00Less PBP Clinic Lab. Services-Program0201.000nl y Charges00		0	0	1		
200.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000		0	0	1		
201. 00     Less PBP Clinic Lab. Services-Program     0     201. 00       Only Charges     0     0		0	0	1		
Only Charges		0	0	2		
		0				201.00
			_			
202.00  Net Charges (line 200 +/- line 201)   0  0  202.00	202.00   Net Charges (line 200 +/- line 201)	0	il C	1		202.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
		Ti +	le XIX	Hospi tal	PPS	piii
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	Aujustillerit	Related Cost			
	Part II, col.		$(col \cdot 1 - col$			
	26)		2)			
	1.00	2.00	3,00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 ADULTS & PEDI ATRI CS	1, 029, 313	72,079	957, 23	4 4, 024	237.88	30.00
31. 00 INTENSIVE CARE UNIT	70, 984		70, 98			1
43.00 NURSERY	26, 478		26, 47			1
200.00 Total (lines 30-199)	1, 126, 775		1, 054, 69			200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	108	25, 691				30.00
31.00 INTENSIVE CARE UNIT	26	10, 253				31.00
43.00 NURSERY	34	2, 074				43.00
200.00 Total (lines 30-199)	168	38, 018				200.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 10/01/2014 To 09/30/2015	9/6/2016 3:17	
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	- 1		
50.00 05000 OPERATI NG ROOM	593, 562					
51.00 05100 RECOVERY ROOM	365, 618					
52.00 05200 DELIVERY ROOM & LABOR ROOM	169, 271					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	421, 512					
60. 00 06000 LABORATORY	223, 431	13, 937, 737	0. 01603	68, 736	1, 102	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000		0	
65. 00 06500 RESPI RATORY THERAPY	46, 273	1, 573, 822	0. 02940	32, 288	949	65.00
65.01 06501 SLEEP LAB	72, 084	837, 343			0	65.01
66. 00 06600 PHYSI CAL THERAPY	293, 006	2, 951, 881	0. 09926	23, 662	2, 349	66.00
69. 00 06900 ELECTROCARDI OLOGY	11, 578	1, 314, 487	0. 00880	3, 457	30	69.00
69. 01 06901 CARDI AC REHAB	62, 424	328, 365	0. 19010	)6 573	109	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 111	2, 432, 646	0. 02799	9 37, 513	1, 050	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 125	912, 214	0. 01986	09 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 693	6, 409, 861	0. 01212	40, 792	494	73.00
76.00 03020 CHEMI CAL DEPENDENCY	12, 032	24, 399	0. 49313	35 0	0	76.00
76. 01 03480 ONCOLOGY	555, 520	7,607,638	0. 07302	21 87	6	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	39, 784	473, 710	0. 08398	34 2	0	90.00
91. 00 09100 EMERGENCY	414, 882	12, 490, 230				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	174, 843	1, 020, 217	0. 17137			92.00
200.00   Total (lines 50-199)	3, 619, 749	90, 795, 946		352, 999	17, 732	200.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2014 To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	)	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0 0		0	0	31.00
43. 00 04300 NURSERY	0	o c		0	0	43.00
200.00 Total (lines 30-199)	0			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	$5 \div col. 6)$	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6,00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1 1100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
30. 00 03000 ADULTS & PEDI ATRI CS	4,024	0.00	10	8 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	180			6 0		31.00
43. 00 04300 NURSERY	434			4 0		43.00
200.00 Total (lines 30-199)	4, 638		16			200.00
200.00  101al (11165 30-177)	4,030	1	1 10	0	I	1200.00

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 151315	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2014		
				To 09/30/2015		
		Tit		Hospi tal	9/6/2016 3:17 PPS	pili
Cost Center Description	Non Physician				Total Cost	
	Anestheti st	J		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65.01 06501 SLEEP LAB	0	0		0 0	0	65.01
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 REHAB	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 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	nored.
				To 09/30/2015	9/6/2016 3:17	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	I	I	1	- 1		
50. 00 05000 OPERATI NG ROOM	0	8, 930, 483				
51.00 05100 RECOVERY ROOM	0	1, 927, 820				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	821, 553				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	26, 801, 540				54.00
60. 00 06000 LABORATORY	0	13, 937, 737			68, 736	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 573, 822			32, 288	65.00
65.01 06501 SLEEP LAB	0	837, 343			0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	2, 951, 881	0.00000	0 0.000000	23, 662	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 314, 487	0.00000	0.000000	3, 457	69.00
69. 01 06901 CARDI AC REHAB	0	328, 365	0.00000	0.000000	573	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 432, 646	0.00000	0.000000	37, 513	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	912, 214	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 409, 861	0. 00000	0.000000	40, 792	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	24, 399	0. 00000	0.000000	0	76.00
76. 01 03480 ONCOLOGY	0	7, 607, 638	0. 00000	0.000000	87	76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0.000000	0	89.00
90. 00 09000 CLINIC	0	473, 710	0. 00000	0.000000	2	90.00
91.00 09100 EMERGENCY	0	12, 490, 230	0. 00000	0 0.000000	17, 439	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 020, 217	0. 00000	0 0.000000		92.00
200.00   Total (lines 50-199)	0	90, 795, 946			352, 999	200. 00

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CCN: 151315	Period: From 10/01/2014 To 09/30/2015	9/6/2016 3:17	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0		50.00
51.00 05100 RECOVERY ROOM	0	0		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
65. 01 06501 SLEEP LAB	0	0		0		65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
69. 01 06901 CARDI AC REHAB	0	0		0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0		76.00
76. 01 03480 ONCOLOGY	0	0		0		76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	0		0		90.00
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
200.00 Total (lines 50-199)	0	0	1	0		200. 00

	Financial Systems CAMERON MEMORIAL C ATION OF INPATIENT OPERATING COST	Provider CCN: 151315	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 10/01/2014 To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		4, 707	1 1.
00	Inpatient days (including private room days, excluding swing-be			4, 024	2
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	(ave)		3, 289	4
00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0,207	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	303	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	380	8
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 171	9
	newborn days)			.,	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	303	11
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)	5 ,		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12
8. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar year	ar, enter O on this lin	e)	C C	
	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT		I	0	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through December 31 o	f the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	129.14	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	129. 14	20
	Total general inpatient routine service cost (see instructions)			6, 928, 641	
. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3' $\!\!\!$	of the cost reporting	period (line 8	49, 073	25
	x line 20)	or the cost reporting		17,070	
o. 00	Total swing-bed cost (see instructions)			530, 819	
. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		6, 397, 822	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		0	0	
. 00	Semi-private room charges (excluding swing-bed charges)	11 20)		0	30
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 $\div$ Average private room per diem charge (line 29 $\div$ line 3)	TThe 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu		tions)	0.00	
. 00 . 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	: 31)		0. 00 0	35
. 00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	6, 397, 822	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
	Adjusted general inpatient routine service cost per diem (see i			1, 589. 92	
). 00 ). 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			1, 861, 796 0	
	modicarry necessary private room cost appricable to the riogram			0	. +0

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151315	Period: From 10/01/2014		
					To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
	Cost Center Description	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0.0	00 0	0	42. (
3. 00	INTENSIVE CARE UNIT	359, 450	180	1, 996. 9	69	137, 789	43.
4.00	CORONARY CARE UNI T						44.
5.00	BURN INTENSIVE CARE UNIT						45.
5.00	SURGI CAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 47.
7.00	Cost Center Description						47.
2 00		+ D 2 2	11			1.00	40
3.00 9.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ns)		1, 682, 475 3, 682, 060	
. 00	PASS THROUGH COST ADJUSTMENTS		300 111311 4011	5137		0,002,000	
D. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sun	n of Parts I and	0	50.
1.00	<pre>III) Pass through costs applicable to Program inpa</pre>	tiont ancillar	w convicos (fi	com Wkst D a	um of Parts II	0	51.
1.00	and IV)		y services (II	UNI WKSL. D, S			51.
2.00	Total Program excludable cost (sum of lines !	,				0	
3.00	Total Program inpatient operating cost exclud		lated, non-phy	/sician anesth	netist, and	0	53.
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	oZ)					
4.00	Program di scharges					0	54.
5.00	Target amount per discharge						55.
5.00	Target amount (line 54 x line 55)				1	0	
7.00 3.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (i	ine 56 minus	Tine 53)	0	
7.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	updated and co	mpounded by the		
	market basket						
0.00 1.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
1.00	which operating costs (line 53) are less than						01.
	amount (line 56), otherwise enter zero (see i		- (				
2.00	Relief payment (see instructions)	ant (and instru	ati ana)			0	
3.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	63.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.
F 00	instructions) (title XVIII only)					401 74/	
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is after Decemb	er 31 of the c	cost reporting	period (see	481, 746	65.
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	481, 746	66.
7 00	CAH (see instructions)			C 11 1			
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 0	or the cost re	eporting period	0	67.
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68.
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.
D. 00	Skilled nursing facility/other nursing facili						70.
1.00	Adjusted general inpatient routine service co	ost per diem (I		• • •			71.
2.00	Program routine service cost (line 9 x line 7			no 2E)			72.
3.00 4.00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•				73.
5.00	Capital -related cost allocated to inpatient	•			Part II, column		75.
	26, line 45)		-				
6.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
7.00 3.00	Inpatient routine service cost (line 74 minus	· ·					77.
9.00	Aggregate charges to beneficiaries for excess		rovi der record	ls)			79.
0.00	Total Program routine service costs for compa		ost limitation	n (line 78 mir	nus line 79)		80.
1.00	Inpatient routine service cost per diem limit		)				81.
2.00 3.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82.
4.00	Program inpatient ancillary services (see ins		- 1				84.
5.00	Utilization review - physician compensation	(see instructio					85.
6. 00	Total Program inpatient operating costs (sum		rough 85)				86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					735	87.
	Adjusted general inpatient routine cost per o		line 2)			1, 589. 92	
8.00	naj de ted general inpatrient reatine eest per s		11110 2)			.,	

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 029, 313	6, 928, 641	0. 14855	9 1, 168, 591	173, 605	90.00
91.00 Nursing School cost	0	6, 928, 641	0.00000	1, 168, 591	0	91.00
92.00 Allied health cost	0	6, 928, 641	0.00000	0 1, 168, 591	0	92.00
93.00 All other Medical Education	0	6, 928, 641	0.00000	1, 168, 591	0	93.00

	Financial Systems CAMERON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 151315	Period: From 10/01/2014	Worksheet D-1	
			To 09/30/2015	Date/Time Prep 9/6/2016 3:17	
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 707	1
00	Inpatient days (including private room days, excluding swing-		·	4, 024	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be			3, 289	4
00	Total swing-bed SNF type inpatient days (including private row reporting period	om days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	303	6
	reporting period (if calendar year, enter 0 on this line)	5			_
00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	380	8
	reporting period (if calendar year, enter 0 on this line)				_
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	108	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
00	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, end		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period	V only (including privat	a room days)	0	1 1 2
. 00	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progra				
	Total nursery days (title V or XIX only)			434	15 16
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions	s)		6, 928, 641	21
. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report			
			ing period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after December	·		0	
. 00	Swing-bed cost applicable to SNF type services after December x line 18) $$	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line 6		23
. 00	Swing-bed cost applicable to SNF type services after December x line 18) $$	31 of the cost reportin r 31 of the cost reporti	g period (line 6 ng period (line	0	23 24
. 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December $\frac{1}{2}$ x line 20)	31 of the cost reportin r 31 of the cost reporti	g period (line 6 ng period (line	0 0 0	23 24 25
. 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December : x line 20) Total swing-bed cost (see instructions)	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting	g period (line 6 ng period (line	0 0 0 485, 182	23 24 25 26
. 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	g period (line 6 ng period (line period (line 8	0 0 0	23 24 25 26
. 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	g period (line 6 ng period (line period (line 8	0 0 485, 182 6, 443, 459 0	23 24 25 26 27 28
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	g period (line 6 ng period (line period (line 8	0 0 485, 182 6, 443, 459 0 0	23 24 25 26 27 28 29
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	g period (line 6 ng period (line period (line 8	0 0 485, 182 6, 443, 459 0	23 24 25 26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	31 of the cost reportin r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	g period (line 6 ng period (line period (line 8	0 0 485, 182 6, 443, 459 0 0 0	23 24 25 26 27 28 29 30 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4)	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28)	g period (line 6 ng period (line period (line 8 arges)	0 0 485, 182 6, 443, 459 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 28 29 30 31 32 33
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi -private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruct	g period (line 6 ng period (line period (line 8 arges)	0 0 485, 182 6, 443, 459 0 0 0 0. 000000 0. 000000 0. 000000 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 30 + line 4) Average semi -private room per diem charge differential (line 32 min Average per diem private room cost differential (line 34 x line	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruct	g period (line 6 ng period (line period (line 8 arges)	0 485, 182 6, 443, 459 0 0 0 0.000000 0.00000 0.000 0.00 0.0	23 24 25 26 27 28 29 30 31 32 33 34 35
.         .	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December 2 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi -private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi -private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc- ne 31)	g period (line 6 ng period (line period (line 8 arges)	0 0 485, 182 6, 443, 459 0 0 0 0. 000000 0. 000000 0. 000000 0. 00 0. 00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 mi Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc- ne 31)	g period (line 6 ng period (line period (line 8 arges)	0 485, 182 6, 443, 459 0 0 0.00000 0.00 0.00 0.00 0.00 0.00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 mil Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	31 of the cost reportin r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc- ne 31) and private room cost di	g period (line 6 ng period (line period (line 8 arges)	0 485, 182 6, 443, 459 0 0 0.00000 0.00 0.00 0.00 0.00 0.00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average semi-private room per diem charge differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	31 of the cost reporting r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruct ne 31) and private room cost di USTMENTS	g period (line 6 ng period (line period (line 8 arges)	0 485, 182 6, 443, 459 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37
1. 00         1. 00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 32 mil Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	31 of the cost reporting r 31 of the cost reporting 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33) (see instructione 31) and private room cost di USTMENTS instructions)	g period (line 6 ng period (line period (line 8 arges)	0 485, 182 6, 443, 459 0 0 0.00000 0.00 0.00 0.00 0.00 0.00	23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	CAMERON MEMORI		CCN: 151315	Peri od:	eu of Form CMS- Worksheet D-1	
					From 10/01/2014 To 09/30/2015		epared
			т;	tle XIX	Hospi tal	9/6/2016 3: 17 PPS	/ pm
	Cost Center Description	Total	Total	Average Pe			
		Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	235, 374					42.
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	359, 450	18	0 1, 996.	94 26	51, 920	
4.00 5.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			1.00 175,221	48.
7.00	Total Program inpatient costs (sum of lines 4			ons)		418, 517	
	PASS THROUGH COST ADJUSTMENTS			•		-	
0. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	38, 018	50.
1.00	) Pass through costs applicable to Program inpa	atient ancillar	v services (f	rom Wkst D	sum of Parts II	17, 732	51.
1.00	and IV)		y services (1	i olin intotti b,		11,102	
2.00	Total Program excludable cost (sum of lines !					55, 750	
3.00	Total Program inpatient operating cost exclud		elated, non-ph	ysician anest	hetist, and	362, 767	53.
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program di scharges					0	54.
5.00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)				1. 50)	0	
2.00 3.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	irget amount (	line 56 minus	line 53)	0	
9.00 9.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi na 1996.	updated and c	ompounded by the	-	
	market basket	511	5				
0.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
1. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.
	amount (line 56), otherwise enter zero (see i		.3 (11163 54 X	00), 01 1% 0	i the target		
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63.
1.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.
1. 00	instructions) (title XVIII only)	thi ough beec			rig period (bee		
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.
4 00	instructions)(title XVIII only)	a costs (lina	44 plus line	4E) (+; +  o V)/		0	44
5.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	le costs (IThe	64 prus rine	os)(litie xvi	TT ONLY). FOR	0	66.
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	0	67.
	(line 12 x line 19)						
8.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient i	routine costs (	line 67 + lin	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
0.00	Skilled nursing facility/other nursing facili	2		•	)		70.
1.00 2.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /0 ÷ line	2)			71.
3.00	Medically necessary private room cost applica		line 14 x l	ine 35)			73.
4.00	Total Program general inpatient routine servi						74.
5.00	Capital-related cost allocated to inpatient i	routine service	e costs (from	Worksheet B,	Part II, column		75.
6 00	26, line 45)	20 2)					7/
5.00 7.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
3.00	Inpatient routine service cost (line 74 minus	· ·					78.
9. 00	Aggregate charges to beneficiaries for excess	s costs (from p		,			79.
. 00	Total Program routine service costs for compa		ost limitatio	n (line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limit		)				81
. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .				82
1. 00	Program inpatient ancillary services (see ins		,				84.
5.00	Utilization review - physician compensation		ons)				85.
5.00	Total Program inpatient operating costs (sum		rough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					735	07
	TIVIAL UNSELVATION DEV VAVS (SEE INSTRUCTIONS)	,				1 / 35	87.
7.00 8.00	Adjusted general inpatient routine cost per o		line 2)			1, 601. 26	

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
		Tit	le XIX	Hospi tal	PPS	
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, 029, 313	6, 928, 641	0. 14855	9 1, 176, 926	174, 843	90.00
91.00 Nursing School cost	0	6, 928, 641	0.00000	0 1, 176, 926	0	91.00
92.00 Allied health cost	0	6, 928, 641	0.00000	0 1, 176, 926	0	92.00
93.00 All other Medical Education	0	6, 928, 641	0.00000	0 1, 176, 926	0	93.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Pre 9/6/2016 3:17	pared:
	Titl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati 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 03000 ADULTS & PEDIATRICS			1, 515, 800		30.00
31.00 03100 I NTENSI VE CARE UNI T			143, 520		31.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		·		•	1
50. 00 05000 OPERATI NG ROOM		0. 4377	79 420, 515	184, 093	50.00
51.00 05100 RECOVERY ROOM		1.0109	52 80, 278	81, 157	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.9645	72 3, 103	2, 993	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1491	98 458, 042	68, 339	54.00
60. 00 06000 LABORATORY		0. 3024	20 828, 892	250, 674	60.00
64.00 06400 INTRAVENOUS THERAPY		0.0000			64.00
65. 00 06500 RESPI RATORY THERAPY		0. 6209	44 413, 779	256, 934	65.00
65. 01 06501 SLEEP LAB		0. 5274		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 6247			
69. 00 06900 ELECTROCARDI OLOGY		0. 3248			
69. 01 06901 CARDI AC REHAB		0.9664			69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 6684		188, 835	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5874			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4376			
76. 00 03020 CHEMI CAL DEPENDENCY		3. 5990			•
76. 01 03480 ONCOLOGY		0. 4505			76.01
OUTPATIENT SERVICE COST CENTERS		011000			10101
88.00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		o o	
90. 00 09000 CLINIC		0.8448		-	90.00
91. 00 09100 EMERGENCY		0. 3700			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1454			
200.00 Total (sum of lines 50-94 and 96-98)		1. 1434	3, 522, 860		•
201.00 Less PBP Clinic Laboratory Services-Pr	cogram only charges (line 61)		3, 522, 800		200.00
202.00 Net Charges (line 200 minus line 201)	ogram only charges (Title Of)		3, 522, 860		201.00
		I	5, 522, 600	I	1202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CON: 151315         Period: From 10/01/2015         Worksheet D-3           Component CON: 152315         To 09/30/2016         To 09/30/2016         Date/Time Prepared: To D0/2016           Cost Center Description         Rite XVIII         Swing Beds - SNP         Cost           1.00         2.00         30.00           0.00         03000 ADULTS & PEDIATRICS         1.00         2.00         30.00           3.00         04300 NURSERY         0         31.00         30.00           3.00         05000 OPERATIN ROUTI NE SERVICE COST CENTERS         0         30.00           3.00         065000 OPERATIN ROUM         0.101952         199         191         51.00           50.00         05000 DELTS & PEDIATRICS         0         31.00         31.00         31.00         31.00         31.00         50.00         64.37779         3.163         1.385         50.00           51.00         DECOVERY ROOM         1.010952         199         191         51.00         52.00         64.300         64.400         64.00         64.00         65.00         65.00         65.01         65.01         65.01         65.01         65.01         65.01         65.01         65.00         6	Health Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	u of Form CMS-	2552-10
Component CCN: 152315         To         09/30/2015         Date/Time Prepared: 96/2016 3:17 pm           Cost Center Description         Title XVIII         Swing Beds - SNF         Cost           Inpatient Program         Inpatient Color 1 x col. 20         Inpatient Program Charges         Inpatient Program Charges         Program Cost Center Description         30.00           0.00         03000 ADULTS & PEDI ATRICS         0         30.00         30.00         31.00           30.00         03000 INTENSIVE CARE UNIT         0         0         31.00         43.00           43.00         043000 RECOVERY ROM         0.437779         3.163         1.385         50.00           50.00         05000 RECOVERY ROM         0.437779         3.163         1.385         50.00           51.00         05000 RECOVERY ROM         0.437779         3.163         1.385         50.00           52.00         05200 DELIVERY ROM & LABOR ROM         0.437779         3.163         1.385         50.00           52.00         05200 DELIVERY ROM & LABOR ROM         0.437779         3.163         1.782         54.00           66.00         06600 INTRAVENDUS THERAPY         0.620944         39.091         24.273         65.01           65.01         06501 CABOR CENDERY	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151315		Worksheet D-3	
Intervention         Product Stress         Product Stress           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Costs (col. 1 x col. 2)         Inpatient Program Costs (col. 1 x col. 2) <t< td=""><td></td><td>Component</td><td>- CON. 157015</td><td></td><td>Data /Tima Dra</td><td>norod.</td></t<>		Component	- CON. 157015		Data /Tima Dra	norod.
Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Program Charges         Cost (col. 1 x col. (col. 2000)           30:00         03000 ADULTS & PEDIATRICS         0         30.00         30.00           30:00         03000 INTENSIVE CARE UNIT         0         30.00         30.00           43:00         04300 INTESSIVE CARE UNIT         0         31.00         31.00           43:00         05000 OPERATIN ROUM         0.437779         3,163         1,385         50.00           50:00         05000 DELIVERY ROMM         0.437779         3,163         1,385         50.00           51:00         05000 DELIVERY ROM & LABOR ROM         0.437779         3,163         1,385         50.00           50:00         05400 RADI LOGY-DI AGNOSTI C         0.149198         11,943         1,782         50.00           65:00         06500 LABORATORY         0.30240         27,739         8,389         60.00           66:00         06500 LABORATORY         0.620944         39,091         24,273         65.00           69:00         06900 ELECTROCARDI DLOGY         0.32481         6693         225         69.00		Component	CCN: 15Z315	10 09/30/2015		
INPATIENT ROUTINE SERVICE COST CENTERS         Program Costs (col. 1 x col. 2)         Program Costs (col. 1 x col. 2)           30.00         03000 ADULTS & PEDIATRI CS         0         30.00         30.00           30.00         03000 ADULTS & PEDIATRI CS         0         31.00           30.00         04300 NUBSERY         0         31.00           A3.00         05000 OPERATING ROOM         0.437779         3.163         1.385           50.00         05000 OPERATING ROOM         0.437779         3.163         1.385           51.00         05000 DELIVERY ROOM         1.010952         189         191           52.00         05000 DELIVERY ROOM         0.4437779         3.163         1.385           51.00         05100 RECOVERY ROOM         0.4437779         3.163         1.385           50.00         05400 RADI DLOCY-DIAGNOSTI C         0.149198         1.943         1.782           65.00         06500 RESPI RATORY THERAPY         0.020443         39.091         24.273           65.01         06501 SLEEP LAB         0.527498         0         0         65.01           66.00         06500 PESPI RATORY THERAPY         0.624727         167.617         104.715         66.00           66.00         06500 PESPI		Ti tl	e XVIII	Swing Beds - SNF		
INPATI ENT ROUTI NE SERVI CE COST CENTERS         (col 1 x col 2)           1.00         2.00         3.00           0.00         03000 ADULTS & PEDI ATRI CS         0         30.00           31.00         03000 ADULTS & PEDI ATRI CS         0         30.00           31.00         04300 NURSERY         0         31.00           ANCILLARY SERVI CE COST CENTERS         0         31.00           50.00         05000 OPERATI NG ROOM         0.437779         3,163         1.385           50.00         05000 OD RECOVER ROOM         0.0437779         3,163         1.385           50.00         05000 RECOVER ROOM         0.0437779         3,163         1.385           50.00         05000 RECOVER ROOM         0.0437779         3,163         1.385           50.00         05000 RECOVER ROOM         0.043777         0         0           52.00         05200 RELIVERY ROOM & LABOR ROOM         0.0400000         0         0         64.00           65.00         06500 RESPI RATORY THERAPY         0.302420         27, 739         8,389         60.00           65.01         06501 SLEEP LAB         0.527498         0         0         65.01           65.00         06900 LECTROCARDIOLOGY         0.5874	Cost Center Description		Ratio of Cos			
IMPATE ENT ROUTE NE SERVICE COST CENTERS         0.00         2.00         3.00           30.00         03000         ADULTS & PEDLATRICS         0         0         30.00           31.00         03000         ADULTS & PEDLATRICS         0         31.00           31.00         03100         100         100         0         31.00           31.00         04300         NURSERY         0         31.00           43.00         04300         0         43.00         43.00           ANCILLARY SERVICE COST CENTERS         0         43.00         50.00         5000         0F5000         00         52.00         50.00         64.00         66.00         66.00         66.00			To Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000 AUULTS & PEDIATRICS         0         30.00           31.00         03100 INTENSI VE CARE UNIT         0         31.00         31.00           30.00         03000 AUULTS & PEDIATRICS         0         31.00         31.00           31.00         03000 NURSERV         0         31.00         31.00           ANCILLARY SERVICE COST CENTERS         0         31.00         0.437779         3.163         1.385           50.00         05100 RECOVERY ROOM         1.010952         189         19         151.00           52.00         05200 DELIVERY ROOM & LABOR ROOM         0.964572         0         0         52.00           60.00         06400 INTRAVENOUS THERAPY         0.302420         27.739         8.389         60.00           60.00         06500 RESPI RATORY THERAPY         0.624727         167.617         104.715           60.00         06600 INTRAVENOUS THERAPY         0.624727         167.617         164.00           61.00         06500 RESPI RATORY THERAPY         0.624727         167.617         104.715           60.00         06600 PHYSICAL THERAPY         0.624727         167.617         104.715           60.00         06500				Charges		
INPATIENT ROUTI NE SERVICE COST CENTERS         0         30.00         03000 ADULTS & PEDIATRICS         0         30.00 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td></th<>						
30.00       03000 ADULTS & PEDIATRICS       0       30.00         31.00       03100       INTENSI VE CARE UNIT       0       31.00         ANCILLARY SERVICE COST CENTERS       0       31.00         50.00       05000 OPERATI NG ROOM       0.437779       3,163       1,385         50.00       05100 RECOVERY ROOM       1.010952       189       191       51.00         52.00       05200 DELI VERY ROOM & LABOR ROOM       0.944572       0       0       52.00         54.00       05400 RADIOLOGY-DI AGNOSTI C       0.101952       189       100       52.00         64.00       06400 INTRAVENOUS THERAPY       0.000000       0       64.00       64.00       6500       6500 RESPI RATORY THERAPY       0.620944       39.091       24.273       65.00       65.01       66501       15.100       65.01       66501       6600 EASPLATORY THERAPY       0.624727       167.617       104.715       66.00       65.01       6690       124.273       67.649       225       69.00       69.01       69.00       69.00       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td></td>			1.00	2.00	3.00	
31.00       03100       INTENSI VE CARE UNI T       31.00         43.00       04300 (NURSERY       31.00         43.00       04300 (NURSERY       0.430777         50.00       05000 OPERATI NG ROOM       0.437777       3.163       1.385         51.00       05100 RECOVERY ROOM       0.944572       0       52.00         54.00       05400 RADI OLOGY - DI AGNOSTI C       0.149198       11,943       1,782       54.00         60.00       06000 LABORATORY       0.302420       27,739       8.389       60.00       60.00       60.00       60.00       60.00       65			1	1		
43.00       04300       NURSERY       43.00         ANCILLARY SERVICE COST CENTERS       43.00         ANCILLARY SERVICE COST CENTERS       0.437779       3,163       1,385       50.00         51.00       05100       RECOVERY ROOM       1.010952       189       191       51.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.964572       0       52.00       54.00       05400       RADIOLOGY-DI AGNOSTIC       0.149198       11,943       1,782       54.00       56.00       66.00       0.6000       LABORATORY       0.302420       27,739       8,389       60.00       66.00       06500       RESPIRATORY THERAPY       0.620944       39,091       24,273       65.00       66.00       66.00       66.00       06500       RESPIRATORY THERAPY       0.624727       167,617       104,715       66.00       66.00       66.00       66.00       66.01       0.66492       0       65.00       69.01       66.02       0.66492       0       67.00       72.00       73.00       RIUG LA SUPPLIES CHARGED TO PATIENT       0.66492       0       72.00       73.00       RIUG LA SUPPLIES CHARGED TO PATIENTS       0.587428       0       72.00       73.00       73.00       73.00       73.00       73.00				-		
ANCILLARY SERVICE COST CENTERS           50.00         05000         DPERATING ROOM         0.437779         3, 163         1, 385         50.00           51.00         05200         DELIVERY ROOM         0.0964572         0         0         52.00           52.00         05200         DELIVERY ROOM & LABOR ROOM         0.149198         11, 943         1, 782         54.00           64.00         0.6400         LAGNATRY         0.302420         27, 739         8, 389         60.00         66.00         0.6000         LABORATORY         0.302420         27, 739         8, 389         60.00         64.00         65.01         0.6501         SEEP LAB         0.620944         39, 091         24, 273         65.00         0.6501         SEEP LAB         0.624727         167, 617         104, 715         66.00         69.01         69.01         0.624727         167, 617         104, 715         66.00         69.01         69.01         0.624727         167, 617         104, 715         66.00         69.01         0.624727         167, 617         104, 715         66.00         69.01         0.0501         ALEP LAB         0.574498         0         0         73.00         73.00         73.00         73.00         73.00         73.00				0		
50.00         05000         0PERATI NG ROOM         0.437779         3, 163         1, 385         50.00           51.00         05100         RECOVERY ROOM & LABOR ROOM         0.964572         0         0         52.00           52.00         05200         DELI VERY ROOM & LABOR ROOM         0.964572         0         0         52.00           64.00         05400         RADI OLOGY-DI AGNOSTI C         0.149198         11,943         1,782         54.00           60.00         060000         LABORATORY         0.302420         27,739         8,389         60.00           64.00         INTRAVENOUS THERAPY         0.000000         0         0         64.00           65.01         06500         RESPI RATORY THERAPY         0.62944         39,091         24,273         65.00           66.00         06600         PHYSI CAL THERAPY         0.624727         167, 617         104,715         66.00         69.01         0.966492         0         0         69.01           69.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         0.686498         13, 645         9,121         10.075.00           72.00         07200         DRUGS CHARGED TO PATI ENTS         0.437606         54,934         24,039<						43.00
51.00       05100       RECOVERY ROOM       1.010952       189       191       51.00         52.00       05200       DELI VERY ROOM & LABOR ROOM       0.964572       0       0.52.00         64.00       05400       RADI LOGX-DI AGNOSTI C       0.149198       11.943       1,782       54.00         60.00       06000       LABORATORY       0.302420       27,739       8,389       60.00         64.00       06400       INTRAVENOUS THERAPY       0.600000       0       64.00         65.01       06500       RESPI RATORY THERAPY       0.620744       39,091       24,273       65.01         066.00       06600       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         65.01       06900       ELECTROCARDI OLOGY       0.324851       693       225       69.00         0.900       06900       REDI CAL SUPPLIES CHARGED TO PATI ENT       0.686498       13,645       9,122       71.00         71.00       07100       IMPL.       DEV. CHARGED TO PATI ENTS       0.587428       0       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00       73.00       0<						
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.964572       0       0       52.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.149198       11,943       1,782       54.00         60.00       LABORATORY       0.302420       27,739       8,389       60.00       64.00         64.00       INTRAVENOUS THERAPY       0.000000       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.620944       39,091       24,273       65.00         65.01       06501       SLEPL LAB       0.527498       0       0       65.01         66.00       06400       INTRAVENDUS THERAPY       0.620944       39,091       24,273       65.01         65.01       06501       SLEPL LAB       0.527498       0       0       65.01         64.00       06900       ELETROCARDI OLOGY       0.324851       693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       72.00         72.00       O7200       IMPL.       DEV. CHARGED TO PATI ENTS       0.867428       0       72.00         73.00       03202       CHEM CAL DEPENDENCY       3.599082 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
54.00       05400       RADI 0L0GY-DI AGNOSTI C       0.149198       11,943       1,782       54.00         60.00       06000       LABORATORY       0.302420       27,739       8,389       60.00         64.00       0KMAVENDUS THERAPY       0.000000       0       64.00         65.00       RESPI RATORY THERAPY       0.620944       39,091       24,273       65.00         65.01       06500       RESPI RATORY THERAPY       0.624727       167,617       104,715       66.00         66.00       0HYSI CAL THERAPY       0.624727       167,617       104,715       66.00       69.00       0.624727       167,617       104,715       66.00       69.01       0.966492       0       0       69.01       69.01       0.7200       MPL. DEV. CHARGED TO PATI ENT       0.668498       13,645       9,122       71.00       72.00       07200       MPL. DEV. CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00       72.00						
60.00       LABORATORY       0.302420       27,739       8,389       60.00         64.00       06400       INTRAVENOUS THERAPY       0.000000       0       64.00         65.00       06500       RESPIRATORY THERAPY       0.620944       39,091       24,273       65.00         65.01       06501       SLEEP LAB       0.527498       0       0       65.00         66.00       06900       ELECTROCARDI OLOGY       0.324851       693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       227,700       29.01         71.00       07100       MEDI AL SUPPLIES CHARGED TO PATIENT       0.668498       13,645       9,12       71.00       27.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.437606       54,934       24,039       73.00         76.00       03248       0NOCLOGY       0.450556       0       0       76.00       76.00       78.099082       0       76.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00<						
64.00       06400       INTRAVENOUS THERAPY       0.000000       0       64.00         65.00       06500       RESPI RATORY THERAPY       0.620944       39,091       24,273       65.00         66.00       06600       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         66.00       06600       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         69.00       06900       ELECTROCARDI OLOGY       0.324851       6633       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       69.01         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.684898       13,645       9,122       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00         76.00       03202       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         76.01       03480       ONCOLOGY       0.437606       54,934       24,039       73.00         76.01       03480       ONCOLOGY       0.450556       0       0       76.00         76.01       03480       ONCOLOGY <t< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>						•
65.00       06500       RESPIRATORY THERAPY       0.620944       39,091       24,273       65.00         65.01       06501       SLEEP LAB       0.527498       0       0       65.01         66.00       06400       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         69.00       06900       ELECTROCARDI OLOGY       0.324851       6693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       69.01         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.688498       13,645       9,122       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00         76.01       03480       ONCOLOGY       0.437606       54,934       24,039       76.00         76.01       03480       ONCOLOGY       0.450556       0       0       76.00         76.01       03480       ONCOLOGY       0.8800       RARGE TO PATI ENTS       0.8800       88.00         89.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
65.01       06501       SLEEP LAB       0.527498       0       65.01         66.00       06600       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         69.01       06901       ELECTROCARDI OLOGY       0.324851       693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.68498       13,645       9,122       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.587428       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00         76.00       03202       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         0.01TPATI ENT SERVICE COST CENTERS       0.000000       0       0       88.00       88.00         89.00       08900       FEDERALLY QUALI FIED HEALTH CENTER       0.000000       0       88.00         99.00       09000       CLINIC       0.84865       0       0       90.00         90.00       09000       CLINIC       0.370014 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
66.00       06600       PHYSI CAL THERAPY       0.624727       167,617       104,715       66.00         69.00       06900       ELECTROCARDI OLOGY       0.324851       693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       69.01         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.684898       13,645       9,122       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.587428       0       0       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0.437606       54,934       24,039       73.00         76.00       03020       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         76.01       03480       ONCOLOGY       0.450556       0       0       76.00         70.00       68800       RURAL HEALTH CLINIC       0.000000       0       88.00       89.00         89.00       08900       FEDERALLY QUALI FIED HEALTH CENTER       0.000000       0       90.00       99.00         90.00       09000       CLINIC       0.370014       0       0       90.00         91.00						
69.00       06900       ELECTROCARDI OLOGY       0.324851       693       225       69.00         69.01       06901       CARDI AC REHAB       0.966492       0       0       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.668498       13,645       9,122       71.00         72.00       07200       IMPL.       DEV.       CHARGED TO PATIENTS       0.587428       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.437606       54,934       24,039       73.00         76.00       03020       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         0.3480       ONCOLOGY       0.450556       0       0       76.00       88.00         0.9000       CLINI C       0.000000       0       89.00       89.00       89.00       89.00       89.00       99.00       991.00       991.00       991.00       991.00       991.00       991.00       991.00       991.00       992.00       085RVATI ON BEDS (NON-DI STINCT PART       1.145434       3,616       4,142       92.00       90.00       91.00       92.00       092200       085RVATI ON BEDS (NON-DI STINCT PART       32,630       178,263 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
69.01       06901       CARDI AC REHAB       0.966492       0       0       69.01         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.668498       13,645       9,122       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.587428       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.437606       54,934       24,039       73.00         76.00       03020       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         0.437606       54,934       24,039       73.00       76.00       0.4800 ONCOLOGY       0       76.00         0.04800 ONCOLOGY       0.450556       0       0       76.01       0       76.01         0UTPATIENT SERVICE COST CENTERS       0.000000       0       88.00       89.00       89.00       89.00       89.00       89.00       89.00       89.00       90.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>						•
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.668498       13,645       9,122       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.587428       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.437606       54,934       24,039       73.00         76.01       03480       ONCOLOGY       0.450556       0       0       76.01         0176.01       03480       RURAL HEALTH CLINIC       0.000000       0       76.01         00000       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       88.00         89.00       09000       CLINIC       0.844865       0       0       90.00         90.00       09100       EMERGENCY       0.370014       0       90.00       90.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       1.145434       3,616       4,142       92.00         90.00       092000       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00						
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.587428       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.437606       54,934       24,039       73.00         76.00       03020       CHEMI CAL DEPENDENCY       3.599082       0       0       76.00         03480       ONCOLOGY       0.450556       0       0       76.01         04480       ONCOLOGY       0.450556       0       0       76.01         04800       RURAL HEALTH CLINIC       0.000000       0       88.00         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       89.00         90.00       09000       CLINIC       0.844865       0       90.00         91.00       09100       EMERGENCY       0.370014       0       91.00         92.00       092000       OBSERVATION BEDS (NON-DI STINCT PART       1.145434       3,616       4,142       92.00         200.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00						
73.00         07300         DRUGS CHARGED TO PATIENTS         0.437606         54,934         24,039         73.00           76.00         03020         CHEMI CAL DEPENDENCY         3.599082         0         0         76.00           03480         ONCOLOGY         0.437606         54,934         24,039         73.00         76.00           01         03480         ONCOLOGY         0.450556         0         0         76.01           01         01700         DUTPATI ENT SERVICE COST CENTERS         0.000000         0         88.00           08900         RURAL HEALTH CLINIC         0.000000         0         89.00         89.00           90.00         09000         CLINIC         0.844865         0         99.00           91.00         09100         EMERGENCY         0.370014         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DI STINCT PART         1.145434         3,616         4,142         92.00           200.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00						
76.00         03020         CHEMI CAL DEPENDENCY         3.599082         0         76.00           76.01         03480         ONCOLOGY         0.450556         0         0         76.01           01         01         01         0.450556         0         0         76.01           01         01         0.450556         0         0         76.01         76.01           01         01         0.450556         0         0         0         76.01         76.01           01         01         0.450556         0         0         0         76.01         76.01           01         01         0.450556         0         0         0         88.00         88.00           88.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         89.00           90.00         09000         CLINIC         0         90.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00         92.00         09200         0BSERVATION BEDS (NON-DI STINCT PART         1.145434         3,616         4,142         92.00           200.00         201.00         Less PBP C						
76. 01         03480         ONCOLOGY         0.450556         0         0         76. 01           0UTPATI ENT SERVICE COST CENTERS         0.000000         0         88.00         88.00         08800         RURAL HEALTH CLINIC         0.000000         0         88.00         89.00         90.00         0.000000         0         90.00         89.00         90.00         0.000000         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         91.00         90.00         91.00         91.00         91.00         92.00         0SERVATI ON BEDS (NON-DI STINCT PART         1.145434         3, 616         4,142         92.00         200.00         10.141 (sum of lines 50-94 and 96-98)         200.00         201.00         20						
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         89.00           90.00         09000         CLINIC         0.844865         0         0         90.00           91.00         09100         EMERGENCY         0.370014         0         91.00           92.00         09200         DBSERVATION BEDS (NON-DI STINCT PART         1.145434         3,616         4,142         92.00           200.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00						
88.00       08800       RURAL HEALTH CLINIC       0.000000       0       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       89.00         90.00       09000       CLINIC       0.844865       0       90.00         91.00       09100       EMERGENCY       0.370014       0       91.00         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART       1.145434       3,616       4,142       92.00         200.00       Total (sum of lines 50-94 and 96-98)       322,630       178,263       200.00       201.00			0. 4505	56 0	0	76.01
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.00000         0.00000         0.00000         90.00         91.00         91.00         91.00         91.00         91.00         92.00         92.00         92.00         92.00         322,630         178,263         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00						
90.00         09000         CLINIC         0.844865         0         90.00         90.00           91.00         09100         EMERGENCY         0.370014         0         91.00         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         1.145434         3,616         4,142         92.00           200.00         Total (sum of lines 50-94 and 96-98)         322,630         178,263         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00					-	
91.00         09100         EMERGENCY         0.370014         0         91.00         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         1.145434         3,616         4,142         92.00           200.00         Total (sum of lines 50-94 and 96-98)         322,630         178,263         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00					-	
92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART         1.145434         3,616         4,142         92.00           200.00         Total (sum of lines 50-94 and 96-98)         322,630         178,263         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00						
200.00         Total (sum of lines 50-94 and 96-98)         322,630         178,263         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00					-	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1. 14543			
				322, 630	178, 263	•
202.00 Net Charges (Line 200 minus Line 201) 322 630 202.00		gram only charges (line 61)		•		•
	202.00 Net Charges (line 200 minus line 201)			322, 630		202.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Pre 9/6/2016 3:17	pared:
	Tit	le 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 03000 ADULTS & PEDI ATRI CS			158, 687		30.00
31.00 03100 INTENSIVE CARE UNIT			13, 631		31.00
43. 00 04300 NURSERY			11, 649		43.00
ANCI LLARY SERVI CE COST CENTERS			1		
50.00 05000 OPERATI NG ROOM		0. 4377			
51.00 05100 RECOVERY ROOM		1.0109			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9645			•
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1491			
60. 00 06000 LABORATORY		0. 30242	20 68, 736	20, 787	60.00
64.00 06400 INTRAVENOUS THERAPY		0.0000		-	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 6209	44 32, 288	20, 049	65.00
65. 01 06501 SLEEP LAB		0. 5274		-	
66. 00 06600 PHYSI CAL THERAPY		0. 62472			
69. 00 06900 ELECTROCARDI OLOGY		0. 3248	51 3, 457	1, 123	69.00
69. 01 06901 CARDI AC REHAB		0.9664	92 573	554	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.6684	98 37, 513	25, 077	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 58742	28 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4376	06 40, 792	17, 851	73.00
76.00 03020 CHEMI CAL DEPENDENCY		3. 5990	32 0	0	76.00
76.01 03480 ONCOLOGY		0. 4505	56 87	39	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	0 00	0	89.00
90. 00 09000 CLINIC		0. 8448	55 2	2	90.00
91. 00 09100 EMERGENCY		0. 3700	14 17, 439	6, 453	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 14543			92.00
200.00 Total (sum of lines 50-94 and 96-98)			352, 999		
201.00 Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			352, 999		202.00
		-		•	

CALCUL	Financial Systems CAMERON MEMORIAL ( ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151315	Period: From 10/01/2014 To 09/30/2015	u of Form CMS-: Worksheet E Part B Date/Time Pre	pared:		
		Title XVIII	Hospi tal	9/6/2016 3:17 Cost	pm		
				1 00			
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00			
. 00	Medical and other services (see instructions)			7, 440, 563	1.00		
2.00	Medical and other services reimbursed under OPPS (see instructi	i ons)		0			
3.00 4.00	PPS payments Outlier payment (see instructions)			0	3.00		
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	tions)		0.000			
. 00	Line 2 times line 5			0	6.00		
. 00	Sum of line 3 plus line 4 divided by line 6			0.00			
3.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	V col 12 Lino 200		0	8.00 9.00		
0.00	Organ acquisitions	v, cor. 13, time 200		0			
1.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 440, 563			
	COMPUTATION OF LESSER OF COST OR CHARGES						
2.00	Reasonable charges Ancillary service charges			0	12.00		
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	13.00		
4.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00		
F 00	Customary charges			0	1 15 00		
5.00 6.00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0			
0.00	had such payment been made in accordance with 42 CFR §413.13(e)		in a chargebasi s	0	10.00		
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000			
8.00	Total customary charges (see instructions)	vifling 10. overede li	no. 11) (coo	0	18.00		
9.00	Excess of customary charges over reasonable cost (complete only instructions)	y IT TINE 18 exceeds IT	ne II) (see	0	19.00		
20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20.00		
	instructions)						
21.00 22.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)		7, 514, 969 0	21.00			
23.00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	1		
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			22.042	1 05 00		
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		33, 042 3, 323, 909	•		
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23] (see	4, 158, 018			
	instructions)						
	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0			
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 4, 158, 018			
31.00	Primary payer payments			287	1		
32.00	Subtotal (line 30 minus line 31)			4, 157, 731	32.00		
2 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.00		
	Allowable bad debts (see instructions)			533, 037			
	Adjusted reimbursable bad debts (see instructions)			346, 474			
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		413, 001			
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			4, 504, 205 0			
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00		
9.50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0			
89. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39.98		
39.99 10.00	RECOVERY OF ACCELERATED DEPRECIATION			0 4, 504, 205	39.9		
10.00	Subtotal (see instructions) Sequestration adjustment (see instructions)			4, 504, 205 90, 084			
	Interim payments		4, 394, 106				
2.00							
3.00	Balance due provider/program (see instructions)	cowith CMS Dub 15 2	chanter 1	20, 015	1		
4.00	Protested amounts (nonallowable cost report items) in accordance §115.2	ue with two PUD. 15-2,	chapter I,	0	44.00		
	TO BE COMPLETED BY CONTRACTOR				1		
	Original outlier amount (see instructions)			0			
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00		
	Time Value of Money (see instructions)			0.00			
	Total (sum of lines 91 and 93)				94.0		

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151315	Period: From 10/01/2014 To 09/30/2015		
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		2, 605, 1	37 0	4, 394, 106 0	1. 2. 3.
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01 02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3. 3. 3. 3. 3.
	Provider to Program					
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0 0	0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		2, 605, 1	37	4, 394, 106	4
00	List separately each tentative settlement payment after		[			5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
D1	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	5 5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
)0 )1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		656, 8	40	20, 015	6
)1 )2	SETTLEMENT TO PROVIDER		000,8		20,015	6
)2 )0	Total Medicare program liability (see instructions)		3, 261, 9	86	4, 414, 121	7
				Contractor Number	NPR Date (Mo/Day/Yr)	,
			)	1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			eriod: rom 10/01/2014 o 09/30/2015		
					9/6/2016 3:17	
				wing Beds - SNF		
		Inpatier	it Part A	Par	-t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		520, 239		0	1.
00	Interim payments payable on individual bills, either		C		0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			1		
01	ADJUSTMENTS TO PROVIDER		0		0	
02			0		0	
23			0		0	
)4 )5					0	
55	Provider to Program				0	3
50	ADJUSTMENTS TO PROGRAM		l c		0	3
51					0	
52			c		0	3
53			C		0	3
54			C		0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		520, 239		0	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		520, 237		0	1
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER		C		0	5
)2					0	
03			c d		0	5
	Provider to Program		1	1		
50	TENTATI VE TO PROGRAM		C		0	
51					0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					-
77	5. 50-5. 98)				0	
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		132, 144		0	-
)2	SETTLEMENT TO PROGRAM		C		0	
00	Total Medicare program liability (see instructions)		652, 383		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
00	Name of Contractor			1.00	2.00	8

Heal th	Health Financial Systems CAMERON MEMORIAL COMMUNITY In Lieu of								
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151315	Period: From 10/01/2014	Worksheet E-1 Part II					
	To 09/30/2015 Date/Time								
	9/6/2016 3: 17 p								
Title XVIII Hospital Cost									
				1.00					
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS								
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION								
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	1, 306 1, 240	1.00 2.00						
2.00									
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2								
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12								
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			99, 072, 093	5.00				
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin			1, 049, 080	6.00				
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HII technology	Wkst. S-2, Pt. I	0	7.00				
0.00	line 168				0 00				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00				
9.00	Sequestration adjustment amount (see instructions)			0	9.00				
10.00	Calculation of the HIT incentive payment after sequestration (	see instructions)		0	10.00				
	I NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH								
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00 31. 00				
31.00	5 (1 5)								
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	5)	0	32.00				

	Financial Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Pre 9/6/2016 3:17	pared:
			Title XVIII	Swing Beds - SNF		
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	6				
1.00	Inpatient routine services - swing bed-SNF	(see instructions)		486, 563	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		A, and sum of Wkst. D,	180, 046	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)					
4.00	Per diem cost for interns and residents no	t in approved teachin	ig program (see		0.00	4.00
	instructions)					
5.00	Program days			303	0	5.00
6.00	Interns and residents not in approved teac				0	6.00
7.00	Utilization review - physician compensation		iod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus li	nes 6 and 7)		666, 609	0	8.00
9.00	Primary payer payments (see instructions)			0	0	
10.00	Subtotal (line 8 minus line 9)			666, 609	0	10.00
11.00	Deductibles billed to program patients (exprofessional services)	clude amounts applica	ble to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)			666, 609	0	12.00
13.00	Coinsurance billed to program patients (front for physician professional services)	om provider records)	(excl ude coi nsurance	912	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				0	14.00
15.00	Subtotal (enter the lesser of line 12 minu:		)	665, 697	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEC			0	0	16.00
16.50	Pioneer ACO demonstration payment adjustme	nt (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0	0	17.00
17.01	Adjusted reimbursable bad debts (see instr			0	0	17.01
18.00	Allowable bad debts for dual eligible bene	ficiaries (see instru	ictions)	0	0	18.00
19.00	Total (see instructions)			665, 697	0	19.00
19.01	Sequestration adjustment (see instructions)	)		13, 314	0	
20.00	Interim payments			520, 239	0	20.00
21.00	Tentative settlement (for contractor use o			0	0	21.00
22.00	Balance due provider/program (line 19 minu:		2	132, 144	0	22.00
23.00	Protested amounts (nonallowable cost repor chapter 1, §115.2	t items) in accordanc	e with CMS Pub. 15-2,	0	0	23.00

	Financial Systems CAMERON MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Pre 9/6/2016 3:17	pared:
		Title XVIII	Hospi tal	Cost	piii
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 682, 060	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3.00	Organ acquisition			0	
4.00	Subtotal (sum of lines 1 through 3)		3, 682, 060		
5.00	Primary payer payments		0	5.00	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 718, 881	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7.00	Reasonable charges Routine service charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	
10.00	Customary charges				10.00
11.00	Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for	5	5	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		5		
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 onl	y if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)			_	
16.00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds lin	e 14) (see	0	16.00
17.00	instructions)	vueti ene)		0	17.00
17.00	Cost of physicians' services in a teaching hospital (see instr COMPUTATION OF REIMBURSEMENT SETTLEMENT	uctions)		0	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)	r, TTTC +7)		3, 718, 881	
20.00	Deductibles (exclude professional component)			411, 972	•
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			3, 306, 909	22.00
23.00	Coinsurance			1, 249	
24.00	Subtotal (line 22 minus line 23)			3, 305, 660	24.00
25.00	Allowable bad debts (exclude bad debts for professional servic	ces) (see instructions)		35, 226	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			22, 897	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		16, 698	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 328, 557	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29.50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	29.50
29.99	Recovery of Accel erated Depreciation		0		
30. 00 30. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 328, 557 66, 571	
	Interim payments			2, 605, 137	
31.00	Tentative settlement (for contractor use only)			2,605,137	
32.00	Balance due provider/program (line 30 minus lines 30.01, 31, a	and 32)		656, 849	
34.00	Protested amounts (nonallowable cost report items) in accordar		chapter 1	030, 047	34.00
200	§115. 2			0	

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151315	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Pre 9/6/2016 3:17	pared
		Title XIX	Hospi tal	PPS	
			Inpatient 1.00	Outpatient 2.00	
_	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
0	Inpatient hospital/SNF/NF services		0		1 1.0
00	Medical and other services			0	2.0
00	Organ acquisition (certified transplant centers only)		0		3. (
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.0
00	Inpatient primary payer payments		0		5.0
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~	Reasonable Charges		102.0/0		
00 00	Routine service charges		183, 968	0	8. 9.
00	Ancillary service charges Organ acquisition charges, net of revenue		352, 999 0	0	9.
00	Incentive from target amount computation		0		10.
00	Total reasonable charges (sum of lines 8 through 11)		536, 967	0	
00	CUSTOMARY CHARGES		550, 707	0	12.
00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.
	basi s			-	
00	Amounts that would have been realized from patients liable for p	ayment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
00	Total customary charges (see instructions)		536, 967	0	16.
00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	536, 967	0	17.
	line 4) (see instructions)			_	
00	Excess of reasonable cost over customary charges (complete only	IT line 4 exceeds lin	e 0	0	18.
00	16) (see instructions)		0	0	10
00 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	19. 20.
00	Cost of covered services (enter the lesser of line 4 or line 16)	trons)	0	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mplated for PDS provi		0	21.
00	Other than outlier payments	inpreted for FFS provi	0	0	22.
00	Outlier payments		0	0	
00	Program capital payments		0	0	24.
00	Capital exception payments (see instructions)		0		25.
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	27.
00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
00	Deducti bl es		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review	2)	0	-	35.
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	0	0	36.
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37) Direct graduate modical education navments (from Wkst E 4)		0	0	38.
00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments				
00 00	Balance due provider/program (line 40 minus line 41)		318, 202 -318, 202	0	41. 42.
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15 2	-310, 202	0	
00	chapter 1, §115.2	with own ide idez,	0	0	40

	SHEET (If you are nonproprietary and do not maintain		CCN: 151315	Period: From 10/01/2014	Worksheet G	
und-ty	ype accounting records, complete the General Fund column onl	y)		To 09/30/2015	Date/Time Pre	pared
		General Fund	Speci fi c	Endowment Fund	9/6/2016 3:17 Plant Fund	pm
		4.00	Purpose Fund		4.00	
0	CURRENT ASSETS	1.00	2.00	3.00	4.00	
-	Cash on hand in banks	1, 827, 133		0 0	0	1 1.
	Temporary investments	0		0 0	0	2.
	Notes receivable	216, 225		0 0	0	
	Accounts receivable	8, 504, 724		0 0	0	
	Other receivable	748, 342		0 0	0	
	Allowances for uncollectible notes and accounts receivable Inventory	853, 493		0 0	0	
	Prepaid expenses	789, 430		0 0	0	
	Other current assets	2, 245, 773		0 0	0	
0. 00	Due from other funds	0		0 0	0	10.
	Total current assets (sum of lines 1-10)	15, 185, 120		0 0	0	11.
-	I XED ASSETS		1			
	Land	1, 317, 868		0 0	0	
	Land improvements Accumulated depreciation	0		0 0	0	
1	Buildings	52, 431, 702			0	
	Accumul ated depreciation	-5, 885, 654		0 0	0	
	Leasehold improvements	0,000,001		0 0	0	
3. 00	Accumulated depreciation	0		0 0	0	18.
	Fixed equipment	0		0 0	0	19.
	Accumul ated depreciation	0		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	Major movable equipment	15, 279, 796		0 0	0	
	Accumulated depreciation Minor equipment depreciable	-7, 726, 426		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumul ated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
	Total fixed assets (sum of lines 12-29)	55, 417, 286		0 0	0	30
	OTHER ASSETS		1			
	Investments	19, 014, 955		0 0	0	
	Deposits on leases Due from owners/officers	0		0 0	0	
	Other assets	1, 443, 554		0 0	0	
	Total other assets (sum of lines 31-34)	20, 458, 509		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	91, 060, 915		0 0	0	
-	CURRENT LI ABI LI TI ES		ı	-1 -1		
7.00	Accounts payable	2, 038, 771		0 0	0	37
	Salaries, wages, and fees payable	2, 101, 064		0 0	0	
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	800, 970		0 0	0	1 .0
	Deferred income	0		0 0	0	
	Accelerated payments Due to other funds	0		0 0	0	42
	Other current liabilities	1, 476, 535		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	6, 417, 340		0 0	0	
	_ONG TERM LIABILITIES	-,,	I			
6.00	Mortgage payable	0		0 0	0	46
	Notes payable	0		0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	47,060,254		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	47,060,254		0 0	0	
	Total liabilities (sum of lines 45 and 50)	53, 477, 594	I	0	0	1 21
	General fund balance	37, 583, 321				52
	Specific purpose fund	57, 505, 521		0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
1	Governing body created - endowment fund balance			0		56
1	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	07 565 5				
	Total fund balances (sum of lines 52 thru 58)	37, 583, 321		0 0	0	
D. 00	Total liabilities and fund balances (sum of lines 51 and 59)	91, 060, 915		0	0	60

Heal th	Financial Systems	CAMERON MEMORIA	AL CON	IMUNI TY			In Lie	u of Form CMS-	2552-10
	ENT OF CHANGES IN FUND BALANCES				CCN: 151315		eriod: com 10/01/2014	Worksheet G-1 Date/Time Pre	
		Caracter	L Euro		Crassi al			9/6/2016 3:17	pm
		General	I Fund		Speci ai	Pui	rpose Fund	Endowment Fund	
1 00	Fund halanass at baginning of pariod	1.00		2.00	3.00		4.00	5.00	1.00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		37	40, 630 <sup>7</sup> , 292, 266			0		2.00
3.00	Total (sum of line 1 and line 2)		37	, 332, 896			0		3.00
4.00	NA RELEASED FROM RESTRICTION	346, 635				0		0	4.00
5.00	CONTRI BUTI ONS	262, 296				0		0	
6.00		0				0		0	
7.00 8.00		0				0		0	
8.00 9.00		0				0		0	
10.00	Total additions (sum of line 4-9)	0		608, 931		Ŭ	0	0	10.00
11.00	Subtotal (line 3 plus line 10)		37	, 941, 827			0		11.00
12.00	INVESTMENT LOSS	6, 126				0		0	12.00
13.00	NA RELEASED FROM RESTRICTION	352, 380				0		0	
14.00		0				0		0	
15. 00 16. 00		0				0		0	
17.00		0				0		0	
18.00	Total deductions (sum of lines 12-17)	0		358, 506		Ŭ	0	0	18.00
19.00	Fund balance at end of period per balance		37	, 583, 321			0		19.00
	sheet (line 11 minus line 18)				L				
		Endowment Fund		Pl ant	Fund				
		6.00	7	7.00	8.00				
1.00	Fund balances at beginning of period	0				0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					~			2.00
3.00 4.00	Total (sum of line 1 and line 2) NA RELEASED FROM RESTRICTION	0		0		0			3.00 4.00
4.00 5.00	CONTRI BUTI ONS			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 12. 00	Subtotal (line 3 plus line 10) INVESTMENT LOSS	0		0		0			11.00
13.00	NA RELEASED FROM RESTRICTION			0					13.00
14.00				0					14.00
15.00				0					15.00
16.00				0					16.00
17.00				0					17.00
18.00	Total deductions (sum of lines 12-17)	0				0			18.00
19.00	Fund balance at end of period per balance	0				0			19.00
	sheet (line 11 minus line 18)	I I			I	I			1

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	i i ovr der	CCN: 151315	Perio From To	10/01/2014 09/30/2015	Worksheet G-2 Parts I & II Date/Time Pre 9/6/2016 3:17	pared:
	Cost Center Description		Inpati ent	0	utpati ent	Total	Ċ
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						1
1.00	Hospi tal		6, 271, 7	09		6, 271, 709	1.0
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	5.0
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			Ŭ		0	7.0
8.00	NURSI NG FACILITY						8.0
9.00	OTHER LONG TERM CARE						9.0
10.00	Total general inpatient care services (sum of lines 1-9)		6, 271, 7	00		6, 271, 709	
10.00	Intensive Care Type Inpatient Hospital Services		0,271,7	07		0,271,707	10.0
11.00	INTENSIVE CARE UNIT		422, 5	62	I	422, 562	11.0
12.00	CORONARY CARE UNIT		422, 5	02		422, 302	12.0
13.00	BURN INTENSIVE CARE UNIT						13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.0
14.00	OTHER SPECIAL CARE (SPECIFY)						14.0
16.00		<b>n</b> 00	422, 5	40		400 E40	
10.00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes	422, 3	02		422, 562	10.0
17.00	Total inpatient routine care services (sum of lines 10 and 16)		6, 694, 2	71		6, 694, 271	17.0
18.00	Ancillary services		10, 457, 0		66, 984, 772	77, 441, 807	18.0
19.00	Outpatient services		10, 437, 0	0	13, 354, 139	13, 354, 139	
20.00	RURAL HEALTH CLINIC			0	13, 354, 139	13, 334, 139	
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY			0	1, 110, 825	1, 110, 825	
22.00	AMBULANCE SERVICES				1, 110, 625	1, 110, 025	22.0
23.00	CMHC						23.0
24.00	AMBULATORY SURGICAL CENTER (D. P. )						24.0
26.00	HOSPICE			0	471,051	471, 051	
27.00	OTHER			0	5, 087, 308	5, 087, 308	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	What	17, 151, 3		87,008,095	104, 159, 401	
20.00	G-3, line 1)	WKSL.	17, 101, 5	00	67,006,095	104, 139, 401	20.0
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				48, 732, 073		29.0
30.00	ADD (SPECIFY)			0	40, 732, 073		30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				0			34.0
36.00	Total additions (sum of lines 30-35)			0	0		36.0
				0	0		
37.00	DEDUCT (SPECI FY)			0			37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00				0			41.0
42.00	Total deductions (sum of lines 37-41)				0		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer	1	1	48, 732, 073		43.0

Heal th	Financial Systems	CAMERON MEMORIAL CO	MMUNI TY		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN	: 151315	Peri od:	Worksheet G-3	
					From 10/01/2014 To 09/30/2015	Date/Time Pre	arod.
					10 097 307 2013	9/6/2016 3: 17	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		28)			104, 159, 401	1.00
2.00	Less contractual allowances and discounts or	n patients' accounts				55, 599, 180	2.00
3.00	Net patient revenues (line 1 minus line 2)					48, 560, 221	3.00
4.00	Less total operating expenses (from Wkst. G-		)			48, 732, 073	4.00
5.00	Net income from service to patients (line 3	minus line 4)				-171, 852	5.00
( 00	OTHER I NCOME						( 00
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00 9.00	Revenues from telephone and other miscellane	eous communication se	ervices			0	8.00 9.00
9.00 10.00	Revenue from television and radio service Purchase discounts					0	9.00 10.00
11.00	Rebates and refunds of expenses					0	10.00
12.00	Parking lot receipts					0	12.00
12.00	Revenue from Laundry and Linen service					0	12.00
14.00		acte				0	14.00
15.00	1 5 5	515				0	14.00
16.00		upplies to other than	natients			0	16.00
17.00			i patrents			0	17.00
18.00	5					0	18.00
19.00						0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a					0	20.00
21.00						0	21.00
22.00	Rental of hospital space					0	22.00
23.00	Governmental appropriations					0	23.00
24.00	OTHER REVENUE					212, 482	24.00
25.00	Total other income (sum of lines 6-24)					212, 482	25.00
26.00	Total (line 5 plus line 25)					40, 630	26.00
	OTHER EXPENSES (SPECI FY)					0	27.00
28.00	Total other expenses (sum of line 27 and sub	oscripts)				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				40, 630	29.00

	Financial Systems		CAMERON MEMORI				u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOME HEALT	TH AGENCY COSTS		Provider HHA CCN:		Period: From 10/01/2014 To 09/30/2015	Worksheet H Date/Time Pre 9/6/2016 3:17	
						Home Health Agency I	PPS	pili
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	4.00	5.00	0.00	
1.00	Capital Related - Bldg. &			0		0	0	1.00
	Fixtures							
2.00	Capital Related - Movable			0		0	0	2.00
	Equipment							
3.00	Plant Operation & Maintenance	0		0		0 0	0	3.00
4.00 5.00	Transportation Administrative and General	183, 219		-		-	247, 429	4.00 5.00
5.00	HHA REIMBURSABLE SERVICES	103,219		<u>/</u>	12,11	0 52,100	247,429	5.00
6.00	Skilled Nursing Care	252, 517	C	33, 148		0 0	285, 665	6.00
7.00	Physical Therapy	153, 409	-			0 0	153, 409	
8.00	Occupational Therapy	28, 531	C	0		0 0	28, 531	8.00
9.00	Speech Pathology	3, 245	C	0		0 0	3, 245	9.00
10.00	Medical Social Services	0	C	0		0 0	0	10.00
11.00	Home Health Aide	47, 242	C	0		0 0	47, 242	
12.00	Supplies (see instructions)	0	C	0		0 0	0	
13.00	Drugs	0	C	-		0 0	0	
14.00		0	C	0		0 0	0	14.00
15 00	HHA NONREI MBURSABLE SERVI CES	0	C	0		0 0	0	15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0				0 0	0	15.00 16.00
17.00	Private Duty Nursing	0				0 0	0	
18.00	Clinic	0					0	18.00
19.00	Health Promotion Activities	0		0		0 0	0	19.00
20.00	Day Care Program	0	C	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	C	0		0 0	0	
22.00	Homemaker Service	0	C	0		0 0	0	22.00
23.00	All Others (specify)	0	C	0		0 0	0	23.00
24.00	Total (sum of lines 1-23)	668, 163	C	33, 148			765, 521	24.00
		Recl assi fi cati on	Trial Balance	Adjustments	Net Expenses for Allocatio	n		
			(col. 6 + col.7)		(col. 8 + col 9)			
		7.00	8.00	9.00	10.00	_		
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0	C	0		0		1.00
	Fi xtures							
2.00	Capital Related - Movable	0	C	0		0		2.00
2 00	Equipment					0		2 00
3.00 4.00	Plant Operation & Maintenance Transportation	0		0		0		3.00 4.00
		0		0				
	Administrative and General	-103.546	143.883	0	143.88	3		5.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	-103, 546	143, 883	0	143, 88	3		5.00
	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	-103, 546	143, 883 285, 665		1			5.00 6.00
5.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	-103, 546		0	285, 66	5		
5.00 6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	285, 665	0		5		6.00
5.00 6.00 7.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 0	285, 665 153, 409 28, 531 3, 245		285, 66 153, 40 28, 53 3, 24	5 9 1 5		6. 00 7. 00
5.00 6.00 7.00 8.00 9.00 10.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0	285, 665 153, 409 28, 531 3, 245 7, 225		285, 66 153, 40 28, 53 3, 24 7, 22	5 9 1 5 5		6.00 7.00 8.00 9.00 10.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 0	285, 665 153, 409 28, 531 3, 245		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2		6.00 7.00 8.00 9.00 10.00 11.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 7,225 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 47, 242 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0 0 0 7,225 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 5 2 0 0 0 0		6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 21.00 21.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES HOME Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 7,225 0 0 0 0 0 0	285, 665 153, 409 28, 531 3, 245 7, 225 47, 242 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 5 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 21.00 22.00 23.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 7,225 0 0 0 0 0 0	285,665 153,409 28,531 3,245 7,225 47,242 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		285, 66 153, 40 28, 53 3, 24 7, 22 47, 24	5 9 1 5 5 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

	Financial Systems		CAMERON MEMORIA				u of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider HHA CCN:		Period: From 10/01/2014 To 09/30/2015	Worksheet H-1 Part I Date/Time Pre 9/6/2016 3:17	pared.
						Home Health	PPS	piii
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
	Fixtures		Ŭ				-	
2.00	Capital Related – Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	0	
4.00 5.00	Transportation Administrative and General	0 143, 883	0	0		0 0	143, 883	4.00
5.00	HHA REIMBURSABLE SERVICES	143,005		0	I		143,003	0.00
6.00 7.00	Skilled Nursing Care Physical Therapy	285, 665 153, 409	0	0		0 0	285, 665 153, 409	
7.00 8.00	Occupational Therapy	28, 531	0	0		0 0	28, 531	
9.00	Speech Pathol ogy	3, 245	0	0		0 0	3, 245	
10.00 11.00	Medical Social Services Home Health Aide	7, 225 47, 242	0	0 0			7, 225 47, 242	
12.00	Supplies (see instructions)	0	0	0		0 0	0	1
13.00 14.00	Drugs DME	0	0	0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES		0	0		0 0	0	14.00
	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
	Health Promotion Activities	0	0	0		0 0	0	
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify) Total (sum of lines 1-23)	0 669, 200	0	0		0 0	0 669, 200	
		Admi ni strati ve			1	<u> </u>	0077200	21100
		& General 5.00	<u>4A + 5)</u> 6.00					-
	GENERAL SERVICE COST CENTERS	3.00	0.00					
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment							3.00
3.00 4.00	Plant Operation & Maintenance Transportation							4.00
5.00	Administrative and General	143, 883						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	78, 243	363, 908					6.00
7.00	Physical Therapy	42, 018	195, 427					7.00
3.00 9.00	Occupational Therapy Speech Pathology	7, 815 889	36, 346 4, 134					8.00 9.00
9.00 10.00	Medical Social Services	1, 979	9, 204					10.00
11.00	Home Health Aide	12, 939	60, 181					11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0					12.00 13.00
	DME	0	0					14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic Health Promotion Activities	0	0					18.00 19.00
19.00	Day Care Program	0	0					20.00
	buj sure rregram							
20. 00 21. 00	Home Delivered Meals Program	0	0					21.00
	3	0 0 0	0 0 0					21.00 22.00 23.00

Heal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider HHA CCN:	CCN: 151315 157117	Period: From 10/01/2014 To 09/30/2015	Worksheet H-1 Part II Date/Time Pre 9/6/2016 3:17	pared:
						Home Health Agency I	PPS	
		Capital Re	ated Costs					
		· · · · ·	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS	-						
1.00	Capital Related - Bldg. &	0				0		1.00
2.00	Fixtures Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C		0		4.00
	i nstructi ons)		-	-				
5.00	Administrative and General	0	0	C		0 -143, 883	525, 317	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C		0 0	285, 665	
7.00	Physical Therapy	0	0	C		0 0	153, 409	
8.00	Occupational Therapy	0	0	C		0 0	28, 531	•
9.00	Speech Pathol ogy	0	0	C		0 0	3, 245	
10.00	Medical Social Services	0	0	C		0 0	7, 225	
11.00	Home Health Aide	0	0	C		0 0	47, 242	
12.00 13.00	Supplies (see instructions) Drugs		0	C C		0 0	0	
	DME		0			0 0	0	•
14.00	HHA NONREI MBURSABLE SERVI CES		0	C.	1	0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	C		0 0	0	15.00
16.00	Respiratory Therapy	0	0	C	)	0 0	0	
17.00	Private Duty Nursing	0	0	C	)	0 0	0	17.00
18.00	Clinic	0	0	C	)	0 0	0	18.00
19.00	Health Promotion Activities	0	0	C		0 0	0	19.00
20.00	Day Care Program	0	0	C		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	C		0 0	0	
22.00	Homemaker Service	0	0	C		0 0	0	
23.00	All Others (specify)	0	0	C		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	C		0 -143, 883	525, 317	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	C		U	143, 883	
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 273897	26.00

LLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider HHA CCN:	CCN: 151315 157117	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part I Date/Time Pre 9/6/2016 3:17	pare
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
. 00	Administrative and General	0	0	31, 321				
00 00	Skilled Nursing Care Physical Therapy	363, 908 195, 427	0 0	0		0 363, 908 0 195, 427		2
00	Occupational Therapy	36, 346	0	0		0 195, 427		
00	Speech Pathol ogy	4, 134	0	0		0 4, 134		
00	Medical Social Services	9, 204	0	0	)	0 9, 204		6
00	Home Health Aide	60, 181	0	0		0 60, 181	15, 977	7
00	Supplies (see instructions)	0	0	0		0 0	-	8
00	Drugs	0	0	0		0 0	-	
. 00	DME	0	0	0		0 0		10
. 00 . 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0			0	11
. 00	Private Duty Nursing	0	0	0		0 0	0	13
00	Clinic	0	0	0		0 0	0	14
. 00	Health Promotion Activities	0	0	0	)	0 0	0	15
. 00	Day Care Program	0	0	0		0 0	0	16
. 00	Home Delivered Meals Program	0	0	0		0 0	0	
. 00	Homemaker Service	0	0	0		0 0	-	18
. 00 . 00	All Others (specify) Total (sum of lines 1–19) (2)	0 669, 200	0	31, 321	171, 8	0 0 87 872, 408	0 231, 610	19 20
. 00	Unit Cost Multiplier: column	009,200	0	51, 521	171,0	0. 000000		21
. 00	26, line 1 divided by the sum					0.000000		2
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		7.00	8.00	9.00	10.00	11.00	13.00	
00	Administrative and General	59, 022	219	6, 219		0 41, 234	0	1
0C	Skilled Nursing Care	0	0	0		0 0		2
00	Physical Therapy	0	0	0		0 0	-	3
00 00	Occupational Therapy Speech Pathology	0	0	0			0	4
00	Medical Social Services	0	0	0		0 0		l
00	Home Heal th Aide	0	0	0		0 0	0	
00	Supplies (see instructions)	0	0	0	)	0 0	0	8
00	Drugs	0	0	0	)	0 0	0	9
. 00	DME	0	0	0		0 0	0	10
	Home Dialysis Aide Services	0	0	0		0 0		· · ·
00	Respiratory Therapy	0	0	0		0 0	0	12
00	Private Duty Nursing Clinic	0	0	0			0	
00	Health Promotion Activities	0	0	0		0 0	0	
00	Day Care Program	0	0	0		0 0	0	
00	Home Delivered Meals Program	Ō	0	0		0 0	0	
. 00	Homemaker Service	0	0	0		0 0	0	18
. 00	All Others (specify)	0	0	0		0 0	0	19
0. 00	Total (sum of lines 1-19) (2)	59, 022	219	6, 219		0 41, 234	0	20
	Unit Cost Multiplier: column							21
. 00			1					
. 00	26, line 1 divided by the sum							
. 00	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to							

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

	n Financial Systems ATION OF GENERAL SERVICE COSTS 1		CAMERON MEMORIA		CCN: 151315	In Lie Period:	u of Form CMS-2 Worksheet H-2	
ALLUU	ATTON OF GENERAL SERVICE COSTS I	TO HHA COST CEN	IERS	HHA CCN:	157117	From 10/01/2014	Part I	pared:
						Home Health	PPS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Agency I	Subtotal	
		SERVICES & SUPPLY		RECORDS & LI BRARY		Resi dents Cost & Post Stepdown Adj ustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\ 0\ 0\ 0\ 0\ 0\ 0\ 0\ 0\ 0\ 0\ 0\ 0$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	1, 692 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			460, 5 247, 3 45, 9 5, 2 11, 6 76, 1	19       0         10       0         95       0         32       0         48       0         58       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0	365, 542 460, 519 247, 310 45, 995 5, 232 11, 648 76, 158 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ \end{array}$
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					21.00
		27.00	28.00					1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	198, 780 106, 750 19, 853 2, 258 5, 028 32, 873 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	659, 299 354, 060 65, 848 7, 490 16, 676 109, 031 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

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

	Financial Systems		CAMERON MEMORI				u of Form CMS-	
ALLOCAT BASI S	ION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	IERS STATISTICA	AL Provider HHA CCN:	CCN: 151315 157117	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Pre 9/6/2016 3:17	pared:
						Home Health	PPS	
		CAPI TAL REL	ATED COSTS			Agency I		
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	on ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	-
		1.00	2.00	4.00	5A	5.00	7.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 469 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	571, 841 171, 887	CAFETERI A	0         203, 208           0         363, 908           0         195, 427           0         36, 346           0         4, 134           0         9, 204           0         60, 181           0         0 <t< td=""><td>59, 022 40. 178353 CENTRAL</td><td>2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 20.00 21.00</td></t<>	59, 022 40. 178353 CENTRAL	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 20.00 21.00
			0.00	10.00	11.00	HR)	REQUIS.)	
1.00	Administrative and General	8.00	9.00	10.00 C	11.00 9	13.00 09 0	<u>14.00</u> 9,937	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		) ) ) ) ) ) ) ) ) ) ) ) ) ) ) ) ) ) )			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 20.00 20.00

Heal th	Financial Systems		CAMERON MEMORIAL	COMMUNI TY		In Lie	u of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provi der	CCN: 151315	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	157117	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre 9/6/2016 3:17	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUI S. )	LI BRARY (TI ME SPENT)					
		15.00	16.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	o					4.00
5.00	Speech Pathol ogy	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00 14.00	Private Duty Nursing Clinic	0	0					13.00 14.00
14.00	Health Promotion Activities	0	0					14.00
16.00		0	0					16.00
	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	o					19.00
20.00	Total (sum of lines 1-19)	0	Ő					20.00
21.00	Total cost to be allocated	0	O					21.00
22.00	Unit cost multiplier	0. 000000	0. 000000					22.00

Heal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		Inlie	eu of Form CMS-2	2552-10
	FIONMENT OF PATIENT SERVICE COST	S			· CCN: 151315	Peri od:	Worksheet H-3	
				HHA CCN:	157117	From 10/01/2014 To 09/30/2015		
				Ti t	le XVIII	Home Health	PPS	
	Cost Conton Description	Enom Wkat	Facility Costs	Charad	Total HHA	Agency I	Average Cost	
	Cost Center Description	From, Wkst. H-2, Part I,	(from Wkst.	Shared Ancillary	Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line		Costs (from	+ 2)		$(col. 3 \div col.$	
				Part II)			4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF T	HE PROGRAM LIN	MITATION COST, O	K	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	2.00	659, 299		659, 29	99 2, 121	310. 84	1.00
2.00	Physical Therapy	3. 00			0 354, 0			
3.00	Occupational Therapy	4.00			0 65, 8			
4.00	Speech Pathol ogy	5.00			0 7,4			
5.00 6.00	Medical Social Services Home Health Aide	6.00 7.00			16, 6 109, 0			
7.00	Total (sum of lines 1-6)	7.00	1, 212, 404		0 1, 212, 40			7.00
7.00			1, 212, 404		Program Visi			7.00
						art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deducti bl es			
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		99915		0 20	59		8.00
8.01	Skilled Nursing Care		50031			39		8.01
9.00	Physi cal Therapy		99915		0 33	24		9.00
9.01	Physical Therapy		50031			00		9.01
10.00	Occupational Therapy		99915			49		10.00
10.01	Occupational Therapy		50031 99915		0 4	41		10. 01 11. 00
11. 00 11. 01	Speech Pathology Speech Pathology		50031		-	6 19		11.00
12.00	Medical Social Services		99915		0	6		12.00
12.01	Medical Social Services		50031		0	9		12.01
13.00	Home Health Aide		99915		0 1:	20		13.00
13.01	Home Health Aide		50031			48		13.01
14.00					0 2, 0			14.00
	Cost Center Description	From Wkst. H-2			Total HHA	Total Charges		
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (col s. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11116	11-2, Tart I)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput			r		-		
15.00	Cost of Medical Supplies	8.00			0	0 0		
16.00	Cost of Drugs	9.00			0	0 C	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &		i l	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	UF AGGREGATE F	KUGRAM CUSI, A	IGGREGATE UF I	HE PRUGRAM LIN	TATION COST, O	×	
4	Cost Per Visit Computation	-		1	1	0 051 155	1	1 1 22
1.00	Skilled Nursing Care	0				0 251, 159		1.00
2.00 3.00	Physical Therapy Occupational Therapy	0				0 134, 881 0 13, 408		2.00 3.00
3.00 4.00	Speech Pathol ogy					0 13, 408		3.00 4.00
4.00 5.00	Medical Social Services	0				0 3, 573		5.00
6.00	Home Heal th Aide	0				0 11, 513		6.00
7.00	Total (sum of lines 1-6)	0				0 417, 708		7.00

	Financial Systems ONMENT OF PATIENT SERVICE COST	S	CAMERON MEMORI		CCN: 151315	Period: From 10/01/2014	u of Form CMS- Worksheet H-3 Part I	
				HHA CCN:	157117		Date/Time Pre 9/6/2016 3:11	
				Titl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
L	imitation Cost Computation	0.00		0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	
	Skilled Nursing Care							8.
. 01 5	Skilled Nursing Care							8.
. 00 F	Physical Therapy							9.
. 01 F	Physical Therapy							9.
0.00 0	Occupational Therapy							10.
0. 01 0	Occupational Therapy							10.
1.00 5	Speech Pathology							11.
1.01 5	Speech Pathology							11.
2.00 1	Medical Social Services							12.
2.01	Medical Social Services							12.
3. 00 H	Home Health Aide							13.
3.01	Home Health Aide							13.
4.00 1	Total (sum of lines 8-13)							14.
		Prog	ram Covered Cha	irges	Cost of Servi ces			
			~					
			Par			Part B		_
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &	Deductibles &	
		(	Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
S	Supplies and Drugs Cost Comput	6.00	7.00	8.00	9.00	10.00	11.00	-
	Cost of Medical Supplies	0	0	0		0 0	(	0 15.
	Cost of Drugs		550	0		0		0 16.
	Cost Center Description	Total Program		-		-		
		Cost (sum of						
		col s. 9-10)						
		12.00						1
P	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	WITATION COST, OF	!	
	BENEFICIARY COST LIMITATION							_
	Cost Per Visit Computation	054.450						1.
	Skilled Nursing Care	251, 159						1.
	Physical Therapy	134, 881						2.
	Occupational Therapy	13, 408						3.
	Speech Pathology	3, 174						4.
	Medical Social Services	3, 573						5.
	Home Health Aide	11, 513						6.
. 00   1	Total (sum of lines 1-6)	417, 708						7.
	Cost Center Description	12.00						-
	imitation Cost Computation	12.00						
I	Skilled Nursing Care							8.
-								8.
.00 5	Skilled Nursing Care		1					9.
00 S 01 S	Skilled Nursing Care Physical Therapy							9.
00 S 01 S 00 F	Physical Therapy							
00 S 01 S 00 F 01 F	Physical Therapy Physical Therapy							10
00 S 01 S 00 F 01 F 0.00 C	Physical Therapy Physical Therapy Occupational Therapy							
. 00 S . 01 S . 00 F . 01 F 0. 00 C 0. 01 C	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy							10.
. 00 S . 01 S . 00 F . 01 F 0. 00 C 0. 01 C 1. 00 S	Physical Therapy Physical Therapy Decupational Therapy Decupational Therapy Speech Pathology							10. 11.
. 00 S . 01 S . 00 F . 01 F 0. 00 C 0. 01 C 1. 00 S 1. 01 S	Physical Therapy Physical Therapy Decupational Therapy Decupational Therapy Speech Pathology Speech Pathology							10. 11. 11.
. 00 S . 01 S . 00 F . 01 F 0. 00 C 0. 01 C 1. 00 S 1. 01 S 2. 00 M	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services							10. 10. 11. 11. 12.
. 00 S . 01 S . 00 F . 01 F 0. 00 C 0. 01 C 1. 00 S 1. 01 S 2. 00 M 2. 01 M	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services							10. 11. 11. 12. 12.
. 00 5 . 01 5 . 00 F . 01 F 0. 00 0 0. 01 0 1. 00 5 1. 01 5 2. 00 M 2. 01 M 3. 00 F	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Health Aide							10. 11. 11. 12. 12. 13.
OO         S           01         S           00         F           01         F           02         OO           03         OO           04         F           05         OO           05         OO           06         C           07         C           08         C           09         C           00         C           00         C           00         C           1         OO           2         OO           2         OO           3         OO           43         OO	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services							10. 11. 11. 12. 12.

Health Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151315	Period:	Worksheet H-3	
			HHA CCN:	157117	From 10/01/2014 To 09/30/2015	Part II Date/Time Pre 9/6/2016 3:17	pared: pm
			Ti tl	e XVIII	Home Health	PPS	
	-				Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 Physical Therapy	66.00	0. 624727	(	)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0. 668498	(		0 col. 2, line 1	5. 00	4.00
5.00 Cost of Drugs	73.00	0. 437606	(		0 col. 2, line 1	6. 00	5.00
	•				'		

	Financial Systems CAMERON MEMORIAL CO ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151315	Peri od:		Worksheet H-4	
		HHA CCN:	157117	From 10/01/20 To 09/30/20		Part I-II Date/Time Pre 9/6/2016 3:17	
		Ti tl	e XVIII	Home Healt Agency I	h	PPS	
					Par		
			Part A		5 &	Deductibles &	
			1.00	Coi nsuranc	ce	Coi nsurance	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	ARY CHARGE		2.00		3.00	
	Reasonable Cost of Part A & Part B Services						
0	Reasonable cost of services (see instructions)			0	0	0	1 1
0	Total charges			0	0	0	2
	Customary Charges		1				
0	Amount actually collected from patients liable for payment for s	servi ces		0	0	0	3
	on a charge basis (from your records)						
00	Amount that would have been realized from patients liable for pa			0	0	0	4
	for services on a charge basis had such payment been made in acc with 42 CFR §413.13(b)	Loi uance					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0.000	000	0. 000000	5
0	Total customary charges (see instructions)			0	0	0	
0	Excess of total customary charges over total reasonable cost (co	omplete		0	0	0	7
	only if line 6 exceeds line 1)						
0	Excess of reasonable cost over customary charges (complete only	ifline		0	0	0	8
~	1 exceeds line 6)			0	_	0	
0	Primary payer amounts			Part A	0	Part B	
				Services		Services	
				1.00		2.00	
00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				0	0	10
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	324, 603	
00	Total PPS Reimbursement - Full Episodes with Outliers				0	324,003	
00	Total PPS Reimbursement - LUPA Episodes				0	11, 490	
00	Total PPS Reimbursement - PEP Episodes				0	1, 408	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	0	
00	Total PPS Outlier Reimbursement - PEP Episodes				0	0	
00	Total Other Payments				0	0	
00	DME Payments				0	0	1
00	Oxygen Payments				0	0	1
00	Prosthetic and Orthotic Payments				0	0	
	Part B deductibles billed to Medicare patients (exclude coinsura	ance)				0	
	Subtotal (sum of lines 10 thru 20 minus line 21)				0	337, 501	
00	Excess reasonable cost (from line 8)				0	0	
00 00					0	337, 501	
00 00 00	Subtotal (line 22 minus line 23)				-	0	
00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)						
00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0	337, 501	20
00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	tructions)			0		26 27
00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst	tructions) 27)			0	337, 501	26 27 28
00 00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2	tructions) 27)			0	337, 501 337, 501	26 27 28 29
00 00 00 00 00 00 00 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions) 27)			0	337, 501	26 27 28 29 30
00 00 00 00 00 00 00 00 00 50	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2	tructions) 27)			000000000000000000000000000000000000000	337, 501 337, 501 0	26 27 28 29 30 30
00 00 00 00 00 00 00 00 50 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	tructions) 27)			000000000000000000000000000000000000000	337, 501 337, 501 0 0	26 27 28 29 30 30 31
00 00 00 00 00 00 00 00 50 00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructions) 27)			0 0 0 0 0 0 0 0	337, 501 337, 501 0 337, 501 337, 501	26 27 28 29 30 30 31 31
00 00 00 00 00 00 00 50 00 50 01 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructi ons) 27)				337, 501 337, 501 0 0 337, 501 6, 750	26 27 28 29 30 30 31 31 31 32
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	27)				337, 501 0 337, 501 0 337, 501 6, 750 330, 751	26 27 28 29 30 30 31 31 31 32 33

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED M BENEFICIARIES		Provider HHA CCN:	CCN: 151315 157117	F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet H-5 Date/Time Prep	barec
				-		Home Health	9/6/2016 3: 17 PPS	pm
						Agency I	115	
			Inpatien	t Part A			t B	
		mm/o	d/yyyy	Amount		mm/dd/yyyy	Amount	
			1.00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				0		330, 751 0	1. ( 2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							3.
~ -	Program to Provider							
01 02 03 04					0 0 0 0		0 0 0 0	3. 3. 3. 3.
25					0		0	3.
	Provider to Program						0	~
50 51 52 53 54					0 0 0 0		0 0 0 0	3 3 3 3 3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				0		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				0		330, 751	4
0	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)							5
	Program to Provider							
)1 )2 )3					0 0 0		0 0 0	5 5 5
, ,	Provider to Program			1	0	11	0	5
0					0		0	5
1					0		0	5
2					0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6			6
)1 \2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				0		0	6 6
)2 )0	Total Medicare program liability (see instructions)				0		330, 751	6 7
	rotal modeled program redorrety (see restructions)			I	0	Contractor Number	NPR Date (Mo/Day/Yr)	/
				)		1.00	2.00	-

Heal th	Financial Systems	CAMERON MEMORIAI	L COMMUNI TY		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151315	Peri od:	Worksheet K	
			lloopi oo (	CN. 1515(1	From 10/01/2014	Data (Tima Dra	norod.
			Hospi ce C	CCN: 151561	To 09/30/2015	Date/Time Pre 9/6/2016 3:17	
					Hospi ce I		
		Salaries (from	Employee	Transportati	on Contracted	Other	
		Wkst. K-1) Be	enefits (from	(see inst.)			
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt.				0	0	1.00
2.00	Capital Related Costs-Brug and Fixt.				0	0	2.00
2.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
3.00 4.00	Transportation - Staff	0	0		0 0	0	4.00
4.00 5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	21, 498	0		0 0	11, 535	
0.00	I NPATI ENT_CARE_SERVI CE	21,470	0	1	0 0	11, 333	0.00
7.00	Inpatient - General Care	66, 420	0		0 2,939	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	
	VI SI TI NG SERVI CES	-					
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0	23, 3	65 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0	1	0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
15.00	Medical Social Services	37, 212	0		0 0	0	15.00
16.00	Spiritual Counseling	7, 135	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00		0	0		0 0	0	21.00
22.00	OTHER HOSPICE SERVICE COSTS	0	0		0 0	0	22.00
22.00 23.00	Drugs, Biological and Infusion Therapy Analgesics	0	0		0 0	0	22.00 23.00
23.00	Sedatives / Hypnotics	0	0		0 0	0	23.00
24.00	Other - Specify	0	0		0 0	0	24.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Pati ent Transportati on	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	
39.00	Total (sum of lines 1 thru 38)	132, 265	0	23, 3	65 2, 939	11, 535	39.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151315	Peri od:	Worksheet K	
			Hospi ce	CCN: 151561	From 10/01/2014 To 09/30/2015		
-					Hospi ce I	77072010 3.17	- piii
		Total (cols.	Recl assi fi cati	Subtotal (co		Total (col. 8	
		1-5)	on	$6 \pm col. 7$		± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		•		-		
1.00	Capital Related Costs-Bldg and Fixt.	0	(		0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	(		0 0	0	2.00
3.00	Plant Operation and Maintenance	0	(		0 0	0	3.00
4.00	Transportation - Staff	0	(		0 0	0	4.00
5.00	Volunteer Service Coordination	0	(		0 0	0	5.00
6.00	Administrative and General	33, 033	(	33, 0	33 0	33, 033	6.00
	I NPATI ENT CARE SERVI CE		l				
7.00	Inpatient - General Care	69, 359	(	69, 3	59 0	69, 359	7.00
8.00	Inpatient - Respite Care	0	(	D	0 0	0	8.00
	VI SI TI NG SERVI CES			•			
9.00	Physi ci an Servi ces	0	(		0 0	0	9.00
10.00	Nursing Care	23, 365	(	23, 3	65 O	23, 365	10.00
11.00	Nursing Care-Continuous Home Care	0	(		0 0	0	11.00
12.00	Physical Therapy	0	(		0 0	0	12.00
13.00	Occupational Therapy	0			0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0			0 0	0	14.00
15.00	Medical Social Services	37, 212	-7, 225	29,9	87 0	29, 987	15.00
16.00	Spiritual Counseling	7,135		7,1			
17.00	Dietary Counseling	0	(		0 0		
18.00	Counseling - Other	0	(		0 0	0	18,00
19.00	Home Health Aide and Homemaker	0			0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	
21.00	Other	0			0 0	0	
	OTHER HOSPICE SERVICE COSTS				I		1
22.00	Drugs, Biological and Infusion Therapy	0	(		0 0	0	22.00
23.00	Anal gesi cs	0	(		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	(		0 0	0	24.00
25.00	Other - Specify	0	(		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	(		0 0	0	26.00
27.00	Patient Transportation	0	(		0 0	0	27.00
28.00	Imaging Services	0			0 0	0	28.00
29.00	Labs and Diagnostics	0			0 0	0	29.00
30.00	Medical Supplies	0			0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0			0 0	0	31.00
32.00	Radiation Therapy	0	(		0 0	0	
33.00	Chemotherapy	0			0 0		
34.00	Other	0	(		0 0		
	HOSPI CE NONREI MBURSABLE SERVI CE			-		-	
35.00	Bereavement Program Costs	0	(		0 0	0	35.00
36.00	Volunteer Program Costs	0	(	b	0 0	0	36.00
37.00	Fundrai si ng	0	(		0 0	0	37.00
38.00	Other Program Costs	0		b	0 0	0	
39.00	Total (sum of lines 1 thru 38)	170, 104	-7, 225	5 162, 8	79 0	162, 879	39.00

Heal th	Financial Systems	CAMERON MEMORIA	L COMMUNITY			In Lie	u of Form CMS-:	2552-10
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 151315	Peri		Worksheet K-1	
						10/01/2014		
			Hospi ce C	CN: 151561	То	09/30/2015	Date/Time Pre	
					Ц	ospice I	9/6/2016 3:17	pin
		Admi ni strator	Director	Soci al		upervi sors	Nurses	
		Auni III Strator	Director	Servi ces	50		Nul 363	
		1.00	2.00	3,00		4,00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0	0		0	0	0	5.00
6.00	Administrative and General	21, 498	0		0	0	0	6.00
	I NPATI ENT CARE SERVI CE							1
7.00	Inpatient - General Care	0	0		0	0	66, 420	7.00
8.00	Inpatient - Respite Care	0	0		0	0	0	8.00
	VISITING SERVICES							
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	11.00
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0	37, 2	12	0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	Imaging Services	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE							0
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundraising	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	21, 498	0	37, 2	12	0	66, 420	39.00

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 151315	Peri od:	Worksheet K-1
					From 10/01/2014	
			Hospi ce C	CN: 151561	To 09/30/2015	Date/Time Prepared:
					11	9/6/2016 3:17 pm
		Tatal	Aidee	All-Other	Hospi ce I	
		Total Therapi sts	Ai des	ALL-Uther	Total (1)	
		6.00	7.00	8.00	9, 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		o		0 21, 498	6.00
0.00	I NPATI ENT CARE SERVI CE				21,170	
7.00	Inpatient - General Care		0		0 66, 420	7.00
8.00	Inpatient - Respite Care		ō		0 0	8.00
	VI SI TI NG SERVI CES					
9.00	Physician Services		0		0 0	9,00
10.00	Nursing Care		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	14.00
15.00	Medical Social Services		0		0 37, 212	15.00
16.00	Spiritual Counseling		0	7, 1		16.00
17.00	Dietary Counseling		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	1 1				
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundraising		0		0 0	37.00
38.00	Other Program Costs		0	_	0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	7, 1	35 132, 265	39.00

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lie	eu of Form CMS-:	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F	PURCHASED SERVICE	S Provider	CCN: 151315	Peri od:	Worksheet K-3	
			Hospi ce (	CCN: 151561	From 10/01/2014 To 09/30/2015		
					Hospi ce I	77072010 3.17	piii
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS					1	
1.00	Capital Related Costs-Bldg and Fixt.						1 1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0		
5.00	Volunteer Service Coordination	0	0		0 0		1
6.00	Administrative and General	0	0		0 0	-	
	I NPATI ENT CARE SERVI CE	-			-	-	
7.00	Inpatient - General Care	0	0		0 0	2, 939	7.00
8.00	Inpatient - Respite Care	0	0		0 0		
	VI SI TI NG SERVI CES					`	
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0 0		
11.00	Nursing Care-Continuous Home Care	0	0		0 0		
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0		
14.00	Speech/ Language Pathol ogy	0	0		0 0	-	1
15.00	Medical Social Services	0	0		0 0	-	
16.00	Spiritual Counseling	0	0		0 0		1
17.00	Dietary Counseling	0	0		0 0	-	
18.00	Counseling - Other	0	0		0 0		
19.00	Home Health Aide and Homemaker	0	0		0 0	-	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		
21.00	Other	0	0		0 0		
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>	0			1 0	21.00
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0		1
29.00	Labs and Diagnostics	0	0		0 0		
30.00	Medical Supplies	0	0		0 0		
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	-	
32.00	Radiation Therapy	0	0		0 0		
33.00	Chemotherapy	0	0		0 0		
34.00	Other	0	0		0 0		
54.00	HOSPICE NONREIMBURSABLE SERVICE	<u> </u>	0		<u> </u>	<sup>'I</sup> 0	34.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0		
37.00	Fundrai si ng	0	0		0 0		
37.00	Other Program Costs		0		0 0		
	Total (sum of lines 1 thru 38)	0	0		0 0		39.00
57.00		, y	0	I		2,757	1 0 7. 00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES         Provider         CCR: 151315         For id: For 01/1201         Worksheet K-3 bit of 71 per (2012)           Impact of the service of the servi	Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY			In Lie	u of Form CMS-	2552-10
Hospice COX:         151561         To         Date/Time_Prepared:           Total         Ai des         Ai des         Hospice 1         Vo/2016.3:17 pm           Total         Ai des         Ai 1-0ther         Total         10           Capital Related Cost-8/0x0le Equip.         0         9.00         9.00         10.00           Capital Related Cost-8/0x0le Equip.         0					CCN: 151315	Per			
Total         Interplets         Aides         All - Other         Total (1)           6.00         7.00         8.00         9.00           100         Capital Related Costs-Bidg and Fixt.         1         1         1           2.00         Capital Related Costs-Bidg and Fixt.         1         1         1           2.00         Capital Related Costs-Woyable Equip.         0         0         0         0         3         0           0.00         Volumeer Service Coordination         0         0         0         0         0         5         0           1.00         Lapitent - Respire 1         Care         0         0         0         0         6         0           1.01         Narsing Care         0						Fro	om 10/01/2014	Date/Time Pre	pared:
Total Therapist         Al des Al des 6.00         Al l-Other         Total (1)           6ENERAL SERVICE COST CENTERS 6.00         8.00         9.00           1.00         Capital Related Costs-Hidg and Fixt. 2.00         2.00         0         0         0         0         0         2.00           3.00         Plant Operation and Maintenance         0         0         0         3.00         4.00         3.00         4.00         3.00         4.00         5.00         6.00         0         0         0         0         0         0         0         0         4.00         5.00         6.00							Hospi ce l	77072010 3.17	piii
Therapists         -         -           6:00         7:00         8:00         9:00           1:00         Capital Related Costs-Bidg and Fixt.         1:00         1:00           2:00         Capital Related Costs-Bidg and Fixt.         1:00         1:00           0:00         Plant Generation and Maintenance         0:00         0:00         3:00           0:00         Volumeer Service Coordination         0:00         0:00         0:00         5:00           0:00         Inpatient - General Care         0:00         0:00         0:00         8:00           1:00         Right ent - Respite Care         0:00         0:00         8:00         0:00         10:00           1:00         Nursing Care         0:00         0:00         0:00         10:00         11:00           1:00         Nursing Care-Continuous Hone Care         0:00         0:00         11:00         11:00           1:00         Nursing Care-Continuous Hone Care         0:00         0:00         13:00         16:00           1:00         Speckr/Language Pathology         0:00         0:00         16:00         17:00         16:00         17:00         16:00         17:00         16:00         17:00         16:00			Total	Aides	All_Other				
CONTROL         6.00         7.00         8.00         9.00           1.00         Capital Related Costs - Budg and Fixt.         1.00				AI des					
GENERAL SERVICE COST CENTRES         Image: Cost of Cost Sell of an Fixt.         Image: Cost Sell of an Fixt.         Image: Cost Sell of Cost Sell o				7.00	8,00		9.00		
2.00         Capital Related Costs-Movable Equip.         2.00         2.00         2.00         2.00         <		GENERAL SERVICE COST CENTERS	I I I						
3.00         Plant Operation and Maintenance         0         0         3.00         3.00           4.00         Transportation - Staff         0 </td <td>1.00</td> <td>Capital Related Costs-Bldg and Fixt.</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>	1.00	Capital Related Costs-Bldg and Fixt.							1.00
4.00         Transportation - Staff         0         0         0         0         0         0         0         5.00         0         0         0         0         0         5.00         0 <t< td=""><td>2.00</td><td>Capital Related Costs-Movable Equip.</td><td></td><td></td><td></td><td></td><td></td><td></td><td>2.00</td></t<>	2.00	Capital Related Costs-Movable Equip.							2.00
5.00         Volunteer Service Coordination         0         0         0         6.00	3.00	Plant Operation and Maintenance		0		0	0		3.00
6.00         Administrative and General         0         0         0         6.00           INPATIENT CARE SERVICE         Inpatient - General Care         0         0         2,939         8.00           Mistrike Services         0         0         0         0         0         8.00           Visitrike Services         0         0         0         0         0         9.00           0.00         Nursing Care         0         0         0         0         10.00           1.00         Nursing Care-Continuous Home Care         0         0         0         11.00           1.00         Nursing Care-Continuous Home Care         0         0         0         12.00           1.00         Nursing Care-Continuous Home Care         0         0         0         13.00           1.40         Speech/ Language Pathology         0         0         0         0         14.00           1.00         Midical Social Services         0         0         0         14.00         16.00           1.00         Dietary Counseling         0         0         0         16.00         16.00           1.00         Home Heal th Aide Anomemaker - Cont. Home Care         0	4.00	Transportation - Staff		0		0	0		4.00
INPATIENT CARE SERVICE         Image: Control of the control of	5.00	Volunteer Service Coordination		0		0	0		5.00
7.00         Inpatient - General Care         0         2.939         7.00           8.00         Inpatient - Respite Care         0         0         0         8.00           11STING SERVICES         0         0         0         0         8.00           9.00         Physician Services         0         0         0         9.00           10.00         Nursing Care         0         0         0         0         10.00           11.00         Nursing Care-Continuous Home Care         0         0         0         0         10.00           12.00         Occupational Therapy         0         0         0         0         11.00           13.00         Occupational Therapy         0         0         0         0         13.00           14.00         Spech/ Language Pathology         0         0         0         14.00           15.00         Indical Social Services         0         0         0         16.00           16.00         Spiritual Conseling         0         0         0         17.00           16.00         Other         0         0         0         17.00           10.00         Other         0	6.00	Administrative and General		0		0	0		6.00
8.00         Inpatient - Respite Care         0         0         8.00           VISITIG SERVICES         0 </td <td></td> <td>I NPATI ENT CARE SERVI CE</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		I NPATI ENT CARE SERVI CE							
VISITING SERVICES         0	7.00	Inpatient - General Care		0		0	2, 939		7.00
9.00         Physician Services         0         1         0         0         0         0         0         0         0         0         0         0         0         0         0         0         1         0         0         0         1         0         0         0         1         0         0         0         1         0         0         0         1         0         0         0         0         0         0         1         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	8.00	Inpatient - Respite Care		0		0	0		8.00
10.00         Nursing Care         0         0         0         11.00           11.00         Nursing Care-Continuous Home Care         0         0         0         11.00           12.00         Physical Therapy         0         0         0         11.00           13.00         Occupational Therapy         0         0         0         13.00           14.00         Speech/ Language Pathology         0         0         0         0         14.00           15.00         Medical Social Services         0         0         0         0         15.00           16.00         Spiritual Counseling         0         0         0         0         16.00           17.00         Ietary Counseling         0         0         0         17.00           10.00         Haide & Homemaker         0         0         0         19.00           10.00         Therapy         0         0         0         20.00         21.00           21.00         Otter         0         0         0         0         22.00         23.00           23.00         Anal gesics         0         0         0         23.00         23.00         23.00		VI SI TI NG SERVICES							
11.00       Nursing Gare-Continuous Home Care       0       0       0       11.00         12.00       Physical Therapy       0       0       0       0       12.00         13.00       Occupational Therapy       0       0       0       0       13.00         14.00       Speech/Language Pathology       0       0       0       0       14.00         15.00       Medical Social Services       0       0       0       0       15.00         16.00       Spiritual Counseling       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       20.00         19.00       Home Heal th Aide and Homemaker       0       0       0       21.00         21.00       Other       Onlysis       0       0       21.00       22.00         22.00       Drugs, Biological and Infusion Therapy       22.00       23.00       23.00       24.00       25.00         23.00       Analgesics       24.00       25.00       25.00       25.00       26.00       29.00       30.00 <td>9.00</td> <td>Physi ci an Servi ces</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>9.00</td>	9.00	Physi ci an Servi ces		0		0	0		9.00
12.00       Physical Therapy       0       0       0       12.00         13.00       Occupational Therapy       0       0       0       0       13.00         14.00       Speech/ Language Pathology       0       0       0       0       13.00         16.00       Spiritual Counseling       0       0       0       0       14.00         16.00       Spiritual Counseling       0       0       0       0       15.00         17.00       Dietary Counseling       0       0       0       0       16.00         18.00       Counseling - Other       0       0       0       17.00         18.00       Counseling - Other       0       0       0       18.00         10.00       HA ide a Homemaker       0       0       0       20.00         10.00       Other       0       0       0       20.00       20.00         10.00       Other       0       0       0       21.00       22.00         21.00       Orugs, Biological and Infusion Therapy       22.00       22.00       23.00       24.00       25.00       24.00       25.00       25.00       25.00       25.00       25.00	10.00	Nursing Care		0		0	0		10.00
13.00       Occupational Therapy       0       0       0       13.00         14.00       Speech/Language Pathology       0       0       0       0       14.00         15.00       Medical Soci al Services       0       0       0       0       14.00         15.00       Speintual Counseling       0       0       0       0       16.00         16.00       Dietary Counseling       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       18.00       18.00         19.00       Home Heal th Aide and Homemaker       0       0       0       19.00	11.00	Nursing Care-Continuous Home Care		0		0	0		11.00
14.00       Speech/Language Pathology       0       0       0       0       14.00         15.00       Medical Social Services       0       0       0       15.00         16.00       Spiritual Counseling       0       0       0       16.00         16.00       Spiritual Counseling       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       17.00         19.00       Home Heal th Ai de and Homemaker       0       0       0       0       19.00         20.00       DTHER HOSPICE SERVICE COSTS       0       0       0       21.00       22.00         21.00       Drugs, Biological and Infusion Therapy       23.00       23.00       24.00       22.00       23.00         23.00       Anal gesics       24.00       24.00       24.00       24.00       24.00       24.00       24.00       26.00       24.00       26.00       24.00       26.00       27.00       28.00       28.00       29.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00	12.00	Physical Therapy	0	0		0	0		12.00
15.00       Medical Social Services       0       0       15.00         16.00       Spiritual Counseling       0       0       0         17.00       Dietary Counseling       0       0       0         18.00       Counseling - Other       0       0       0       16.00         19.00       Home Heal th Aide and Homemaker       0       0       0       18.00         19.00       Heal th Aide and Homemaker       0       0       0       18.00         19.00       Home Heal th Aide and Homemaker       0       0       0       20.00         21.00       Other       0       0       0       21.00       21.00         0       Drugs, Biological and Infusion Therapy       22.00       23.00       23.00       23.00         22.00       Sedatives / Hypnotics       24.00       25.00       24.00       25.00         24.00       Sedatives / Hypnotics       0       0       0       26.00         25.00       Durable Medical Equipment/Oxygen       24.00       25.00       25.00         26.00       Durable Medical Equipment/Dygen       0       0       29.00         29.00       Labs and Diagnostics       0       0	13.00	Occupational Therapy	0	0		0	o		13.00
15.00       Medical Social Services       0       0       15.00         16.00       Spiritual Counseling       0       0       0         17.00       Dietary Counseling       0       0       0         18.00       Counseling - Other       0       0       0       16.00         19.00       Home Heal th Aide and Homemaker       0       0       0       18.00         19.00       Heal th Aide and Homemaker       0       0       0       18.00         19.00       Home Heal th Aide and Homemaker       0       0       0       20.00         21.00       Other       0       0       0       21.00       21.00         0       Drugs, Biological and Infusion Therapy       22.00       23.00       23.00       23.00         22.00       Sedatives / Hypnotics       24.00       25.00       24.00       25.00         24.00       Sedatives / Hypnotics       0       0       0       26.00         25.00       Durable Medical Equipment/Oxygen       24.00       25.00       25.00         26.00       Durable Medical Equipment/Dygen       0       0       29.00         29.00       Labs and Diagnostics       0       0	14.00	Speech/ Language Pathology	0	0		0	o		14.00
17.00       Dietary Counseling       0       0       0       17.00         18.00       Counseling - Other       0       0       0       18.00         19.00       Home Healt Aide and Homemaker       0       0       0       18.00         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       20.00         21.00       Other       0       0       0       20.00       21.00         22.00       Drugs, Biological and Infusion Therapy       22.00       23.00       23.00         23.00       Anal gesics       24.00       25.00       25.00       24.00         25.00       Other - Specify       26.00       26.00       26.00       26.00         26.00       Durable Medical Equipment/Oxygen       0       0       27.00       28.00         26.00       Imaging Services       0       0       0       28.00       29.00         28.00       Imaging Services (including E/R Dept.)       0       0       0       31.00         29.00       Labs and Diagnostics       0       0       0       32.00       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0	15.00			0		0	o		15.00
18.00       Counseling - Other       0       0       0       18.00         19.00       Home Health Aide and Homemaker       0       0       0       19.00         00       H Aide & Homemaker - Cont. Home Care       0       0       0       20.00         01.00       Other       0       0       0       0       21.00         01.00       Other       0       0       0       0       21.00         01.00       Anal gesics       22.00       23.00       Anal gesics       24.00       23.00         24.00       Sedatives / Hypontics       24.00       25.00       26.00       0       0       0       27.00         25.00       Durable Medical Equipment/Oxygen       0       0       0       27.00       28.00       29.00       28.00       29.00       28.00       29.00       28.00       29.00       28.00       29.00       28.00       29.00       28.00       29.00       20.00       20.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00	16.00	Spiritual Counseling		0		0	o		16.00
18.00       Counseling - Other       0       0       18.00         19.00       Home Heal th Aide and Homemaker       0       0       0       19.00         0.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       20.00         0.00       Other       0       0       0       20.00       21.00         0       Other       0       0       0       21.00       22.00         20.00       Anal gesi cs       22.00       23.00       Anal gesi cs       24.00       23.00         24.00       Sedatives / Hypontics       24.00       25.00       26.00       26.00       27.00         25.00       Durable Medical Equipment/Oxygen       0       0       0       27.00         26.00       Durable Medical Supplites       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       29.00       28.00         29.00       Labs and Diagnostics       0       0       0       30.00         30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00	17.00	Dietary Counseling		0		0	o		17.00
19.00       Home Heal th Ai de and Homemaker       0       0       0       19.00         20.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       20.00         21.00       Other       0       0       0       0       20.00         21.00       Other       0       0       0       0       21.00         0       Other       0       0       0       0       21.00         22.00       Anal gesi cs       22.00       23.00       Anal gesi cs       22.00       23.00         24.00       Sedatives / Hypotics       24.00       24.00       25.00       24.00         25.00       Other - Specify       0       0       0       27.00         26.00       Durable Medical Equipment/Oxygen       26.00       27.00       28.00       28.00         29.00       Labs and Di agnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       33.00         32.00       Chemotherapy       0       0       0       33.00      <	18.00			0		0	o		18.00
20.00         HH Ai de & Homemaker - Cont. Home Care         0         0         0         20.00           0 Other         0	19.00			0		0	o		19.00
OTHER HOSPICE SERVICE COSTS           22.00         Drugs, Biological and Infusion Therapy         22.00           23.00         Analgesics         23.00           24.00         Sedatives / Hypnotics         24.00           25.00         Other - Specify         25.00           26.00         Durable Medical Equipment/Oxygen         26.00           27.00         Patient Transportation         0         0         27.00           28.00         Labs and Diagnostics         0         0         28.00           29.00         Labs and Diagnostics         0         0         29.00         28.00           30.00         Medical Supplies         0         0         0         29.00         30.00           31.00         Outpatient Services (including E/R Dept.)         0         0         0         31.00           32.00         Radiation Therapy         0         0         0         32.00           33.00         Chemotherapy         0         0         0         33.00           400         0         0         0         33.00         33.00           34.00         Other         0         0         0         34.00           HOSPICE NONREI MBURSABL	20.00			0		0	o		20.00
22.00       Drugs, Biological and Infusion Therapy       22.00         23.00       Anal gesics       23.00         24.00       Sedatives / Hypnotics       24.00         25.00       Other - Specify       25.00         26.00       Durable Medical Equipment/Oxygen       26.00         27.00       Patient Transportation       0       0       27.00         28.01       Imaging Services       0       0       28.00         29.00       Labs and Diagnostics       0       0       28.00         30.00       Medical Supplies       0       0       29.00         30.00       Medical Supplies       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         44.00       Other       0       0       0       33.00         56.00       Volunteer Program Costs       0       0       0       35.00         86.00       Volunteer Program Costs       0       0       0       36.00       36.00	21.00	Other		0		0	o		21.00
23.00       Analgesics       23.00         24.00       Sedatives / Hypnotics       24.00         25.00       Other - Specify       25.00         26.00       Durable Medical Equipment/Oxygen       26.00         27.00       Patient Transportation       0       0         28.00       Imaging Services       0       0       0         29.00       Labs and Diagnostics       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       33.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         ***********************************		OTHER HOSPICE SERVICE COSTS							
24.00       Sedatives / Hypnotics       24.00         25.00       Other - Specify       25.00         26.00       Durable Medical Equipment/Oxygen       26.00         27.00       Patient Transportation       0       0       0         28.00       Imaging Services       0       0       0       27.00         28.00       Labs and Diagnostics       0       0       0       29.00         20.00       Medical Supplies       0       0       0       29.00         30.00       Medical Supplies       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       30.00         31.00       Chemotherapy       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Progr	22.00	Drugs, Biological and Infusion Therapy							22.00
25.00       Other - Specify       25.00       25.00         26.00       Durable Medical Equipment/Oxygen       26.00         27.00       Pati ent Transportation       0       0       0         28.00       Imagi ng Services       0       0       0       27.00         28.00       Labs and Diagnostics       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       29.00         31.00       Outpati ent Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       HOSPICE NONREI MBURSABLE SERVICE       34.00       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundrai sing       0       0       0       <	23.00	Anal gesi cs							23.00
26.00       Durable Medical Equipment/Oxygen       26.00         27.00       Patient Transportation       0       0       0       27.00         28.00       Imaging Services       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       31.00         32.00       Chemotherapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         Toto       35.00       0       0       0       36.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundrai sing       0       0       0       38.00         38.00       Other Program Costs       0       0	24.00	Sedatives / Hypnotics							24.00
27.00       Pati ent Transportation       0       0       0       27.00         28.00       Imaging Services       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       31.00       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       35.00       36.00       37.00       38.00       0       0       0       38.00	25.00	Other - Specify							25.00
28.00       Imaging Services       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundraising       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00	26.00	Durable Medical Equipment/Oxygen							26.00
29.00       Labs and Diagnostics       0       0       0       29.00         30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundraising       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00	27.00	Patient Transportation		0		0	0		27.00
30.00       Medical Supplies       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       36.00         37.00       Fundraising       0       0       0       37.00       36.00         38.00       Other Program Costs       0       0       0       37.00	28.00	Imaging Services		0		0	0		28.00
31.00       Outpatient Services (including E/R Dept.)       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00	29.00	Labs and Diagnostics		0		0	0		29.00
32.00       Radiation Therapy       0       0       0       32.00         33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00	30.00	Medical Supplies		0		0	0		30.00
33.00       Chemotherapy       0       0       0       33.00         34.00       Other       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00	31.00	Outpatient Services (including E/R Dept.)		0		0	0		31.00
34.00         Other         0         0         0         34.00           HOSPI CE NONREI MBURSABLE SERVI CE	32.00	Radiation Therapy		0		0	o		32.00
34.00         Other         0         0         34.00           HOSPICE NONREI MBURSABLE SERVICE	33.00	Chemotherapy		0		0	o		33.00
35.00       Bereavement Program Costs       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       36.00         37.00       Fundraising       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00				0		0	0		34.00
36.00         Volunteer Program Costs         0         0         36.00           37.00         Fundraising         0         0         0         37.00           38.00         Other Program Costs         0         0         0         38.00		HOSPI CE NONREI MBURSABLE SERVI CE					I		
37.00         Fundraising         0         0         0         37.00           38.00         Other Program Costs         0         0         0         38.00	35.00	Bereavement Program Costs		0		0	0		35.00
37.00         Fundraising         0         0         0         37.00           38.00         Other Program Costs         0         0         0         38.00	36.00	Volunteer Program Costs		0		0	o		36.00
	37.00	5		0		0	o		37.00
39.00         Total (sum of lines 1 thru 38)         0         0         0         2,939         39.00	38.00	Other Program Costs		0		0	o		38.00
	39.00	Total (sum of lines 1 thru 38)	0	0		0	2, 939		39.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST			CCN: 151315 CCN: 151561	Period: From 10/01/2014 To 09/30/2015		pared:
					Hospi ce I		
			CAPI TAL RE	LATED COST			
		NET EXPENSES FOR COST	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATI ON &	TRANSPORTATI ON	
		ALLOCATI ON			MALNT.		
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3.00	Plant Operation and Maintenance	0	0		0 0		3.00
4.00	Transportation - Staff	0	0		0 0		4.00
5.00	Volunteer Service Coordination	0	0		0 0		5.00
6.00	Administrative and General	33, 033	0		0 0	0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	69, 359	0		0 0		7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	-		0 0		9.00
10.00	Nursing Care	23, 365			0 0	-	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	0	14.00
15.00	Medical Social Services	29, 987	0		0 0	0	15.00
16.00	Spiritual Counseling	7, 135	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	·					
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0		37.00
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	162, 879	0		0 0	0	39.00

Hospice CCN:         1515d1         From         10/01/2014         Page 3/2/2015           Services         SUBTOTAL         ADMINISTRATIVETOTAL (col: 5A)         Nospice 1           Subtroation         Subtroation </th <th>Heal th</th> <th>Financial Systems</th> <th>CAMERON MEMORI</th> <th>AL COMMUN</th> <th>I TY</th> <th></th> <th></th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Heal th	Financial Systems	CAMERON MEMORI	AL COMMUN	I TY			In Lie	u of Form CMS-	2552-10
Hospice CCN:         15151         To         09/30/2015         Da           UVOLUNTEER SCRVICES COORDINATAR         ADMINISTRATIVE TOTAL & GENERAL         ADMINISTRATIVE TOTAL & GENERAL         ADMINISTRATIVE TOTAL & GENERAL         Colspan="2">COLSPAN & GENERAL         Colspan="2"         Cols	COST AL	LOCATION - HOSPICE GENERAL SERVICE COST		Prov	'i der	CCN: 151315			Worksheet K-4	4
Control         Control <t< td=""><td></td><td></td><td></td><td></td><td></td><td>20N 1515/1</td><td></td><td></td><td>Part I</td><td></td></t<>						20N 1515/1			Part I	
Construction         Construction<				ноѕр	n ce (	CN: 151561	10	09/30/2015	Date/Time Pre 9/6/2016 3:17	
VOLUNTEER         SUBTORL (cols. 0 - 5)         ADMINISTRATIVETOTAL (col. 5A & GENERAL SERVICE COST CENTERS           1.00         Capital Related Costs-Movable Equip.         5.00         5A         6.00         7.00           2.00         Capital Related Costs-Movable Equip.         5.00         5A         6.00         7.00           3.00         Plant Operation and Maintenance         0         33.033         33.033         33.033           0.00         Transportation - Staff         0         0         33.033         33.033           1.00         Capitent - General Care         0         69.359         17.645         87.004           0         Inpatient - Respite Care         0         0         0         0         0           9.00         Physicial Thorapy         0         0         0         0         0           11.00         Nursing Care         0         0         0         0         0           12.00         Physicial Thorapy         0         0         0         0         0           13.00         Occupational therapy         0         0         0         0         0           14.00         Spech/ Language Pathology         0         0         0							F	losni ce l	77072010 3.17	/ piii
SERVICES         (cols. 0 - 5)         & GENERAL         ± col. 6)           1.00         Capital Related Costs-Bidg and Fixt.         5.00         5A         6.00         7.00           1.00         Capital Related Costs-Movable Equip.         5.00         5A         6.00         7.00           0.01         Capital Related Costs-Movable Equip.         33.03         33.03         33.03         33.03           0.01         Plant Operation and Maintenance         0         33.03         33.03         33.03           1.00         Inpatient Cenceral Care         0         69.359         17.645         87.004           0.0         Inpatient - Respite Care         0         0         0         0         0           0.0         Nursing Care-Continuous Home Care         0         0         0         0         0           0.0         Nursing Care-Continuous Home Care         0			VOLUNTEER	SUBTOT	AL	ADMI NI STRATI				
COORDINATOR         Coord           GENERAL SERVICE COST CENTERS         5.00         5A         6.00         7.00           1.00         Capital Related Costs-Blog and Fixt.         Capital Related Costs-Movable Equip.         7.00         7.00           3.00         Plant Operation and Maintenance         0         3.033         33.033         7.00           3.00         Plant Operation and Maintenance         0         33.033         33.033         7.00           1.00         Capital Related Costs-Blog and Fixt         0         33.033         33.033         7.00           1.00         Transportation - Staff         0         33.033         33.033         7.04           0.00         Instrative and General         0         33.033         7.04         7.04           1.00         Instrative and General         0         0         0         0           0.01         Instrative and General         0         0         0         0           1.00         Nursing Care         0         0         0         0         0           1.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0           1.00         Nursing Care-Continuou			SERVI CES							
GENERAL SERVICE COST CENTERS         Control           1.00         Capital Related Costs-Bidg and Fixt.         Capital Related Costs-Movable Equip.           3.00         Plant Operation and Maintenance         Plant Operation and Maintenance         Capital Related Costs-Movable Equip.           3.00         Plant Operation and Maintenance         0         33, 033         33, 033           0.01         The and Ceneral Care         0         0         33, 033           1NPATIENT CARE SERVICE         0         0         0           1NPATIENT CARE SERVICES         0         0         0           9.00         Physician Services         0         0         0           9.00         Physic Care Continuous Home Care         0         0         0         0           9.00         Physic Care Services         0         0         0         0         0           9.00         Physic Care Services         0         0         0         0         0           9.00         Physic Care Services         0         0         0         0         0           9.00         Physic Care Services         0         0         0         0         0           10.00 Accupational Therapy         0         <			COORDI NATOR							
1.00       Capital Related Costs-Bidg and Fixt.         2.00       Capital Related Costs-Movable Equip.         3.00       Plant Operation and Maintenance         4.00       Transportation - Staff         5.00       Volunteer Service Coordination       0         33,033       33,033         INPATIENT CARE SERVICE			5.00	5A		6.00		7.00		
2.00         Capit 1al. Related Costs-Movable Equip.           3.00         Plant Operation and Maintenance           4.00         Transportation - Staff           5.00         Volunteer Service Coordination         0           0.00         Administrative and General         0         33,033           1NPATIENT CARE SERVICE			_							
3.00       Plant Operation and Maintenance       0         4.00       Transportation - Staff       0         5.00       Volunteer Service Coordination       0         6.00       Administrative and General       0       33,033         INPATIENT CARE SERVICE	1.00	Capital Related Costs-Bldg and Fixt.								1.00
4.00         Transportation - Staff         0         33,033         33,033           1NPATIENT CARE SERVICE         0         33,033         33,033           INPATIENT CARE SERVICE         0         69,359         17,645         87,004           1npatient - Respite Care         0         69,359         17,645         87,004           0         Inpatient - Respite Care         0         0         0         0           9.00         Physician Services         0         0         0         0         0           9.00         Nursing Care-Continuous Home Care         0         0         0         0         0           10.00         Nursing Care-Continuous Home Care         0         0         0         0         0           10.00         Physical Therapy         0         0         0         0         0         0           10.00         Speech / Language Pathology         0         0         0         0         0         0         0         0           10.00         Speech / Language Pathology         0         0         0         0         0         0         0         0         0         0         0         0         0	2.00	Capital Related Costs-Movable Equip.								2.00
5.00         Vol uniteer Service Coordination         0         33,033         33,033           IMPATIENT CARE SERVICE         0         33,033         33,033         33,033           INPATIENT CARE SERVICE         0         0         0         0         0           100         Inpatient - General Care         0         69,359         17,645         87,004           0         0         0         0         0         0         0         0           0         0         0         0         0         0         0         0           0         0         Nursing Care         0         0         0         0         0           1100         Nursing Care-Continuous Home Care         0	3.00	Plant Operation and Maintenance								3.00
6.00         Administrative and General         0         33,033         33,033         33,033           INPATIENT CARE SERVICE	4.00	Transportation - Staff								4.00
INPATIENT CARE SERVICE         Impatient         Centre of Care         O <td>5.00</td> <td>Volunteer Service Coordination</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>	5.00	Volunteer Service Coordination	0							5.00
7.00       Inpatient - General Care       0       69,359       17,645       87,004         8.00       Physician Services       0       0       0       0         9.00       Physician Services       0       0       0       0       0         10.00       Nursing Care-Continuous Home Care       0 <td>6.00</td> <td>Administrative and General</td> <td>0</td> <td>3</td> <td>3, 033</td> <td>33, 0</td> <td>33</td> <td></td> <td></td> <td>6.00</td>	6.00	Administrative and General	0	3	3, 033	33, 0	33			6.00
8.00         Inpatient - Respite Care         0         0         0           VISITING SERVICES         0 <td></td> <td>INPATIENT CARE SERVICE</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		INPATIENT CARE SERVICE								
VISITING SERVICES         0	7.00	Inpatient - General Care	0	6	9, 359	17,6	45	87, 004		7.00
9.00         Physician Services         0         0         0         0         0         0         0           10.00         Nursing Care         0         23,365         5,944         29,309           11.00         Nursing Care-Continuous Home Care         0         0         0         0           12.00         Physical Therapy         0         0         0         0         0           13.00         Occupational Therapy         0         0         0         0         0         0           14.00         Speech/Language Pathology         0         0         0         0         0         0         0           15.00         Medical Social Services         0         29,987         7,629         37,616         16         60         0<	8.00	Inpatient - Respite Care	0		0		0	0		8.00
10.00       Nursing Care       0       23,365       5,944       29,309         11.00       Nursing Care-Continuous Home Care       0       0       0       0         12.00       Physical Therapy       0       0       0       0         12.00       Physical Therapy       0       0       0       0       0         13.00       Occupational Therapy       0       0       0       0       0       0         14.00       Speech/ Language Pathology       0       <	ľ	VISITING SERVICES								
11.00       Nursing Care-Continuous Home Care       0       0       0       0         12.00       Physical Therapy       0       0       0       0         13.00       Occupational Therapy       0       0       0       0         14.00       Speech/ Language Pathology       0       0       0       0       0         14.00       Speech/ Language Pathology       0       0       0       0       0       0         15.00       Medical Social Services       0       29,987       7,629       37,616         16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Healt h Aide and Homemaker       0       0       0       0         20.00       Dther       0       0       0       0       0         21.00       Drugs, Biological and Infusion Therapy       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0         <	9.00	Physi ci an Servi ces	0		0		0	0		9.00
12.00       Physical Therapy       0       0       0         13.00       Occupational Therapy       0       0       0         14.00       Speech/Language Pathology       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       29,987       7,629       37,616         16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Health Aide and Homemaker       0       0       0       0         10.00       Other       0       0       0       0       0         10.00       Other       0       0       0       0       0       0         20.00       Anal gesics       0       0       0       0       0       0         21.00       Other       Specif Y       0       0       0       0         23.00       Anal gesics       0       0       0 <td< td=""><td>10.00</td><td>Nursing Care</td><td>0</td><td>2</td><td>3, 365</td><td>5, 9</td><td>44</td><td>29, 309</td><td></td><td>10.00</td></td<>	10.00	Nursing Care	0	2	3, 365	5, 9	44	29, 309		10.00
13.00       Occupational Therapy       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       29,987       7,629       37,616         16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0       0         20.00       HH Aide & Homemaker       0       0       0       0       0       0         21.00       Other       0       0       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         23.00       Analgesics       0       0       0       0       0       0         24.00       Sedatives / Hypotics       0       0       0       0	11.00	Nursing Care-Continuous Home Care	0		0		0	0		11.00
14.00       Speech/ Language Pathology       0       0       0       0         15.00       Medical Social Services       0       29,987       7,629       37,616         16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0       0         18.00       Counseling - Other       0       0       0       0       0       0         19.00       Home Health Aide and Homemaker       0       0       0       0       0       0         19.00       Home Health Aide and Homemaker       0	12.00	Physical Therapy	0		0		0	0		12.00
15.00       Medical Social Services       0       29,987       7,629       37,616         16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0         0       Other       0       0       0       0       0         0       Other       0       0       0       0       0         0       Other       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         23.00       Analgesics       0       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0       0         25.0	13.00	Occupational Therapy	0		0	)	0	0		13.00
16.00       Spiritual Counseling       0       7,135       1,815       8,950         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0         0       Other       0       0       0       0       0         0       Other       0       0       0       0       0         0       Drugs, Biological and Infusion Therapy       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0         23.00       Analgesics       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0         25.00       Other - Speci fy       0       0       0       0       0       0         26.00	14.00	Speech/ Language Pathol ogy	0		0	)	0	0		14.00
17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Ai de and Homemaker       0       0       0       0         19.00       HH Ai de and Homemaker       0       0       0       0       0         20.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       0         20.00       Other       0       0       0       0       0       0         21.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         23.00       Anal gesics       0       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0       0         25.00       Other - Specify       0       0       0       0       0       0         27.00       Patient Transportation       0       0       0       0       0       0       0       0	15.00	Medical Social Services	0	2	9, 987	7,6	29	37, 616		15.00
18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0         21.00       Other       0       0       0       0       0       0         21.00       Other       O       0       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0         23.00       Anal gesics       0       0       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0       0         25.00       Other - Specify       0       0       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       0         27.00       Pati ent Transportation       0       0       0       0       0       0         28.00       Imaging Services       0       0       0       0       0 <td>16.00</td> <td>Spiritual Counseling</td> <td>0</td> <td></td> <td>7, 135</td> <td>1, 8</td> <td>15</td> <td>8, 950</td> <td></td> <td>16.00</td>	16.00	Spiritual Counseling	0		7, 135	1, 8	15	8, 950		16.00
19.00       Home Heal th Ai de and Homemaker       0       0       0         20.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0         21.00       Other       0       0       0       0       0       0         OTHER HOSPICE SERVICE COSTS         The HOSPICE SERVICE COSTS         The HOSPICE SERVICE COSTS         O       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0         23.00       Anal gesics       0       0       0       0       0         24.00       Sedatives / Hypnotics       0	17.00	Dietary Counseling	0		0	)	0	0		17.00
20.00         HH Aide & Homemaker - Cont. Home Care         0         0         0         0           21.00         Other         0 <td< td=""><td>18.00</td><td>Counseling - Other</td><td>0</td><td></td><td>0</td><td>)</td><td>0</td><td>0</td><td></td><td>18.00</td></td<>	18.00	Counseling - Other	0		0	)	0	0		18.00
21.00         Other         0         0         0         0           OTHER HOSPICE SERVICE COSTS         0	19.00	Home Health Aide and Homemaker	0		0		0	0		19.00
OTHER HOSPICE SERVICE COSTS22.00Drugs, Biological and Infusion Therapy00023.00Analgesics00024.00Sedatives / Hypnotics00025.00Other - Specify00026.00Durable Medical Equipment/Oxygen00027.00Patient Transportation00028.00Imaging Services00029.00Labs and Diagnostics00030.00Medical Supplies00031.00Outpatient Services (including E/R Dept.)00032.00Radiation Therapy00033.00Chemotherapy00040.00Other00035.00Bereavement Program Costs00036.00Volunteer Program Costs00000000	20.00	HH Aide & Homemaker - Cont. Home Care	0		0	)	0	0		20.00
22.00       Drugs, Biological and Infusion Therapy       0       0       0       0         23.00       Analgesics       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0         25.00       Other - Specify       0       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       0         26.00       Dirasportation       0       0       0       0       0       0         27.00       Patient Transportation       0       0       0       0       0       0         28.00       Imaging Services       0       0       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0       0       0         30.00       Medical Supplies       0       0       0       0       0       0         31.00       Otherapy       0       0       0       0       0       0       0 <tr< td=""><td>21.00</td><td>Other</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>0</td><td></td><td>21.00</td></tr<>	21.00	Other	0		0		0	0		21.00
23.00       Analgesics       0       0       0         24.00       Sedatives / Hypnotics       0       0       0         25.00       Other - Specify       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         27.00       Patient Transportation       0       0       0       0         28.00       Imaging Services       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0       0         32.00       Chemotherapy       0       0       0       0       0       0         34.00       Other       0       0       0       0       0       0         35.00       Bereavement Program Costs       0       0       0       0       0         35.00       Bereavement Program Costs       0       0 <td></td> <td>OTHER HOSPICE SERVICE COSTS</td> <td></td> <td></td> <td></td> <td>_</td> <td></td> <td></td> <td></td> <td></td>		OTHER HOSPICE SERVICE COSTS				_				
24.00       Sedatives / Hypnotics       0       0       0         25.00       Other - Specify       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         27.00       Patient Transportation       0       0       0       0         28.00       Imaging Services       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0       0         32.00       Chemotherapy       0       0       0       0       0         34.00       Other       0       0       0       0       0         4000       Other       0       0       0       0	22.00	Drugs, Biological and Infusion Therapy	0		0		0	0		22.00
25.00       Other - Specify       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         27.00       Pati ent Transportation       0       0       0       0         28.00       Imaging Services       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0       0         32.00       Chemotherapy       0       0       0       0       0         33.00       Chemotherapy       0       0       0       0       0         4MSPICE NONREI MBURSABLE SERVICE	23.00	Anal gesi cs	0		0		0	0		23.00
26.00       Durable Medical Equipment/Oxygen       0       0       0         27.00       Patient Transportation       0       0       0         28.00       Imaging Services       0       0       0       0         28.00       Imaging Services       0       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0       0         33.00       Chemotherapy       0       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE       U         35.00       Bereavement Program Costs       0       0       0       0         36.00       0       0       0       0       0       0       0       0	24.00	Sedatives / Hypnotics	0		0		0	0		24.00
27.00       Pati ent Transportation       0       0       0         28.00       Imagi ng Services       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0         33.00       Chemotherapy       0       0       0       0         34.00       Other       0       0       0       0         400       Dter       0       0       0       0         35.00       Bereavement Program Costs       0       0       0       0         35.00       Vol unteer Program Costs       0       0       0       0       0	25.00	Other - Specify	0		0	)	0	0		25.00
28.00       Imaging Services       0       0       0         29.00       Labs and Diagnostics       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0         33.00       Chemotherapy       0       0       0       0         34.00       Other       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE       Under Program Costs       0       0       0         35.00       Bereavement Program Costs       0       0       0       0         36.00       Vol unteer Program Costs       0       0       0       0			0		0		0	0		26.00
29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0         32.00       Radiation Therapy       0       0       0       0       0         33.00       Chemotherapy       0       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREIMBURSABLE SERVICE	27.00	Patient Transportation	0		0	)	0	0		27.00
30.00       Medical Supplies       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0         32.00       Radiation Therapy       0       0       0       0         33.00       Chemotherapy       0       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE	28.00	Imaging Services	0		0		0	0		28.00
31.00       Outpatient Services (including E/R Dept.)       0       0       0         32.00       Radiation Therapy       0       0       0       0         33.00       Chemotherapy       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE	29.00	Labs and Diagnostics	0		0	)	0	0		29.00
32.00       Radiation Therapy       0       0       0         33.00       Chemotherapy       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE       0       0       0       0       0         35.00       Bereavement Program Costs       0       0       0       0         36.00       Vol unteer Program Costs       0       0       0       0	30.00	Medical Supplies	0		0	)	0	0		30.00
32.00       Radiation Therapy       0       0       0         33.00       Chemotherapy       0       0       0       0         34.00       Other       0       0       0       0       0         HOSPICE NONREI MBURSABLE SERVICE       0       0       0       0       0         35.00       Bereavement Program Costs       0       0       0       0         36.00       Vol unteer Program Costs       0       0       0       0		Outpatient Services (including E/R Dept.)	0		0		0	o		31.00
34. 00OtherOOOHOSPI CE NONREI MBURSABLE SERVI CE35. 00Bereavement Program CostsOOO36. 00Vol unteer Program CostsOOOO			0		0		0	o		32.00
HOSPI CE NONREI MBURSABLE SERVI CE         35.00       Bereavement Program Costs       0       0       0       0         36.00       Vol unteer Program Costs       0       0       0       0	33.00	Chemotherapy	0		0		0	o		33.00
35.00         Bereavement Program Costs         0	34.00	Other	0		0		0	0		34.00
36.00 Volunteer Program Costs 0 0 0 0										
5	35.00	Bereavement Program Costs	0		0		0	0		35.00
	36.00	Volunteer Program Costs	0		0		0	o		36.00
		Fundrai si ng	0		0		0	0		37.00
38.00         Other         Program         Costs         O	38.00	Other Program Costs	0		0		0	0		38.00
39.00         Total (sum of lines 1 thru 38)         0         162,879         162,879	39.00	Total (sum of lines 1 thru 38)	0	16	2, 879			162, 879		39.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Li	eu of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi de	r CCN: 151315	Peri od:	Worksheet K-4	1
			Hospico	CCN: 151561	From 10/01/201 To 09/30/201		narad
			nospi ce	CCN. 151501	10 09/30/201	9/6/2016 3: 17	
					Hospi ce I		
		CAPI TAL RE	LATED COST				
		BUI LDI NGS &	MOVABLE	- PLANT	TRANSPORTATIO	N VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (S			SERVI CES	
		FT.)	VALUE)	MAINT. (SC	).	COORDI NATOR	
				FT.)		(HOURS)	
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS	0					1 1 00
1.00 2.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip.	0		0			1.00
2.00	Plant Operation and Maintenance	0		0	0		3.00
4.00	Transportation - Staff	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0		0	0	0 0	
6.00	Administrative and General	0		0	0	0 0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0		0	0	0 0	
8.00	Inpatient - Respite Care	0		0	0	0 0	8.00
	VI SI TI NG SERVI CES						
9.00	Physician Services	0		0	0		
10. 00 11. 00	Nursing Care Nursing Care-Continuous Home Care	0		0	0		
12.00	Physical Therapy	0		0	0		
12.00	Occupational Therapy	0		0	0		
14.00	Speech/ Language Pathol ogy	0		0	0		
15.00	Medical Social Services	0		0	0		
16.00	Spiritual Counseling	0		0	0	0 0	
17.00	Dietary Counseling	0		0	0	0 0	17.00
18.00	Counseling - Other	0		0	0	0 0	18.00
19.00	Home Health Aide and Homemaker	0		0	0	0 0	
20.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	0 0	
21.00		0		0	0	0 0	21.00
22.00	OTHER HOSPICE SERVICE COSTS	0		0	0	ol c	22.00
22.00	Drugs, Biological and Infusion Therapy Analgesics	0		0	0		
24.00	Sedatives / Hypnotics	0		0	0		
25.00	Other - Specify	0		0	0		
26.00	Durable Medical Equipment/Oxygen	0		0	0		
27.00	Patient Transportation	0		0	0	0 0	27.00
28.00	Imaging Services	0		0	0	0 0	28.00
29.00	Labs and Diagnostics	0		0	0	0 0	29.00
30.00	Medical Supplies	0		0	0	0 0	30.00
31.00	Outpatient Services (including E/R Dept.)	0		0	0	0 0	
32.00	Radiation Therapy	0		0	0	0 0	
33.00	Chemotherapy	0		0	0	0 0	
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	0		0	0	0 0	34.00
35.00	Bereavement Program Costs	0		0	0	0 0	35.00
36.00	Volunteer Program Costs	0		0	0		
37.00	Fundrai si ng	0		0	0	0 0	
38.00	Other Program Costs	0		0	0	0 0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0		0	0	0 0	
40.00	Unit Cost Multiplier	0. 000000	0. 00000	0.000	0.0000	0.000000	40. 00

	Financial Systems	CAMERON MEMORIAL	COMMUNITY	In Lie	u of Form CMS-2552-
COST A	ALLOCATION - STATISTICAL BASIS		Provider CCN: 151315	Period: From 10/01/2014	Worksheet K-4 Part II
			Hospi ce CCN: 151561		Date/Time Prepared
				Hospi ce I	77072010 0. 17 pm
		RECONCILIATION AD	MI NI STRATI VE		
			& GENERAL		
			(ACC. COST)		
		6A	6.00		
1 00	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1. (
2.00	Capital Related Costs-Movable Equip.	0			2.0
3.00	Plant Operation and Maintenance	0			3. (
4.00	Transportation - Staff	0			4. (
5.00	Volunteer Service Coordination		100.01/		5.0
6.00	Administrative and General	-33, 033	129, 846		6.0
7 00	INPATIENT CARE SERVICE	0	(0.350		
7.00	Inpatient - General Care	0	69, 359		7.0
8.00	Inpatient - Respite Care VISITING SERVICES	0	0		8.0
9.00	Physician Services	0	0		9.0
9.00 10.00	Nursing Care	0	23, 365		10.0
10.00	Nursing Care-Continuous Home Care	0	23, 303		10.0
12.00	Physical Therapy	0	0		11.0
12.00	Occupational Therapy	0	0		12.0
14.00	Speech/ Language Pathol ogy	0	0		13. (
14.00	Medical Social Services	0	29, 987		14.0
16.00	Spiritual Counseling	0	7, 135		16.0
17.00	Di etary Counsel i ng	0	0		17.0
18.00	Counseling - Other	0	0		18.0
19.00	Home Health Aide and Homemaker	0	o		19.0
20.00	HH Aide & Homemaker - Cont. Home Care	0	o		20.0
21.00	Other	0	o		20.0
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>			21.0
22.00	Drugs, Biological and Infusion Therapy	0	0		22.0
23.00	Anal gesi cs	0	o		23.0
24.00	Sedatives / Hypnotics	0	o		24.0
25.00	Other - Specify	0	o		25.0
26.00	Durable Medical Equipment/Oxygen	0	o		26.0
27.00	Patient Transportation	0	ō		27.0
28.00	I maging Services	0	0		28.0
29.00	Labs and Diagnostics	0	ō		29.0
30.00	Medical Supplies	0	o		30.0
31.00	Outpatient Services (including E/R Dept.)	0	o		31.0
32.00	Radi ati on Therapy	0	o		32.0
33.00	Chemotherapy	0	o		33. 0
34.00	Other	0	ō		34.0
	HOSPI CE NONREI MBURSABLE SERVI CE	· -			
35.00	Bereavement Program Costs	0	0		35.0
36.00	Volunteer Program Costs	0	0		36.0
37.00	Fundrai si ng	0	0		37.0
38.00	Other Program Costs	0	0		38.0
			33, 033		39. (
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		33, 033		39.0

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	r centers		CCN: 151315 CCN: 151561	Fro	iod: m 10/01/2014 09/30/2015	Worksheet K-5 Part I Date/Time Pre 9/6/2016 3:17	pared:
					Hospi ce I		
		CAPI TAL REI	ATED COSTS				
Cost Center Description	Hospice Trial Balance (1)	BLDG & FIXT	MVBLE EQUIN		EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00		4.00	4A	
1.00 Administrative and General		0	6, 4	18	37, 585	44,003	1.00
2.00 Inpatient - General Care	87,004	0		0	0	87,004	2.00
3.00 Inpatient - Respite Care	0	0	1	0	0	0	3.00
4.00 Physician Services	0	0	1	0	0	0	4.00
5.00 Nursing Care	29, 309	0	1	0	0	29, 309	5.00
6.00 Nursing Care-Continuous Home Care	0	0	1	0	0	0	6.00
7.00 Physical Therapy	0	0	1	0	0	0	7.00
8.00 Occupational Therapy	0	0		0	0	0	8.00
9.00 Speech/ Language Pathology	0	0		0	0	0	9.00
10.00 Medical Social Services	37, 616	0		0	0	37, 616	10.00
11.00 Spiritual Counseling	8, 950	0		0	0	8, 950	11.00
12.00 Dietary Counseling	0	0		0	0	0	12.00
13.00 Counseling - Other	0	0		0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00 Other	0	0		0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
18.00 Anal gesi cs	0	0		0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00 Other - Specify	0	0		0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00 Patient Transportation	0	0		0	0	0	22.00
23.00 Imaging Services	0	0		0	0	0	23.00
24.00 Labs and Diagnostics	0	0		0	0	0	24.00
25.00 Medical Supplies	0	0		0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00 Radiation Therapy	0	0		0	0	0	27.00
28.00 Chemotherapy	0	0		0	0	0	28.00
29.00 Other	0	0		0	0	0	29.00
30.00 Bereavement Program Costs	0	0		0	0	0	30.00
31.00 Volunteer Program Costs	0	0		0	0	0	31.00
32.00 Fundrai si ng	0	0		0	0	0	32.00
33.00 Other Program Costs	0	0		0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	162, 879	0	6, 4	18	37, 585	206, 882	34.00
35.00 Unit Cost Multiplier (see instructions)	1		1	1		0	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS         Provider COX: 15135         Provider COX: 15135         Provider COX: 15135         Worksheet K-5- From 10/01/2016         Worksheet K-5- Part 1                  Cost Center Description               ADMINISTRATIVE 6 GENERAL               OPERATION OF LINEN SERVICE               Worksheet K-5- Part 1 Bospice COX: 15135               Bospice COX: 15135                 1.00             Administrative and General             1.05             10.052               Administrative and General             11.00             10.00	Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY			In Lie	u of Form CMS-:	2552-10
Hospice CN:         151561         To         09/33/2015         Date/Time Prepared: Ve/2016 3:17 pm           Cost Center Description         ADMINISTRATIVE OPERATION OF & CENERAL         LAUNDRY & PLANT         HUSEKEEPI M USEKEEPI M         DIETARY           1.00         Administrative and General         11,662         7.00         8.00         9.00         10.00         1           2.00         Inpatient - General Care         23,099         0         0         0         0         0         2.00           3.00         Inpatient - Respite Care         0	ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 151315				
Cost Center Description         ADMI NI STRATIVE 8 Cost Center Description         ADMI NI STRATIVE (betration of the specific of the				Hospi ce (	CN: 151561				nared
Cost Center Description         AOMINISTRATIVE 8 CENERAL 5.00         OPERATIVE 7.00         LAUNDRY & LAUNDRY & 8.00         HOUSEKEEPING 9.00         DIETARY           1.00         Administrative and General         11.62         12.094         0         <				nospi ce e			077 007 2010	9/6/2016 3: 17	pm
8 GENERAL         PLANT         LINEN SERVICE         ////////////////////////////////////						L			
5.00         7.00         8.00         9.00         10.00           1.00         Administrative and General         11,662         12,094         0         0         0         1.00           2.00         Inpatient - General Care         23,099         0         0         0         0         0         2.00           3.00         Inpatient - Respite Care         0		Cost Center Description					HOUSEKEEPI NG	DI ETARY	
1 00         Administrative and General         11,682         12,094         0         0         0         1         00           2.00         Inpatient - General Care         23,099         0						CE	0.00	10.00	
2.00         Inpatient - General Care         23,099         0         <	1 00	Administrative and General				0			1 00
3.00         Inpatient - Respite Care         0<							-	-	
4 00         Physician Services         0			23, 077	0		0	0		
5.00         Nursing Care         7,781         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0			0	0		0	0	-	
6 00         Nursing Care-Continuous Home Care         0				0		0	0		
7.00         Physical Therapy         0         0         0         0         7.00           8.00         Occupational Therapy         0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td>				0		0	0		
8.00         Occupational Therapy         0         0         0         0         0         0         8.00           9.00         Speech/ Language Pathology         0	7.00		0	0		0	0	0	7.00
10.00       Medical Social Services       9,986       0       0       0       10.00         11.00       Spiritual Counseling       2,376       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       0       11.00         13.00       Counseling - Other       0       0       0       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       0       13.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       16.00         16.00       Other       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       20.00       20.00       21.00       22.00       23.00       22.00       23.00       22.00       23.	8.00		0	0		0	0	0	8.00
11.00       Spiritual Counseling       2,376       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       12.00         14.00       Home Heal th Ai de and Homemaker       0       0       0       0       12.00         14.00       Home Heal th Ai de and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       15.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       18.00       19.00         20.00       Other - Specify       0       0       0       0       20.00       21.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.0	9.00	Speech/ Language Pathology	0	0		0	0	0	9.00
12.00       Dietary Counseling       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       13.00         14.00       Home Health Aide and Homemaker       0       0       0       0       13.00         14.00       Home Health Aide and Homemaker       0       0       0       0       0       13.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       15.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00       0       0       0       18.00       0       0       0       18.00       0       0       0       18.00       0 <t< td=""><td>10.00</td><td>Medical Social Services</td><td>9, 986</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>10.00</td></t<>	10.00	Medical Social Services	9, 986	0		0	0	0	10.00
13.00       Counseling - Other       0       0       0       13.00         14.00       Home Heal th Ai de and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       16.00         19.00       Sedatives / Hypnotics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       21.00         23.00       Inaging Services       0       0       0       0       22.00         23.00       Labs and Diagnostics       0       0       0       0       24.00         24.00       Labs and Diagnostics       0       0       0       0       25.00 <td< td=""><td>11.00</td><td>Spiritual Counseling</td><td>2, 376</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>11.00</td></td<>	11.00	Spiritual Counseling	2, 376	0		0	0	0	11.00
14.00       Home Heal th Ai de and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Analgesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       21.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25	12.00	Dietary Counseling	0	0		0	0	0	12.00
15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       16.00         18.00       Anal gesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       21.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         22.00       Patient Transportation       0       0       0       0       23.00         24.00       Labs and Di agnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       28.00	13.00	Counseling - Other	0	0		0	0	0	13.00
16.00       Other       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       18.00         20.00       Other - Specify       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Pati ent Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       23.00       23.00         25.00       Medical Supplies       0       0       0       0       24.00       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0	14.00		0	0		~	0	0	14.00
17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Analgesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       25.00         25.00       Medical Supplies       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       27.00         29.00       Oth			0	0		-	0	-	
18.00       Analgesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       20.00         21.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0			0	0		0	0		
19.00       Sedatives / Hypnotics       0<			0	0		0	0		•
20.00       Other - Specify       0			0	0		~	0	•	
21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       0       0       <			0	0		0	0		
22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       33.00         32.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>-</td><td></td></td<>			0	0		0	0	-	
23.00       Imaging Services       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       31.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       0       33.00         34.00       Total (sum of lines			0			~	0		
24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundrai si ng       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       0       34.00			0	0		0	0		
25.00       Medical Supplies       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundrai si ng       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       34.00			0	0		0	0	-	
26.00Outpatient Services (including E/R Dept.)000026.0027.00Radiation Therapy000027.0028.00Chemotherapy000028.0029.00Other000028.0029.00Other000029.0030.00Bereavement Program Costs000030.0031.00Volunteer Program Costs000031.0032.00Fundrai sing000032.0033.00Other Program Costs000033.0034.00Total (sum of lines 1 thru 33) (2)54,92412,0940000			0	0		-	0	-	
27.00Radiation Therapy000027.0028.00Chemotherapy000028.0029.00Other000029.0030.00Bereavement Program Costs0000029.0031.00Volunteer Program Costs000031.0032.00Fundraising000032.0033.00Other Program Costs000033.0034.00Total (sum of lines 1 thru 33) (2)54,92412,09400034.00			0	0		-	0	-	
28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundrai sing       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       34.00			0	0			0	-	
29.00       0ther       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Volunteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       34.00			0	0			0		
31.00       Volunteer Program Costs       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       34.00			0	0		0	0		
31.00Volunteer Program Costs000031.0032.00Fundraising000032.0033.00Other Program Costs0000033.0034.00Total (sum of lines 1 thru 33) (2)54,92412,09400034.00			0	0			0		
32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       54,924       12,094       0       0       0       34.00			0	0		0	0	0	31.00
34.00         Total (sum of lines 1 thru 33) (2)         54,924         12,094         0         0         0         34.00	32.00		0	0		0	0	0	32.00
	33.00		0	0		0	0	0	33.00
35.00 Unit Cost Multiplier (see instructions)	34.00	Total (sum of lines 1 thru 33) (2)	54, 924	12, 094		0	0	0	34.00
	35.00	Unit Cost Multiplier (see instructions)							35.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151315 CCN: 151561	Period: From 10/01/2014 To 09/30/2015		pared:
					Hospi ce I	//0/2010 3.1/	piii
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ON ETERNA	ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	11, 114			95 0		1.00
2.00	Inpatient - General Care	0			0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	0			0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0			0 0	0	6.00
7.00	Physical Therapy	0			0 0	0	7.00
8.00	Occupational Therapy	0			0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0			0 0	0	9.00
10.00	Medical Social Services	0			0 0	0	10.00
11.00	Spiritual Counseling	0			0 0	0	11.00
12.00	Di etary Counsel i ng	0			0 0	0	12.00
13.00	Counseling - Other	0			0 0	0	13.00
14.00	Home Heal th Ai de and Homemaker	0			0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	15.00
16.00	Other	0			0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0			0 0	0	17.00
18.00	Anal gesi cs	0			0 0	0	18.00
19.00	Sedatives / Hypnotics	0			0 0	0	19.00
20.00	Other - Specify	0			0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0			0 0	0	21.00
22.00	Patient Transportation	0			0 0	0	22.00
23.00	Imaging Services	0			0 0	0	23.00
24.00	Labs and Diagnostics	0			0 0	0	24.00
25.00	Medi cal Supplies	0			0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0			0 0	0	26.00
27.00	Radi ati on Therapy	0			0 0	0	27.00
28.00	Chemotherapy	0			0 0	0	28.00
29.00	Other				0 0	0	29.00
30.00	Bereavement Program Costs				0 0	0	30.00
31.00	Volunteer Program Costs				0 0	0	31.00
32.00	Fundrai si ng				0 0		32.00
33.00	Other Program Costs				0 0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	11, 114	, s	2	95 0	0	34.00
	Unit Cost Multiplier (see instructions)	11, 114	0		/5		34.00
00.00		I	I	I	I	I	1 00.00

ALLOCATION OF GENERAL SERVICE COST TO HOSPICE COST CENTERS         Provider CCN: 151315 Hospice CN: 151315 To 09/30/2015         Period : From 10/071/201 To 09/30/2015         Period : Part I To 09/30/2015           Cost Center Description         Subtotal (cols. 4A-23)         Intern & Subtotal (cols. 4A-23)         Period cr (sols. 24)         Hospice CN: (sols. 24)         Hospice CN: (sols. 24)         Hospice CN: (sols. 24)         Cost Sols. 26)         Cost. 26 (sols. 26)           1.00         Administrative and General (sols. 24)         79,288         Not Sols. 26)         Cost. 26 (sols. 26)	Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY			In Lie	u of Form CMS-2	2552-10
Cost Center Description         Subtotal (cols. 4A-23) 8 elevations All ustments All ustme	ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS			From	m 10/01/2014	Part I Date/Time Pre	pared:
Image: constraint of the second sec							Hospi ce I		
Image: constraint of the second sec		Cost Center Description	Subtotal	Intern &	Subtotal			Total Hospice	
Low         Administrative and General         24.00         25.00         26.00         27.00         26.27.00           1.00         Administrative and General         79.288         0         10.00         24.00         25.00         26.00         27.00         28.00         0         1.00           2.00         Inpatient - General Care         110.103         0         110.103         42.353         152.456         2.00         0 <td< td=""><td></td><td>···· ·</td><td>(cols. 4A-23)</td><td></td><td>(cols. 24 :</td><td></td><td></td><td></td><td></td></td<>		···· ·	(cols. 4A-23)		(cols. 24 :				
Stepdow         Adjustments         24.00         25.00         26.00         27.00         28.00           1.00         Inpatient - General Care         110,103         0         110,103         42.353         152,456         2.00           2.00         Inpatient - Respit Care         0			l` í	& Post	25)	(5	See Part II)		
Vert         24.00         25.00         26.00         27.00         28.00            1.00         Admin istrative and General Inpatient - General Care         110,103         110,103         42,353         152,456         2.00           3.00         Inpatient - Respite Care         0         0         0         0         3.00           0.00         Physical Services         0				Stepdown	,			, , , , , , , , , , , , , , , , , , ,	
1.00         Admin istrative and General         79, 288         1.00           2.00         Inpatient - General Care         110, 103         0         110, 103         42, 353         152, 456         2.00           2.00         Inpatient - Respite Care         0 </td <td></td> <td></td> <td></td> <td>Adjustments</td> <td></td> <td></td> <td></td> <td></td> <td></td>				Adjustments					
2.00         Inpatient - General Care         110,103         0         110,103         42,353         152,456         2.00           3.00         Inpatient - Respite Care         0			24.00		26.00		27.00	28.00	
1.00         Inpatient - Respite Care         0<	1.00	Administrative and General	79, 288						1.00
4.00         Physician Services         0         0         0         0         0         14,267         51,357         5.00           6.00         Nursing Care-Continuous Home Care         0 <t< td=""><td>2.00</td><td>Inpatient - General Care</td><td>110, 103</td><td>(</td><td>110, 1</td><td>03</td><td>42, 353</td><td>152, 456</td><td>2.00</td></t<>	2.00	Inpatient - General Care	110, 103	(	110, 1	03	42, 353	152, 456	2.00
5.00         Nursing Care         37,090         0         37,090         14,267         51,357         5.00           6.00         Nursing Care-Continuous Home Care         0	3.00	Inpatient - Respite Care	0	(		0	0	0	3.00
6.00         Nursing Care-Continuous Home Care         0	4.00	Physician Services	0	(		0	0	0	4.00
6.00         Nursing Care-Continuous Home Care         0	5.00	Nursing Care	37,090	(	37,0	090	14, 267	51, 357	5.00
7.00         Physical Therapy         0         0         0         0         7.00           8.00         Occupational Therapy         0 <td>6.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>6.00</td>	6.00		0	0		0	0	0	6.00
8.00         Occupational Therapy         0			0	C		0	0	0	
9.00         Speech/ Language Pathology         0         18,311         65,913         10.00           11.00         Spiritual Counseling         0         11,326         47,602         18,311         65,913         10.00           12.00         Dietary Counseling         0         0         0         0         0         11,326         47,602         0         0         0         12.00           13.00         Counseling - Other         0         0         0         0         0         14.00           Home Heal th Aide and Homemaker         Cont. Home Care         0         0         0         0         15.00           16.00         Drugs, Biological and Infusion Therapy         0         0         0         0         16.00           17.00         Drugs, Biological and Infusion Therapy         0         0         0         0         18.00           19.00         Sedatives / Hypnotics         0<			0	(		0	0	0	8.00
10.00       Medical Social Services       47,602       0       47,602       18,311       65,913       10.00         11.00       Spiritual Counseling       11,326       0       11,326       4,357       15,683       11.00         12.00       Dietary Counseling       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       20.00         10.00       Durable Medical Equipment/0xygen       0       0       0       0       20.00         21.00       Datalet Medical Equipment/0xygen       0       0       0       20.00			0	(		0	0	0	
11.00       Spiritual Counseling       11,326       0       11,326       4,357       15,683       11.00         12.00       Dietary Counseling       0       0       0       0       12.00         13.00       Counseling       0       0       0       0       12.00         13.00       Counseling       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       14.00         15.00       It Aide & Homemaker - Cont. Home Care       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       18.00       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       21.00         22.00       Patient Transportation       0       0       0       22.00 <t< td=""><td></td><td></td><td>47.602</td><td>(</td><td>47.6</td><td>502</td><td>18.311</td><td>-</td><td></td></t<>			47.602	(	47.6	502	18.311	-	
12.00       Dietary Counseling       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       15.00         16.00       Anal gesics       0       0       0       0       17.00       18.00         18.00       Anal gesics       0       0       0       0       19.00       20.00       19.00       20.00       19.00       20.00       21.00       21.00       21.00       21.00       22.00       21.00       22.00       2				(					
13.00       Counseling - Other       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       18.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       21.00         23.00       Imaging Services       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       24.00         25.00       Medical Supplies       0       0       0       26.00         27.00       Radiation Therapy       0       0 </td <td></td> <td></td> <td></td> <td>(</td> <td></td> <td></td> <td></td> <td></td> <td></td>				(					
14.00       Home Heal th Ai de and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       14.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0       0       21.00         23.00       Patient Transportation       0       0       0       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       0       0       0       22.00       0       22.00       0       22.			-				-	-	
15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       18.00         20.00       Other - Specify       0       0       0       19.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       21.00         23.00       Imaging Services       0       0       0       22.00         24.00       Labs and Di agnostics       0       0       0       23.00         24.00       Labs and Di agnostics       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00			0			0	0	-	
16.00       Other       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypotics       0       0       0       0       18.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         23.00       Patient Transportation       0       0       0       0       22.00         23.00       Labs and Diagnostics       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       24.00         25.00       Medical Supplies       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0 <t< td=""><td></td><td></td><td>0</td><td>(</td><td></td><td>0</td><td>0</td><td>-</td><td></td></t<>			0	(		0	0	-	
17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Analgesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Pati ent Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       23.00         25.00       Medical Supplies       0       0       0       25.00         26.00       Outpati ent Services (including E/R Dept.)       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>U</td> <td>0</td> <td>-</td> <td></td>			0			U	0	-	
18.00       Analgesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       0       30.00       30.00			0				-		
19.00       Sedatives / Hypnotics       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       0       30.00			0		1	-	0	-	
20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Pati ent Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       24.00         26.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       27.00         26.00       Outpati ent Program Costs       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00         28.00       Chemotherapy       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       22.00         33.00			0				0	-	
21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       0       0       0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>0</td><td>-</td><td></td></td<>			0				0	-	
22.00       Pati ent Transportation       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Di agnostics       0       0       0       0       24.00         25.00       Medi cal Supplies       0       0       0       0       25.00         26.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       25.00         26.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radi ati on Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00         28.00       Chemotherapy       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       0       0       0			0				0		
23.00       Imaging Services       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00       31.00       31.00         32.00       Fundraising       0       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       0       33.00			0			-	0	-	
24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       285, 409       34.00		1	0			-	0	-	
25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       285, 409       34.00			0				0	-	
26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundrai sing       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       285, 409       34.00			0				0	-	
27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundrai si ng       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       32.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       34.00			0			-	0	-	
28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       30.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       32.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       285, 409       34.00			0			-	0	-	
29.00       Other       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       32.00         34.00       Total (sum of lines 1 thru 33) (2)       285, 409       0       285, 409       285, 409       34.00			0				0		
30.00         Bereavement Program Costs         0         0         0         0         30.00           31.00         Vol unteer Program Costs         0         0         0         0         31.00           32.00         Fundraising         0         0         0         0         32.00           33.00         Other Program Costs         0         0         0         0         32.00           34.00         Total (sum of lines 1 thru 33) (2)         285,409         0         285,409         285,409         34.00			0			0	0	-	
31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       32.00         34.00       Total (sum of lines 1 thru 33) (2)       285,409       0       285,409       285,409       34.00			0			0	0		
32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       285,409       0       285,409       285,409       34.00					í.	0	0	-	
33.00         Other Program Costs         0         0         0         0         33.00           34.00         Total (sum of lines 1 thru 33) (2)         285,409         0         285,409         285,409         34.00			0		()	0	0		
34.00         Total (sum of lines 1 thru 33) (2)         285,409         0         285,409         285,409         34.00			0		()	0	0	-	
			e e e e e e e e e e e e e e e e e e e	-		Ŭ	0	-	
35.00 [0111 COST MULTIPITEL (See THST ACTIONS) ] ] ] 0.36400/] [35.00			200, 409		203,4	107	0 201447	200, 409	
	35.00	joni i cost multipiter (see fiistructions)	I	l	I	I	0. 304007		33.00

Heal th	Financial Systems	CAMERON MEMORI	AL CO	MMUNI TY			In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		Provi der	CCN: 151315	P	eri od:	Worksheet K-5	
STATI S	STICAL BASIS					F	rom 10/01/2014	Part II	
				Hospi ce C	CN: 151561	T	o 09/30/2015	Date/Time Pre	
								9/6/2016 3:17	pm
				COCTC			Hospi ce I		
		CAPITAL REL	LATED	CUSIS					
	Cost Center Description	BLDG & FIXT	M\/D	LE EQUIP	EMPLOYEE		Doconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)		ARE FEET)	BENEFITS		Reconciliation	& GENERAL	
					DEPARTMENT			(ACCUM. COST)	
					(GROSS			(ACCOM. COST)	
					SALARI ES)				
		1.00		2.00	4.00		5A	5.00	
1.00	Administrative and General	0		301	125, 0	40	0	44,003	1.00
2.00	Inpatient - General Care	0		0		0		87,004	2.00
3.00	Inpatient - Respite Care	0		0		0	0	0	3.00
4.00	Physician Services	0		0		0	0	0	4.00
5.00	Nursing Care	0		0		0	0	29, 309	5.00
6.00	Nursing Care-Continuous Home Care	0		0		0	0	0	6.00
7.00	Physical Therapy	0		0		0	0	0	7.00
8.00	Occupational Therapy	0		0		0	0	0	8.00
9.00	Speech/ Language Pathol ogy	0		0		0	0	0	9.00
10.00	Medical Social Services	0		0		0	0	37, 616	10.00
11.00	Spiritual Counseling	0		0		0	0	8, 950	11.00
12.00	Dietary Counseling	0		0		0		0	12.00
13.00	Counseling - Other	0		0		0	-	0	13.00
14.00	Home Health Aide and Homemaker	0		0		0		0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0		0		0	15.00
16.00	Other	0		0		0		0	16.00
17.00	Drugs, Biological and Infusion Therapy	0		0		0		0	17.00
18.00	Anal gesi cs	0		0		0	-	0	18.00
19.00	Sedatives / Hypnotics	0		0		0	-	0	19.00
20.00	Other - Specify	0		0		0		0	20.00
21.00	Durable Medical Equipment/Oxygen	0		0		0		0	21.00
22.00	Patient Transportation	0		0		0		0	22.00
23.00	I maging Services	0		0		0 0		0	23.00
24.00 25.00	Labs and Diagnostics	0		0		0	-	0	24.00 25.00
25.00 26.00	Medical Supplies	0		0		0		0	25.00 26.00
28.00	Outpatient Services (including E/R Dept.) Radiation Therapy			0		0	-	0	27.00
27.00	Chemotherapy			0		0		0	27.00
28.00	Other	0		0		0	-	0	28.00
30.00	Bereavement Program Costs	0		0		0		0	30.00
30.00	Volunteer Program Costs			0		0	-	0	31.00
32.00	Fundrai si ng	0		0		0	-	0	32.00
33.00	Other Program Costs	0		0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0		301	125, 0	~	U U	206, 882	34.00
35.00	Total cost to be allocated	0		6, 418	37, 5			54, 924	35.00
	Unit Cost Multiplier (see instructions)	0. 000000		21. 322259				0. 265485	
	· · · · · · · · · · · · · · · · · · ·					1			

Heal th	Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			CCN: 151315	Peri od:	Worksheet K-5	
STATI S	TI CAL BASI S				From 10/01/2014		
			Hospi ce (	CCN: 151561	To 09/30/2015		pared:
					llaani aa l	9/6/2016 3:17	pm
	Cost Conton Description	OPERATION OF	LAUNDRY &	HOUSEKEEPIN	Hospice I G DIETARY	CAFETERI A	
	Cost Center Description		LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(POUNDS OF	SERVICE)	(WEALS SERVED)	(FIES)	
		(SOUARE ILLI)	LAUNDRY)	JERVICE)			
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	301	0.00		0 0		1.00
2.00	Inpatient - General Care	0	0		0 0		2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursi ng Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0		24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundraising	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	301	0		0 0	245	34.00
35.00	Total cost to be allocated	12,094	0	0.0000	0 0	11, 114	35.00
36.00	Unit Cost Multiplier (see instructions)	40. 179402	0. 000000	0.0000	0. 000000	45. 363265	36.00

	Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (	CCN: 151315 CCN: 151561	Period: From 10/01/2014 To 09/30/2015	
					Hospi ce I	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT NRSI NG	(COSTED		(TIME SPENT)	
		HR)	REQUIS.)			
		13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	2, 322		0 0	
2.00	Inpatient - General Care	0	0		0 0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	3.00
4.00	Physician Services	0	0		0 0	4.00
5.00	Nursing Care	0	0		0 0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	6.00
7.00	Physical Therapy	0	0		0 0	7.00
8.00	Occupational Therapy	0	0		0 0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	9.00
10.00	Medical Social Services	0	0		0 0	10.00
11.00	Spiritual Counseling	0	0		0 0	11.00
12.00	Di etary Counsel i ng	0	0		0 0	12.00
13.00	Counseling - Other	0	0		0 0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	15.00
16.00	Other	0	0		0 0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	17.00
18.00	Anal gesi cs	0	0		0 0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	19.00
20.00	Other - Specify	0	0		0 0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	21.00
22.00	Patient Transportation	0	0		0 0	22.00
23.00	Imaging Services	0	0		0 0	23.00
24.00	Labs and Diagnostics	0	0		0 0	24.00
25.00	Medical Supplies	0	0		0 0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	26.00
27.00	Radiation Therapy	0	0		0 0	27.00
28.00	Chemotherapy	0	0		0 0	28.00
29.00	Other	0	0		0 0	29.00
30.00	Bereavement Program Costs	0	0		0 0	30.00
31.00	Volunteer Program Costs	0	0		0 0	31.00
32.00	Fundrai si ng	0	0		0 0	32.00
33.00	Other Program Costs	0	0		0 0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	2, 322		0 0	34.00
	Total cost to be allocated	0	395	1	0 0	35.00
35.00		9	575		0	35.00

Heal th	Financial Systems	CAMERON MEMORIAL CO	MMUNI TY		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 151315	Peri od:	Worksheet K-5	
					From 10/01/2014		
			Hospi ce (	CCN: 151561	To 09/30/2015		
					Hospice I	9/6/2016 3:17	pm
	Cast Contar Decarintian	Wheet	C Dort	Coot to Char		lloopi oo Charad	
	Cost Center Description				ge Total Hospice		
		L,	col. 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
				1.00	Records)	x 2)	
			0	1.00	2.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00		27 0	0	1.00
2.00	OCCUPATIONAL THERAPY		67.00				2.00
3.00	SPEECH PATHOLOGY		68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 4376	06 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	)			5.00
6.00	LABORATORY		60.00	0. 3024	20 0	0	6.00
6.01	BLOOD LABORATORY		60.01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0. 6684	98 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00
9.00	RADI OLOGY-THERAPEUTI C		55. OC	•			9,00
10.00	CHEMI CAL DEPENDENCY		76.00	•	82 0	0	10.00
10.01	ONCOLOGY		76.01			0	10.01
11.00	Totals (sum of lines 1-10)		,			0	11.00
		I		I	I		

Health Financial Systems CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der	CCN: 151315	Period: From 10/01/2014	Worksheet K-6	
	Hospi ce C	CCN: 151561			
			Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				285, 409	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3, 196	2.00
3.00 Average cost per diem (line 1 divided by line 2)				89.30	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3, 022				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	269, 865				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		-	14		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)		1, 2	50		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	404				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	36, 077				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)			0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			160		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			14, 288		13.00