Health Financia	al Syst	ems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	eu of Form CMS-	-2552-10
This report is	requi r	red by Law (42 USC 1395	g; 42 CFR 413.20(b)). Faili	ire to report can re	sult in all interim	FORM APPROVE	D
payments made	since t	the beginning of the co	st reporting period being o	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-	-0050
HOSPITAL AND H AND SETTLEMENT			OST REPORT CERTIFICATION	Provi der CCN: 15131	From 10/01/2013	Worksheet S Parts I-III Date/Time Pro 2/25/2016 9:4	
PART I - COST	REPORT	STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 2/25/20)16 Time:	9:47 am
use only	2. [] Manually submitted co	st report				
			report enter the number o Enter "F" for full or "L"		resubmitted this o	ost report	
Contractor use only	(1) (2) (3)]Cost Report Status As Submitted Settled without Audit Settled with Audit		this Provider CCN 1		lor Code: olumn 1 is 4: mes reopened =	

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
· · · · · · · · · · · · · · · · · · ·	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	125, 228	316, 762	69, 198	-663, 019	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	63, 882	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-122		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	189, 110	316, 640	69, 198	-663, 019	200. 00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151315 Peri od: Worksheet S-2 From 10/01/2013 To 09/30/2014 Part I Date/Time Prepared: 2/25/2016 9:46 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 416 E MAUMEE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ANGOLA Zi p Code: 47803-County: STEUBEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CAMERON MEMORIAL 151315 99915 02/01/2003 N 0 3.00 COMMUNI TY Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF CAMERON MEMORIAL 157315 99915 N 02/01/2003 N 0 7 00 7.00 COMMUNITY 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA CAMERON HOME HEALTH 157117 99915 04/01/1984 Ν Ρ Ν 12.00 CARE 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce CAMERON HOSPICE 14.00 99915 05/01/1997 151561 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2013 09/30/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2 or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 2 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" "N" for no for ves or Other In-State In-State Out-of Out-of Medicai d Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state o 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Health Financial Systems CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151315 Peri od: Worksheet S-2 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/25/2016 9:46 am Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems CAMERON MEMORIAL COMMUNIT	Υ	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	F	eriod: rom 10/01/2013 o 09/30/2014	Date/Time Pre	epared:
		V 1.00	2/25/2016 9: 4 XI X	alli
95.00 If line 94 is "Y", enter the reduction percentage in the applicable col 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		1. 00 0. 00 N	2. 00 0. 00 N	95.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable col	umn.	0.00	0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive in the control of th	nethod of payment	Y N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimburser training programs? Enter "Y" for yes or "N" for no in column 1. (see in yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the reimbursed. If yes complete Wkst. D-2, Pt. II.	nstructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee so CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108. 00
Physi cal 1.00	0ccupational 2.00	Speech 3.00	Respi ratory 4.00	-
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	Y	109. 00
			1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstrate the current cost reporting period? Enter "Y" for yes or "N" for no.	ation project (410	OA Demo)for	N	110. 00
		1. 00	2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long	2 is "E", enter i term care (include	n column des	0	115. 00
psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.		n CMS		
116.00 s this facility classified as a referral center? Enter "Y" for yes or 117.00 s this facility legally-required to carry malpractice insurance? Enter no.		'N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	1 if the policy i	s 1		118. 00
	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	118. 01
110. OTELS Calmounts of marpractice premirums and pard rosses.	84,000			7116.01
118.02 Are mal practice premiums and paid losses reported in a cost center other and paid losses reported in a cost center other properties and constall a listing submit supporting cohodule listing		1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting schedule listing and amounts contained therein.	g cost centers			110.00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see in	"Y" for yes or the Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devious patients? Enter "Y" for yes or "N" for no.	ces charged to	Y		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "	'N" for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification of the polyment of the certification of the control of the certification of	rtification date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certified heart transplant center.	tification date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certain center.	tification date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certified lung transplant center.	fication date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the	certi fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the	e certification			131. 00
date in column 1 and termination date, if applicable, in column 2. 132.00 of this is a Medicare certified islet transplant center, enter the cert	tification date			132. 00
in column 1 and termination date, if applicable, in column 2. 133.00 f this is a Medicare certified other transplant center, enter the cer	tification date			133. 00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0P0), enter the 0P0 number and termination date, if applicable, in column 2.	er in column 1			134. 00
- 				

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE:		ORIAL COMMUNITY Provider	CCN: 151315	Peri od:		u of Form CMS- Worksheet S-	
					0/01/2013 9/30/2014	Part I Date/Time Pro 2/25/2016 9:	epared: 46 am
					1. 00	2.00	+
All Providers							
40.00 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. home office chain numb	If yes, and home per. (see instruc	office cos	ts	Y		140. 0
1.00 If this facility is part of a chai		2.00	ugh 142 +bo	nomo one	3. 00	of the	_
home office and enter the home off	3		9	Halle and	adul ess	or the	
41.00 Name:	Contractor's Name:			ctor's Nu	mber:		141. C
42. 00 Street: 43. 00 Ci ty:	PO Box: State:		Zip Coo	do:			142. C
+3. 00 01 ty.	State.		Z1 p CO				145.
						1.00	
44.00 Are provider based physicians' cos	ts included in Workshee	et A?				Y	144. (
					1. 00	2.00	-
45.00 If costs for renal services are cl					N		145. C
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	lude Medicare utilizati						
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	column 1. (See CMS Pub			lf	N		146. 0
47.00Was there a change in the statisti	cal basis? Entor "V" fo	or yes or "N" for	no			1. 00 N	147.
18.00Was there a change in the order of						N N	148.
9.00 Was there a change to the simplifi		? Enter "Y" for y	es or "N" f			N	149.
		Part A	Part B	T	itle V	Title XIX	4
Does this facility contain a provi	der that qualifies for	an exemption fro	m the appli	cation of	3.00 f the Lowe	4.00	
or charges? Enter "Y" for yes or "							
55.00 Hospi tal		N	N		N	N	155.
56.00 Subprovider – IPF 57.00 Subprovider – IRF		N N	N N		N N	N N	156. 157.
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. (
60.00HOME HEALTH AGENCY 61.00CMHC		N	N N		N N	N N	160. (
51. OO CWITC			I IN		IN	IN	101.
						1.00	
Multicampus 55.00 s this hospital part of a Multica	mnua haanital that haa	000 05 moss 00mn	unna in dif	Forant CD	2000	N	1,5
Enter "Y" for yes or "N" for no.	ilipus nospi tai that nas	one or more camp	uses in air	rerent ce	SAS?	IN IN	165. (
	Name	County		Zip Code	CBSA	FTE/Campus	
66.00 f ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,						0.0	100.
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
oor amir o (see Tristi dettoris)					1		
						1.00	
Health Information Technology (HIT 57.00 Is this provider a meaningful user				ent Act		Υ	 167. (
8.00 If this provider is a CAH (line 10	5 is "Y") and is a mear IT assets (see instruct	ningful user (lin tions)	e 167 is "Y				72168. (
reasonable cost incurred for the H	ot a meaningful user, o	does this provide	r qualify f	or a hard	Ishi p		168.
68.01 If this provider is a CAH and is n	Fn+on "\/" f '		I DSTELLON	5)		I	
reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u transition factor. (see instructio	ser (line 167 is "Y") a	'N" for no. (see and is not a CAH	(line 105 i	s´"N"), e	enter the	0.0	00169. 0
68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u	ser (line 167 is "Y") a	'N" for no. (see and is not a CAH	(line 105 i	s "N"), e	ginning 1.00	0. 0 Endi ng 2. 00	00169. (

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	FICATION DATA	Provi der CCN: 151315	Peri od: From 10/01/2013	Worksheet S-2 Part I	2
				Date/Time Pre	
				2/25/2016 9: 4	6 am
				1.00	
171.00 If line 167 is "Y", does this provider have	N	171. 00			
Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no.					
(see instructions)					

Heal th	Financial Systems	CAMERON MEMORIAL (COMMUNI TY		In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		_		Period: From 10/01/2013 Fo 09/30/2014	Worksheet S-2 Part II Date/Time Pre	2 epared:
					Y/N	2/25/2016 9: 4 Date	46 am
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	oonses. Enter N foi	all NO re	esponses. Enter	all dates in	the	
1. 00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of				N		1.00
	,	3	(Y/N	Date	V/I	
0.00			0.16	1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary. Is the provider involved in business transact	on and in column 3	, "V" for	N Y			2.00
	contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	d to the provider of the control of	orits he board				
				1.00	7ype 2. 00	3.00	
	Financial Data and Reports			1.00	2.00	3.00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for enter date availal	Compiled,	Y	A		4.00
5. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		t from	N			5. 00
	those on the filed financial statements? If y						
					Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6.00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N		6.00
7 00	the legal operator of the program?	2.16.112/11					7 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and		d during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s	n an approved grad	duate medio	cal education	N		9. 00
10.00	Was an approved Intern and Resident GME progr		enewed in t	the current	N		10.00
44 00	cost reporting period? If yes, see instruction		D				44.00
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		R in an App	proved	N		11. 00
	Treaching Trogram on norksheet X: Tr yes, see	Thisti deti ons.				Y/N 1.00	
	Bad Debts					1.00	
12. 00 13. 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb				st reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments	waived? If	fyes, see inst	ructions.	N	14. 00
15 00	Bed Complement Did total beds available change from the price	or cost reporting	neriod2 lf	vas saa instr	ructions	N	15. 00
13.00	pro total beds available change from the price	or cost reporting	perrou: II		rt A	Part B	13.00
		Descri pti	on	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	01/21/2015	Y	16. 00
17. 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			N		N	17. 00
18. 00	yes, enter the paid-through date 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			N		N	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of			N		N	19. 00
20. 00	other PS&R Report information? If yes, see instructions. 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

Health Financial Systems	CAMERON ME	MORIAL COMM	MUNI TY		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTIONNAIRE	P	rovi der		From 10/01/2013	Worksheet S-2 Part II Date/Time Pre 2/25/2016 9:4	pared:
				Pa	rt A	Part B	
	De	escription		Y/N	Date	Y/N	
		0		1.00	2. 00	3. 00	

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Home Office Costs .00 Were home office costs claimed on the cost report? .00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 1.00 2.00	. 00	If line 34 is yes, were there new agreements	or amended ex	kisting agreemen	ts with the pr	rovi der-based	Y	35.
Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office. If line 36 is yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO		physicians during the cost reporting period?	If yes, see i	nstructions.				
Home Office Costs 6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 8.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 9.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO						Y/N	Date	
Were home office costs claimed on the cost report? No. 00 Were home office costs claimed on the cost report? No. 01 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO						1. 00	2.00	
If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO		Home Office Costs						
If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO	. 00	Were home office costs claimed on the cost re	eport?			N		36.
If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO				prepared by the	home office?		1	37.
If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO	-	3 ·	· · ·				1	
the provider? If yes, enter in column 2 the fiscal year end of the home office. 16 line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 16 line 36 is yes, did the provider render services to the home office? If yes, see instructions. 1 line 36 is yes, did the provider render services to the home office? If yes, see instructions. 1 loo 2 loo 3 loo	. 00		of the home of	fice different	from that of		1	38.
2.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO							1	1
see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO	9. 00						ĺ	39.
1.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO					<i>y</i>			
instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO	0. 00		ervices to the	home office?	If ves. see			40.
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO	ļ				J .			
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. .00 Enter the employer/company name of the cost report BLUE & CO								
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. .00 Enter the employer/company name of the cost report BLUE & CO				1.	00	2.	00	
Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. BLUE & CO Enter the first name, last name and the title/position KYLE SMITH SMITH		Cost Report Preparer Contact Information						
held by the cost report preparer in columns 1, 2, and 3, respectively. .00 Enter the employer/company name of the cost report BLUE & CO	. 00	Enter the first name, last name and the title	e/position	KYLE		SMI TH		1 41.
respectively. 1.00 Enter the employer/company name of the cost report BLUE & CO								
2.00 Enter the employer/company name of the cost report BLUE & CO			., _, and o,					
	00		report	BLUE & CO				42.
	50	preparer.	opor t	1202 4 00				72.
3.00 Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM	3 00		of the cost	317-713-7957		KCSMLTH@RLUFANI	DCO COM	43.
report preparer in columns 1 and 2, respectively.								'5.

						From 10/01/2013 To 09/30/2014	Part II Date/Time Pre 2/25/2016 9:4	
		Part B			•			
		Date						
		4. 00						
	PS&R Data							
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	01/21/2015						16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)							17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.							18. 00
19. 00	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.							19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:							20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.							21. 00
				3. 00				
	Cost Report Preparer Contact Information			3.00				
	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		MANAGE	R				41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report						42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective							43. 00

 Heal th Financial
 Systems
 CAMERON

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 151315

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared:

Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Available	1. 00
Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Available	1. 00
Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Available	1. 00
	1. 00
1.00 2.00 3.00 4.00 5.00	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
	3. 00
	4. 00
	5. 00
	6. 00
	7. 00
beds) (see instructions)	
8.00 INTENSIVE CARE UNIT 31.00 2 730 2,592.00 0 8	8. 00
9.00 CORONARY CARE UNIT	9. 00
	0. 00
	1. 00
	2. 00
	3. 00
	4. 00
	5. 00 6. 00
	7. 00
	8. 00
	9. 00
	0.00
	1. 00
	2. 00
23. 00 AMBULATORY SURGI CAL CENTER (D. P.)	3. 00
24. 00 HOSPICE 116. 00 0 0 2.	4. 00
24. 10 HOSPICE (non-distinct part) 30. 00 2	4. 10
	5. 00
	6. 00
	6. 25
	7. 00
	8. 00
	9. 00
	1. 00
	2. 00
	2. 00
outpati ent days (see instructions)	2.01
	3. 00

Provi der CCN: 151315 | Peri od: | Worksheet S-3 | Part | | Provi der CCN: 151315 | Prom 10/01/2013 | Part | Prepared: | Provider CCN: 151315 | Provider CCN: 15

				'	0 07/30/2014	2/25/2016 9: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	o am
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	55p6.15112			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 105	189	3, 197			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.0		649	413				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	320	0	320			5. 00
6.0	Hospital Adults & Peds. Swing Bed NF		0	251			6. 00
7.0	Total Adults and Peds. (exclude observation	1, 425	189	3, 768			7. 00
	beds) (see instructions)						
8.00		38	13	108			8. 00
9.00	CORONARY CARE UNIT						9. 00
10. (OO BURN INTENSIVE CARE UNIT						10. 00
11. (11. 00
12. (12.00
13. (32	361			13. 00
14. (00 Total (see instructions)	1, 463	234	4, 237	0. 00	308. 39	14.00
15. (0	0	0			15. 00
16. (OO SUBPROVI DER - I PF						16. 00
17. (17. 00
18. (18. 00
19. (19. 00
20. (•						20. 00
21. (21. 00
22. (2, 864	0	5, 709	0.00	9. 41	
23. (` ′						23. 00
24. (0	0	0	0.00	2. 10	
24.		0	0	0			24. 10
25. (25. 00
26. (0	0	0	0.00		
26. :		0	0	0			
27. (,				0.00	319. 90	
28. (80	620			28. 00
29. (0					29. 00
30. (, , , , , , , , , , , , , , , , , , , ,			0			30.00
31. (0			31. 00
32.		0	0	0			32. 00
32. (0			32. 01
0.0	outpatient days (see instructions)						00.00
33. (00 LTCH non-covered days	0	I		l	I	33. 00

 Heal th Financial
 Systems
 CAMERON

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 151315

				To	09/30/2014	Date/Time Prep 2/25/2016 9:40	
		Full Time		Di sch	arges	2/23/2010 7. 40	J dill
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12.00	13.00	14.00	15. 00	
1. 00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and		0	398	76	1, 192	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)			206	186		2. 00
3.00	HMO IPF Subprovider			200	0		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		200	7.	4 400	13.00
14. 00	Total (see instructions)	0. 00	0	398	76	1, 192	14. 00
15.00	CAH visits						15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF						16. 00 17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY			•			19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days						33. 00
55. 55	2.55.1 6676164 4435	I		1	ı	l	33.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA			CCN: 151315 t CCN: 157117	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S-4 Date/Time Pre 2/25/2016 9:4	pared:
					Home Health	PPS	o aiii
					Agency I		
					1.	00	-
0.00	County			1	STUEBEN		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1.00	Home Health Aide Hours	0			0 0		
2.00	Unduplicated Census Count (see instructions)	0. 00	121.00		0.00 0.00 0.00 0.00 0.00		2. 00
				Number of En	iproyees (ruir ii	ille Equi varent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal					
)	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		<i>S</i>	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		0.00			0.00	
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			1. 3.		1. 00 3. 00	
6. 00	Direct Nursing Service			3.		3. 67	
7. 00	Nursi ng Supervi sor			0.		0.00	
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			1.		1. 34 0. 00	
10.00	Occupational Therapy Service			0.		0.00	
11. 00	Occupational Therapy Supervisor			0.	0.00	0.00	
12.00	Speech Pathology Service			0.			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.		0. 00 0. 74	13. 00 14. 00
15. 00	Medical Social Service Supervisor			0.			15. 00
16.00	Home Heal th Ai de			1.			16.00
17. 00 18. 00	Home Health Aide Supervisor VOLUNTEER			0. 0.			17. 00 18. 00
10.00	HOME HEALTH AGENCY CBSA CODES			0.	0.00	0.04	10.00
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			99915			20.00
	during this cost reporting period (line 20 contains the first code).						
	contains the mist code).	Full Ep	oi sodes				
		Without Outliers	With Outliers	LUPA Epi sode	es PEP Only Enisodes	Total (cols. 1-4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	PPS ACTIVITY DATA	7.0				0.5.4	
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	768 130, 249			32 12 91 1, 944	954 157, 660	
23. 00	Physical Therapy Visits	1, 159			17 9	1, 256	
24. 00	Physical Therapy Visit Charges	227, 872				246, 965	
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	139 27, 404		•	0 0	188 37, 134	
27. 00	Speech Pathology Visits	30		1	0 0	43	1
28. 00	Speech Pathology Visit Charges	5, 957	2, 383	1	0 0	8, 340	28. 00
29. 00 30. 00	Medical Social Service Visits	33 8, 138		3	0 0	41	29. 00 30. 00
31. 00	Medical Social Service Visit Charges Home Health Aide Visits	314			1 9	10, 111 382	1
32. 00	Home Health Aide Visit Charges	16, 241		5	53 420	19, 710	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	2, 443	241	1	50 30	2, 864	33. 00
34. 00	29, and 31) Other Charges	0	(0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	415, 861		20, 4	-	479, 920	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	124			40 3	167	36. 00
37. 00	· •			1	0	4	
38. 00	Total Non-Routine Medical Supply Charges	8, 617	142	3, 0	09 1	11, 769	38. 00

Heal th	Financial Systems		CAMERON MEMORI.	AL COMMUNITY		In Li∈	eu of Form CMS-2	2552-10
HOSPI 7	TAL IDENTIFICATION DATA				CCN: 151315 t CCN: 151561	Peri od: From 10/01/2013 To 09/30/2014		pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled	Title XIX Nursing	All Other	Total (sum of cols. 1, 2 &	
				Nursing Facility	Facility		5)	
		1.00	2.00	3. 00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	C)	0 0	0	1.00
2.00	Routine Home Care	1, 710	184	1, 067	1	45 232	2, 126	2. 00
3.00	Inpatient Respite Care	0	0	C		0 0	0	3. 00
4.00	General Inpatient Care	0	0	C		0 0	0	4.00
5.00	Total Hospice Days	1, 710	184	1, 067	1	45 232	2, 126	5. 00
	Part II - CENSUS DATA							
			_					1

3

61.33

0

10

0.00

106. 70

0

11

13. 18

0

11

21.09

0

6.00

7. 00

8.00

9. 00

65

32.71

51

51

0.00

33. 53

51

Number of Patients Receiving Hospice Care

to Medicare Average Length of Stay (line 5/line 6)

Unduplicated Census Count

Total Number of Unduplicated Continuous Care Hours Billable

6.00

7.00

8.00

9.00

Heal th	Financial Systems CAMERON MEMORIAL CO	MMUNI TY		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151315	Peri od:	Worksheet S-10	0
				From 10/01/2013 To 09/30/2014	Date/Time Prep 2/25/2016 9:40	
					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 column	1 8)	0. 420624	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				2, 286, 642	2.00
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?				2, 280, 042	3.00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental	navments	from Medicaio	12		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	1 2	TTOII WCarcarc	• •	0	5.00
6.00	Medicaid charges	mour our u			8, 167, 563	
7.00	Medicaid cost (line 1 times line 6)				3, 435, 473	1
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, 148, 831	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	
10.00	Stand-alone SCHIP charges				0	
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (lino 11 m	inus lina O	if a zoro thon	0	11. 00 12. 00
12.00	lenter zero)	TITIE II III	THUS TITLE 9,	II < Zel O tileli	U	12.00
	Other state or local government indigent care program (see instr	uctions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not inclu				0	13. 00
14.00	Charges for patients covered under state or local indigent care				0	14. 00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local indi	gent care	program (lir	ne 15 minus line	0	16. 00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fun	ndi ng char	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of ho				0	•
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	1, 148, 831	
. ,	8, 12 and 16)	a. goc	oar o program	(34 31 111133	., ,	. ,
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
20.00	T-+-1 :-: +: -1: +:	6.11	1.00	2. 00	3. 00	20.00
20.00	Total initial obligation of patients approved for charity care (charges excluding non-reimbursable cost centers) for the entire		1, 266, 85	57, 313	1, 324, 167	20.00
21. 00	Cost of initial obligation of patients approved for charity care		532, 86	24, 107	556, 976	21 00
21100	times line 20)	(002,00	21,107	333, 773	200
22. 00	Partial payment by patients approved for charity care			0 0	0	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		532, 86	59 24, 107	556, 976	23. 00
					4 00	
24. 00	Does the amount in line 20 column 2 include charges for patient	days hevo	nd a Length o	of stay limit	1. 00	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care p		na a rength c	71 Stay IIIIII t		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigen	9	ogram's Lengt	h of stay limit	0	25. 00
26. 00				, and the second	5, 114, 367	26. 00
27. 00	Medicare bad debts for the entire hospital complex (see instruct	i ons)			362, 470	27. 00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin				4, 751, 897	
	10 . 6	maa (lina	1 +: maa li ma	20)	1, 998, 762	29. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (iine	i times iine	; 20)		
29. 00 30. 00		,	i times iine	: 20)	2, 555, 738 3, 704, 569	30. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNITY		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O			CCN: 151315 P	eri od:	Worksheet A	
				rom 10/01/2013 o 09/30/2014	Date/Time Pre	narod:
				0 09/30/2014	2/25/2016 9: 4	
Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	Reclassi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
OFFICE AND ASSESSED OF A SENTERO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT		2 400 251	2 400 251	1 207 001	1 200 450	1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP		2, 488, 251 1, 066, 515			1, 200, 450 2, 674, 550	1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	o	5, 125, 602			5, 125, 602	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	3, 157, 818	5, 064, 051			8, 636, 648	5. 00
7. 00 00700 OPERATION OF PLANT	497, 527	1, 409, 779			1, 929, 213	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	158, 623			158, 623	8. 00
9. 00 00900 HOUSEKEEPI NG	447, 162	190, 520			637, 682	9. 00
10. 00 01000 DI ETARY	376, 007	347, 421	723, 428	-612, 940	110, 488	10.00
11. 00 01100 CAFETERI A	0	0	1	0,2,0.0	572, 513	11. 00
13.00 01300 NURSING ADMINISTRATION	727, 436	64, 457			791, 893	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	126, 176	83, 253			209, 429	14. 00
15. 00 01500 PHARMACY	394, 839	1, 608, 236			2, 003, 075	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	288, 527	226, 279	514, 806	0	514, 806	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 460, 247	1, 093, 699	2, 553, 946	385, 371	2, 939, 317	30.00
31. 00 03100 NTENSI VE CARE UNIT	1, 460, 247	1, 093, 099 0	2, 555, 946			31.00
43. 00 04300 NURSERY	0	0	1	, , , , ,	49, 012	43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	47,012	47,012	43.00
50. 00 05000 OPERATI NG ROOM	1, 533, 952	1, 687, 415	3, 221, 367	-649, 803	2, 571, 564	50. 00
51.00 05100 RECOVERY ROOM	0	0	C	649, 803	649, 803	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	586, 884	99, 434	686, 318	-516, 871	169, 447	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 318, 028	936, 699	2, 254, 727	0	2, 254, 727	54.00
60. 00 06000 LABORATORY	859, 891	1, 212, 951	2, 072, 842	0	2, 072, 842	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	O C	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	39, 263	737, 724	776, 987		599, 839	65. 00
65. 01 06501 SLEEP LAB	0	0	0	164, 735	164, 735	65. 01
66. 00 06600 PHYSI CAL THERAPY	560, 427	27, 543			587, 970	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	51, 535	252, 514 20, 825			264, 927 72, 360	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 278, 201			814, 995	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 270, 201	1, 270, 201	463, 206	463, 206	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	l ol	0	i c	0	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	123, 208	9, 953	133, 161	0	133, 161	76. 00
76. 01 03021 ONCOLOGY	o	1, 714, 718			1, 714, 718	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	O C	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
90. 00 09000 CLI NI C	117, 453	26, 166			143, 619	90.00
91. 00 09100 EMERGENCY	1, 390, 500	263, 263	1, 653, 763	2, 700	1, 656, 463	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
101.00 10100 HOME HEALTH AGENCY	645, 088	94, 846	739, 934	-75, 869	664, 065	101 00
SPECIAL PURPOSE COST CENTERS	043,000	74, 040	737, 734	-73,007	004, 003	101.00
113. 00 11300 NTEREST EXPENSE		212, 605	212, 605	-212, 605	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	o	0		0		114. 00
116. 00 11600 HOSPI CE	123, 698	28, 768	152, 466	-24, 885	127, 581	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14, 825, 666	27, 530, 311	42, 355, 977	403, 134	42, 759, 111	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	C	0		194. 00
194. 01 07951 MOB	0	25, 602				194. 01
194. 02 07952 COMMUNITY HEALTH	76, 938	8, 223	85, 161	0	85, 161	
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	07 104	77 724	174 042	100 770		194. 03
194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG	97, 106 123, 168	77, 736 396, 507			51, 064 401, 299	
194. 06 07956 GUEST MEALS	123, 100	370, 307 O	317, 0/3	40, 427	401, 299	
194. 07 07957 OUTSI DE LAUNDRY		0		10, 42/		194. 00
194. 08 07958 CANCER CENTER		0	0			194. 07
194. 09 07959 URGENT CARE	738, 438	582, 417	1, 320, 855	-179, 500		
200.00 TOTAL (SUM OF LINES 118-199)	15, 861, 316	28, 620, 796			44, 482, 112	
	·			·		

Peri od: From 10/01/2013 To 09/30/2014 Worksheet A Date/Ti me Prepared: 2/25/2016 9:46 am

				2/25/2016 9: 4	46 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	1			
1. 00	00100 CAP REL COSTS-BLDG & FIXT	-200, 126			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-363, 323			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-184, 945			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 130, 933			5. 00
7. 00	00700 OPERATION OF PLANT	-3, 300			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0	637, 682		9. 00
10.00	01000 DI ETARY	-9, 968	1	l e e e e e e e e e e e e e e e e e e e	10.00
11. 00	01100 CAFETERI A	-210, 234		l e e e e e e e e e e e e e e e e e e e	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0		l control of the cont	14. 00
15.00	01500 PHARMACY	-115, 430			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-402	514, 404		16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F41 00/	2 207 421	T	1 20 00
30.00	03000 ADULTS & PEDIATRICS	-541, 886			30.00
31.00	03100 NTENSIVE CARE UNIT	0			31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	49, 012	4	43. 00
50. 00	05000 OPERATING ROOM	-1, 137, 056	1, 434, 508		50.00
51. 00	05100 RECOVERY ROOM	-1, 137, 030			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			i de la companya del companya de la companya de la companya del companya de la co	54. 00
60.00	06000 LABORATORY	-9, 333			60.00
64. 00	06400 NTRAVENOUS THERAPY	-7, 333	2,003,307		64. 00
65. 00	06500 RESPI RATORY THERAPY		_		65. 00
65. 01	06501 SLEEP LAB		1		65. 01
66. 00	06600 PHYSI CAL THERAPY		1		66.00
69. 00	06900 ELECTROCARDI OLOGY		1		69. 00
69. 01	06901 CARDI AC REHAB				69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS				73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0	133, 161		76. 00
76. 01	03021 ONCOLOGY	0	1, 714, 718	3	76. 01
	OUTPATIENT SERVICE COST CENTERS	•			
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	0	143, 619		90.00
91. 00	09100 EMERGENCY	-1, 862	1, 654, 601		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS			,	
101.00	10100 HOME HEALTH AGENCY	0	664, 065		101. 00
	SPECIAL PURPOSE COST CENTERS	ı	1	1	
	11300 I NTEREST EXPENSE	0	1	l e e e e e e e e e e e e e e e e e e e	113. 00
	11400 UTILIZATION REVIEW-SNF	0			114. 00
	11600 H0SPI CE	0	,	i de la companya del companya de la companya de la companya del companya de la co	116.00
118. 00	,	-4, 908, 798	37, 850, 313	3	118. 00
400.00	NONREI MBURSABLE COST CENTERS			N. C.	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		l e e e e e e e e e e e e e e e e e e e	190.00
	07950 DAYCARE-I NFANT/TODDLER	0			194. 00
		0			194. 01
	207952 COMMUNITY HEALTH 807953 ASSISTED LIVING/CAMERON WOODS	0		1	194. 02
	107953 ASSESTED LEVENG/CAMERON WOODS	0	1		194. 03
		0			194. 04 194. 05
	07955 MARKETI NG 07956 GUEST MEALS	0	1		194. 05
	7 07956 GUEST MEALS 	0	40, 427 0		194. 06
	07957 OUTSIDE LAUNDRY BO7958 CANCER CENTER		1		194. 07
	0/958 CANCER CENTER				194. 08
200.00		-4, 908, 798			200.00
200.00	I TOTAL (SUM OF LINES 110-177)	-4, 700, 790	1 37, 373, 314	'I	1200.00

| Peri od: | Worksheet A-6 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: Provi der CCN: 151315

					To 09/30/2014 [Date/Time Prepared: 2/25/2016 9:46 am
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2.00	3.00	4.00	5. 00		
1. 00	A - LABOR AND DELIVERY ADULTS & PEDIATRICS	30.00	397, 767	67, 392		1.00
2. 00	NURSERY	43.00	41, 911	7, 101		2.00
3.00	EMERGENCY	91.00	2, 309	391		3. 00
0.00	0	— — /// —	441, 987	74, 884		0.00
	B - PROPERTY INSURANCE	'		,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70, 857		1.00
	0		0	70, 857		
	C - CAFETERIA					
1. 00	CAFETERI A	11.00	297, 568	274, 945		1. 00
2.00	GUEST MEALS	194.06	21, 012	19, 415		2. 00
	0		318, 580	294, 360		
1 00	D - INTEREST EXPENSE	1 00		170.050		1.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	170, 850 41, 755		1.00
2.00	CAP KEL COSTS-MVBLE EQUIP			4 <u>1, 755</u> 212, 605		2.00
	E - DEPRECIATION EXPENSE		<u> </u>	212, 003		
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 566, 280		1.00
00	0	— — 	 	1, 566, 280		1.00
	F - ICU		-1	.,,		
1.00	INTENSIVE CARE UNIT	31.00	45, 620	34, 168		1. 00
	0 — — — — —	T = T	45, 620	34, 168		
	G - ADVERTISING COST					
1.00	ADMI NI STRATI VE & GENERAL		2 <u>0, 3</u> 97	10 <u>5, 8</u> 53		1.00
	0		20, 397	105, 853		
	H - PROPERTY TAX					
1. 00	CAP REL COSTS-BLDG & FIXT		0	<u>36, 772</u>		1.00
	0		0	36, 772		
1 00	I - EDUCATION COSTS	F 00	07.104	24 472		1 00
1. 00	ADMI NI STRATI VE & GENERAL	5.00	9 <u>7, 1</u> 06 97, 106	<u>26, 6</u> 72 26, 672		1.00
	J - SLEEP LAB		97, 100	20, 072		
1.00	SLEEP LAB	65. 01	O	164, 735		1. 00
2.00	ELECTROCARDI OLOGY	69. 00	o	12, 413		2. 00
2.00	0	<u> </u>	 	177, 148		2.00
	K - UTILITIES	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	,		
1. 00	OPERATION OF PLANT	7.00	0	21, 907		1. 00
	0			21, 907		
	L - PUBLIC RELATIONS					
1. 00	MARKETING	194. 05	0	<u>7, 8</u> 74		1. 00
	0		0	7, 874		
	M - MSW					
1. 00	HOME HEALTH AGENCY	101.00	25, 731	0		1. 00
	N - RECOVERY ROOM		25, 731	U		
1. 00	RECOVERY ROOM	51.00	649, 803	0		1. 00
1.00	n Recovery Room		649, 803	0		1.00
	O - IMPLANTABLE DEVICES		047,003	٥		
1. 00	IMPL. DEV. CHARGED TO	72.00	0	463, 206		1. 00
00	PATIENTS	,2:00	٩	100, 200		
				463, 206		
	P - HOME HEALTH					
1.00	ADMI NI STRATI VE & GENERAL	5. 00	100, 754	0		1. 00
	0		100, 754	0		
	Q - URGENT CARE	1				
1.00	ADMI NI STRATI VE & GENERAL		179, 500	0		1.00
	U LIGORI CE DECLACO		179, 500	0		
1 00	R - HOSPI CE RECLASS	11/ 00	04/			1 00
1. 00	HOSPICE	116.00	846	0		1.00
500 00	Grand Total: Increases		1, 880, 324	3, 092, 586		500.00
JUU. UU	prana rotar. Hicheases	1	1, 000, 324	3, 072, 300		500.00

Peri od: Worksheet A-6
From 10/01/2013
To 09/30/2014 Date/Time Prepared: 2/25/2016 9: 46 am

	-					2/25/2016 9:	46 am
		Decreases					
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	- LABOR AND DELIVERY						
	ELIVERY ROOM & LABOR ROOM	52.00	441, 987	74, 884			1.0
00		0.00	0	0	-		2. 0
00		0.00	0_	0	0		3. 0
0			441, 987	74, 884			_
	- PROPERTY INSURANCE		-1		11		
00 AI	DMINISTRATIVE & GENERAL		0	7 <u>0, 8</u> 57			1.0
0			0	70, 857			_
	- CAFETERI A	40.00	040 500	224 242			٠.,
	I ETARY	10.00	318, 580	294, 360			1. (
0		0.00	0_	0			2. (
0			318, 580	294, 360			_
	- INTEREST EXPENSE				1		
	NTEREST EXPENSE	113. 00	0	212, 605			1. (
0			•	0			2.0
0			0	212, 605			╛
	- DEPRECIATION EXPENSE						
0 <u>C</u>	AP REL COSTS-BLDG & FIXT	1.00	•	1, 566, 280	9		1.0
0			0	1, 566, 280			
	- ICU						
0 AI	DULTS & PEDIATRICS	30. 00	45, 620	3 <u>4, 1</u> 68			1. (
0			45, 620	34, 168			
	- ADVERTISING COST						
00 M	ARKETING	1 <u>94.</u> 05	2 <u>0, 3</u> 97	10 <u>5, 8</u> 53			1. (
0			20, 397	105, 853			
	- PROPERTY TAX						
0 AI	DMINISTRATIVE & GENERAL	500	0	3 <u>6, 7</u> 72			1. (
0			0	36, 772			
I	- EDUCATION COSTS						
0 EI	DUCATION	194. 04	97, 106	<u> 26, 6</u> 72			1. (
0			97, 106	26, 672			
J	- SLEEP LAB						
) RI	ESPI RATORY THERAPY	65.00	0	177, 148	0		1. (
)		0.00	0	0	0		2. (
0				177, 148			1
K	- UTILITIES						
о М	OB	194. 01	0	21, 907	0		1. (
0				21, 907			
L	- PUBLIC RELATIONS	<u> </u>					
	DMINISTRATIVE & GENERAL	5.00	0	7, 874	0		1. (
0							
М	- MSW						
	OSPI CE	116.00	25, 731	0	0		1.0
0			25, 731				
N	- RECOVERY ROOM						
	PERATING ROOM	50.00	649, 803	0	0		1.0
0			649, 803				
0	- IMPLANTABLE DEVICES		017,000				
	EDICAL SUPPLIES CHARGED TO	71.00	0	463, 206	0		1.0
	ATI ENT	71.00		403, 200			''
0	<u> </u>	+		463, 206			
P	- HOME HEALTH		<u> </u>	100, 200			
	OME HEALTH AGENCY	101.00	100, 754	0	0		1.0
	OIIIE TIEXETTI NOENOT	— — 1011. 00	100, 754	— — <u> </u>			'''
0	- URGENT CARE		100, 734				
	RGENT CARE	194. 09	179, 500	0			1.
	NOLIVI OAKL		179, 500	0	0		'. '
ר	- HOSPICE RECLASS		179, 000	0			\dashv
	OME HEALTH AGENCY	101. 00	846	^			1. (
0 H	OWL HEALTH AGENCY			0	0		1.0
1()			1, 880, 324	3, 092, 586			500.0
3 00 E	rand Total: Decreases						

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

					rom 10/01/2013 To 09/30/2014		pared:
						2/25/2016 9: 4	6 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				T		
1.00	Land	750, 190	0	(0	0	1. 00
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	30, 866, 978	19, 675	(19, 675	1, 555, 613	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fi xed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	17, 426, 469	27, 164, 205	(27, 164, 205	262, 661	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	49, 043, 637	27, 183, 880	(27, 183, 880	1, 818, 274	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	49, 043, 637	27, 183, 880	(27, 183, 880	1, 818, 274	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	750, 190	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	29, 331, 040	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	44, 328, 013	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	74, 409, 243	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	74, 409, 243	0				10. 00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet A-7 Part II Date/Time Prep	pared:
			CI	IMMADY OF CAP	N TAI	2/25/2016 9: 46	6 am
			SL	JMMARY OF CAP	'I IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 488, 251	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	ol	2.00
3.00	Total (sum of lines 1-2)	2, 488, 251	0		0 0	ol	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum			İ	
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 488, 251				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 066, 515	1, 066, 515				2.00
	1	4 0// 545	0 1 -//	I .		,	

0 1, 066, 515 1, 066, 515

2, 488, 251 1, 066, 515 3, 554, 766

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 10/01/2013 To 09/30/2014		nared.
						2/25/2016 9: 4	
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col .			
		1.00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	30, 081, 230	0	30, 081, 230	0. 404402	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	44, 303, 241				0	2. 00
3.00	Total (sum of lines 1-2)	74, 384, 471		74, 384, 47			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	-NIERS		ı .	892, 695	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXI	0	0		0 1, 244, 712		2. 00
3.00	Total (sum of lines 1-2)	0	0		2, 137, 407		3. 00
<u> </u>			SL	JMMARY OF CAPI		_	7. 7.
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	Soot Sonton Boson Pt. on				Capi tal -Rel ate		
			,	,	d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		70.057	27.77		1 000 004	1 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0				1, 000, 324	1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)		_		-,,		2. 00 3. 00
3.00	Total (Sum Of Titles 1-2)	1	10,637	J 30, 77.	2, 1,000,313] 3,311,331	3.00

 DMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet A-8

 From 10/03/2014
 Date/Time Prepared:

				To	09/30/2014		pared:
				Expense Classification on		2/25/2016 9: 46	o alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 A	2. 00 -170. 850	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-41, /55	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3.00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		Ö				
6. 00	Rental of provider space by suppliers (chapter 8)	В	-29, 819	CAP REL COSTS-MVBLE EQUIP	2. 00	9	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	О	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 688, 275			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-387, 105			0	12. 00
	transactions (chapter 10)	A 0 1	307, 103				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В В	-179 222	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0	SALETERIA.	0. 00	ō	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than	В	-115, 430	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and	В	402	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts	В	-402	MIEDI CAE RECORDS & ELBRART			
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	-29, 052	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		O		0. 00	0	21. 00
22.00	charges (chapter 21)		0		0.00		22.00
22. 00	Interest expense on Medicare overpayments and borrowings to		U		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	O	RESTRATORT THERALT	03.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
21.00	therapy costs in excess of	7. 5 5	· ·	THISTORE THEIR T	00.00		21.00
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00	J	30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for	А	-133, 141	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
33. 00	Depreciation and Interest LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	EMPLOYEE CHRISTMAS PARTY	A		ADMINISTRATIVE & GENERAL	5. 00		33. 00
		<u> </u>				<u> </u>	

					0 77 307 2014	2/25/2016 9: 40	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	0 1 0 1 5 11	D : (0 (0)		0 1 0 1	1. "	W . A 7 D C	
	Cost Center Description	Basi s/Code (2)		Cost Center		Wkst. A-7 Ref.	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00		33. 02
33. 03	MEALS ON WHEELS	В	-9, 448	DI ETARY	10. 00	0	33. 03
33. 04	BREAKFAST CART	В	-520	DI ETARY	10. 00	0	33. 04
33. 05	REIMBURSEMENT FOUNDATION	В	-47, 674	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
	DEVELOPMENT						
33.06	RENTAL INCOME OFFSET - CANCER	В	-29, 276	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 06
	CENTER						
33.07	ATM SURCHARGE REVENUE	В	-1, 295	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33.08	OP EDUCATION	В	-730	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 08
33. 09	EMS	В	-1, 862	EMERGENCY	91.00	0	33. 09
33. 10			0		0.00		33. 10
	DIETICIAN CONSULTATIONS	В	-1. 960	CAFETERI A	11. 00		
	HAF EXPENSE	l A	·	ADMINISTRATIVE & GENERAL	5. 00		33. 12
50.00	1	l .	-4, 908, 798	1	0.00		50.00
55.00	(Transfer to Worksheet A,		., 700, 770				00.00
	column 6, line 200.)						
	33. 4 3, 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions).
 - A. Costs if cost, including applicable overhead, can be determined.
- B. Amount Received if cost cannot be determined.
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 151315 Perio	od:	Worksheet A-8	-1
	10/01/2013		
То	09/30/2014		
		2/25/2016 9:4	<u>6 am</u>
Line No. Cost Center Expense I tems Ai	mount of	Amount	
Allo	owable Cost	Included in	
	V	Wks. A, column	
		5	
1.00 2.00 3.00	4. 00	5. 00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANI	ZATIONS OR (CLAIMED	
HOME OFFICE COSTS:			
1.00 4.00 EMPLOYEE BENEFITS DEPARTMENT CMO OVERHEAD - BENEFITS	0	184, 215	1.00
2.00 5.00 ADMINISTRATIVE & GENERAL CMO OVERHEAD - A&G	o	40, 982	2.00
3.00 7.00 PERATION OF PLANT CMO OVERHEAD - PLANT OPS	0	3, 300	3.00

* 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.

0

RENT PAID TO CMO

29,048

29,048

187, 656

416, 153

4.00

5.00

·			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 OFFICE:			

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

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

6. 00	С	CAMERON MEDICAL	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

2.00 CAP REL COSTS-MVBLE EQUIP

- 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.

4.00

5.00

Heal th	Financial Syste	ems		CAMERON MEMOR	TAL COMMUNITY	,		In Lie	u of Form CMS	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ZATIONS AND HON	IE Provi d	er CCN:	: 151315	Peri od:	Worksheet A-	8-1
OFFICE	COSTS							From 10/01/2013	D 1 (T' D	
								To 09/30/2014	Date/Time Pr 2/25/2016 9:	
	N - ±	WI+ A 7 D-6							2/23/2010 9.	40 alli
		Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED A	AS A RESULT OF	TRANSACTI ONS	WI TH	RELATED C	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:								
1.00	-184, 215	0								1. 00
2.00	-40, 982	0								2. 00
3.00	-3, 300	0								3. 00
4.00	-158, 608	9								4. 00
5.00	-387, 105									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		
Type of Business		
Type of Business		
6. 00		1
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

						0 09/30/2014	2/25/2016 9:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	60. 00	LABORATORY	18, 000	9, 333	8, 667	0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	578, 386	541, 886	36, 500	0	0	2. 00
3.00	50. 00	OPERATING ROOM	1, 167, 056	1, 137, 056	30,000	0	0	3. 00
4.00	0. 00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 763, 442	1, 688, 275	75, 167		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		LABORATORY	0		-			
2.00		ADULTS & PEDIATRICS	0		0	0	1	
3.00		OPERATING ROOM	0	0	0	0	0	0.00
4.00	0. 00		0	0	0	0	0	
5. 00	0. 00		0	0	0	0	0	0.00
6. 00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	1
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	7.00
10. 00	0. 00		0	0	0	0	0	1
200.00		15.	0	0	0	0	0	200.00
	Wkst. A Line #	3	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		LABORATORY	13.00			9, 333		1. 00
2. 00		ADULTS & PEDIATRICS		1	-	541, 886	•	2. 00
3. 00		OPERATING ROOM			-	1, 137, 056		3. 00
4. 00	0.00				0	1, 137, 030	1	4. 00
5. 00	0.00				0	0		5. 00
6. 00	0.00				0	0		6.00
7. 00	0.00				0	0		7. 00
8. 00	0.00		0		0	0		8. 00
9. 00	0.00				n	0		9.00
10. 00	0.00				0	0		10.00
200.00	3.00				· ·	1, 688, 275		200.00
200.00	I	I		1		1,000,270	I	1 200. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY E SUPPLIERS	Provi der CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet A-8 Parts I-VI Date/Time Pre 2/25/2016 9:4	pared:
			Respi ratory Therapy	Cost	
				1. 00	
	PART I - GENERAL INFORMATION				
1. 00 2. 00	Total number of weeks worked (excluding aides) (see instruct Line 1 multiplied by 15 hours per week	i ons)		52 780	1. 00 2. 00
3. 00	Number of unduplicated days in which supervisor or therapist	was on provider site (se	e instructions)	365	
4.00	Number of unduplicated days in which therapy assistant was o			0	4. 00
5. 00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or thera	niete (ega instructions)		0	5. 00
6. 00	Number of unduplicated offsite visits - therapy assistants (by therapy	0	6.00
	assistant and on which supervisor and/or therapist was not p	resent during the visit(s)) (see		
7. 00	instructions) Standard travel expense rate			3. 25	7.00
8.00	Optional travel expense rate per mile			0. 00	
	Supervi sors	Therapists Assistants		Trai nees	
9. 00	1. 00 Total hours worked 2, 078. 00	2. 00 3. 00 18, 616. 16 0.	4. 00 00 0. 00	5. 00	9. 00
10.00	AHSEA (see instructions) 60.84	•	00 0.00	0. 00	
11. 00	Standard travel allowance (columns 1 and 2, 30.42	30. 42 0.	00		11. 00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)				
12. 00	Number of travel hours (provider site) 0	О	0		12. 00
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site) 0	0	0		12. 01 13. 00
	Number of miles driven (offsite)				13. 00
	Part II - SALARY EQUIVALENCY COMPUTATION			1. 00	
14. 00	Supervisors (column 1, line 9 times column 1, line 10)			126, 426	14. 00
15.00	Therapists (column 2, line 9 times column 2, line 10)			1, 132, 607	
16. 00 17. 00	Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respir	atory therapy or lines 14	-16 for all	0 1, 259, 033	16. 00 17. 00
	others)	a.c.,		., 20,, 000	'''
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18. 00 19. 00		
19. 00 20. 00	Trainees (column 5, line 9 times column 5, line 10) Total allowance amount (sum of lines 17–19 for respiratory t	herapy or lines 17 and 18	for all others)	1, 259, 033	•
	If the sum of columns 1 and 2 for respiratory therapy or col	umns 1-3 for physical the	rapy, speech path		
	occupational therapy, line 9, is greater than line 2, make note that the amount from line 20. Otherwise complete lines 21-23.	o entries on lines 21 and	22 and enter on	Tine 23	
21. 00	Weighted average rate excluding aides and trainees (line 17	9	1 and 2, line 9	0.00	21. 00
22. 00	for respiratory therapy or columns 1 thru 3, line 9 for all Weighted allowance excluding aides and trainees (line 2 time			0	22. 00
23. 00	Total salary equivalency (see instructions)	3 11116 21)		1, 259, 033	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL	EXPENSE COMPUTATION - PR	OVI DER SITE		
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)			11, 103	24. 00
25. 00	Assistants (line 4 times column 3, line 11)			0	25. 00
26. 00	Subtotal (line 24 for respiratory therapy or sum of lines 24		2 and 4 for all	11, 103	1
27. 00	Standard travel expense (line 7 times line 3 for respiratory others)	therapy or sum of fines	3 and 4 for all	1, 186	27. 00
28. 00	Total standard travel allowance and standard travel expense	at the provider site (sum	of lines 26 and	12, 289	28. 00
	27) Optional Travel Allowance and Optional Travel Expense				
29. 00	Therapists (column 2, line 10 times the sum of columns 1 and	2, line 12)		0	1
30. 00 31. 00	Assistants (column 3, line 10 times column 3, line 12) Subtotal (line 29 for respiratory therapy or sum of lines 29	and 30 for all others)		0	30. 00 31. 00
32. 00	Optional travel expense (line 8 times columns 1 and 2, line	•	y or sum of	0	32.00
00.00	columns 1-3, line 13 for all others)				
33. 00 34. 00	Standard travel allowance and standard travel expense (line Optional travel allowance and standard travel expense (sum o			0	33. 00 34. 00
35. 00	Optional travel allowance and optional travel expense (sum o	· · · · · · · · · · · · · · · · · · ·		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL	EXPENSE COMPUTATION - SER	VICES OUTSIDE PRO	OVI DER SITE	
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)			0	36.00
37. 00	Assistants (line 6 times column 3, line 11)			0	37. 00
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and	6)		0	38. 00 39. 00
J7. UU	Optional Travel Allowance and Optional Travel Expense			0	J 37. UU
40. 00	Therapists (sum of columns 1 and 2, line 12.01 times column	2, line 10)		0	•
41. 00 42. 00	Assistants (column 3, line 12.01 times column 3, line 10) Subtotal (sum of lines 40 and 41)			0	41. 00 42. 00
42.00	Optional travel expense (line 8 times the sum of columns 1-3	, line 13.01)		0	
	Total Travel Allowance and Travel Expense - Offsite Services		lowing three line		
44.00	or 46, as appropriate. Standard travel allowance and standard travel expense (sum o	flines 38 and 39 - see i	nstructions)	0	 44. 00
	, and a second country of the contract of the			9	,

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES F SUPPLIERS	CAMERON MEMORI <i>A</i> FURNI SHED BY		CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet A-8 Parts I-VI Date/Time Pre 2/25/2016 9:4	-3 pared:
					Respi ratory Therapy	Cost	
					тнег ару		
IE 00			6.1.	1.40		1. 00	45.00
	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	
0.00	optional travel arrowance and optional travel	Therapi sts	Assi stants	Ai des	Trai nees	Total	40.00
		1.00	2.00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION	0.05	740.05	1 0	20 00	0.05	47.00
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)	9. 25	740. 25	0.0	0.00	9. 25	47.00
8. 00	Overtime rate (see instructions)	91. 26	0. 00	0.0	0.00		48. 00
9. 00	Total overtime (including base and overtime	844. 16	0.00	1			49.00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	100.00	0. 00	0. (0. 00	100.00	50.00
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2, 080. 00	0.00	0. (0.00	2, 080. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE			1			
2. 00	Adjusted hourly salary equivalency amount (see instructions)	60. 84	0. 00	0.0	0.00		52. 0
3. 00	Overtime cost limitation (line 51 times line 52)	126, 547	0		0 0		53. 0
4. 00	Maximum overtime cost (enter the lesser of	844	0		0		54.00
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	563	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	281	0		0 0	281	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1 250 022	
7. 00 8. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	34 or 35))			1, 259, 033 0	57. 0 58. 0
9. 00	Travel allowance and expense - Offsite service)		0	59.0
0. 00	Overtime allowance (from column 5, line 56)					281	
	Equipment cost (see instructions)					0	
	Supplies (see instructions) Total allowance (sum of lines 57-62)					0 1, 259, 314	1
	Total cost of outside supplier services (from	vour records)				503, 052	
	Excess over limitation (line 64 minus line 63		enter zero)			0	1
20.00	LINE 33 CALCULATION	-	4 25	11 -45		11 102	100 0
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	11, 103 1, 186 12, 289	100. 0
	LINE 34 CALCULATION						
	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others		101. 00
	Line 31 - Time 27 Tol Teaplifatory therapy of	Sull Of Titles 2:	and 30 ron a	iii others			101. 0
01. 01 01. 02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						
01. 01 01. 02 02. 00					4.0	0	102. 0 102. 0

Heal th	Financial Systems	CAMERON MEMORI.	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
COST A	ILLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet B Part I Date/Time Pre 2/25/2016 9:4	pared: 6 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL REL	ATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 000, 324 2, 311, 227 4, 940, 657	1, 000, 324	2, 311, 22	4, 940, 657		1. 00 2. 00 4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 505, 715 1, 925, 913	80, 896 155, 512	337, 33	4 154, 975	7, 917, 965 2, 573, 734	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	158, 623 637, 682	13, 611 936			201, 759 779, 935	1
10. 00	01000 DI ETARY	100, 520	40, 921	88, 76		248, 093	1
11. 00	01100 CAFETERI A	362, 279	19, 500			516, 768	1
13.00	01300 NURSING ADMINISTRATION	791, 893	4, 388	9, 51	7 226, 590	1, 032, 388	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	209, 429	20, 192			312, 724	1
15. 00	01500 PHARMACY	1, 887, 645	10, 179			2, 042, 893	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	514, 404	14, 606	47, 29	89, 874	666, 174	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 397, 431	84, 796	183, 93	564, 544	3, 230, 707	30.00
31.00	03100 INTENSIVE CARE UNIT	79, 788	4, 904			3, 230, 707 109, 540	1
43. 00	04300 NURSERY	49, 012	3, 900			74, 427	•
	ANCILLARY SERVICE COST CENTERS	, , ,			,		
50.00	05000 OPERATI NG ROOM	1, 434, 508	89, 710			1, 994, 218	
51. 00	05100 RECOVERY ROOM	649, 803	20, 300			916, 544	•
52. 00	05200 DELIVERY ROOM & LABOR ROOM	169, 447	23, 693			289, 667	•
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 254, 727	58, 988			2, 852, 223	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	2, 063, 509	33, 170 0		267, 848	2, 436, 477 0	1
65. 00	06500 RESPIRATORY THERAPY	599, 839	11, 066		-	647, 140	1
65. 01	06501 SLEEP LAB	164, 735	14, 674			211, 239	1
66. 00	06600 PHYSI CAL THERAPY	587, 970	40, 443			890, 709	•
69.00	06900 ELECTROCARDI OLOGY	264, 927	1, 463			269, 562	1
69. 01	06901 CARDI AC REHAB	72, 360	17, 228	37, 37	1 16, 053	143, 012	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	814, 995	0		0	814, 995	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	463, 206	0		0	463, 206	
73.00	07300 DRUGS CHARGED TO PATIENTS	122 1/1	0	F2 4F	0	0	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03021 ONCOLOGY	133, 161 1, 714, 718	108, 225	52, 45 234, 75		223, 989 2, 057, 701	1
70.01	OUTPATIENT SERVICE COST CENTERS	1, 714, 710	100, 223	234, 73	5 0	2,037,701	70.01
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	1
90.00	09000 CLI NI C	143, 619	0		36, 586	180, 205	90.00
	09100 EMERGENCY	1, 654, 601	55, 146	119, 62	1 433, 847		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	664, 065	0	20, 70	5 177, 307	862, 077	101 00
101.00	SPECIAL PURPOSE COST CENTERS	004, 003	0	20, 70	5 177, 307	002,011	101.00
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 H0SPI CE	127, 581	0	4, 25		162, 611	
118.00		37, 850, 313	928, 447	2, 155, 31	4, 704, 031	37, 385, 897	118. 00
100.00	NONREI MBURSABLE COST CENTERS		2 471	7 50		11 000	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	0	3, 471	7, 52	0 0		194. 00
	07951 MOB	3, 695	0		0		194. 01
	07952 COMMUNITY HEALTH	85, 161	0		23, 965	109, 126	•
	07953 ASSISTED LIVING/CAMERON WOODS	0	0		0 0	0	194. 03
	07954 EDUCATI ON	51, 064	0		0 0		194. 04
	07955 MARKETI NG	401, 299	5, 928	1		452, 098	
	07956 GUEST MEALS	40, 427	0	•	6, 545		194.06
	07957 OUTSIDE LAUNDRY 07958 CANCER CENTER		0		0		194. 07 194. 08
	07958 CANCER CENTER 07959 URGENT CARE	1, 141, 355	62, 478	135, 52	5 174, 104	1, 513, 462	
200.00		1, 141, 333	02,470	130, 32	1/4, 104		200. 00
201.00			0		0 0		201. 00
202.00		39, 573, 314	1, 000, 324	2, 311, 22	4, 940, 657		

				'	0 09/30/2014	2/25/2016 9: 4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
		& GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL CEDIMOS OCCI OFNITEDO	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 917, 965					5.00
7. 00	00700 OPERATION OF PLANT	643, 768	3, 217, 502	,			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	50, 466	54, 281				8.00
9. 00	00900 HOUSEKEEPING	195, 085	3, 733				9.00
10.00	01000 DI ETARY	62, 056	163, 193			481, 482	10.00
11. 00	01100 CAFETERI A	129, 259	77, 766			401, 402	11.00
13. 00	01300 NURSING ADMINISTRATION	258, 231	17, 497		34, 700	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	78, 222	80, 527		27, 735	0	14. 00
15. 00	01500 PHARMACY	510, 989	40, 594			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	166, 630	86, 943	1	13, 012	0	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	100,030	00, 743	,	<u> </u>		10.00
30. 00	03000 ADULTS & PEDIATRICS	808, 109	338, 167	66, 015	261, 947	465, 742	30.00
31. 00	03100 NTENSI VE CARE UNI T	27, 399	19, 558			15, 740	1
43. 00	04300 NURSERY	18, 616	15, 553		64, 373	13, 740	
43.00	ANCI LLARY SERVI CE COST CENTERS	10,010	15, 555	7, 77 1	04, 373		45.00
50. 00	05000 OPERATI NG ROOM	498, 814	357, 764	33, 354	117, 105	0	50.00
51. 00	05100 RECOVERY ROOM	229, 255	80, 955			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	72, 454	94, 486		27, 393	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	713, 427	235, 243			0	54.00
60. 00	06000 LABORATORY	609, 436	132, 280			0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	.02,200	0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	161, 869	44, 132	1	21, 230	0	65. 00
65. 01	06501 SLEEP LAB	52, 837	58, 519			0	65. 01
66. 00	06600 PHYSI CAL THERAPY	222, 793	161, 287			0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	67, 426	5, 832			0	69. 00
69. 01	06901 CARDI AC REHAB	35, 772	68, 707			0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	203, 855	0	1	o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	115, 862	O	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	O	0	o	0	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	56, 026	96, 430	0	22, 599	0	76. 00
76. 01	03021 ONCOLOGY	514, 693	431, 603	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
90.00	09000 CLI NI C	45, 075	0	0	0	0	90.00
91.00	09100 EMERGENCY	566, 098	219, 923	56, 659	161, 619	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	215, 631	38, 067	0	342	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 H0SPI CE	40, 674	7, 816		0		116. 00
118.00		7, 370, 827	2, 930, 856	306, 434	1, 029, 976	481, 482	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 751	13, 842		0		190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0	0	-		194. 00
	07951 MOB	924	0	72			194. 01
194. 02	07952 COMMUNITY HEALTH	27, 296	0	0			194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
	07954 EDUCATI ON	12, 773	0	0	0		194. 04
	07955 MARKETI NG	113, 083	23, 641	0	0		194. 05
	07956 GUEST MEALS	11, 749	0	0	0		194. 06
	07957 OUTSI DE LAUNDRY	0	0	0	0		194. 07
	07958 CANCER CENTER	0	0	0	0		194. 08
	07959 URGENT_CARE	378, 562	249, 163	0	16, 093	0	194. 09
200.00	, ,						200. 00
201.00		_ 0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	7, 917, 965	3, 217, 502	306, 506	1, 046, 069	481, 482	J202. 00

| Peri od: | Worksheet B | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: Provi der CCN: 151315

			To	09/30/2014	Date/Time Pre	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	2/25/2016 9: 4 MEDI CAL	6 am
3331 33.113.1 3333.1 pt/ 3.1	57.11 Z 1 Z 1 T 1 T 1	ADMI NI STRATI ON	SERVICES &		RECORDS &	
	44.00	40.00	SUPPLY	45.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	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						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	778, 579					11. 00
13.00 01300 NURSING ADMINISTRATION	40, 727					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	15, 015	l	516, 111	0 (00 100		14.00
15. 00 01500 PHARMACY	20, 303	l :	2, 402	2, 630, 193 0	050 005	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	30, 878	0	270	U _I	950, 895	16. 00
30. 00 03000 ADULTS & PEDIATRICS	147, 166	520, 735	23, 290	0	11, 406	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 956		0	O	951	31.00
43. 00 04300 NURSERY	2, 583	9, 180	0	0	2, 039	43. 00
ANCI LLARY SERVI CE COST CENTERS	50 577	0.40.050	(5.050	ام	0.4.075	
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	59, 577		65, 353	0	24, 975	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	42, 019 8, 961	148, 643 31, 749	0 8, 501	0	0	51. 00 52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	89, 810		6, 680	0	189. 003	54.00
60. 00 06000 LABORATORY	79, 840		120, 232	O	316, 912	60.00
64.00 06400 INTRAVENOUS THERAPY	0	o	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 534	0	4, 677	0	24, 476	65.00
65. 01 06501 SLEEP LAB	40.041	0	1 010	0	77 (00	65. 01
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	40, 041	0	1, 010 489	0	77, 699 49, 700	66. 00 69. 00
69. 01 06901 CARDI AC REHAB	3, 794		176	0	29, 494	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	156, 927	ő	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	89, 434	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 630, 193	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	10, 051	0	60	0	16, 049	76.00
76. 01 03021 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	0	23	U _I	0	76. 01
88. 00 08800 RURAL HEALTH CLINIC	0	ol	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0	o	0	89. 00
90. 00 09000 CLI NI C	9, 889	35, 010	3, 838	0	44, 162	90.00
91. 00 09100 EMERGENCY	107, 045	378, 697	24, 446	0	164, 029	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	38, 104	O	1, 554	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	50, 101	<u> </u>	1,001	<u> </u>		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	8, 355	l .	240	0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	759, 648	1, 348, 843	509, 602	2, 630, 193	950, 895	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	0	0	190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0		0	ő	0	194.00
194. 01 07951 MOB	0	О	713	0	0	194. 01
194. 02 07952 COMMUNI TY HEALTH	5, 368	0	712	0		194. 02
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
194. 04 07954 EDUCATI ON	10 405	0	271	0		194. 04 194. 05
194. 05 07955 MARKETI NG 194. 06 07956 GUEST MEALS	10, 495 3, 068	1	271 0	0		194. 05
194. 07 07957 OUTSI DE LAUNDRY	0,000	1	o	ol		194. 07
194. 08 07958 CANCER CENTER	0	O	0	0	0	194. 08
194. 09 07959 URGENT_CARE	0	0	4, 813	0	0	194. 09
200.00 Cross Foot Adjustments	_				2	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 778, 579	1, 348, 843	0 516, 111	2, 630, 193	950, 895	201.00
202.00 TOTAL (30III TITIES TTO-201)	110,319	1, 340, 043	510, 111	2,000,170	730, 073	1202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	CAMERON MEMORI			eri od:	of Form CMS-2552-10 Worksheet B Part I
			-	o 09/30/2014	Date/Time Prepared: 2/25/2016 9:46 am
Cost Center Description	Subtotal	Intern &	Total		2/23/2010 9.40 dill
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments	27, 00		
GENERAL SERVI CE COST CENTERS	24. 00	25. 00	26. 00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9. 00 10. 00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	5, 873, 284 195, 541	0	5, 873, 284 195, 541		30. 00 31. 00
43. 00 04300 NURSERY	196, 742	O	196, 742		43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	3, 362, 010 1, 473, 617	0	3, 362, 010 1, 473, 617		50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	539, 112		539, 112		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 198, 202	О	4, 198, 202		54. 00
60. 00 06000 LABORATORY	3, 751, 913	0	3, 751, 913		60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	906, 546	0	906, 546		64. 00 65. 00
65. 01 06501 SLEEP LAB	353, 042	Ö	353, 042		65. 01
66. 00 06600 PHYSI CAL THERAPY	1, 443, 552	0	1, 443, 552		66. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	394, 497 283, 373	0	394, 497 283, 373		69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 175, 777	Ö	1, 175, 777		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	668, 502	0	668, 502		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CHEMI CAL DEPENDENCY	2, 630, 193 425, 204	0	2, 630, 193 425, 204		73. 00 76. 00
76. 01 03021 0NCOLOGY	3, 004, 020	o	3, 004, 020		76. 01
OUTPATIENT SERVICE COST CENTERS	_				
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0	0		88. 00 89. 00
90. 00 09000 CLI NI C	318, 179	Ö	318, 179		90.00
91. 00 09100 EMERGENCY	3, 941, 731	0	3, 941, 731		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92. 00
101.00 10100 HOME HEALTH AGENCY	1, 155, 775	0	1, 155, 775		101.00
SPECIAL PURPOSE COST CENTERS					
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	219, 696	o	219, 696		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	36, 510, 508	O	36, 510, 508		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	27, 593	0	27, 593		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	o	27,373		194. 00
194. 01 07951 MOB	5, 404	0	5, 404		194. 01
194.02 07952 COMMUNITY HEALTH 194.03 07953 ASSISTED_LIVING/CAMERON_WOODS	142, 502	0	142, 502 0		194. 02 194. 03
194. 04 07954 EDUCATION	63, 837	o	63, 837		194. 04
194. 05 07955 MARKETI NG	599, 588	О	599, 588		194. 05
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	61, 789	0	61, 789 0		194. 06 194. 07
194. 07 07957 00151 DE LAUNDRY 194. 08 07958 CANCER CENTER	0	0	0		194. 07
194. 09 07959 URGENT CARE	2, 162, 093	O	2, 162, 093		194. 09
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	39, 573, 314	0	39, 573, 314		201. 00 202. 00
		-1		1	1

Provider CCN: 151315 | Period: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					To	09/30/2014	Date/Time Pre	
				CAPI TAL REI	ATED COSTS		2/25/2016 9: 4	6 am
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DELAKTMENT	
			0	1. 00	2.00	2A	4. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	o	0	4. 00
5.00	1	ADMINISTRATIVE & GENERAL	0	80, 896	223, 824	304, 720	0	5. 00
7.00		OPERATION OF PLANT	0	155, 512		492, 846	0	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	13, 611 936		43, 136 2, 966	0	8. 00 9. 00
10.00	1	DIETARY	0	40, 921		129, 685	0	10.00
11. 00	1	CAFETERI A	0	19, 500		61, 799	0	11. 00
13.00	1	NURSING ADMINISTRATION	0	4, 388		13, 905	0	13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	20, 192		63, 992	0	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	10, 179 14, 606		32, 259 61, 896	0	15. 00 16. 00
10.00		I ENT ROUTINE SERVICE COST CENTERS		14, 000	47,270	01, 070		10.00
30. 00		ADULTS & PEDIATRICS	0	84, 796	183, 936	268, 732	0	30. 00
31.00		INTENSIVE CARE UNIT	0	4, 904		15, 542	0	31.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	3, 900	8, 460	12, 360	0	43. 00
50. 00		OPERATING ROOM	0	89, 710	194, 596	284, 306	0	50.00
51. 00		RECOVERY ROOM	0	20, 300		64, 333	0	
52. 00		DELIVERY ROOM & LABOR ROOM	0	23, 693		75, 086	0	52. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	58, 988		186, 942	0	54. 00
60. 00 64. 00	1	LABORATORY INTRAVENOUS THERAPY	0	33, 170 0		105, 120 0	0	60. 00 64. 00
65. 00	1	RESPI RATORY THERAPY	0	11, 066	-	35, 071	0	65. 00
65. 01	1	SLEEP LAB	0	14, 674	31, 830	46, 504	0	65. 01
66. 00		PHYSI CAL THERAPY	0	40, 443		128, 171	0	66.00
69. 00 69. 01		ELECTROCARDI OLOGY CARDI AC REHAB	0	1, 463 17, 228		4, 635 54, 599	0	69. 00 69. 01
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,220		0	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00 76. 01	1	CHEMI CAL DEPENDENCY ONCOLOGY	0	0 108, 225	52, 450 234, 758	52, 450 342, 983	0	76. 00 76. 01
70.01		TIENT SERVICE COST CENTERS		106, 223	234, 730	342, 903	0	76.01
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00		CLI NI C	0	0		174 77	0	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	55, 146	119, 621	174, 767 O	0	91. 00 92. 00
72.00		REI MBURSABLE COST CENTERS	I.			<u> </u>		72.00
101.00		HOME HEALTH AGENCY	0	0	20, 705	20, 705	0	101. 00
112 00	-	AL PURPOSE COST CENTERS						112 00
		INTEREST EXPENSE UTILIZATION REVIEW-SNF						113. 00 114. 00
		HOSPI CE	0	0	4, 251	4, 251	0	116. 00
118.00	-	SUBTOTALS (SUM OF LINES 1-117)	0	928, 447	2, 155, 314	3, 083, 761	0	118. 00
100.00		I MBURSABLE COST CENTERS		2 471	7 500	11 000	-	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN DAYCARE-INFANT/TODDLER	0	3, 471 0		11, 000		190. 00 194. 00
	07951	l e e e e e e e e e e e e e e e e e e e	0	Ö	Ö	o		194. 01
	1	COMMUNITY HEALTH	0	0	0	0		194. 02
		ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194. 03
	1	EDUCATI ON MARKETI NG	0	5, 928	12, 859	18, 787		194. 04 194. 05
		GUEST MEALS	0	0, 720	0	0		194. 06
	1	OUTSI DE LAUNDRY	0	0	0	О		194. 07
		CANCER CENTER	0	0	0	0		194. 08
194. 09 200. 00		URGENT CARE Cross Foot Adjustments	0	62, 478	135, 525	198, 003	0	194. 09 200. 00
200.00	1	Negative Cost Centers		n	0	0	0	200.00
202.00	1	TOTAL (sum lines 118-201)	0	1, 000, 324	2, 311, 227	3, 311, 551		202. 00

In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151315 Peri od: Worksheet B

From 10/01/2013

Part II

Date/Time Prepared: 09/30/2014 2/25/2016 9:46 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 304, 720 5 00 7.00 00700 OPERATION OF PLANT 24, 775 517, 621 7.00 1, 942 00800 LAUNDRY & LINEN SERVICE 8.00 8, 733 53, 811 8.00 9.00 00900 HOUSEKEEPI NG 7,508 601 11, 817 22, 892 9.00 01000 DI ETARY 2.388 159, 756 10.00 10.00 26, 254 1, 429 11.00 01100 CAFETERI A 4,974 12, 511 C 1, 199 0 11.00 13 00 01300 NURSING ADMINISTRATION 9,938 2, 815 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 3,010 14 00 12, 955 332 607 14.00 0 15.00 01500 PHARMACY 19,665 6, 531 C 285 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 6,413 13, 987 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 31, 105 03000 ADULTS & PEDIATRICS 54, 403 11, 590 5.731 154, 534 31.00 03100 INTENSIVE CARE UNIT 1,054 3, 146 175 5, 222 31.00 43 00 43.00 04300 NURSERY 716 2,502 1, 751 1, 409 ANCILLARY SERVICE COST CENTERS 50 00 19, 196 50.00 05000 OPERATING ROOM 57, 556 5.856 2.563 0 05100 RECOVERY ROOM 8,823 13, 024 2, 954 51.00 51.00 862 05200 DELIVERY ROOM & LABOR ROOM 52.00 2,788 15, 201 1,036 599 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 1.896 54.00 27.455 37, 845 4, 422 0 54.00 60.00 06000 LABORATORY 23, 454 21, 281 162 1, 221 0 60.00 64.00 06400 I NTRAVENOUS THERAPY C 0 64.00 65.00 06500 RESPIRATORY THERAPY 6, 229 7, 100 261 465 0 65.00 2, 033 06501 SLEEP LAB 65.01 9.414 957 547 Λ 65.01 06600 PHYSI CAL THERAPY 66.00 8,574 25, 947 424 1,042 0 66.00 06900 ELECTROCARDI OLOGY 938 69.00 2,595 261 0 0 69.00 o 06901 CARDI AC REHAB 1.377 11, 053 0 69.01 69.01 424 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 7,845 C 0 0 0 71.00 72.00 4, 459 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 0 03020 CHEMI CAL DEPENDENCY 76 00 2 156 15, 513 0 495 0 76 00 03021 ONCOLOGY 0 76.01 19,807 69, 435 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 C 0 0 90.00 09000 CLI NI C 1,735 0 0 0 90.00 91.00 09100 EMERGENCY 21, 786 35, 380 9, 947 3,537 0 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 6, 124 101.00 10100 HOME HEALTH AGENCY 8, 298 0 7 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 1,565 1, 257 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 283, 663 471, 506 53, 798 22, 540 159, 756 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 106 2, 227 0 0 0 190, 00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 0 194. 01 07951 MOB 13 0 194. 01 36 0 194. 02 07952 COMMUNITY HEALTH 1.050 C 0 0 194 02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 o 0 194. 03 194. 04 07954 EDUCATI ON 492 0 0 194. 04 0 194. 05 07955 MARKETI NG 0 194. 05 3, 803 0 4.352 οĺ 194.06 07956 GUEST MEALS 0 194. 06 452 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 0 C 0 194.08 07958 CANCER CENTER 0 0 194. 08 0 194, 09 194. 09 07959 URGENT CARE 14.569 40, 085 0 352 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 304, 720 517, 621 53, 811 22.892 159, 756 202. 00

Provi der CCN: 151315

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared:

			То	09/30/2014	Date/Time Pre 2/25/2016 9:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	O dill
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	00.400					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	80, 483 4, 210	1				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 552		82. 448			14. 00
15. 00 01500 PHARMACY	2, 099	1	384	61, 223		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	3, 192	Ö	43	0	85, 531	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			1	,		
30. 00 03000 ADULTS & PEDIATRICS	15, 212		3, 721	0	1, 026	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	409	1	0	0	86	31. 00
43. 00 04300 NURSERY	267	210	0	0	183	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	4 1EC	4, 825	10, 440	ol	2, 246	50.00
51. 00 05100 RECOVERY ROOM	6, 159 4, 344		10, 440	0	2, 240	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	926		1, 358	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 284	0	1, 067	o	17, 000	54.00
60. 00 06000 LABORATORY	8, 253	O	19, 207	0	28, 506	60.00
64.00 06400 INTRAVENOUS THERAPY	C	O	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	159	0	747	0	2, 202	65. 00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	4, 139	0	161	0	6, 989	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	392	0	78 28	0	4, 470 2, 653	69. 00 69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	392	0	25, 069	0	2, 653	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			14, 287	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	61, 223	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	1, 039	o	10	0	1, 444	76. 00
76. 01 03021 ONCOLOGY	C	0	4	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS	-			_1		
88. 00 08800 RURAL HEALTH CLINIC	C	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	1, 022	801	0 613	0	0 3, 972	89. 00 90. 00
91. 00 09100 EMERGENCY	11, 065	l I	3, 905	0	3, 972 14, 754	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11,000	0,000	3, 703		14, 754	92.00
OTHER REIMBURSABLE COST CENTERS			l.			
101.00 10100 HOME HEALTH AGENCY	3, 939	0	248	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	T					
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF 116.00 11600 HOSPI CE	864	0	38		0	114. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	78, 526	1 9		61, 223	85, 531	
NONREI MBURSABLE COST CENTERS	70, 320	30, 000	01, 400	01, 223	05, 551	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	С	O	0	0	0	190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	C	O	0	0		194. 00
194. 01 07951 MOB	C	O	114	0		194. 01
194. 02 07952 COMMUNI TY HEALTH	555	l .	114	0		194. 02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS	C		0	0		194. 03
194. 04 07954 EDUCATI ON	1 005		0	0		194. 04
194. 05 07955 MARKETI NG 194. 06 07956 GUEST MEALS	1, 085 317	1	43	0		194. 05 194. 06
194.00 07930 GUEST MEALS 194.07 07957 OUTSIDE LAUNDRY	317	1	0	0		194. 06
194. 08 07958 CANCER CENTER		1	0	ol		194. 07
194. 09 07959 URGENT CARE		ol	769	ol		194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	80, 483	30, 868	82, 448	61, 223	85, 531	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS CAMERON MEMORIAL COMMUNITY Provi der CCN: 151315

				''	2/25/2016 9	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments	24 00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10. 00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	FF7 071		FF7 071		20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	557, 971 26, 029	0	557, 971 26, 029		30. 00 31. 00
	04300 NURSERY	19, 398		26, 029 19, 398		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	17, 370	U	17, 370		43.00
50. 00	05000 OPERATING ROOM	393, 147	0	393, 147		50.00
51. 00	05100 RECOVERY ROOM	97, 742		97, 742		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	97, 721	Ö	97, 721		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	285, 911	o	285, 911		54. 00
60.00	06000 LABORATORY	207, 204	0	207, 204		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0		64. 00
65.00	06500 RESPIRATORY THERAPY	52, 234	0	52, 234		65. 00
65. 01	06501 SLEEP LAB	59, 455	0	59, 455		65. 01
66. 00	06600 PHYSI CAL THERAPY	175, 447	0	175, 447		66. 00
69. 00	06900 ELECTROCARDI OLOGY	12, 977	0	12, 977		69. 00
	06901 CARDI AC REHAB	70, 526	1	70, 526		69. 01
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	32, 914	0	32, 914		71.00
72. 00 73. 00	07200 NPL. DEV. CHARGED TO PATIENTS	18, 746		18, 746		72. 00 73. 00
76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY	61, 223 73, 107	0	61, 223 73, 107		76.00
76. 00	03021 ONCOLOGY	432, 229		432, 229		76.00
70.01	OUTPATIENT SERVICE COST CENTERS	102, 22,	J	102, 227		70.01
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 CLI NI C	8, 143	0	8, 143		90. 00
91.00	09100 EMERGENCY	283, 807	0	283, 807		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
	OTHER REIMBURSABLE COST CENTERS					
101. 00	10100 HOME HEALTH AGENCY	39, 321	0	39, 321		101. 00
440.00	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE	7, 975	0	7, 975		114. 00 116. 00
118.00		3, 013, 227				118.00
110.00	NONREI MBURSABLE COST CENTERS	3,013,227	U	3,013,227		110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 333	0	13, 333		190. 00
	07950 DAYCARE-I NFANT/TODDLER	13, 333	Ö	0		194. 00
	07951 MOB	163	Ö	163		194. 01
	07952 COMMUNITY HEALTH	1, 719		1, 719		194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	1	. 0		194. 03
194. 04	07954 EDUCATI ON	492	0	492		194. 04
194.05	07955 MARKETI NG	28, 070	0	28, 070		194. 05
194.06	07956 GUEST MEALS	769	0	769		194. 06
	07957 OUTSI DE LAUNDRY	0	0	0		194. 07
	07958 CANCER CENTER	0	0	0		194. 08
	07959 URGENT_CARE	253, 778	1	253, 778		194. 09
200.00		0		0		200. 00
201.00	1 9	2 211 551	0	0 211 551		201. 00
202.00	TOTAL (sum lines 118-201)	3, 311, 551	0	3, 311, 551		202. 00

	Financial Systems	CAMERON MEMORI				eu of Form CMS-:	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 10/01/2013 To 09/30/2014	Worksheet B-1 Date/Time Pre	
		CADITAL DEL	LATED COSTS	'	0 0 0 0 0 0 1 1	2/25/2016 9: 4	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE TELT)	(SQUARE TELT)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		,	
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	_
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	102, 597					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		109, 281 0	15 0/1 21/			2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	8, 297		15, 861, 316 3, 555, 575		31, 655, 349	4.00
7.00	00700 OPERATION OF PLANT	15, 950	15, 950	497, 527		2, 573, 734	7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	1, 396				,	
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	96 4, 197		447, 162 57, 427		779, 935 248, 093	
11. 00	01100 CAFETERI A	2,000				516, 768	
13.00	01300 NURSI NG ADMI NI STRATI ON	450				1, 032, 388	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 071 1, 044		126, 176 394, 839			
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 498					
	INPATIENT ROUTINE SERVICE COST CENTERS	T=			_		4
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 697 503		1, 812, 394 45, 620			
43. 00	04300 NURSERY	400					1
	ANCILLARY SERVICE COST CENTERS		1				4
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	9, 201		884, 149 649, 803			
51.00	05200 DELIVERY ROOM & LABOR ROOM	2, 082 2, 430					
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 050				l	
60.00	06000 LABORATORY	3, 402	3, 402	859, 891	0		
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 135	1, 135	39, 263		0 647, 140	1
65. 01	06501 SLEEP LAB	1, 505			o o	l	
66. 00	06600 PHYSI CAL THERAPY	4, 148			0	890, 709	
69. 00 69. 01	06900 ELECTROCARDI OLOGY	150	l .		0		
71. 00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 767		51, 535 0			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	l	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	122 200	0	l .	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03021 ONCOLOGY	11, 100	2, 480 11, 100				
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , ,			_		1
88.00	08800 RURAL HEALTH CLINIC	0	0	(1	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	117, 453	-		
	09100 EMERGENCY	5, 656	5, 656				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	979	569, 219	9 0	862, 077	101 00
101.00	SPECIAL PURPOSE COST CENTERS		,,,,	307, 217	,	002,077	11011.00
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	0	201	98, 813	0	162, 611	114.00
118.00		95, 225	l .				
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	356					190. 00 194. 00
	07950 DATCARE-TNFANT/TODDLER		_			l .	194. 0
194. 02	07952 COMMUNITY HEALTH	0	0	76, 938	0	l	
	07953 ASSISTED LIVING/CAMERON WOODS	0	_	(0	l	194. 0
	107954 EDUCATI ON 107955 MARKETI NG	608	_	102, 771		51, 064 452, 098	
	07956 GUEST MEALS	0	0	21, 012		46, 972	
	07957 OUTSI DE LAUNDRY	0	0	(1	l	194. 0
	3 07958 CANCER CENTER 07959 URGENT CARE	6, 408	0 6, 408	558, 938	0	l .	194. 0
200.00		0, 400	0, 400	330, 730		1, 515, 402	200. 0
201.00	Negative Cost Centers						201. 0
		1, 000, 324	2, 311, 227	4, 940, 657	'	7, 917, 965	202. 0
202.00	Part I)	9. 750032	21. 149395	0. 311491		0. 250130	203. 0
202.00	Unit cost multiplier (Wkst. B, Part I				f .	l	1
	Cost to be allocated (per Wkst. B,	,		C)	304, 720	204. 00
203.00	Cost to be allocated (per Wkst. B, Part II)	,		0. 000000		304, 720 0. 009626	

	Financial Systems	CAMERON MEMORI				u of Form CMS-	
COST	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 10/01/2013	Worksheet B-1	
				Т	o 09/30/2014	Date/Time Pre 2/25/2016 9:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	- Calli
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(POUNDS OF LAUNDR)	SERVIC)			
		7. 00	8.00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS		ı				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	82, 748	ł .				7. 00
8. 00 9. 00	OO8OO LAUNDRY & LINEN SERVICE OO9OO HOUSEKEEPING	1, 396					8. 00 9. 00
10.00	01000 DI ETARY	4, 197	1, 138		13, 735		10.00
11.00	01100 CAFETERI A	2,000			0	19, 289	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	450 2, 071	0 264	0 81	0	1, 009 372	1
15. 00	01500 PHARMACY	1, 044			١	503	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 236	0	0	0	765	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	8, 697	9, 229	765	13, 286	3, 646	30.00
31. 00	03100 INTENSIVE CARE UNIT	503				3, 040 98	1
43.00	04300 NURSERY	400		188	0	64	1
F0 00	ANCILLARY SERVICE COST CENTERS	0.001	1 4 //0	0.40		4.47/	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	9, 201 2, 082	4, 663 2, 352		0	1, 476 1, 041	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 430			0	222	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 050		253	0	2, 225	1
60.00	06000 LABORATORY	3, 402			0	1, 978	1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 135			0	0 38	1
65. 01	06501 SLEEP LAB	1, 505				0	1
66. 00	06600 PHYSI CAL THERAPY	4, 148				992	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	150 1, 767	208 338		0	0 94	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 707	0	1	0	0	1
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	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03021 ONCOLOGY	2, 480 11, 100			0	249 0	1
, 0, 0,	OUTPATIENT SERVICE COST CENTERS	117.00			9] , , , , ,
88. 00	08800 RURAL HEALTH CLINIC	0	0		1	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 245	1
91. 00	09100 EMERGENCY	5, 656	1	1	0	2, 652	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	979	Ιο	1	O	044	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	979			l of	944	1101.00
	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	201				207	114.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	201 75, 376			0 13, 735		116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , ,	127010	5, 555	107700	10/020]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	356					190. 00
	07950 DAYCARE-I NFANT/TODDLER 07951 MOB	0	0 10				194. 00 194. 01
	07952 COMMUNITY HEALTH		0		0		194. 01
194. 03	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194. 03
	07954 EDUCATI ON	0	0	0	0		194. 04
	07955 MARKETI NG 07956 GUEST MEALS	608		0	0		194. 05 194. 06
	07957 OUTSI DE LAUNDRY	0	Ö	Ö	0		194. 07
	07958 CANCER CENTER	0	0	0	0		194. 08
200.00	07959 URGENT CARE Cross Foot Adjustments	6, 408	0	47	O	0	194. 09 200. 00
201.00							201. 00
202.00		3, 217, 502	306, 506	1, 046, 069	481, 482	778, 579	202. 00
202 00	Part I)	20 002120	7 152000	242 412111	25 OEE11E	40 242004	202 00
203. 00 204. 00		38. 883139 517, 621		1	1	40. 363886 80, 483	203.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	6. 255390	1. 255799	7. 493290	11. 631307	4. 172482	205. 00
	, דיו	I	I	I	ı I		I

	Financial Systems	CAMERON MEMORIA				u of Form CMS-255	- IC
COST AL	LOCATION - STATISTICAL BASIS		Provi der		eriod: rom 10/01/2013	Worksheet B-1	
				To		Date/Time Prepar 2/25/2016 9:46 a	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	272372010 7.40 8	A111
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY		
		(DIRECT NRSING	(COSTED	KLQUI 3.)	(TIME SPENT)		
		HR)	REQUIS.)	15.00	17, 00		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					· · · · · · · · · · · · · · · · · · ·	1. 00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					i i	2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					· · · · · · · · · · · · · · · · · · ·	5. 00
7. 00	00700 OPERATION OF PLANT					-	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 H0USEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERI A						1. 00
	01300 NURSING ADMINISTRATION	196, 451				· · · · · · · · · · · · · · · · · · ·	3. 00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	2, 673, 077 12, 440	100		l I	4. 00 5. 00
	01600 MEDICAL RECORDS & LIBRARY		1, 399		83, 954	l I	6. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		·				
	03000 ADULTS & PEDIATRICS	75, 842	120, 628		1, 007		0.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	2, 036 1, 337	0	0	84 180		1.00
	ANCILLARY SERVICE COST CENTERS	1,007			100		0. 00
50.00	05000 OPERATING ROOM	30, 709	338, 484	0	2, 205		0.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	21, 649 4, 624	0 44, 029	0	0	· · · · · · · · · · · · · · · · · · ·	1. 00 2. 00
	05400 RADI OLOGY-DI AGNOSTI C	4, 024	34, 597	0	16, 687		4. 00
60.00	06000 LABORATORY	0	622, 713	0	27, 980		0. 00
	06400 I NTRAVENOUS THERAPY	0	0	0	0		4.00
	06500 RESPIRATORY THERAPY 06501 SLEEP LAB	0	24, 225 0	0	2, 161 0		5. 00 5. 01
4	06600 PHYSI CAL THERAPY	0	5, 232	0	6, 860		6. 00
	06900 ELECTROCARDI OLOGY	0	2, 534	0	4, 388		9.00
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	913 812, 743	0	2, 604		9. 01 1. 00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	0	463, 206	0	Ö		2. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	100	0	· · · · · · · · · · · · · · · · · · ·	3.00
	03020 CHEMI CAL DEPENDENCY 03021 ONCOLOGY	0	310 118		1, 417 0		6. 00 6. 01
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	110	<u> </u>	<u> </u>	,	0. 0 1
	08800 RURAL HEALTH CLINIC	0	0	0	0	l I	8. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	5, 099	0 19, 880	0	0 3, 899	l I	9.00
	09100 EMERGENCY	55, 155	126, 615	0	14, 482		1. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92	2. 00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	8, 049	0	0	10.	1. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0, 049	0	O _I	10	1. 00
	11300 I NTEREST EXPENSE						3. 00
	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE		1, 244	0	0		4. 00 6. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	196, 451	2, 639, 359		83, 954		8.00
ļ	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	0	0	0	0		0.00
4	07950 DAYCARE-INFANT/TODDLER 07951 MOB	0	3. 695	0	0		4. 00 4. 0
	07952 COMMUNITY HEALTH	0	3, 690		Ö	· · · · · · · · · · · · · · · · · · ·	4. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	· · · · · · · · · · · · · · · · · · ·	4. 03
	07954 EDUCATI ON 07955 MARKETI NG	0	0 1, 404	0	0		4. 04 4. 05
	07956 GUEST MEALS		0	0	0		4. 06
	07957 OUTSI DE LAUNDRY	0	0	0	O		4. 07
	07958 CANCER CENTER 07959 URGENT CARE	0	0 24, 929	0	0	· · · · · · · · · · · · · · · · · · ·	4.08
200.00	Cross Foot Adjustments		24, 929		U U		0.00
201.00	Negative Cost Centers					20-	1. 00
202.00	Cost to be allocated (per Wkst. B,	1, 348, 843	516, 111	2, 630, 193	950, 895	202	2. 00
202.00	Part I)	6. 866053	0. 193077	26, 301. 930000	11. 326381	30,	3. 00
	Unit cost multiplier (Wkst R Part I)		0. 170077				4. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	30, 868	82, 448	61, 223	85, 531	20·	4. UC
203. 00		1	82, 448 0. 030844				5. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151315	Peri od: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

					To 09/30/2014	Date/Time Pre 2/25/2016 9:4	pared: 6 am
			Ti tl	e XVIII	Hospi tal	Cost	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Áďj.		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	3000 ADULTS & PEDIATRICS	5, 873, 284		5, 873, 28	4 0	0	30.00
31.00 0	3100 INTENSIVE CARE UNIT	195, 541		195, 54	1 0	0	31.00
43.00 0	4300 NURSERY	196, 742		196, 74	2 0	0	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	3, 362, 010		3, 362, 01	0 0	0	
51.00 0	5100 RECOVERY ROOM	1, 473, 617		1, 473, 61	7 0	0	51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	539, 112		539, 11	2 0	0	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	4, 198, 202		4, 198, 20	2 0	0	54.00
60.00 0	6000 LABORATORY	3, 751, 913		3, 751, 91	3 0	0	60.00
64.00 0	6400 INTRAVENOUS THERAPY	0			0	0	64.00
65.00 0	6500 RESPI RATORY THERAPY	906, 546	(906, 54	6 0	0	65.00
65. 01 0	6501 SLEEP LAB	353, 042	(353, 04	2 0	0	65. 01
66.00 0	16600 PHYSI CAL THERAPY	1, 443, 552	(1, 443, 55	2 0	0	66.00
69.00 0	6900 ELECTROCARDI OLOGY	394, 497		394, 49	7 0	0	69. 00
69. 01 0	6901 CARDI AC REHAB	283, 373		283, 37	3 0	0	69. 01
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 175, 777		1, 175, 77	7 0	0	71. 00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	668, 502		668, 50	2 0	0	72. 00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	2, 630, 193		2, 630, 19	3 0	0	73. 00
76. 00 0	3020 CHEMI CAL DEPENDENCY	425, 204		425, 20	4 0	0	76. 00
76. 01 0	3021 ONCOLOGY	3, 004, 020		3, 004, 02	0 0	0	76. 01
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
90.00 0	99000 CLI NI C	318, 179		318, 17	9 0	0	90.00
91.00 0	9100 EMERGENCY	3, 941, 731		3, 941, 73	1 0	0	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	875, 353		875, 35	3	0	92. 00
	THER REIMBURSABLE COST CENTERS						
	0100 HOME HEALTH AGENCY	1, 155, 775		1, 155, 77	5	0	101. 00
	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE						113. 00
	1400 UTILIZATION REVIEW-SNF						114. 00
	1600 HOSPI CE	219, 696		219, 69			116. 00
200.00	Subtotal (see instructions)	37, 385, 861	(37, 385, 86	1 0		200.00
201.00	Less Observation Beds	875, 353		875, 35			201. 00
202.00	Total (see instructions)	36, 510, 508	(36, 510, 50	0	0	202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151315	Peri od: Worksheet C
		From 10/01/2013 Part I
		To 00/20/2014 Doto/Time Dropored.

					To 09/30/2014	Date/Time Pre 2/25/2016 9:4	
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
			7.00		0.00	Rati o	
	INDATIENT POUTINE CEDVICE COCT CENTERS	6.00	7. 00	8. 00	9. 00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	E 244 222		E 24/ 22			20.00
30. 00	l l	5, 346, 333		5, 346, 333			30.00
31. 00	03100 I NTENSI VE CARE UNI T	234, 852		234, 852			31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	289, 600		289, 600)[]		43. 00
50. 00	05000 OPERATING ROOM	1, 216, 671	6, 644, 416	7, 861, 087	0. 427677	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	236, 740	1, 480, 274			0. 000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	420, 278	331, 266			0. 000000	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 158, 620	21, 683, 857			0. 000000	
60.00	06000 LABORATORY	1, 806, 658	11, 001, 060			0. 000000	60.00
64. 00	06400 I NTRAVENOUS THERAPY	1,000,030	11,001,000			0. 000000	64. 00
65. 00	06500 RESPIRATORY THERAPY	957, 727	552, 586	`		0. 000000	65. 00
65. 01	06501 SLEEP LAB	757, 727	739, 783			0. 000000	65. 01
66. 00	06600 PHYSI CAL THERAPY	621, 953	1, 703, 770			0. 000000	66. 00
69. 00	06900 ELECTROCARDI OLOGY	97, 493	1, 061, 074			0. 000000	69. 00
69. 01	06901 CARDI AC REHAB	6, 968	217, 574			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	699, 146	1, 460, 585			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	442, 166	554, 432			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 116, 333	4, 566, 064			0. 000000	
76.00	03020 CHEMI CAL DEPENDENCY	542	141, 725			0.000000	76. 00
76. 01	03021 ONCOLOGY	4, 346	6, 161, 831	6, 166, 177	0. 487177	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	(88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(89. 00
90.00	09000 CLI NI C	0	486, 343	486, 343	0. 654228	0.000000	90. 00
91.00	09100 EMERGENCY	531, 188	10, 570, 579	11, 101, 767	0. 355054	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	201, 522	666, 896	868, 418	1. 007986	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	1, 067, 682	1, 067, 682	2		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 HOSPI CE	0	319, 832				116. 00
200.00		15, 389, 136	71, 411, 629	86, 800, 765			200. 00
201.00		45 000					201. 00
202.00	Total (see instructions)	15, 389, 136	71, 411, 629	86, 800, 765)		202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151315	From 10/01/2013	Worksheet C Part I Date/Time Prepared: 2/25/2016 9:46 am

			10 09/30/2014	2/25/2016 9:46 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE 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 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			76.00
76. 01 03021 ONCOLOGY	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 INTEREST EXPENSE	1			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151315	Peri od: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

					10 09/30/2014	2/25/2016 9:4	pared: 6 am
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
	03000 ADULTS & PEDI ATRI CS	5, 873, 284		5, 873, 28		0,0,0,20.	1
	03100 I NTENSI VE CARE UNI T	195, 541		195, 54			
43.00	04300 NURSERY	196, 742		196, 74	2 0	196, 742	43. 00
	ANCILLARY SERVICE COST CENTERS			T			4
	05000 OPERATING ROOM	3, 362, 010		3, 362, 01		-,,	
51. 00	05100 RECOVERY ROOM	1, 473, 617		1, 473, 61		1, 473, 617	
52.00	05200 DELIVERY ROOM & LABOR ROOM	539, 112		539, 11		539, 112	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 198, 202		4, 198, 20		4, 198, 202	
	06000 LABORATORY	3, 751, 913		3, 751, 91		3, 751, 913	1
64. 00	06400 I NTRAVENOUS THERAPY	0		1	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	906, 546	0			906, 546	1
	06501 SLEEP LAB	353, 042	0	353, 04		353, 042	
66. 00	06600 PHYSI CAL THERAPY	1, 443, 552	0	1, 443, 55		1, 443, 552	1
69. 00	06900 ELECTROCARDI OLOGY	394, 497		394, 49		394, 497	1
	06901 CARDI AC REHAB	283, 373		283, 37		283, 373	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 175, 777		1, 175, 77		1, 175, 777	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	668, 502		668, 50		668, 502	
	07300 DRUGS CHARGED TO PATIENTS	2, 630, 193		2, 630, 19		2, 630, 193	1
	03020 CHEMI CAL DEPENDENCY	425, 204		425, 20		,	1
	03021 ONCOLOGY	3, 004, 020		3, 004, 02	0 0	3, 004, 020	76. 01
	OUTPATIENT SERVICE COST CENTERS	_		1	_	_	
	08800 RURAL HEALTH CLINIC	0		•	0	-	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0	ľ	
	09000 CLI NI C	318, 179		318, 17		318, 179	
	09100 EMERGENCY	3, 941, 731		3, 941, 73		3, 941, 731	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	875, 353		875, 35	3	875, 353	92.00
	OTHER REIMBURSABLE COST CENTERS	4 455 775		1 455 77	el .	4 455 775	101 00
101.00	10100 HOME HEALTH AGENCY	1, 155, 775		1, 155, 77	5	1, 155, 775	1101.00
112 00	SPECIAL PURPOSE COST CENTERS			I			112 00
	11300 INTEREST EXPENSE						113. 00 114. 00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	210 (0)		210 (0	,	210 (0)	
200.00		219, 696		219, 69		219, 696	
200.00		37, 385, 861	0	, ,		37, 385, 861 875, 353	
		875, 353		875, 35			
202. 00	Total (see instructions)	36, 510, 508	0	36, 510, 50	8 0	36, 510, 508	1202.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151315	
		From 10/01/2013 Part

					To 09/30/2014	Date/Time Pre 2/25/2016 9:4	pared: 6 am
			Ti t	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 346, 333		5, 346, 333	3		30.00
31.00	03100 INTENSIVE CARE UNIT	234, 852		234, 852	2		31.00
	04300 NURSERY	289, 600		289, 600			43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 216, 671	6, 644, 416			0.000000	
	05100 RECOVERY ROOM	236, 740	1, 480, 274			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	420, 278	331, 266			0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 158, 620	21, 683, 857	22, 842, 477		0.000000	
	06000 LABORATORY	1, 806, 658	11, 001, 060	12, 807, 718		0.000000	
	06400 I NTRAVENOUS THERAPY	0	0	1	0.00000	0. 000000	
	06500 RESPI RATORY THERAPY	957, 727	552, 586			0.000000	
	06501 SLEEP LAB	0	739, 783			0.000000	1
	06600 PHYSI CAL THERAPY	621, 953	1, 703, 770			0. 000000	
	06900 ELECTROCARDI OLOGY	97, 493	1, 061, 074			0.000000	
	06901 CARDI AC REHAB	6, 968	217, 574			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	699, 146	1, 460, 585			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	442, 166	554, 432			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 116, 333	4, 566, 064			0. 000000	
	03020 CHEMI CAL DEPENDENCY	542	141, 725			0. 000000	1
	03021 ONCOLOGY	4, 346	6, 161, 831	6, 166, 177	0. 487177	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC	0	0			0. 000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0. 000000	
	09000 CLI NI C	0	486, 343			0. 000000	
	09100 EMERGENCY	531, 188	10, 570, 579			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	201, 522	666, 896	868, 418	1. 007986	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS	1		1	1		
101. 00	10100 HOME HEALTH AGENCY	0	1, 067, 682	1, 067, 682	2		101. 00
	SPECIAL PURPOSE COST CENTERS	1		1	1		
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	_	040				114.00
	11600 HOSPI CE	0	319, 832				116. 00
200.00		15, 389, 136	71, 411, 629	86, 800, 765			200.00
201.00		45 000 101	74 444 100	0, 000 7,	_		201. 00
202.00	Total (see instructions)	15, 389, 136	71, 411, 629	86, 800, 765)		202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15	From 10/01/2013	Worksheet C Part I Date/Time Prepared: 2/25/2016 9:46 am

			10 07/30/2014	2/25/2016 9: 46 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		 	
'	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 427677			50.00
51.00 05100 RECOVERY ROOM	0. 858244			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 717339			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 183789			54.00
60. 00 06000 LABORATORY	0. 292942			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 600237			65.00
65. 01 06501 SLEEP LAB	0. 477224			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 620690			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 340504			69.00
69. 01 06901 CARDI AC REHAB	1. 262004			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 544409			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 670784			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 462867			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	2. 988775			76. 00
76. 01 03021 ONCOLOGY	0. 487177			76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 654228			90.00
91. 00 09100 EMERGENCY	0. 355054			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1. 007986			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TREDUCTIONS FOR MEDICAID ONLY	O CHARGE RATIOS NET OF	Provi der CCN: 151315	From 10/01/2013	Worksheet C Part II Date/Time Prepared:

					lo 09/30/2014	Date/lime Pre 2/25/2016 9:4	
			Ti t	le XIX	Hospi tal	PPS	o aiii
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
	, and the second	(Wkst. B, Part				Reduction	
		1, col. 26)		Cost (col. 1		Amount	
			ĺ	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 362, 010	393, 147	2, 968, 86	3 0	0	50. 00
51.00	05100 RECOVERY ROOM	1, 473, 617	97, 742	1, 375, 87	5 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	539, 112	97, 721	441, 39	1 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 198, 202	285, 911	3, 912, 29	1 0	0	54.00
60.00	06000 LABORATORY	3, 751, 913	207, 204	3, 544, 70	9 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	906, 546	52, 234	854, 31:	2 0	0	65. 00
65. 01	06501 SLEEP LAB	353, 042	59, 455	293, 58	7 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	1, 443, 552				0	66. 00
69.00	06900 ELECTROCARDI OLOGY	394, 497	12, 977	381, 520	0	0	69. 00
69. 01	06901 CARDI AC REHAB	283, 373	· ·			0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 175, 777	1			0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	668, 502	1			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 630, 193		2, 568, 970	0	0	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	425, 204	73, 107	352, 09	7 0	0	76. 00
	03021 ONCOLOGY	3, 004, 020				0	76. 01
	OUTPATIENT SERVICE COST CENTERS				•	•	ĺ
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	318, 179	8, 143	310, 03	6 0	0	90. 00
91.00	09100 EMERGENCY	3, 941, 731	283, 807		4 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	875, 353				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 155, 775	39, 321	1, 116, 45	4 0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 H0SPI CE	219, 696	7, 975	211, 72	1 0	0	116. 00
200.00		31, 120, 294	1			0	200. 00
201.00	, ,	875, 353					201. 00
202.00	1	30, 244, 941					202.00
		•	•	•	•	•	•

Health Financial Systems	CAMERON MEI	MORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provi der CCN: 151315	From 10/01/2013	Worksheet C Part II Date/Time Prepared:

						2/25/2016 9:4	46 am	
				Ti t	le XIX	Hospi tal	PPS	
		Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			Capital and	(Worksheet C,	Cost to Charg	ge		
			Operating Cost	Part I, column	Ratio (col.	6		
			Reducti on	8)	/ col. 7)			
			6.00	7. 00	8. 00			
		LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3, 362, 010	7, 861, 087	0. 42767	77		50.00
51.00		RECOVERY ROOM	1, 473, 617	1, 717, 014				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	539, 112	751, 544	0. 71733	39		52.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	4, 198, 202	22, 842, 477	0. 18378	39		54.00
60.00	06000	LABORATORY	3, 751, 913	12, 807, 718	0. 29294	12		60.00
64.00	06400	INTRAVENOUS THERAPY	0	C	0.00000	00		64. 00
65.00	06500	RESPI RATORY THERAPY	906, 546	1, 510, 313	0. 60023	37		65. 00
65. 01	06501	SLEEP LAB	353, 042	739, 783	0. 47722	24		65. 01
66.00	06600	PHYSI CAL THERAPY	1, 443, 552	2, 325, 723	0. 62069	90		66. 00
69. 00	06900	ELECTROCARDI OLOGY	394, 497	1, 158, 567	0. 34050)4		69. 00
69. 01	06901	CARDI AC REHAB	283, 373	224, 542	1. 26200)4		69. 01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 175, 777	2, 159, 731	0. 54440)9		71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	668, 502	996, 598	0. 67078	34		72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	2, 630, 193	5, 682, 397	0. 46286	57		73. 00
76.00	03020	CHEMI CAL DEPENDENCY	425, 204	142, 267	2. 98877	75		76. 00
76. 01		ONCOLOGY	3, 004, 020	6, 166, 177	0. 48717	77		76. 01
		TIENT SERVICE COST CENTERS						
88. 00	08800	RURAL HEALTH CLINIC	0	C	0.00000	00		88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.00000	00		89. 00
90.00	09000	CLINIC	318, 179	486, 343	0. 65422	28		90. 00
91.00	09100	EMERGENCY	3, 941, 731	11, 101, 767	0. 35505	54		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	875, 353	868, 418	1. 00798	36		92.00
		REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	1, 155, 775	1, 067, 682	1. 08250)9		101. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114. 00
	1	HOSPI CE	219, 696			11		116. 00
200.00		Subtotal (sum of lines 50 thru 199)	31, 120, 294	80, 929, 980				200. 00
201.00		Less Observation Beds	875, 353					201. 00
202.00) 	Total (line 200 minus line 201)	30, 244, 941	80, 929, 980				202. 00

Hoal t	h Financial Systems	CAMERON MEMORI	AL CC	MMIINII TV		In Lie	eu of Form CMS-2	0552_10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		AL CC			Period: From 10/01/2013 To 09/30/2014	Worksheet D Part II	pared:
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Tota	I Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(fron	n 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	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	393, 147		7, 861, 087	0. 05001	2 285, 546	14, 281	50.00
51.00	05100 RECOVERY ROOM	97, 742		1, 717, 014	0. 05692	52, 882	3, 010	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	97, 721		751, 544	0. 13002	2, 590	337	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	285, 911	2	22, 842, 477	0. 01251	7 415, 639	5, 203	54.00
60.00	06000 LABORATORY	207, 204	1	2, 807, 718	0. 01617	8 647, 760	10, 479	60.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0. 00000	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	52, 234		1, 510, 313	0. 03458	363, 737	12, 580	65.00
65. 01	06501 SLEEP LAB	59, 455		739, 783	0. 08036	0 8	0	65. 01
66.00	06600 PHYSI CAL THERAPY	175, 447		2, 325, 723	0. 07543	158, 119	11, 928	66.00
	1 1	1	1		1		1	1

12, 977

70, 526

32, 914

18, 746

61, 223

73, 107

432, 229

0

8, 143

283, 807

2, 453, 164

90, 631

1, 158, 567

2, 159, 731

5, 682, 397

6, 166, 177

224, 542

996, 598

142, 267

486, 343

868, 418

11, 101, 767

79, 542, 466

0.011201

0.314088

0.015240

0.018810

0.010774

0.513872

0.070097

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0.000000

0. 016743

0.025564

0.104363

39, 081

223, 842

147, 623

377, 389

4, 096

10, 468

168, 846

2, 897, 618

0

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3, 411

2, 777

4, 066

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86, 686 200. 00

17, 621

287

69.00

69.01

71.00

72.00

73.00

76.00

76. 01

88.00

0 89.00

90.00

92.00

268 91.00

69. 00 06900 ELECTROCARDI OLOGY

03021 ONCOLOGY

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

69.01

73.00

76.00

76. 01

88.00

200.00

06901 CARDI AC REHAB

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

Total (lines 50-199)

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

03020 CHEMI CAL DEPENDENCY

Health Financial S	Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF I THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCILLARY S	ERVICE OTHER PAS	S Provi d	er CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prep 2/25/2016 9:40	pared: 6 am
				Ti	tle XVIII	Hospi tal	Cost	
Cost	Center Description		Non Physician Anesthetist Cost	Nursing Scho	ol Allied Heal	th AII Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4. 00	5. 00	

		11 11	e xviii	Hospi tai	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anestheti st			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 OPERATING ROOM	0	0	0	0	0	50. 00
51.00 O5100 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 03021 ONCOLOGY	0	0	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						1
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	o	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200. 00

∐oal +h	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lio	u of Form CMS-2	0552 10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Pre 2/25/2016 9:40	pared:
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Outpatient Cost (sum of	Total Charges (from Wkst. C Part I, col.		Ratio of Cost	Inpatient Program Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.	ŭ	
		4)	ŕ		7)		
		6.00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	7, 861, 08			285, 546	
51. 00	05100 RECOVERY ROOM	0	1, 717, 01	1		52, 882	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	751, 54	1		2, 590	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 842, 47	1		415, 639	
60.00	06000 LABORATORY	0	12, 807, 71			647, 760	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	(0. 000000	0. 000000	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	1, 510, 31	0. 000000	0.000000	363, 737	65.00
65. 01	06501 SLEEP LAB	0	739, 78	0. 000000	0.000000	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	2, 325, 72	0. 000000	0. 000000	158, 119	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 158, 56	0. 000000	0. 000000	39, 081	69.00
69. 01	06901 CARDI AC REHAB	0	224, 54	0. 000000	0. 000000	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 159, 73	0. 000000	0. 000000	223, 842	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	996, 59	0. 000000	0.000000	147, 623	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 682, 39	0. 000000	0. 000000	377, 389	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	142, 26	0. 000000	0. 000000	0	76.00
76. 01	03021 ONCOLOGY	0	6, 166, 17	0. 000000	0.000000	4, 096	76. 01

0.000000

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0.000000

486, 343

868, 418

11, 101, 767

79, 542, 466

88.00

89. 00 Ωl

90.00

0

10, 468 91. 00

168, 846 92. 00

2, 897, 618 200. 00

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50-199)

0UTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC

90. 00 | 09000 | CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared:

				2/25/2016 9: 46		6 am
			e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)			50. 00
51. 00 05100 RECOVERY ROOM	0	C)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)			54. 00
60. 00 06000 LABORATORY	0	C)			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	C)			64. 00
65. 00 06500 RESPI RATORY THERAPY	0	C)			65. 00
65. 01 06501 SLEEP LAB	0	C) (65. 01
66. 00 06600 PHYSI CAL THERAPY	0	C)			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C) (69. 00
69. 01 06901 CARDI AC REHAB	0	C)			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C) (73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	C) (76. 00
76. 01 03021 0NC0L0GY	0	C)			76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C) (88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C)			89. 00
90. 00 09000 CLI NI C	0	C)			90.00
91. 00 09100 EMERGENCY	0	C) (91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C) (92.00
200.00 Total (lines 50-199)	0	C) (200. 00

Health Financial Systems		CAMERON	MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provider CCN: 151315	Peri od: From 10/01/2013	

				o 09/30/2014	Date/Time Pre 2/25/2016 9:4	
		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	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	1		1	
50.00 05000 OPERATING ROOM	0. 427677		1, 752, 657		0	
51.00 05100 RECOVERY ROOM	0. 858244		322, 269	0	0	1 0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 717339)	0	0	1 02.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 183789	l .	5, 207, 035		0	54.00
60. 00 06000 LABORATORY	0. 292942		3, 292, 260	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000		(C	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 600237		316, 756		0	65. 00
65. 01 06501 SLEEP LAB	0. 477224		4, 778		0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 620690		541, 870		0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 340504		331, 389		0	69. 00
69. 01 06901 CARDI AC REHAB	1. 262004		82, 125		0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 544409		306, 867		0	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 670784	0	169, 745		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 462867	0	1, 674, 799			73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	2. 988775		2, 268		0	76. 00
76. 01 03021 0NC0L0GY	0. 487177	0	2, 215, 747	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	l .			0	
90. 00 09000 CLI NI C	0. 654228	l .	253, 105		0	
91. 00 09100 EMERGENCY	0. 355054		2, 219, 050			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 007986	0	423, 414			
200.00 Subtotal (see instructions)		0	19, 116, 134	22, 235	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			C	0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	19, 116, 134	22, 235	1 0	202. 00

Health Financial Systems		CAMERON	MEMORIAL C	OMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der CCN: 151315		Worksheet D
					From 10/01/2013	

					To 09/30/2014	Date/Time Pr 2/25/2016 9:	
			Ti tl	e XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	LARY SERVICE COST CENTERS		1	1			
	OPERATI NG ROOM	749, 571		•			50. 00
	RECOVERY ROOM	276, 585					51. 00
	DELIVERY ROOM & LABOR ROOM	0	_				52. 00
	RADI OLOGY-DI AGNOSTI C	956, 996					54. 00
	LABORATORY	964, 441	0				60. 00
	INTRAVENOUS THERAPY	0	0				64. 00
	RESPI RATORY THERAPY	190, 129					65. 00
	SLEEP LAB	2, 280					65. 01
	PHYSI CAL THERAPY	336, 333					66. 00
	ELECTROCARDI OLOGY	112, 839	0				69. 00
69. 01 06901	CARDI AC REHAB	103, 642	0				69. 01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	167, 061	0				71. 00
	IMPL. DEV. CHARGED TO PATIENTS	113, 862	0				72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	775, 209	8, 846				73. 00
	CHEMI CAL DEPENDENCY	6, 779	0				76. 00
76. 01 03021	ONCOLOGY	1, 079, 461	0				76. 01
OUTPAT	FLENT SERVICE COST CENTERS						
88. 00 08800	RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00 09000	CLI NI C	165, 588	0				90.00
91.00 09100	EMERGENCY	787, 883	521				91.00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART	426, 795	1, 670				92. 00
200.00	Subtotal (see instructions)	7, 215, 454	11, 037				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	7, 215, 454	11, 037				202. 00

Health Financial Systems		CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OT	THER HEALTH SERVICES AND	ID VACCINE COST	Provi der CCN: 151315		Worksheet D
			Component CCN: 157315	From 10/01/2013 To 09/30/2014	

			Component	t CCN: 15Z315 T	o 09/30/2014	Date/Time Pre 2/25/2016 9:4	
-			Ti tl	e XVIII S	wing Beds - SNF		o am
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 427677) C	0	0	1 00.00
	05100 RECOVERY ROOM	0. 858244) C	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 717339	0	C	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 183789	0	C	0	0	54.00
60.00	06000 LABORATORY	0. 292942	0	C	0	0	60.00
64. 00	06400 INTRAVENOUS THERAPY	0. 000000	0) c	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 600237	0) c	0	0	65. 00
65. 01	06501 SLEEP LAB	0. 477224	0) c	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0. 620690	0	ol c	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 340504	0	ol c	0	0	69. 00
69. 01	06901 CARDI AC REHAB	1. 262004	0	ol c	0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 544409	0	ol c	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 670784	0	ol c	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 462867	0	ıl c	0	0	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	2. 988775	0	ol c	0	0	76. 00
76. 01	03021 ONCOLOGY	0. 487177	0	ol c	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 CLI NI C	0. 654228	0) c	0	0	90.00
91. 00	09100 EMERGENCY	0. 355054	0	ol c	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 007986	0	ol c	0	0	92.00
200.00	Subtotal (see instructions)		0	ol c	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program			c	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		0	ol c	0	0	202. 00

Health Financial Systems	CAMERON MEMORIAL CO	DMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER	HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151315 Component CCN: 15Z315	From 10/01/2013	
		Title XVIII	Swing Reds - SNE	Cost

		Compone	111 CON. 132313	10 07/30/2014	2/25/2016 9:46 am
		Ti ·	tle XVIII	Swing Beds - SNF	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Servi ces No			
	Subject To	Subject To			
		Ded. & Coins			
	(see inst.)	(see inst.)	_		
ANCILLARY SERVICE COST CENTERS	6.00	7. 00			
50. 00 05000 OPERATING ROOM			0		50.00
51. 00 05100 RECOVERY ROOM	0				51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0				52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0				54.00
60. 00 06000 LABORATORY					60.00
64. 00 06400 I NTRAVENOUS THERAPY					64. 00
65. 00 06500 RESPIRATORY THERAPY					65. 00
65. 01 06501 SLEEP LAB					65. 01
66. 00 06600 PHYSI CAL THERAPY			0		66. 00
69. 00 06900 ELECTROCARDI OLOGY			0		69.00
69. 01 06901 CARDI AC REHAB			0		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o		o		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o		o		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	o		o		76. 00
76. 01 03021 ONCOLOGY	o		o		76. 01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		89. 00
90. 00 09000 CLI NI C	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
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 +/- line 201)	0		0		202. 00

Health Financial Syst	cems	CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-25					2552-10
APPORTIONMENT OF INPA	ATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
					rom 10/01/2013		
					To 09/30/2014	Date/Time Pre 2/25/2016 9:4	
-			Ti t	le XIX	Hospi tal	PPS	<u>o ani</u>
Cost Cen	ter Description	Capi tal	Swing Bed	Reduced	<u> </u>	Per Diem (col.	
	·	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
		(from Wkst. B,	_	Related Cost			
		Part II, col.		(col. 1 - col.			
		26)		2)			
		1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUT	INE SERVICE COST CENTERS						
30.00 ADULTS & PEDIA	ATRI CS	557, 971	43, 160	514, 811	3, 817	134. 87	30. 00
31.00 INTENSIVE CARE	UNIT	26, 029		26, 029	108	241. 01	31.00
43. 00 NURSERY		19, 398		19, 398	361	53. 73	43.00
200.00 Total (lines 3	30-199)	603, 398		560, 238	4, 286		200. 00
Cost Cen	ter Description	I npati ent	Inpati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
I NPATI ENT ROUT	INE SERVICE COST CENTERS						
30.00 ADULTS & PEDIA	ATRI CS	189	25, 490)			30. 00
31.00 INTENSIVE CARE	UNIT	13	3, 133	3			31. 00
43. 00 NURSERY		32	1, 719				43. 00
200.00 Total (lines 3	30-199)	234	30, 342	2			200. 00

Heal th	Financial Systems	CAMERON MEMORI	ΔI C	MMIINII TV		In lie	eu of Form CMS-2	2552_10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		AL CO			Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part II	pared:
				Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(fror	n Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part	t I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00		2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	393, 147		7, 861, 087	0.05001	2 74, 359	3, 719	50.00
51.00	05100 RECOVERY ROOM	97, 742		1, 717, 014	0. 05692	14, 469	824	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	97, 721		751, 544	0. 13002	25, 725	3, 345	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	285, 911	1 2	22, 842, 477	0. 01251	70, 811	886	54.00
60.00	06000 LABORATORY	207, 204	-	12, 807, 718	0. 01617	78 110, 417	1, 786	60.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0.00000	00	0	64. 00
65.00	06500 RESPI RATORY THERAPY	52, 234		1, 510, 313	0. 03458	58, 533	2, 024	65. 00
65. 01	06501 SLEEP LAB	59, 455		739, 783	0. 08036		0	65. 01
66. 00	06600 PHYSI CAL THERAPY	175, 447	ı	2, 325, 723			2, 868	•
			ı					

12, 977

70, 526

32, 914

18, 746

61, 223

73, 107

432, 229

0

8, 143

283, 807

2, 453, 165

90, 632

1, 158, 567

2, 159, 731

5, 682, 397

6, 166, 177

224, 542

996, 598

142, 267

486, 343

868, 418

11, 101, 767

79, 542, 466

0.011201

0.314088

0.015240

0.018810

0.010774

0.513872

0.070097

0.000000

0.000000

0.016743

0.025564

0.104364

5, 958

69, 753

68, 227

426

33

250

0

0

32, 465

30, 803

600, 241

67

0

735

17

18 76. 01

0

21, 531 200. 00

3, 215

134

1, 063

69.00

69.01

71.00

72.00

73.00

76.00

0 88.00

0 89.00

90.00

92.00

830 91.00

69. 00 06900 ELECTROCARDI OLOGY

69.01

73.00

76. 01

88.00

200.00

06901 CARDI AC REHAB

76. 00 03020 CHEMI CAL DEPENDENCY

03021 ONCOLOGY

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

Total (lines 50-199)

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 10/01/2013		
				To 09/30/2014		
		T: 4	I - VIV	11: 4-1	2/25/2016 9: 4	o alli
0 1 0 1 1	N : 6 1 1		le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					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 INTENSIVE CARE UNIT	0	0)	0	0	31. 00
43. 00 04300 NURSERY	0	0	1	o	0	43.00
200.00 Total (lines 30-199)	0	0	1	o	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient		
	Days	5 ÷ col. 6)	Program Days	Program		
		ĺ .		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 817	0.00	18	9 0		30.00
31.00 03100 INTENSIVE CARE UNIT	108	0.00	1	3 0		31.00
43. 00 04300 NURSERY	361	l	l .			43. 00
200. 00 Total (lines 30-199)	4, 286	l .	23			200. 00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PAS			Period: From 10/01/2013 To 09/30/2014		
				le XIX	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Health		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1				
	05000 OPERATING ROOM	0)		0	0	00.00
	05100 RECOVERY ROOM	0)		0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0) C		0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0)		0	0	54. 00
	06000 LABORATORY	0)		0	0	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0) (0	0	64. 00
	06500 RESPI RATORY THERAPY	0) (0	0	65. 00
	06501 SLEEP LAB	0) (0	0	65. 01
	06600 PHYSI CAL THERAPY	0) (0	0	66. 00
	06900 ELECTROCARDI OLOGY	0) (0	0	69. 00
	06901 CARDI AC REHAB	0) (0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0) (0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0) (0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0) (0	0	73. 00
	03020 CHEMI CAL DEPENDENCY	0) (0	0	76. 00
76. 01	03021 ONCOLOGY	0) ()	0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0) (0	0	00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0) (0	0	89. 00
90 00	logonol CLL NLC		nl c)l	nl n	l n	90 00

0 0 0

0 88.00 0 89.00 0 90.00 0 91.00 0 92.00 0 200.00

90. 00 | 09000 | CLI NI C 91. 00 | 09100 | EMERGENCY

92. 00 | 09200 | 098ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

	Financial Systems	CAMERON MEMORI				u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS				From 10/01/2013 To 09/30/2014	Part IV Date/Time Pre	narod:
					10 09/30/2014	2/25/2016 9: 4	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
	·	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	7, 861, 087			74, 359	
51.00	05100 RECOVERY ROOM	0	1, 717, 014			14, 469	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	751, 544			25, 725	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 842, 477			70, 811	
60.00	06000 LABORATORY	0	12, 807, 718			110, 417	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 510, 313			58, 533	
65. 01	06501 SLEEP LAB	0	739, 783	0. 00000		0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	2, 325, 723	0. 00000	0. 000000	38, 012	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 158, 567	0.00000	0. 000000	5, 958	69. 00
69. 01	06901 CARDI AC REHAB	0	224, 542	0. 00000	0. 000000	426	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 159, 731	0.00000	0. 000000	69, 753	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	996, 598	0.00000	0. 000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 682, 397	0.00000	0. 000000	68, 227	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0	142, 267	0. 00000	0. 000000	33	76. 00
76. 01	03021 ONCOLOGY	0	6, 166, 177	0. 00000	0. 000000	250	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89. 00
00 00	ODDOO CLINIC	1	106 212	0 00000	0 000000	0	00 00

486, 343 11, 101, 767

868, 418 79, 542, 466

0.000000

0.000000

0.000000

0. 000000 0. 000000

0.000000

0.000000

90.00 0

91.00

30, 803 92. 00 600, 241 200. 00

32, 465

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151315	From 10/01/2013	Worksheet D Part IV Date/Time Prepared:

					2/25/2016 9:4	16 am
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE 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	O		0		76. 00
76. 01 03021 ONCOLOGY	0	O		0		76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C)	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O		0		89. 00
90. 00 09000 CLI NI C	0	O		0		90.00
91. 00 09100 EMERGENCY	0	0		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0		0		92.00
200.00 Total (lines 50-199)	0	0		0		200. 00
	1		•	1		•

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prep 2/25/2016 9:46	
	Title XVIII	Hospi tal	Cost	

			077 007 2011	2/25/2016 9: 4	6 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			4, 388	1.00
2.00	Inpatient days (including private room days, excluding swing-be			3, 817	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			0.407	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed		04 0 11	3, 197	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
	reporting period		04 6 11	200	, 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	320	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) through Dagambar	21 of the cost		7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) till ough becember	31 OF THE COST	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room)	days) after December 2	1 of the cost	251	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at ter becember 3	1 of the cost	251	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (eveluding	swing had and	1, 105	9. 00
7.00	newborn days)	the frogram (excluding	Swifig-bed and	1, 103	7. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	v (including private r	nom days)	o	10. 00
10.00	through December 31 of the cost reporting period (see instruction		oom days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		nom davs) after	320	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		oom days) area	1	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	o	12. 00
.2.00	through December 31 of the cost reporting period	sy (s. aarg pr. vac	o room dayo,	ا	.2.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program			0	14.00
15.00	Total nursery days (title V or XIX only)	, , ,	<i>,</i>	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
	reporting period	-			
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	129. 14	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	129. 14	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			5, 873, 284	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	1 -6 +1++!		,	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	i or the cost reportin	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	or the cost reporti	ing period (Title	J 0 1	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	32, 414	25. 00
20.00	x line 20)	or the cost reporting	perrou (rriie o]	20.00
26. 00	Total swing-bed cost (see instructions)			484, 209	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ne 21 minus Line 26)		5, 389, 075	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			5/ 551/ 5/ 5	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)		<i>3</i> ,	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost an	5, 389, 075	37.00		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	,		1, 411. 86	
39. 00	Program general inpatient routine service cost (line 9 x line 3	,		1, 560, 105	
40. 00	Medically necessary private room cost applicable to the Program	,		0	
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 560, 105	41. 00

Heal th	Financial Systems CAME	ERON MEMORIA	L COMMUNIT	Υ	In Lie	eu of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST			der CCN: 151315	Peri od:	Worksheet D-1	
					From 10/01/2013 To 09/30/2014		oared:
				: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		2/25/2016 9: 4	
	Cost Center Description	Total	Total	itle XVIII Average Pe	Hospital r Program Days	Cost Program Cost	
				aysDiem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00		00 0		42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	195, 541		1, 810.	56 0	0	43. 00 44. 00
45. 00							44. 00 45. 00
46. 00	· ·						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. I					1, 336, 761	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 tl PASS THROUGH COST ADJUSTMENTS	hrough 48)(s	ee instruc	tions)		2, 896, 866	49. 00
50. 00	Pass through costs applicable to Program inpatie	nt routine s	ervices (f	rom Wkst. D, su	m of Parts I and	0	50. 00
			•				
51. 00	Pass through costs applicable to Program inpatien and IV)	nt ancillary	servi ces	(from Wkst. D,	sum of Parts II	0	51. 00
52. 00	Total Program excludable cost (sum of lines 50 a	nd 51)				0	52. 00
53. 00	Total Program inpatient operating cost excluding	capital rel	ated, non-	physician anest	hetist, and	0	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program di scharges					0	54. 00
55. 00						0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating	cost and tar	act amount	(line 56 minus	· line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	cost and tar	get amount	(Title 50 illitius	1111e 55)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost report	ing period e	ndi ng 1996	, updated and c	compounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost	report und	ated by th	e market basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55,	, 59 or 60 e	nter the I	esser of 50% of	the amount by	0	61. 00
	which operating costs (line 53) are less than expanded amount (line 56), otherwise enter zero (see instance)		(lines 54	x 60), or 1% c	of the target		
62. 00		i ucti ons)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment	(see instruc	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs the state of the sta	hrough Decem	her 31 of	the cost report	ing period (See	0	64. 00
04.00	instructions)(title XVIII only)	iii ougii beceiii	DC1 31 01	the cost report	ing perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine costs a	fter Decembe	r 31 of th	e cost reportin	g period (See	451, 795	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine or	osts (line 6	4 plus lir	e 65)(title XVI	II only). For	451, 795	66. 00
	CAH (see instructions)	·	·	, ,	3,		
67. 00	Title V or XIX swing-bed NF inpatient routine cost (line 12 x line 19)	sts through	December 3	1 of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine co	sts after De	cember 31	of the cost rep	orting period	0	68. 00
	(line 13 x line 20)		: (7	! (0)			(0.00
69.00	Total title V or XIX swing-bed NF inpatient routine PART III - SKILLED NURSING FACILITY, OTHER NURSING					0	69. 00
70. 00	Skilled nursing facility/other nursing facility/	ICF/IID rout	ine servic	e cost (line 37	')		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost	per diem (li	ne 70 ÷ li	ne 2)			71. 00 72. 00
73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable	to Program	(line 14 x	line 35)			72.00
74.00	Total Program general inpatient routine service	costs (line	72 + line	73)			74. 00
75. 00	Capital-related cost allocated to inpatient routi 26, line 45)	ine service	costs (fro	m Worksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2))					76. 00
77. 00	Program capital -related costs (line 9 x line 76)	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line Aggregate charges to beneficiaries for excess cost		ovider rec	ords)			78. 00 79. 00
80. 00	Total Program routine service costs for comparison	, ,		,	nus line 79)		80. 00
81.00	Inpatient routine service cost per diem limitation						81.00
82. 00 83. 00	Inpatient routine service cost limitation (line Reasonable inpatient routine service costs (see						82. 00 83. 00
84. 00	Program inpatient ancillary services (see instruc		,				84. 00
85.00	Utilization review - physician compensation (see						85.00
86. 00	Total Program inpatient operating costs (sum of PART IV - COMPUTATION OF OBSERVATION BED PASS THE		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)					620	
88. 00			line 2)			1, 411. 86	
U7. UU	Observation bed cost (line 87 x line 88) (see in:	sti ucti UHS)				875, 353	07.00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	557, 971	5, 389, 075	0. 10353	7 875, 353	90, 631	90.00
91.00 Nursing School cost	0	5, 389, 075	0.00000	0 875, 353	0	91.00
92.00 Allied health cost	0	5, 389, 075	0.00000	0 875, 353	0	92.00
93.00 All other Medical Education	0	5, 389, 075	0.00000	0 875, 353	0	93.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Li€	In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15131	5 Period: From 10/01/2013	Worksheet D-1		
		To 09/30/2014	Date/Time Pre 2/25/2016 9:4		
	Title XIX	Hospi tal	PPS		
Cost Center Description					
			1. 00		

		Title XIX	Hospi tal	2/25/2016 9: 40 PPS	o alli
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	9 ,		4, 388	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			3, 817	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 197	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December (21 of the cost	320	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	days) at ter beceiliber .	of the cost	320	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
0.00	reporting period	D D D	1 -6	251	0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	uays) arter becember 3	i or the cost	251	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	189	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	onlv (including private	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this line	e) , ,		
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			361 32	
10.00	SWING BED ADJUSTMENT			32	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 or	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost		10 00
16.00	reporting period	arter becember 31 or	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	ofter December 21 of th	no cost	0. 00	20. 00
20.00	reporting period	arter becember 31 or tr	ie cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			5, 873, 284	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	period (line 6	0	23. 00
	x line 18)	,			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	· ·			
26. 00	Total swing-bed cost (see instructions)	. 04		454, 304	
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		5, 418, 980	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	Tine 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d nrivate room cost di	fferential (line	0 5, 418, 980	36. 00 37. 00
37.00	27 minus line 36)	a private room cost ur	Torontial (Tille	5, 410, 700	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 440 70	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			1, 419. 70 268, 323	
40. 00	Medically necessary private room cost applicable to the Program			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		268, 323	41. 00

Provider COX 19371 DIT OPERATING COST	Heal th	Financial Systems CAMERON MEMORIAL COMMUNITY In Lie	eu of Form CMS-2	2552-10				
Cost Denter Description	COMPUT	FATION OF INPATIENT OPERATING COST Provider CCN: 151315 Period:	Worksheet D-1					
Doct Denter Description			Date/Time Pre					
Total Program Royce Prog		Title XIX Hospital		<u>6 am</u>				
1		Cost Center Description Total Total Average Per Program Days	Program Cost					
1.00								
Interestive Care Type Inpatrient Despital Units 43. 00 INTERSITY CARE UNIT 1 195,541 108 1,810.56 13 23,537 44,00 0 800 800 100 100 100 100 100 100 100								
	42.00		17, 440	42. 00				
44.00 CORRINARY CARE UNIT 44.00 45.00 SURSICAL INTERISTY CARE UNIT 45.00 SURSICAL INTERISTY CARE UNIT 45.00 Total Program inpatient and Lifery Service cost (Mist. D-3. cul. 3. line 200) 1.00	43. 00		3 23, 537	43. 00				
46.00 SURGICAL INTERSIVE CARE UNIT 44.00 THER SPECIAL CARE (SPECIFY) 47.00 THER SPECIAL CARE (SP		CORONARY CARE UNIT		44. 00				
47.00 OTHER SPECIAL CARE (SPECIFY)								
28.00 Program inpatient anciliary service cost (West. D-3, col. 3, line 200) 1,00 281.660 48.00 700 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 900, 920 49.00 700								
Both Program Inpati ent and Illary service cost (Mist. D. 3. of. 3. Tine 200) 281,680 481,00 500,000 Program Inpati ent costs (sum of lines 4.1 Hornugh 48) (see Instructions) 500,000 500,000 500,000 Program								
49.00 PROSE THROUGH COST ADUSTNERMS 500, 980 49.00	48 00	Program inpatient ancillary service cost (Wkst D-3 col 3 line 200)		48 00				
0.00 Pass through costs applicable to Program inpatient routine services (From West. D., sum of Parts II and D. 1011) 1115								
1110 Seas through costs applicable to Program Inpatient ancillary services (from Wkst. D, sum of Parts II 21,531 51,00 and IV) 52,00 Total Program excludable cost (sum of lines 50 and 51) 53,00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 539,107 53,00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 539,107 53,00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 539,107 53,00 Total Program inpatient operating cost and target anount per discharges 0,00 55,00 Cost 10,00 Total Program discharges 0,00 10,00 Total Program discharges 0,00 10,00 Total Program discharges 0,00 10,00 10,00 Total Program discharges 10,00 10,00 10,00 Total Program discharges 10,00 10	F0 00		20.040	F0 00				
51.00 Pass through costs applicable to Program inpatient ancillary services (From Wist. D., sum of Parts II 21,531 51.00 21,000 21,000 21,000 22,000 23,000	50.00		30, 342	50.00				
	51. 00		21, 531	51. 00				
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended education costs (line 49 minus line 52)	52 00		51 873	52 00				
TARKET ANDURY AND LIMIT COMPUTATION 55:00 Target amount per discharge 0.055:00 Target amount per discharge 0.065:00 Target amount per discharge 0.065:00 Target amount per discharge 0.060:00 0.00 55:00 0.00 0.00 55:00 0.00			1					
54 00 Program discharges 0.0 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge 0.00 55.00 Target amount (line 54 x line 55) 0.00 55.00 Target amount (line 54 x line 55) 0.00 56.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00 57.00 0.00			L					
56. 00 Target amount (line 54 x line 55) 57. 00 Brows payment (see instructions) 58. 00 Bonus payment (see instructions) 58. 00 Bonus payment (see instructions) 59. 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60. 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60. 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60. 01 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 61. 00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 62. 00 Legic from the cost report (see instructions) 63. 00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 64. 00 Lesser of lines 53/54 or 55 from the cost report (see instructions) 65. 00 Lesser of lines 53/54 or 55 from the cost report (see instructions) 66. 00 Lesser of lines 53/54 or 55 from the cost report (see instructions) 67. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (tile XVIII only For CAM (see instructions)) 68. 00 Tile V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tille XVIII only). For CAM (see instructions) 69. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tille XVIII only). For CAM (see instructions) 69. 00 Tille V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Tille V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Tille V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Tille December 31 of the cost reporting period (line 31 x line 20) 69. 00 Tille December 31 of the cost reporting period (line 31 x line 20) 69. 00 Tille December 31 of the cost reporting period (line 31 x line 20) 69. 00 Tille December 31 of the cost reporting period (line 31 x line 20) 69. 00 Tille December 31	54. 00		0	54. 00				
57. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57. 00		Target amount per discharge	0.00	55. 00				
S8.00 Bonus payment (see instructions) 0 S8.00			1					
Design of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 0.00			1					
Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00	59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	59. 00				
61.00 If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medic are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medic are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medic are swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 70.00 Sk lilled nursing facility/fother nursing facility/for/fill proutine service cost (line 37) 70.00 Adjusted general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 71.00 Program capital -related costs (line 75 + line 2) 72.00 Program capital -related costs (line 75 + line 2) 73.00 Aggregate charges to beneficiaries for excess costs (from provider records) 74.00 Program capital -related costs (line 76 + line 81) 85.00 Aggregate charges to beneficiaries for excess co	60 00		0.00	60 00				
amount (line 56), otherwise enter zero (see instructions) 0 62.00			1					
62.00 Relief payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68) 69.00 Agusted general inpatient routine service costs (line 7 + line 2) 70.00 Skilled nursing facility/other nursing facility/								
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 6.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 6.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 6.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 7.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 7.10 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 7.10 Adjusted general inpatient routine service costs (line 72 + line 73) 7.10 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 7.10 Capital-related costs (line 75 + line 2) 7.10 Aggregate charges to beneficiaries for excess costs (from provider records) 7.10 Aggregate charges to beneficiaries for excess costs (from provider records) 7.10 Inpatient routine service costs (line 9 x line 71) 8.10 Aggregate charges to beneficiaries for excess costs (from provider records) 8.10 Aggregate charges to beneficiaries for excess costs (from provider records) 8.10 Aggregate charges to beneficiaries for excess costs (from provider records) 8.10 Aggregate char	62. 00		0	62. 00				
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (!itle XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (!itle XVIII only) Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (!itle XVIII only). For CAH (See instructions)	63. 00		0	63. 00				
instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY 70.00 SkIlled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 77.00 Reasonable inpatient routine service costs (see instructions) 78.00 Unjatient routine service cost (see instructions) 78.00 Unjatie	64 00							
Instructions) (itle XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see i		instructions)(title XVIII only)						
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.02 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.03 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program coutine service cost from more provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 81.00 Inpatient routine service cost film itation (line 78 minus line 79) 81.00 Inpatient routine service cost from compensation to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	65. 00		0	65. 00				
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/Othe	66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00				
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 ÷ line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 1, 419.70 88.00	67 00			67 00				
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 9 x line 76) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IIV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	07.00			07.00				
Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	68. 00		0	68. 00				
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 8.00 Inpatient routine service cost (line 74 minus line 77) 8.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Weasonable inpatient routine service (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 71.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 72.00 Total program inpatient routine cost per diem (line 27 ÷ line 2) 73.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2)	69. 00		0	69. 00				
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost (see instructions) 82.00 Inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 79.00 Total observation bed days (see instructions) 80.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	70.00			70.00				
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Routine Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Routilization review - physician compensation (see instructions) 85.00 Routilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,419.70 88.00								
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75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 80.00 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 Total Program inpatient routine service costs (from Worksheet B, Part II, column 75.00 76.00 Total Program routine 75 line 2) 76.00 Total Program routine service cost (line 75 iline 2) 76.00 Total Program routine service cost (line 76) 77.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 Paggregate tharges to beneficiaries for excess costs (from provider records) 77.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 77.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2)								
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00								
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,419.70 88.00	7/ 00			77,00				
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient operating costs (sum of lines 27 ÷ line 2) 88.00								
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81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Part IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Reasonable inpatient routine service costs (see instructions) 85.00 Reasonable inpatient routine service costs (see instructions) 86.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00								
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84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00	82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00				
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		· · · · · · · · · · · · · · · · · · ·						
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00								
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 1,419.70 88.00		Total Program inpatient operating costs (sum of lines 83 through 85)						
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,419.70 88.00	87. 00		620	87. 00				
89.00 Observation bed cost (line 87 x line 88) (see instructions) 880,214 89.00	88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 419. 70	88. 00				
	89. 00	Observation bed cost (line 87 x line 88) (see instructions)	880, 214	89. 00				

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	557, 971	5, 418, 980	0. 10296	6 880, 214	90, 632	90.00
91.00 Nursing School cost	0	5, 418, 980	0.00000	0 880, 214	0	91.00
92.00 Allied health cost	0	5, 418, 980	0.00000	0 880, 214	0	92.00
93.00 All other Medical Education	0	5, 418, 980	0.00000	0 880, 214	0	93.00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	CAMERON MEMORIAL COMMUNITY	CCN: 151315	Period:	u of Form CMS-2 Worksheet D-3	
INFAII	ENT ANCIELART SERVICE COST AFFORTIONWENT	Frovider	CCN. 151515	From 10/01/2013	WOLKSHEET D-3	
				To 09/30/2014	Date/Time Pre 2/25/2016 9:4	
		Ti tI	e XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.22	2)	
	LABATI ENT. DOUTLAGE CERVICES COCT. CENTERS		1. 00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		1	1, 376, 250		30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT			76, 000		30.00
	04300 NURSERY			76,000		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 42767	77 285, 546	122, 121	50.00
51. 00	05100 RECOVERY ROOM		0. 85824		45, 386	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 71733		1, 858	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 18378			
60.00	06000 LABORATORY		0. 29294			60.00
64.00	06400 I NTRAVENOUS THERAPY		0. 00000	00	0	64. 00
65.00	06500 RESPI RATORY THERAPY		0. 60023	363, 737	218, 328	65. 00
65. 01	06501 SLEEP LAB		0. 47722	24 0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY		0. 62069	158, 119	98, 143	66. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 34050	·	13, 307	69. 00
69. 01	06901 CARDI AC REHAB		1. 26200		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 54440		121, 862	l
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 67078	·	99, 023	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 46286	·	174, 681	73.00
76.00	03020 CHEMI CAL DEPENDENCY		2. 98877		0	76. 00
76. 01	03021 ONCOLOGY		0. 48717	77 4, 096	1, 995	76. 01
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0.00000	20	0	88. 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.00
90.00	09000 CLINIC		0.65422		0	90.00
91. 00	09100 EMERGENCY		0. 35505		_	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 00798		-	92.00
200.00	1		1.33776	2, 897, 618	-	
201.00	,	rogram only charges (line 61)	1	0		201. 00
202.00		5 5 2 2 5 2 2 7 2 2 7		2, 897, 618		202. 00
			•			•

	Financial Systems	CAMERON MEMORIAL COMMUNITY			u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
		Component		From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2016 9:4	pared:
		Ti tl	e XVIII	Swing Beds - SNF		
	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					1
	03000 ADULTS & PEDIATRICS			0		30. 00
	03100 INTENSIVE CARE UNIT			0		31.00
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS		T.			
	05000 OPERATING ROOM		0. 42767		0	00.00
	05100 RECOVERY ROOM		0. 85824		0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM		0. 71733		0	52.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 18378			
	06000 LABORATORY		0. 29294		6, 860	
	06400 I NTRAVENOUS THERAPY		0. 00000		0	64. 00
	06500 RESPI RATORY THERAPY		0. 60023			1
	06501 SLEEP LAB		0. 47722		0	
	06600 PHYSI CAL THERAPY		0. 62069	•		1
	06900 ELECTROCARDI OLOGY		0. 34050		151	
	06901 CARDI AC REHAB		1. 26200		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 54440		8, 817	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 67078		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 46286	•	18, 897	1
	03020 CHEMI CAL DEPENDENCY		2. 98877		0	76. 00
76. 01	03021 ONCOLOGY		0. 48717	77 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS					1
	08800 RURAL HEALTH CLINIC		0. 00000		0	00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
	09000 CLI NI C		0. 65422		0	90. 00
	09100 EMERGENCY		0. 35505		0	
02 00	OOOOO OPSEDVATION PEDS (NON DISTINCT DADT		1 00700	1 750	1 772	02 00

202. 00

1, 773 92. 00 151, 207 200. 00 201. 00

1.007986

275, 732

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART 200.00 | Total (sum of lines 50-94 and 96-98) | Less PBP Clinic Laboratory Services-Program only charges (line 61) | Net Charges (line 200 minus line 201)

Heal th	Financial Systems CAMERON MEMORIAL	COMMUNI TY		In Lie	eu of Form CMS-:	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Pre 2/25/2016 9:4	pared:
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1	4
30. 00	03000 ADULTS & PEDI ATRI CS			275, 025	l	30.00
31. 00	03100 INTENSIVE CARE UNIT			14, 353		31. 00
43. 00	04300 NURSERY			17, 699		43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 4276			
51.00	05100 RECOVERY ROOM		0. 8582			
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 7173			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1837			1
60.00	06000 LABORATORY		0. 2929			1
64. 00	06400 I NTRAVENOUS THERAPY		0.0000		0	
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB		0. 6002 0. 4772			1
66. 00	06600 PHYSI CAL THERAPY		0. 4772		0 23, 594	
69.00	06900 ELECTROCARDI OLOGY		0. 8206			
69. 00	06901 CARDI AC REHAB		1. 2620			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5444			
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6707		37, 774	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 4628		31, 580	
76. 00	03020 CHEMI CAL DEPENDENCY		2. 9887			
76. 01	03021 ONCOLOGY		0. 4871			
70.01	OUTPATIENT SERVICE COST CENTERS		0. 4071	77 230	122	70.01
88. 00	08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
90.00	09000 CLINIC		0. 6542		Ö	
91. 00	09100 EMERGENCY		0. 3550			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 0079			1
200.00				600, 241	281, 680	
201.00	,	(line 61)		0		201. 00
202.00		,		600, 241		202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151315	From 10/01/2013	Worksheet E Part B Date/Time Prepared: 2/25/2016 9:46 am
	T1 11 10 11 1		0 1

			10 09/30/2014	2/25/2016 9: 4	
		Title XVIII	Hospi tal	Cost	o an
		II ti c XVIII	nospi tui	0031	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			7, 226, 491	1.00
2.00	Medical and other services (see mistractions) Medical and other services reimbursed under OPPS (see instructions)	one)		7, 220, 471	
	,	ons)		0	
3.00	PPS payments				
4.00	Outlier payment (see instructions)	:>		0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruction)	ions)		0. 000	
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 226, 491	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	5 6.7		0	
11.00	Customary charges			Ü	11.00
15. 00	Aggregate amount actually collected from patients liable for par	umont for sorvices on a	chargo basis	0	15. 00
				0	
16. 00	Amounts that would have been realized from patients liable for patients liable for patients liable for patients and the same and the sa	payment for services on	a chargebasis	U	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	.e 11) (see	0	19. 00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
	instructions)			 -	
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		7, 298, 756	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			24, 771	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		3, 158, 707	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu		and 231 (see	4, 115, 278	
27.00	instructions)	as 1110 Sam St 111165 22	u.u 20] (000	.,	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	5 55)		0	
30.00	Subtotal (sum of lines 27 through 29)			4, 115, 278	
31. 00	Primary payer payments			4, 024	
32. 00	Subtotal (line 30 minus line 31)				
32.00		2)		4, 111, 254	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)	T		33. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			445, 052	•
35. 00	Adjusted reimbursable bad debts (see instructions)			338, 240	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		318, 636	
37. 00	Subtotal (see instructions)			4, 449, 494	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruct	ions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			4, 449, 494	
40. 01	Sequestration adjustment (see instructions)			88, 990	1
41. 00	Interim payments			4, 043, 742	1
42. 00					42.00
	37				
43.00					43. 00
44. 00					44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems CAME
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2013 Part I
To 09/30/2014 Date/Ti me Prepared: 2/25/2016 9: 46 am Provi der CCN: 151315

					2/25/2016 9: 46	6 am
			e XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 379, 89		4, 043, 742	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	04/29/2014	45, 90		0	3. 01
3.01	ADJUSTMENTS TO PROVIDER	04/29/2014		0		3. 01
						3. 02
3.03				0		
3.04				0		3. 04
3. 05	Dravi dan ta Dragnam			0	U	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 50	ADJUSTIVIENTS TO FROGRAWI			0		3. 51
3. 51				0		3. 52
3. 52				0		3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		45, 90			3. 99
3. 77	3. 50-3. 98)		45, 70	O .		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 425, 79	9	4, 043, 742	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		_,, .		.,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			<u>'</u>	'	
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provi der to Program			-I		
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		125, 22	0	316, 762	6. 01
6. 01	SETTLEMENT TO PROVIDER			0	310, 702	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 551, 02		4, 360, 504	7. 00
7.00	Total medicale program frability (see instructions)		2, 331, 02	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
00				T	1	

 DMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet E-1 Part I

 Component CCN: 15Z315
 To 09/30/2014
 Date/Time Prepared: 20/2024
 Health Financial Systems CAME
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Componen	CCN. 152315 1	0 09/30/2014	2/25/2016 9:4	
		Ti tl	e XVIII Sv	ving 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	
1.00	Total interim payments paid to provider		529, 892		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	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)					ļ
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	I	0		0	3.0 ⁻
3. 01 3. 02	ADJUSTMENTS TO PROVIDER				0	3.02
3. 02					0	3. 0.
3. 03						3.0
3. 05						3.02
3.03	Provider to Program					3.0
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			l o		0	3.5
3. 52			0		0	3. 5
3. 53			0		0	3. 5
3.54			0		0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		529, 892		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T	T			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					ł
5. 01	TENTATI VE TO PROVI DER		Ιο		0	5.0
5. 02	TENTATIVE TO TROVIDER		Ö		ĺ	5.02
5. 03			l o		0	5.03
	Provider to Program	L	-	I.		
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 5 ⁻
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 9
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		63, 882		0	6.0
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 0
7. 00	Total Medicare program liability (see instructions)		593, 774		NDD Data	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
00	1	I .		l .	ı	, 5.00

Heal th	Financial Systems CAMERON MEMORIAL (COMMUNI TY	In Lie	u of Form CMS-2	2552-10		
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151315 Period: From 10/01/2013 To 09/30/2014 Pa						
		Title XVIII	Hospi tal	Cost			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1, 192	1. 00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		1, 143			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			649	3. 00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		3, 305	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			86, 800, 765	5. 00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		1, 324, 167	6. 00		
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	rtified HIT technology	Wkst. S-2, Pt. I	94, 072	7. 00		
8.00	Calculation of the HIT incentive payment (see instructions)			70, 610	8. 00		
9.00	Sequestration adjustment amount (see instructions)			1, 412	9. 00		
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		69, 198	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00		
31.00	Other Adjustment (specify)			0	31.00		
22 00	On Delance due provider (line 0 (on line 10) minus line 30 and line 31) (one instructions)						

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

0 30.00 0 31.00 69,198 32.00

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNI TY				In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der	CCN:	151315			Worksheet E-2
					From	10/01/2013	
		Component	CCN	l: 15Z315	To	09/30/2014	Date/Time Prepared:
							2/25/2016 9:46 am
							_

				2/25/2016 9:4	6 am
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		456, 313	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	152, 719	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst	ructions)			
4.00	Per diem cost for interns and residents not in approved teaching	g program (see		0.00	4. 00
	instructions)				
5.00	Program days		320	0	5. 00
6.00	Interns and residents not in approved teaching program (see ins	tructions)		0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		609, 032	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		609, 032	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applical	ole to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		609, 032	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	3, 140	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14))	605, 892	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (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
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instru-	ctions)	0	0	18. 00
19.00	Total (see instructions)		605, 892	0	19. 00
19. 01	Sequestration adjustment (see instructions)		12, 118	0	19. 01
20.00	Interim payments		529, 892	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	d 21)	63, 882	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151315	From 10/01/2013	Worksheet E-3 Part V Date/Time Pre 2/25/2016 9:4	pared:
	Title XVIII	Hospi tal	Cost	
·				
			1. 00	

		Title XVIII	Hospi tal	Cost	o un
			noopi tai	5551	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PAI	RT A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces		2, 896, 866	1.00	
2.00	Nursing and Allied Health Managed Care payment (see instructions)		ol	2. 00
3.00	Organ acqui si ti on	,		ol	3. 00
4.00	Subtotal (sum of lines 1 through 3)			2, 896, 866	4. 00
5.00	Primary payer payments			o	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 925, 835	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for pay			0	11. 00
12.00	Amounts that would have been realized from patients liable for patients.	ayment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)			_	
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds line	e 14) (see	0	16. 00
17.00	instructions)	±!>			17 00
17. 00	Cost of physicians' services in a teaching hospital (see instruc COMPUTATION OF REIMBURSEMENT SETTLEMENT	tions)		0	17. 00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	lino 40)			18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11116 49)		2, 925, 835	
20. 00	Deductibles (exclude professional component)			344, 544	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 581, 291	
23. 00	Coi nsurance			2, 301, 271	
24. 00	Subtotal (line 22 minus line 23)			2, 578, 859	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		31, 882	
26. 00	Adjusted reimbursable bad debts (see instructions)	(See That detrons)		24, 230	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	tions)		13, 977	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	(10113)		2, 603, 089	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2,003,007	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	
30. 00	Subtotal (see instructions)			2, 603, 089	
30. 00	Sequestration adjustment (see instructions)			52, 062	
31. 00	Interim payments			2, 425, 799	
32. 00	Tentative settlement (for contractor use only)			2, 423, 777	
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, and	32)		125, 228	
34. 00	Protested amounts (nonallowable cost report items) in accordance		chanter 1	123, 220	34. 00
5 1. 00	§115. 2	211 0110 1 010. 10 2,	5ap (01 1,	ı Y	0 1. 00
				'	'

Health Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN	N: 151315	Peri od: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2016 9:46 am

			10 07/30/2014	2/25/2016 9: 4	
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
8. 00	Reasonable Charges Routine service charges		307, 078		8. 00
9. 00	Ancillary service charges		600, 241	0	
10. 00	Organ acquisition charges, net of revenue		000, 241	U	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		907, 319	0	
12.00	CUSTOMARY CHARGES		707, 317		12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	g-			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		907, 319	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	907, 319	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instru		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c		0	0	21. 00
22 00	Other than outlier payments	ompreted for FF3 provide	0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		0	Ü	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35. 00
36.00			0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		0	U	38. 00 39. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	0	1
40. 00 41. 00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		663, 019	0	
41.00	Balance due provider/program (line 40 minus line 41)		-663, 019	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	-003, 019	0	
43.00	chapter 1, §115.2	WI CIT ONG TUD 13-2,		O	15.00
			'		•

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

Peri od: Worksheet G From 10/01/2013 To 09/30/2014 Date/Time Prepared:

			'	0 09/30/2014	2/25/2016 9: 4	
	<u> </u>	General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CURRENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	2, 511, 810		0	0	1.00
2. 00	Temporary investments	2,511,610		_	0	2.00
3. 00	Notes recei vabl e	178, 272	1	_	0	3.00
4. 00	Accounts recei vabl e	7, 311, 230	1	0	ő	4. 00
5.00	Other recei vable	626, 260	1	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	o c	0	0	6. 00
7.00	Inventory	995, 724	1 C	0	0	7. 00
8.00	Prepai d expenses	516, 261	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	12, 502, 750	1		0	10.00
11. 00	Total current assets (sum of lines 1-10)	24, 642, 307	7 <u> </u>	0	0	11. 00
40.00	FI XED ASSETS			1	_	
12. 00	Land	3, 620, 135	1	_	0	12.00
13. 00 14. 00	Land improvements				0	13. 00 14. 00
15. 00	Accumulated depreciation Buildings	52, 618, 223	1	0	0	15.00
16. 00	Accumulated depreciation	-12, 137, 425	1	0	0	16.00
17. 00	Leasehold improvements	-12, 137, 423		0	0	17. 00
18. 00	Accumulated depreciation			0	0	18. 00
19. 00	Fi xed equipment	l o		0	Ō	19.00
20.00	Accumulated depreciation	i c	o c	0	0	20.00
21.00	Automobiles and trucks	l c	ol c	0	0	21.00
22.00	Accumulated depreciation	0	ol c	0	0	22. 00
23.00	Major movable equipment	18, 150, 885	5 C	0	0	23. 00
24.00	Accumul ated depreciation	-15, 253, 791	ı c	0	0	24. 00
25.00	Mi nor equi pment depreci able	0	o	0	0	25. 00
26.00	Accumul ated depreciation	0	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	_	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	46, 998, 027	7 C	0	0	30. 00
	OTHER ASSETS	10.500.055	-1	1		
31. 00	Investments	19, 532, 955	1		-	31.00
32. 00	Deposits on Leases			_	0	32.00
33. 00	Due from owners/officers	1 242 7//			0	33.00
34. 00 35. 00	Other assets Total other assets (sum of Lines 21 24)	1, 243, 766	1	_	0	34. 00 35. 00
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	20, 776, 721 92, 417, 055	1		0	36.00
30.00	CURRENT LIABILITIES	72,417,000	7	U	0	30.00
37. 00	Accounts payable	4, 520, 102	2 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 887, 147	1	0	0	38.00
39. 00	Payroll taxes payable	1,007,117		0	Ö	39. 00
40. 00	Notes and Loans payable (short term)	444, 195	٦	0	Ö	40.00
41. 00	Deferred income	1, ., .		0	ő	41.00
42.00	Accel erated payments	l o				42.00
43.00	Due to other funds	l c	ol c	0	0	43.00
44.00	Other current liabilities	1, 609, 085	5 C	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	8, 460, 529	e o	0	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	C	0	0	0	46. 00
47.00	Notes payable	0	0	0		47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	46, 664, 260	1	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	46, 664, 260	1		0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	55, 124, 789	P C	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	37, 292, 266				52.00
53.00	Specific purpose fund		C			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	_	56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	37, 292, 266		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	92, 417, 055	1	n	0	60.00
55. 50	59)	,2,117,000				55.50
	· ·	•	•	1	•	

					То	09/30/2014	Date/Time Prep 2/25/2016 9:40	
		Genera	l Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period		34, 397, 127			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 737, 208					2.00
3.00	Total (sum of line 1 and line 2)		37, 134, 335			0		3. 00
4.00	OTHER CHANGES IN NET ASSESTS	145, 602			0		0	4. 00
5. 00 6. 00		0			0		0	5. 00 6. 00
7. 00		0			0			7. 00
8. 00		0			0			8. 00
9. 00		o o			o		o o	9. 00
10. 00	Total additions (sum of line 4-9)		145, 602			0	_	10.00
11. 00	Subtotal (line 3 plus line 10)		37, 279, 937			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13. 00		0			0		0	13.00
14. 00		0			0		0	14.00
15. 00		0			0		0	15. 00
16.00		0			0		0	16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0		U	0	U	17. 00 18. 00
19. 00	Fund balance at end of period per balance		37, 279, 937			0		19. 00
17.00	sheet (line 11 minus line 18)		31,217,731			O		17.00
		Endowment Fund	PI ant	Fund				
			7.00	0.00				
1.00	Fund balances at beginning of period	6.00	7. 00	8. 00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				U			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	OTHER CHANGES IN NET ASSESTS		0		Ĭ			4. 00
5.00			0					5. 00
6.00			O					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) Deductions (debit adjustments) (specify)	U	0		0			11. 00 12. 00
13. 00	beductions (debit adjustments) (specify)		0					13. 00
14. 00			0					14. 00
15. 00			o					15. 00
16. 00			0					16. 00
17. 00		1	o					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)							

Health Financial Systems C.
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Peri od: | Worksheet G-2 | From 10/01/2013 | Parts I & II | To 09/30/2014 | Date/Time Prepared: Provi der CCN: 151315

			To 09/30/2014	Date/Time Pre 2/25/2016 9:4	
	Cost Center Description	Inpatient	Outpati ent	Total	J dill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>.</u>			
	General Inpatient Routine Services				
1.00	Hospi tal	5, 346, 33	33	5, 346, 333	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8. 00 9. 00	NURSING FACILITY				8. 00 9. 00
10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)	5, 346, 33	22	5, 346, 333	9. 00 10. 00
10.00	Intensive Care Type Inpatient Hospital Services	5, 340, 3.	ာ၁	0, 340, 333	10.00
11. 00	INTENSIVE CARE UNIT	234, 85	52	234, 852	11. 00
12. 00	CORONARY CARE UNIT	254, 0	72	254, 052	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 234, 85	52	234, 852	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 581, 18		5, 581, 185	17. 00
18. 00	Ancillary services	9, 703, 70		68, 004, 248	18. 00
19. 00	Outpati ent servi ces		0 11, 827, 818	11, 827, 818	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY		1, 067, 682	1, 067, 682	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00 25. 00	CMHC AMBULATORY SURGICAL CENTER (D. P.)				24. 00 25. 00
26. 00	HOSPICE		0 319, 832	319, 832	26. 00
27. 00	OTHER		0 5, 521, 099	5, 521, 099	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 15, 284, 88			28. 00
20.00	G-3, line 1)	10, 201, 00	77,000,770	72, 021, 001	20.00
	PART II - OPERATING EXPENSES	<u> </u>			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		44, 482, 112		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00 40. 00			0		39. 00 40. 00
41. 00					40.00
41.00	Total deductions (sum of lines 37-41)				41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	44, 482, 112		43. 00
. 5. 00	to Wkst. G-3, line 4)		1., .52, 112		

	Financial Systems CAMERON MEMORIAL			u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 151315	Peri od: From 10/01/2013	Worksheet G-3	
			To 09/30/2014	Date/Time Pre	pared:
				2/25/2016 9: 4	6 am
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			92, 321, 864	
2.00	Less contractual allowances and discounts on patients' accoun	its		47, 466, 078	•
3.00	Net patient revenues (line 1 minus line 2)			44, 855, 786	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		44, 482, 112	
	Net income from service to patients (line 3 minus line 4)			373, 674	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	0.00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	1
11. 00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service				13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			2, 363, 534	24. 00
25.00	Total other income (sum of lines 6-24)			2, 363, 534	25. 00
26.00	Total (line 5 plus line 25)			2, 737, 208	•
	OTHER EXPENSES (SPECIFY)			0	1
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			2, 737, 208	20 00

						Agency I		
		Sal ari es			Contracted/Pur	Other Costs	Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2.00	instructions)	Servi ces	5. 00	5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5. 00	6. 00	
1.00	Capi tal Related - Bldg. &			0		0	0	1.00
1.00	Fixtures			Ĭ	1	· ·		1.00
2.00	Capital Related - Movable			o		0	0	2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3. 00
4.00	Transportation	0	0	1	0	0	0	4. 00
5.00	Administrative and General	177, 310	0	0	12, 268	50, 523	240, 101	5.00
	HHA REIMBURSABLE SERVICES	000 000		20.055			074 077	, ,,
6. 00 7. 00	Skilled Nursing Care Physical Therapy	239, 822 146, 098	0	32, 055	0	0	1	6. 00 7. 00
8. 00	Occupational Therapy	27, 089	0			0		1
9. 00	Speech Pathology	3, 428	0			0	3, 428	ı
10. 00	Medical Social Services	0, 120	0		ol o	0	0, 120	1
11. 00	Home Heal th Aide	50, 495	0	Ö	o o	0	50, 495	
12.00	Supplies (see instructions)	0	0	l c	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13. 00
14.00	DME	0	0	C	0	0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES							
15. 00	Home Dialysis Aide Services	0	0	0	ή	0		
16. 00	Respi ratory Therapy	0	0	0	0	0	0	16. 00
17. 00	, ,	0	0	0	0	0	0	17. 00
18.00	Clinic	0	0	0	0	0	0	18.00
19. 00 20. 00	Health Promotion Activities	0	0			0	0	19. 00 20. 00
21. 00	Day Care Program Home Delivered Meals Program		0			0		21.00
22. 00	1	0	0			0		22. 00
23. 00	All Others (specify)	846	0	Ö		0	846	1
	Total (sum of lines 1-23)	645, 088	0	32, 055	12, 268	50, 523		
		Reclassi fi cati	Recl assi fi ed	Adjustments	Net Expenses	·		
		on	Trial Balance		for Allocation			
			(col. 6 +		(col. 8 + col.			
		7.00	col . 7)	0.00	9)			
	CENEDAL CEDVICE COCT CENTEDS	7. 00	8. 00	9. 00	10.00			
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0					1.00
1.00	Fixtures		0	٦)			1.00
2.00	Capital Related - Movable	0	0	0	0			2. 00
	Equipment							
3.00	Plant Operation & Maintenance	0	0	0	0			3. 00
4.00	Transportation	0	0	0	0			4. 00
5.00	Administrative and General	-100, 754	139, 347	0	139, 347			5. 00
	HHA REIMBURSABLE SERVICES	_		_				
6.00	Skilled Nursing Care	0	271, 877	0				6.00
7.00	Physical Therapy	0	146, 098		146, 098			7.00
8.00	Occupational Therapy	0	27, 089		27, 089			8. 00
9.00	Speech Pathology Medical Social Services	25, 731	3, 428 25, 731		3, 428 25, 731			9. 00 10. 00
	Home Heal th Ai de	25, 731	50, 495					11. 00
	Supplies (see instructions)	0	30, 473		0 30, 473			12.00
	Drugs	0	0		ol ő			13.00
14.00		0	0	o c	o			14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	0	0			15. 00
16. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	0	0	0			16. 00
17. 00	, ,	0	0	0	0			17. 00
	Clinic	0	0	0	0			18.00
	Health Promotion Activities	0	0	0	0			19.00
	Day Care Program		0		J O			20.00
	Home Delivered Meals Program Homemaker Service		0					21. 00 22. 00
	All Others (specify)	-846	0					23. 00
	Total (sum of lines 1-23)	-75, 869	664, 065		664, 065			24.00
	(2.2. 2	,	, 300	,	1 22., 300			

	Fixtures							
2.00	Capital Related - Movable	o		o			0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	o	0	o	0		0	3. 00
4.00	Transportation	o	0	o	0	0		4. 00
5.00	Administrative and General	139, 347	0	o	0	0	139, 347	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	271, 877	0	0	0	0	271, 877	6.00
7.00	Physical Therapy	146, 098	0	l ol	0	0		7. 00
8.00	Occupational Therapy	27, 089	0	l ol	0	0	27, 089	
9.00	Speech Pathology	3, 428	0	l ol	0	0		1
10.00	Medical Social Services	25, 731	0	o	0	0	25, 731	10.00
11. 00	Home Health Aide	50, 495	0	0	0	0	50, 495	1
12. 00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13. 00	Drugs		0	0	0	ū	Ö	13. 00
14. 00	DME	l o	0	o	0	0		14. 00
11.00	HHA NONREI MBURSABLE SERVI CES	<u>۷</u>		<u> </u>	<u> </u>			1 1. 00
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	15. 00
16. 00	Respiratory Therapy		0	1	0	0	0	16. 00
17. 00	Private Duty Nursing		0	1	0	0	_	17. 00
18. 00	Clinic		0	1	0	0	0	18. 00
19. 00	Health Promotion Activities		0		0	0	0	19. 00
20. 00	Day Care Program		0		0	0	0	20.00
21. 00	Home Delivered Meals Program		0		0	0	0	21.00
22. 00	Homemaker Service		0		0	0	0	22.00
	All Others (specify)		0		0	0	0	23. 00
24. 00		664, 065	0		0	0	664, 065	1
24.00	Total (Suil of Titles 1-23)	Admi ni strati ve	Total (cols.	U U	U	U	004, 003	24.00
		& General	4A + 5)					
		5. 00	6.00					
	GENERAL SERVICE COST CENTERS	5.00	0.00					
1.00	Capital Related - Bldg. &							1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable							2. 00
2.00	Equi pment							2.00
3.00	Plant Operation & Maintenance							3. 00
4. 00	Transportation							4. 00
5. 00	Administrative and General	139, 347						5. 00
3.00	HHA REIMBURSABLE SERVICES	137, 347						3.00
6.00	Skilled Nursing Care	72, 201	344, 078					6.00
7. 00	Physical Therapy	38, 799	184, 897					7. 00
8. 00	Occupational Therapy	7, 194	34, 283					8. 00
9. 00	Speech Pathology	910	4, 338					9. 00
10. 00	Medical Social Services	6, 833	32, 564					10.00
11. 00	1	1	·					11. 00
	Home Health Aide	13, 410	63, 905 0	i e				12.00
12. 00 13. 00	Supplies (see instructions) Drugs		0					ł
14. 00	DME		0					13.00
14.00		j U	0					14. 00
15 00	HHA NONREI MBURSABLE SERVI CES	1 0						1 1 00
15.00	Home Dialysis Aide Services	0	0	l				15.00
16.00	Respiratory Therapy	0	0					16.00
17. 00	Private Duty Nursing	0	0					17. 00
	Clinic	0	0					18. 00
19.00	Health Promotion Activities	0	0	l .				19.00
20. 00	Day Care Program	0	0	l .				20.00
21. 00	9	0	0	l .				21. 00
22. 00	Homemaker Servi ce	0	0	l .				22. 00
23. 00	All Others (specify)	0	0					23. 00
24. 00	Total (sum of lines 1-23)		664, 065					24. 00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BAS	IS	Provi der	CCN: 151315	Peri od: From 10/01/2013	Worksheet H-1 Part II
		HHA CCN:	157117	To 09/30/2014	Date/Time Prepared: 2/25/2016 9:46 am
				Home Health Agency I	PPS
	Capital Related Costs	5			

						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati or	Reconciliation		
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)				(ACCUM. COST)	
				(SQUARE FEET)				
		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
	Fixtures		_			_		
2.00	Capital Related - Movable		0			0		2. 00
0.00	Equi pment							0.00
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0	(7		4. 00
5. 00	instructions) Administrative and General		0	O		-139, 347	E24 710	5. 00
5.00	HHA REIMBURSABLE SERVICES		U	U	1	-139, 347	524, 718	3.00
6. 00	Skilled Nursing Care	1 0	0	C			271, 877	6. 00
7. 00	Physical Therapy		0	0			146, 098	
8. 00	Occupati onal Therapy		0	0			27, 089	
9. 00	Speech Pathology		0	0			3, 428	
10.00	Medical Social Services		0	0		1	25, 731	10.00
11. 00	Home Health Aide		0	0			50, 495	
12. 00	Supplies (see instructions)		0				0	12.00
13. 00	Drugs		0				0	13.00
14. 00	DME		0				0	14. 00
14.00	HHA NONREI MBURSABLE SERVI CES	0	U		1	<u> </u>	U	14.00
15. 00	Home Dialysis Aide Services	1 0	0	0		0	0	15. 00
16. 00	Respiratory Therapy		0	0	1		0	16. 00
17. 00	Pri vate Duty Nursing		0	0			0	17. 00
18. 00	Clinic		0	0			0	18. 00
19. 00	Health Promotion Activities		0	0			0	19. 00
20. 00	Day Care Program		0	0			0	20.00
21. 00	Home Delivered Meals Program		0	0			0	21. 00
22. 00		1 0	0	Ö			Ő	22. 00
23. 00		1 0	0	Ö			Ő	23. 00
24. 00	Total (sum of lines 1-23)	1 0	0	Ö		-139, 347	524, 718	
25. 00	Cost To Be Allocated (per	1 0	o o	n)	139, 347	25. 00
20.00	Worksheet H-1, Part I))		.57,017	
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000	D	0. 265566	26. 00
	•	•			•	•	. '	•

HHA CCN: 151315 | Fer Tod: | Worksheet H-2 | From 10/01/2013 | Part I | Part I | Date/Time Prepared: | 2/25/2016 9: 46 am

342

38, 104

0

20.00

21.00

Home Health Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ADMI NI STRATI VE HHA Trial BLDG & FIXT Cost Center Description Subtotal Bal ance (1) **BENEFITS** & GENERAL DEPARTMENT 1.00 2.00 5. 00 0 4.00 4A 1.00 Administrative and General 0 20, 705 177, 307 198, 012 49, 529 1.00 0 344, 078 86,064 2 00 C 344.078 2 00 Skilled Nursing Care 3.00 Physical Therapy 184, 897 0 C 0 184, 897 46, 248 3.00 4.00 Occupational Therapy 34, 283 000000000000000 0 34, 283 8,575 4.00 Speech Pathology 0 1, 085 5 00 4, 338 Ω 4, 338 5 00 0 6.00 Medical Social Services 32, 564 C 32, 564 8, 145 6.00 7.00 Home Heal th Aide 63, 905 63, 905 15, 985 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 0 0 0 9.00 Ω 0 9 00 Drugs 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 0 Respiratory Therapy 12.00 12.00 0 0 13.00 Private Duty Nursing 0 13.00 0 14.00 Clinic 0 14.00 Health Promotion Activities 15.00 15.00 0 Day Care Program 0 0 0 16, 00 16.00 17.00 Home Delivered Meals Program 0 0 0 17 00 0 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 C 19.00 20.00 Total (sum of lines 1-19) (2) 664,065 20, 705 177, 307 862,077 215, 631 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. NURSI NG Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE ADMI NI STRATI ON 8.00 9.00 10.00 11.00 13.00 1.00 Administrative and General 38, 067 342 С 38, 104 1. 00 0000000000000000000 2 00 Skilled Nursing Care 0 2.00 O C 0 0 3.00 Physical Therapy C 0 3.00 4.00 Occupational Therapy 0 0 0 0 4.00 Speech Pathology 0 5.00 0 0 0 0 0 0 0 0 0 5.00 0 0 6.00 Ω Medical Social Services 6.00 7.00 Home Health Aide 0 0 7.00 Supplies (see instructions) 8.00 8.00 9 00 0 0 0 9 00 Drugs 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services 11.00 0 0 12.00 Respiratory Therapy 0 12.00 0 Private Duty Nursing 13.00 0 13.00 14.00 Clinic 0 14.00 Health Promotion Activities 0 15.00 15.00 0 16, 00 Day Care Program 0 0 0 16.00 0 0 Home Delivered Meals Program Ω ol 17.00 17.00 18.00 Homemaker Service 0 0 0 0 18.00 All Others (specify) 19.00 19.00

Total (sum of lines 1-19) (2)

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

Unit Cost Multiplier: column

6 decimal places.

38,067

20.00

21.00

⁽¹⁾ Column 0, line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Provider CCN: 151315 | Peri od: From 10/01/2013 | Worksheet H-2 | Part I | To 09/30/2014 | Date/Time Prepared: 2/35/2014 | Dat

				TITIA CON.	137117	10 07/30/2014	2/25/2016 9: 4	
						Home Health	PPS	
	Coot Contan Decement on	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Agency I Intern &	Subtotal	
	Cost Center Description	SERVICES &	PHARWACT	RECORDS &	Subtotal	Residents Cost		
		SUPPLY		LI BRARY		& Post		
		JUFFLI		LIDRAKI		Stepdown		
						Adjustments		
		14. 00	15.00	16. 00	24.00	25. 00	26.00	
1.00	Administrative and General	1, 554	0		0 325, 60			1. 00
2.00	Skilled Nursing Care	0	0		0 430, 14	2 0	430, 142	2. 00
3.00	Physical Therapy	0	0		0 231, 14	5 0	231, 145	3. 00
4.00	Occupational Therapy	0	0		0 42, 85	68 0	42, 858	4. 00
5.00	Speech Pathology	0	0		0 5, 42	23 0	5, 423	5. 00
6.00	Medical Social Services	0	0		0 40, 70	0	40, 709	6. 00
7.00	Home Health Aide	0	0		0 79, 89	0 0	79, 890	7. 00
8.00	Supplies (see instructions)	0	0		0	0	0	8. 00
9.00	Drugs	0	0		0	0	0	9. 00
10.00	DME	0	0		0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0		0	0	_	11. 00
12. 00	Respiratory Therapy	0	0		0	0	0	12. 00
13. 00	Private Duty Nursing	0	0		0	0	0	13. 00
14. 00	Clinic	0	0		0	0	0	14. 00
15. 00	Health Promotion Activities	0	0		0	0	0	15. 00
16.00	Day Care Program	0	0		0	0	_	
17. 00	Home Delivered Meals Program	0	0		0	0	0	17. 00
18. 00	Homemaker Service	0	0		0	0	_	18.00
19. 00	All Others (specify)	0	0		0 1 155 7	0 0	_	19. 00
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	1, 554	o _l		0 1, 155, 77	5	1, 155, 775	20. 00 21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
		11)	20.00					
1.00	Administrative and General	27. 00	28. 00					1. 00
2.00	Skilled Nursing Care	168, 710	598, 852					2. 00
3.00	Physical Therapy	90, 660	321, 805					3.00
4. 00	Occupational Therapy	16, 810	59, 668					4. 00
5. 00	Speech Pathology	2, 127	7, 550					5. 00
6. 00	Medical Social Services	15, 967	56, 676					6. 00
7. 00	Home Heal th Aide	31, 334	111, 224					7. 00
8. 00	Supplies (see instructions)	0.700.	0					8. 00
9. 00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11. 00	Home Dialysis Aide Services	o	0					11. 00
12.00	Respiratory Therapy	O	0					12. 00
13.00	Private Duty Nursing	0	0					13. 00
14.00	Clinic	0	0					14.00
15. 00	Health Promotion Activities	0	0					15. 00
16.00	Day Care Program	0	0					16. 00
17. 00	Home Delivered Meals Program	0	0					17. 00
18. 00	Homemaker Service	0	0					18. 00
19. 00		0	0					19. 00
20. 00	Total (sum of lines 1-19) (2)	325, 608						20.00
21. 00	Unit Cost Multiplier: column	0. 392220						21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	1 p. 4000.	1						1

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

Health Financial Systems	CAMERON MEMORIAL C	In Lieu of Form CMS-2552-10		
ALLOCATION OF GENERAL SERVICE COSTS TO	HHA COST CENTERS STATISTICAL	Provi der CCN: 151315		Worksheet H-2
BASIS		HHA CCN: 157117	From 10/01/2013 To 09/30/2014	Date/Time Prepared:
				2/25/2016 9:46 am
			Home Health	PPS

								2/25/2016 9: 4	6 am
							Home Health Agency I	PPS	
		CAPITAL REL	_ATED_COSTS				Agency		
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		/PLOYEE	Reconciliatio	nADMI NI STRATI VE		
		(SQUARE FEET)	(SQUARE FEET)		ENEFITS		& GENERAL	PLANT	
					PARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
					LARI ES)				
		1.00	2. 00		4. 00	5A	5. 00	7. 00	
1.00	Administrative and General	0	979		569, 219		0 198, 012		1. 00
2.00	Skilled Nursing Care	0	0		C	1	0 344, 078		2. 00
3. 00 4. 00	Physical Therapy	0	0		C		0 184, 897 0 34, 283		3. 00 4. 00
5. 00	Occupational Therapy Speech Pathology		0		C		0 34, 283 0 4, 338		5. 00
6. 00	Medical Social Services	l ő	0		C		0 32, 564		
7.00	Home Health Aide	0	0		C		0 63, 905		7. 00
8.00	Supplies (see instructions)	0	0		C		0 0	0	8. 00
9. 00	Drugs	0	0	l .	C		0	0	9. 00
10. 00 11. 00	DME	0	0	l .	C		0 0	0	10.00
12. 00	Home Dialysis Aide Services Respiratory Therapy		0	l .	C		0	0	11. 00 12. 00
13. 00	Private Duty Nursing	l ő	0	l .	C	1	o o	ő	13. 00
14. 00	Clinic	0	0		C		0 0	0	14. 00
15. 00	Health Promotion Activities	0	0		C		0 0	0	15. 00
16.00	Day Care Program	0	0		C		0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0				0	0	17. 00 18. 00
	All Others (specify)	0	0					0	19. 00
	Total (sum of lines 1-19)	0	979		569, 219	6	862, 077		20. 00
21. 00	Total cost to be allocated	0	20, 705		177, 307		215, 631		
22. 00		0. 000000			0. 311492		0. 250130		22. 00
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF		I ETARY _S SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		(POUNDS OF	SERVIC)	(WLAL	J JLKVLD)	(1123)	ADMINI STRATION	SUPPLY	
		LAUNDR)	ĺ				(DIRECT NRSING	(COSTED	
							HR)	REQUIS.)	
1. 00	Administrative and General	8.00	9.00		10.00	11.00	13. 00 4 0	14. 00 8, 049	1. 00
2. 00	Skilled Nursing Care	0	0		C	1	0 0	0,049	2. 00
3. 00	Physical Therapy	0	Ö		C		o o	Ö	3. 00
4.00	Occupational Therapy	0	0		C		0 0	0	4. 00
5.00	Speech Pathology	0	0		C		0	0	5. 00
6.00	Medical Social Services	0	0		C	1	0	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0		C		0 0	0	7. 00 8. 00
9. 00	Drugs		0	l	C		0 0	0	9. 00
10.00	DME	0	0		C		o o	0	10. 00
11. 00	Home Dialysis Aide Services	0	0		C		0 0	0	11. 00
12.00	Respiratory Therapy	0	0		C		0	0	12.00
13.00		0	0				0	0	13.00
	Clinic Health Promotion Activities		0		(á	0 0	0	00
16. 00	1	0	Ö	ŀ	C		o o	Ö	16. 00
17. 00	Home Delivered Meals Program	0	0		C)	0 0	0	17. 00
18.00		0	0		C		0	0	18.00
19. 00	All Others (specify) Total (sum of lines 1-19)	0	0		C		0	0	19. 00
	Total cost to be allocated		342		(94 38, 10		8, 049 1, 554	
	Unit cost multiplier	0. 000000			0. 000000				
	'		'				1		

Health Financial Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lieu of Form CMS-2552-10		
ALLOCATION OF GENERAL SERVICE COSTS TO HH/ BASIS	A COST CENTERS STATISTICAL	Provi der CCN: 151315	Peri od: From 10/01/2013	Worksheet H-2 Part II	
BASI S		HHA CCN: 157117		Date/Time Prepared: 2/25/2016 9:46 am	
			Home Health	PPS	
			Agency I		

				Home Health	PPS	
				Agency I		
	Cost Center Description	PHARMACY	MEDI CAL			
		(COSTED	RECORDS &			
		REQUIS.)	LI BRARY			
			(TIME 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	Physi cal Therapy	0	0			3. 00
4.00	Occupati onal Therapy	0	0			4. 00
5.00	Speech Pathology	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	o			9. 00
10.00	DME	0	O			10.00
11. 00	Home Dialysis Aide Services	0	O			11. 00
12.00	Respi ratory Therapy	0	o			12. 00
13.00	Private Duty Nursing	0	o			13. 00
14.00	Clinic	0	o			14. 00
15.00	Health Promotion Activities	0	o			15. 00
16.00	Day Care Program	0	o			16. 00
17. 00	Home Delivered Meals Program	0	o			17. 00
18. 00	Homemaker Service	0	o			18. 00
19. 00	All Others (specify)	0	o			19. 00
20. 00	Total (sum of lines 1-19)	0	o			20.00
21. 00	Total cost to be allocated	0	o			21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000			22. 00
	I P					

	Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPOR7	TIONMENT OF PATIENT SERVICE COST	S		Provi der		Peri od:	Worksheet H-3	
				HHA CCN:	157117	From 10/01/2013 To 09/30/2014	Part I Date/Time Prep 2/25/2016 9:40	pared: 6 am
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1. 00	Skilled Nursing Care	2.00	598, 852		598, 85	2 1, 827	327. 78	1. 00
2. 00	Physical Therapy	3.00						2. 00
3.00	Occupational Therapy	4. 00	59, 668	O	59, 66			3. 00
4.00	Speech Pathology	5. 00			.,		106. 34	4. 00
5.00	Medical Social Services	6. 00			56, 67		1, 049. 56	5. 00
6.00	Home Heal th Ai de	7. 00			111, 22	· ·		6. 00
7. 00	Total (sum of lines 1-6)		1, 155, 775	C	1,155,77 Program Visit			7. 00
			1			rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	· ·		, ,		Deductibles 8			
		_			Coi nsurance			
	Limitation Cost Computation	0	1.00	2.00	3.00	4. 00	5. 00	
8.00	Skilled Nursing Care		99915	28	92	6		8. 00
9.00	Physi cal Therapy		99915	65	1, 19	1		9. 00
10.00	Occupational Therapy		99915	21	l .			10. 00
11.00	Speech Pathology		99915	0	1			11. 00
12.00	Medical Social Services		99915	0	1			12.00
13.00	Home Health Aide Total (sum of lines 8-13)		99915	46 160				13. 00 14. 00
14.00		From Wkst H-2	Facility Costs		Total HHA		Ratio (col. 3	14.00
	2001 2011101 20001 Pt. 011	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)	ŕ	
		0	1.00	Part II)	2.00	4.00	F 00	
	Supplies and Drugs Cost Computa		1.00	2. 00	3.00	4. 00	5. 00	
15.00	Cost of Medical Supplies	8. 00	0	O		0 0	0. 000000	15. 00
16. 00	Cost of Drugs	9. 00				0 0	0. 000000	16. 00
			Program Visits		Cost of			
			Par	+ R	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	2001 2011101 20001 Pt. 011	''	Deductibles &		''	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	OF AGGREGATE F	PROGRAM COSI, A	GGREGATE OF TH	IE PROGRAM LIM	ITATION COST, OF	₹	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	28	926		9, 17	8 303, 524		1. 00
	Physical Therapy	65			9, 31			2. 00
2.00			167		3, 18	8 25, 356		3. 00
3.00	Occupational Therapy	21				0 4 570		4.00
3. 00 4. 00	Speech Pathology	0	43		1	0 4, 573		
3. 00 4. 00 5. 00	Speech Pathology Medical Social Services	0 0	43 41			0 43, 032		5. 00
3. 00 4. 00 5. 00 6. 00	Speech Pathology Medical Social Services Home Health Aide	0 0 46	43 41 336		4, 57	0 43, 032 2 33, 398		5. 00 6. 00
3. 00 4. 00 5. 00 6. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	0 0	43 41 336			0 43, 032 2 33, 398		5. 00
3. 00 4. 00 5. 00 6. 00	Speech Pathology Medical Social Services Home Health Aide	0 0 46	43 41 336		4, 57	0 43, 032 2 33, 398	11.00	5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11. 00	5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11.00	5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11.00	5. 00 6. 00 7. 00 8. 00 9. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11.00	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11.00	5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 46 160	43 41 336 2, 704		4, 57 26, 25	0 43, 032 2 33, 398 5 580, 601	11.00	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00

Heal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		HHA CCN:			Date/Time Pre 2/25/2016 9:4	pared:
					le XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance		
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa	ations	1	1				
	Cost of Medical Supplies Cost of Drugs		435		o	0	_	15. 00 16. 00
10.00	Cost Center Description	Total Program	433		<u> </u>		0	10.00
	oost conten bescriptron	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF T	HE PROGRAM LI	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							1
4 00	Cost Per Visit Computation	040.700	I					4 00
1.00	Skilled Nursing Care	312, 702						1. 00 2. 00
2. 00 3. 00	Physical Therapy Occupational Therapy	180, 035 28, 544						3.00
4. 00	Speech Pathology	4, 573						4.00
5. 00	Medical Social Services	43, 032						5. 00
6. 00	Home Health Aide	37, 970						6.00
7. 00	Total (sum of lines 1-6)	606, 856						7. 00
	Cost Center Description	·						
		12. 00						
	Limitation Cost Computation							
	Skilled Nursing Care							8. 00
9.00	Physical Therapy							9. 00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
	Medical Social Services Home Health Aide							12.00
	Total (sum of lines 8-13)							13. 00 14. 00
14.00	Total (Suii Of TitleS 0-13)	I	I					14.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNI	ΤY			In Lie	u of Form CMS-2	2552-10	
APPORT	IONMENT OF PATIENT SERVICE COST		Provi	der	CCN: 151315	Peri		Worksheet H-3		
				HHA (CN:	157117		m 10/01/2013 09/30/2014	Part II Date/Time Pre	pared:
									2/25/2016 9: 4	6 am
						e XVIII	Home Health PPS			
						,		Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total H	łΑ	HHA Shared	T	Fransfer to		
		Part I, col.	Rati o	Charge (f	rom	Ancillary		Part I as		
		9, line		provi de	r	Costs (col.	1	Indi cated		
				records)	x col. 2)				
		0	1. 00	2. 00		3.00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED H	0SPI	TAL DEPARTMEN	NTS			
1.00	Physical Therapy	66. 00	0. 620690		0)	0 со	ol. 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. 544409		0)	Осо	I. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 462867		0)	Осо	l. 2, line 1	5. 00	5. 00

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151315	Peri od:	worksheet H-4	
	HHA CCN:	157117	From 10/01/2013 To 09/30/2014		
	Ti tl	e XVIII	Home Health Agency I	PPS	0 0
	•		Par	t B	
		Part A	Not Subject to	Subject to Deductibles &	
			Coi nsurance	Coinsurance	
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE	S			
Reasonable Cost of Part A & Part B Services		I			١,
Reasonable cost of services (see instructions) Total charges			0 0		
Customary Charges			<u> </u>		1 1
Amount actually collected from patients liable for payment for	servi ces		0 0	0	3
on a charge basis (from your records)				_	
Amount that would have been realized from patients liable for properties on a charge basis had such payment been made in accept with 42 CFR §413.13(b)			0 0	0	4
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	0. 000000	0. 000000	
Total customary charges (see instructions)			0 0	0	
Excess of total customary charges over total reasonable cost (conflying line 6 exceeds line 1)	omplete		0 0	0	
Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0 0	0	8
Primary payer amounts			0 0		1
			Part A	Part B	
			Servi ces 1. 00	Servi ces 2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
Total reasonable cost (see instructions)			0		
00 Total PPS Reimbursement - Full Episodes without Outliers 00 Total PPS Reimbursement - Full Episodes with Outliers			9, 741	374, 380	
00 Total PPS Reimbursement - LUPA Episodes with outfreis			5, 293 933		
00 Total PPS Reimbursement - PEP Episodes			0	2, 853	
Total PPS Outlier Reimbursement - Full Episodes with Outliers			82	571	1!
O Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00 Total Other Payments 00 DME Payments			0	0	
00 Oxygen Payments			0	0	
oxygen rayments			Ö	Ö	
00 Prosthetic and Orthotic Payments	ance)			0	
Part B deductibles billed to Medicare patients (exclude coinsur			16, 049	l	
Part B deductibles billed to Medicare patients (exclude coinsur 30 Subtotal (sum of lines 10 thru 20 minus line 21)				1 0	
Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			14 040	l .	
Part B deductibles billed to Medicare patients (exclude coinsur; Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			16, 049	403, 321	
Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			16, 049	403, 321 0	2!
Part B deductibles billed to Medicare patients (exclude coinsuration Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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)				403, 321 0	2! 20 2
Part B deductibles billed to Medicare patients (exclude coinsuration Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins			16, 049	403, 321 0 403, 321	2! 20 2: 2:
Part B deductibles billed to Medicare patients (exclude coinsuration Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins Total costs - current cost reporting period (line 26 plus line 25)				403, 321 0 403, 321 403, 321	25 26 27 28 29
Part B deductibles billed to Medicare patients (exclude coinsurations) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins Total costs - current cost reporting period (line 26 plus line 20) REASONABLE COST REIMBURSEMENT			16, 049	403, 321 0 403, 321 403, 321 426	25 26 27 28 29 30
Part B deductibles billed to Medicare patients (exclude coinsuration Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins Total costs - current cost reporting period (line 26 plus line 25)			16, 049	403, 321 0 403, 321 403, 321 426 0	25 26 27 28 29 30 30
Part B deductibles billed to Medicare patients (exclude coinsurations) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins Total costs - current cost reporting period (line 26 plus line 20) REASONABLE COST REIMBURSEMENT Pioneer ACO demonstration payment adjustment (see instructions)			16, 049 16, 049 0 0	403, 321 0 403, 321 403, 321 426 0	25 26 27 28 29 30 30 31
Part B deductibles billed to Medicare patients (exclude coinsurations) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 instance to the cost of the cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instance to the cost of the cost			16, 049 16, 049 0 0 16, 049	403, 321 0 403, 321 403, 321 426 0 403, 747 8, 066 395, 803	25 26 27 28 29 30 30 31 31 32
Part B deductibles billed to Medicare patients (exclude coinsure Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) 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 ins Total costs - current cost reporting period (line 26 plus line REASONABLE COST REIMBURSEMENT Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	27)		16, 049 16, 049 0 0 16, 049 321	403, 321 0 403, 321 403, 321 426 0 403, 747 8, 066	25 26 27 28 29 30 31 31 32 33

PROGRAM BENEFICIARIES

HHA CCN: 157117

ne H	leal th	PPS

				Agency I		
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		15, 728		395, 803	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	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)					
3. 01	Program to Provider	I	0		0	3. 01
3. 01			0			3. 01
3. 02			0			3. 02
3. 04			0			3. 04
3. 05			0			3. 05
3.03	Provider to Program	L	U O		0	5. 05
3. 50	Trovider to rrogium		0		0	3. 50
3. 51			0		ol ol	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 728		395, 803	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
	TO BE COMPLETED BY CONTRACTOR	ı				
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	Frogram to Frovider		0		0	5. 01
5. 02			0			5. 02
5. 02			o			5. 03
0.00	Provider to Program		0		0	0.00
5. 50	Trovinger to rrogium		0		0	5. 50
5. 51			0		O	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		122	6. 02
7.00	Total Medicare program liability (see instructions)		15, 728		395, 681	7. 00
				Contractor	NPR Date	
		,)	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
0.00	Invaline of Contractor	I	ļ		ı l	0.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 151315	Peri od: Worksheet K
		From 10/01/2013

Hospi ce CCN: 151561 To 09/30/2014 Date/Time Prepared: 2/25/2016 9:46 am Hospi ce I Salaries (from Empl oyee Transportation Contracted 0ther Wkst. K-1) Benefits (from Wkst. K-2) Services (from Wkst. K-3) (see inst.) 1.00 2.00 3.00 4.00 5. 00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 2.00 Capital Related Costs-Movable Equip. 0 2.00 3.00 Plant Operation and Maintenance 0 0 0 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 4.00 0 5.00 Volunteer Service Coordination 0 0 0 0 5.00 6, 960 Administrative and General 19, 468 0 6.00 0 0 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 62, 331 0 2, 571 0 7.00 8.00 0 0 8.00 0 0 VISITING SERVICES 9.00 Physician Services 0 0 0 0 9.00 10.00 Nursing Care 0 19, 237 0 0 0 0 0 0 0 0 0 10.00 0 Nursing Care-Continuous Home Care 0 11.00 0 0 11.00 12.00 Physical Therapy 0 0 0 0 12.00 13.00 Occupational Therapy 0 13.00 Speech/ Language Pathology Medical Social Services 0 0 0 14.00 0 14.00 0 33, 548 0 15.00 15.00 0 16.00 Spiritual Counseling 8, 351 0 0 16.00 Dietary Counseling 0 0 17.00 17.00 0 0 0 0 0 Counseling - Other 18.00 18.00 01 0 19.00 Home Health Aide and Homemaker 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 20.00 0 0 0 21.00 0ther 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 0 22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 23.00 Anal gesi cs 0 0 0 0 23.00 0 0 0 0 0 0 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 25.00 0 26.00 Durable Medical Equipment/Oxygen 0 0 26.00 0 0 27.00 27.00 Patient Transportation 0 28 00 I maging Services 0 0 28.00 Labs and Diagnostics 0 29.00 0 29.00 0 30.00 Medical Supplies 0 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 32 00 0 0 32.00 Radiation Therapy 0 33.00 Chemotherapy 0 0 33.00 34.00 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 35.00 0 0 36.00 Volunteer Program Costs 0 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 0 37.00 Other Program Costs 0 38.00 38.00 0 0 0 0 0 39.00 Total (sum of lines 1 thru 38) 123, 698 19, 237 2.571 6, 960 39. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 151315	
	Hospi ce CCN: 151561	From 10/01/2013 To 09/30/2014 Date/Time Prepared:

Capital Related Costs-Bidg and Fixt Capital Related Costs Capi				Hospi ce Co		com 10/01/2013 0 09/30/2014		
Total (cols. Reclassificat Subtrata (col. Adjustments Total (col. S. 1.5) Col. Col. S. Ecol. E						Hooni oo I	2/25/2016 9: 4	<u>6 am</u>
1-5			Total (cols	oclassi fi cati S	Subtotal (col		Total (col 9	
SENERAL SERVICE COST CENTERS						Auj us tillerits		
GENERAL SERVICE COST CENTERS						9 00		
1.00		GENERAL SERVICE COST CENTERS	0.00	71.00	0.00	7, 00	10.00	
2 00 Capit tal Related Costs-Movable Equip.	1.00		0	0	0	0	0	1.00
1.00			O	o	0	0	0	2.00
5. 00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	1 .	O	0	0	0	0	3. 00
5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	4.00	Transportation - Staff	O	o	0	0	0	4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination	O	0	0	0	0	5. 00
Total Impatient - General Care 64,902 0 64,902 0 64,902 7.00	6.00	Administrative and General	26, 428	0	26, 428	0	26, 428	6. 00
8. 00 Inpatient - Respite Care 0 0 0 0 0 0 0 0 0		INPATIENT CARE SERVICE						
VISITING SERVICES	7.00	Inpatient - General Care	64, 902	0	64, 902	0	64, 902	7. 00
9.00 Physician Services	8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
10.00 Nursing Care 19,237 0 19,237 0 19,237 10.00		VISITING SERVICES						
11. 00	9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 Speech/ Language Pathology 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 0 15.00 Medical Social Services 33,548 -25,731 7,817 0 7,817 15.00 16.00 Spiritual Counseling 8,351 0 8,351 0 8,351 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 0 19.00 Home Healt H. Aide and Homemaker 0 846 846 0 846 19.00 10.00 Healt H. Aide and Homemaker 0 846 846 0 846 19.00 10.00 Other 0 0 0 0 0 0 0 10.00 Other Specify 0 0 0 0 0 0 10.00 Other Specify 0 0 0 0 0 0 10.00 Other Specify 0 0 0 0 0 0 10.00 Other Transportation 0 0 0 0 0 0 10.00 Other Transportation 0 0 0 0 0 0 10.00 Other Services 0 0 0 0 0 0 10.00 Other Services 0 0 0 0 0 0 10.00 Other Services 0 0 0 0 0 0 10.00 Other Services 0 0 0 0 0 0 10.00 Other Oth	10.00		19, 237	0	19, 237	0	19, 237	10.00
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 33,548 -25,731 7,817 0 7,817 15.00 16.00 Spiritual Counseling 8,351 0 8,351 0 8,351 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 0 0 19.00 HH Ai de and Homemaker 0 846 846 0 844 19.00 19.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 10.00 Other 0 0 0 0 0 0 10.00 Other 0 0 0			0	0	0	0	0	
14.00 Speech Language Pathology	12.00	Physi cal Therapy	0	0	0	0	0	12. 00
15. 00 Medical Social Services 33,548 -25,731 7,817 0 7,817 15. 00 16. 00 Spiritual Counseling 8,351 0 8,351 0 8,351 16. 00 17. 00 Dietary Counseling 0 0 0 0 0 0 18. 00 Counseling - Other 0 0 0 0 0 0 0 19. 00 Home Heal th Aide and Homemaker 0 846 846 0 846 19. 00 19. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 19. 00 Other 0 0 0 0 0 0 0 19. 00 Other 0 0 0 0 0 0 0 19. 00 Other 0 0 0 0 0 0 0 21. 00 Other 0 0 0 0 0 0 22. 00 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 26. 00 Other - Specify 0 0 0 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 28. 00 Imaging Services 0 0 0 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 31. 00 Other Homemaker 0 0 0 0 0 0 32. 00 Radiation Therapy 0 0 0 0 0 0 33. 00 Other Diagnostics 0 0 0 0 0 34. 00 Other Diagnostics 0 0 0 0 0 35. 00 Other Diagnostics 0 0 0 0 0 36. 00 Other Diagnostics 0 0 0 0 0 37. 00 Other Diagnostics 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 38. 00 Other Program Costs 0 0 0 0 0 39. 00 Other Program Costs 0 0 0 0 0 30. 00 Other Program Costs 0 0 0 0 0 30. 00 Other Program Costs 0 0 0 0 0 30. 00 Other Program Costs 0 0 0 0 0 30. 00 Other Pr			0	0	0	0	0	
16.00 Spiritual Counseling			0	0	0	0	0	
17.00 Dietary Counseling		1		-25, 731		0	'	1
18.00			1	9		0		1
19.00		1	0	9	0	0	_	ı
20.00			0	9	0	0	Ĭ	
21.00 Other		1	0	i	846	0		ı
OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 22.00				~	0	0	_	
Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 22.00	21. 00		0	0	0	0	0	21.00
23.00 Analgesics 0 0 0 0 0 0 23.00	22.00			ما				22.00
24.00 Sedatives / Hypnotics 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 0 0 0 26.00 0 0			- 1	- 1	- 1	_	_	
25. 00 Other - Specify 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 29. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9	0	-1	-	0	_	1
26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0			0	0	0	0	0	1
27. 00 Patient Transportation 0 0 0 0 0 27. 00 28. 00 I maging Services 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 <td< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td></td<>				0	0	0	0	
28. 00 Imaging Services 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 0 0 32. 00 33. 00 Other 0 0 0 0 0 0 0 0 0 33. 00 34. 00 Other NONREI MBURSABLE SERVI CE 8 8 8 0 0 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td>				0	0	0	0	1
29. 00 Labs and Diagnostics 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 0 0 0 0 0		·		0	0	0	0	
30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 31. 00 0 0 0 0 0 31. 00 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 0 34. 00 Other			0	0	0	0		
31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00				0	0	0	o n	
32. 00 Radiation Therapy 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 0 38. 00		1		0	0	0	_	
33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 0 0 0 0 0 34. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,		0	0	0	o n	
34. 00 Other HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 38. 00				0	0	0	o n	
HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 38. 00		1	1 1	-	0	0	_	
35. 00 Bereavement Program Costs 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 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 38. 00	01.00		<u> </u>	<u> </u>	<u> </u>			01.00
36. 00 Volunteer Program Costs 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	35. 00		O	ol	0	0	0	35. 00
37. 00 Fundrai si ng 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 38. 00		1		ol	ol	0	0	
38.00 Other Program Costs 0 0 0 0 38.00				ol	ol	0	_	1
				o	0	0	0	1
	39. 00	1	152, 466	-24, 885	127, 581	0	127, 581	39. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CC	N: 151315	Peri od:	Worksheet K-1

Hospi ce CCN: 151561 To 09/30/2014 Date/Time Prepared:

			1.0001.00			2/25/2016 9: 4	6 am
					Hospi ce I		
		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	1.00					
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 0	0	
4. 00	Transportation - Staff	0	0	,	0 0		
5. 00	Volunteer Service Coordination	0	0	,	0 0		
6.00	Administrative and General	19, 468	0	,	0 0	0	
	I NPATI ENT CARE SERVI CE	,					
7.00	Inpatient - General Care	62, 331	C		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0		1
	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	1	0 0		
11. 00	Nursing Care-Continuous Home Care	0	0	,	0 0	0	
12. 00	Physical Therapy	0	0		0 0	_	
13. 00	Occupational Therapy	0	0		0 0	0	
14. 00	Speech/ Language Pathology	0	0		0 0	Ö	
15. 00	Medical Social Services	33, 548	0		0 0	0	
16. 00	Spiritual Counseling	8, 351	0		0 0	Ö	
17. 00	Di etary Counsel i ng	0	0		0 0	0	
18. 00	Counseling - Other	o	0	,	0 0	0	
19. 00	Home Health Aide and Homemaker	o	0	,	0 0	0	
20. 00	HH Aide & Homemaker - Cont. Home Care	o	0	,	0 0	Ö	
21. 00	Other	o	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	Pati ent Transportation	0	O	1	0 0	0	27. 00
28.00	I maging Services	0	O	1	0 0	0	28. 00
29.00	Labs and Diagnostics	0	O	1	0 0	0	29. 00
30.00	Medical Supplies	0	O	1	0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	O	1	0 0	0	31.00
32.00	Radi ati on Therapy	o	0)	0 0	0	32.00
33.00	Chemotherapy	o	0)	0 0	0	33.00
34.00	Other	o	0)	0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	<u> </u>					
35.00	Bereavement Program Costs	0	C		0 0	0	35. 00
36.00	Volunteer Program Costs		O		0 0	0	36.00
37. 00	Fundrai si ng		O		0 0	0	37. 00
38.00	Other Program Costs	o	0		0 0	0	38. 00
39.00	Total (sum of lines 1 thru 38)	123, 698	0)	0 0	0	39. 00
		·					

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2552-10
	CE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der Hospi ce	CCN: 151315 CCN: 151561	Peri od: From 10/01/2013 To 09/30/2014	
					Hospi ce I	
		Total Therapi sts	Ai des	All-Other	Total (1)	
		6. 00	7. 00	8. 00	9. 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	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		(0	0 19, 468	6. 00
	INPATIENT CARE SERVICE	_		_		
7. 00	Inpatient - General Care			0	0 62, 331	7.00
8.00	Inpatient - Respite Care			0	0 0	8. 00
	VI SI TI NG SERVI CES		1			
9. 00	Physi ci an Servi ces		(0	0 0	9. 00
	Nursing Care		(0	0 0	10.00
	Nursing Care-Continuous Home Care		(0	0	11. 00
	Physical Therapy	0	9	0	0	12.00
	Occupational Therapy	0			0	13.00
	Speech/ Language Pathology	0			0 0	14.00
	Medical Social Services				0 33, 548	15. 00 16. 00
	Spiritual Counseling				0 8, 351	16.00
	Di etary Counsel i ng)		0	17.00
	Counseling - Other Home Health Aide and Homemaker)		0	19.00
	HH Aide & Homemaker - Cont. Home Care]		0	20.00
20.00	HH AI de & Holliellaker - Cort. Hollie Care				o _l	20.00

0

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123, 698

21.00

22.00

23.00

24.00

25.00

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

OTHER HOSPICE SERVICE COSTS

Sedatives / Hypnotics Other - Specify

Patient Transportation

Imaging Services Labs and Diagnostics

Medical Supplies

Radiation Therapy

Chemotherapy

Fundrai si ng

0ther

Anal gesi cs

Drugs, Biological and Infusion Therapy

Outpatient Services (including E/R Dept.)

Durable Medical Equipment/Oxygen

HOSPICE NONREIMBURSABLE SERVICE

 $\hbox{\tt Bereavement Program Costs}$

Volunteer Program Costs

38.00 Other Program Costs
39.00 Total (sum of lines 1 thru 38)

21.00

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29. 00

30.00

32.00 33.00

34.00

35.00

36.00

 Heal th
 Financial
 Systems
 CAMERON
 MEMORIAL
 COMPONENTIAL

 HOSPICE
 COMPENSATION
 ANALYSIS
 CONTRACTED
 SERVICES/PURCHASED
 SERVICES
 Provider CCN: 151315

						2/25/2016 9: 4	16 am
					Hospi ce I		
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces			
		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	ol o	3.00
4.00	Transportation - Staff	ol	(ol	0	ol o	4.00
5.00	Volunteer Service Coordination	0	(0	ol o	5.00
6. 00	Administrative and General		(0		
0.00	I NPATI ENT CARE SERVI CE	<u> </u>		71			1 0.00
7. 00	Inpatient - General Care	0	(0	0 2, 571	7. 00
8. 00	Inpatient - Respite Care		(Ö	0 2,371	1
0.00	VI SI TI NG SERVI CES	<u> </u>		4	<u> </u>	9 0	0.00
9. 00	Physician Services	0	(1	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	
13. 00	Occupational Therapy	0	(0	0 0	
14. 00	Speech/ Language Pathology	0	()	0	0	
15. 00	Medical Social Services	0	(0	0 0	
16. 00	Spiritual Counseling	0	(0	0 0	
17. 00	Dietary Counseling	0	(0	0 0	17. 00
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	20.00
21.00	Other	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	o o	27. 00
28. 00	Imaging Services		(0		
29. 00	Labs and Diagnostics		(0	ol o	
30. 00	Medical Supplies		Č		0		
31. 00	Outpatient Services (including E/R Dept.)		(Ö		
32. 00	Radiation Therapy				0		
33. 00	Chemotherapy		(0		
34. 00	Other	l U	(0	0 0	34.00
25 02	HOSPI CE NONREI MBURSABLE SERVI CE			1	0		35 00
35. 00	Bereavement Program Costs	0	(0	0 0	
36. 00	Volunteer Program Costs	0	(0	0 0	
37. 00	Fundrai si ng	0	(2	0	0 0	
38. 00	Other Program Costs	0	-		0	0 0	
39. 00	Total (sum of lines 1 thru 38)	0	(0	0 2, 571	39. 00

Health Financial Systems	CAMERON MEMORIAL C	OMMUNI TY		In Lieu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS CONTRAC	TED SERVICES/PURCHASED SERVICES	Provi der CCN: 151315	Peri od:	Worksheet K-3

From 10/01/2013 To 09/30/2014 Hospi ce CCN: 151561 Date/Time Prepared: 2/25/2016 9:46 am Hospi ce I All-Other Total Ai des Total (1) Therapi sts 7.00 8.00 9. 00 6.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 3.00 0 3 00 Plant Operation and Maintenance 0 4.00 Transportation - Staff 0 0 4.00 5.00 Volunteer Service Coordination 0 0 5.00 0 6.00 Administrative and General 0 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 2, 571 7.00 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 0 0 9.00 10.00 Nursing Care 0 0 0 10.00 Nursing Care-Continuous Home Care 0 0 0 11.00 11.00 12.00 Physical Therapy 0 12.00 0 0 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 14.00 0 Medical Social Services 0 0 0 15.00 15.00 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 17.00 0 0 18.00 Counseling - Other 18.00 0 Home Health Aide and Homemaker 0 19.00 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 25.00 Other - Specify 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 0 28. 00 Imaging Services 0 0 0 28.00 0 29 00 Labs and Diagnostics 0 29.00 0 30.00 Medical Supplies 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 Radiation Therapy 0 0 32.00 0 32.00 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 Bereavement Program Costs 0 0 0 35.00 0 0 0 0 36.00 Volunteer Program Costs 0 36.00 37.00 Fundrai si ng 0 0 37.00 38.00 Other Program Costs 0 0 38.00

39. 00

2, 571

39.00 Total (sum of lines 1 thru 38)

 OMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-4 Part I

 Hospice CCN: 151561
 To 09/30/2014
 Date/Time Prepared: Date/Time

			nospi ce c	.CN. 131301	10 09/30/2014	2/25/2016 9: 4	
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUILDINGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1. 00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS	I I					
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	ا	ŭ		0		2. 00
3.00	Plant Operation and Maintenance	ا	0		0		3. 00
4. 00	Transportation - Staff		0		0	-	4.00
5.00	Volunteer Service Coordination		0		0		5.00
6. 00	Administrative and General	26, 428	0		0		6.00
0.00	I NPATI ENT CARE SERVI CE	20, 420	O		O C	<u> </u>	0.00
7. 00	Inpatient - General Care	64, 902	0		0 0	o lo	7. 00
8. 00	Inpatient - Respite Care	04, 702	0		0		8.00
0.00	VI SI TI NG SERVI CES	<u> </u>	<u> </u>		0	<u> </u>	0.00
9. 00	Physician Services		0		0 0	0	9. 00
10. 00	Nursing Care	19, 237	0		0	•	10.00
11. 00	Nursing Care-Continuous Home Care	17, 237	0		0		11.00
12. 00	Physical Therapy		0		0 (٥	12.00
13. 00	Occupational Therapy		0		0 (13.00
14. 00			0		-		14.00
15. 00	Speech/ Language Pathology Medical Social Services	7, 817	0		0 (15.00
16. 00			0		0 (16.00
	Spiritual Counseling	8, 351	0		0 (17.00
17. 00 18. 00	Di etary Counsel i ng		0		0 (18.00
	Counseling - Other	0.44	0		0 0		•
19. 00 20. 00	Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care	846	0		0 0		19. 00 20. 00
			0				
21. 00	Other OTHER HOSPICE SERVICE COSTS	l d	U		0 (U U	21. 00
22. 00	Drugs, Biological and Infusion Therapy		0		0 0	0	22. 00
			0		0 0	1	•
23. 00	Anal gesi cs		0		0 (23. 00 24. 00
24. 00 25. 00	Sedatives / Hypnotics		0		0 0	-	25.00
	Other - Specify		0		0 (26.00
26. 00 27. 00	Durable Medical Equipment/Oxygen		0		0 0	٠	26.00
28. 00	Patient Transportation		0		0 (1 °	28.00
	I maging Services		0		0 (28.00
29. 00	Labs and Diagnostics	0	0		-1	0	
30. 00	Medical Supplies	0	0		0 0	٠	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		٦	0	31.00
32. 00	Radi ati on Therapy	0	0		0		32.00
33. 00	Chemotherapy	0	0		0		33.00
34. 00	Other	0	0		0 0	0	34. 00
25 22	HOSPI CE NONREI MBURSABLE SERVI CE						25 22
	Bereavement Program Costs	0	0		0	1	35. 00
36. 00	Volunteer Program Costs	0	0		0		36.00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	127 501	0		0		38. 00
39.00	Total (sum of lines 1 thru 38)	127, 581	0		0 0	0	39. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 151315	Peri od: From 10/01/2013	Worksheet K-4 Part I

151561 To 09/30/2014 Date/Time Prepared: Hospi ce CCN: 2/25/2016 9:46 am Hospi ce I VOLUNTEER SUBTOTAL ADMINISTRATIVE TOTAL (col. 5A SERVI CES (cols. 0 - 5)& GENERAL ± col. 6) COORDI NATOR 5A 6.00 7. 00 5.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 26, 428 26, 428 Administrative and General 0 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 64, 902 16, 957 81, 859 7.00 8.00 0 0 8.00 VISITING SERVICES 9.00 Physician Services 00000000000 9.00 10.00 Nursing Care 19, 237 5,026 24, 263 10.00 Nursing Care-Continuous Home Care 11.00 0 11.00 0 12.00 Physical Therapy C 0 0 12.00 13.00 Occupational Therapy 0 13.00 0 Speech/ Language Pathology Medical Social Services 14.00 0 0 14.00 7.817 2.042 9 859 15.00 15.00 16.00 Spiritual Counseling 8, 351 2, 182 10, 533 16.00 Dietary Counseling 17.00 17.00 0 0 Counseling - Other 18.00 18.00 0 0 19.00 Home Health Aide and Homemaker 846 221 1, 067 19.00 20.00 HH Aide & Homemaker - Cont. Home Care C 0 0 20.00 0 21.00 0ther 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 23.00 Anal gesi cs 0 0 0 0 0 0 0 0 0 0 0 0 0 23.00 0 0 24.00 Sedatives / Hypnotics 0 0 24.00 0 25.00 Other - Specify 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 26.00 0 0 27.00 Patient Transportation 0 0 0 0 0 27.00 Imaging Services 28 00 0 0 28.00 0 29.00 Labs and Diagnostics 29.00 0 30.00 Medical Supplies 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 32 00 0 0 32.00 Radiation Therapy 0 33.00 33.00 Chemotherapy 0 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00

0

127, 581

0

127, 581

38.00

39.00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

38.00

 DMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-4 Part II Date/Time Prepared: 2/25/2016 9: 46 am

			,			2/25/2016 9:4	6 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		,	ĺ	FT.)		(HOURS)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0				3. 00
4. 00	Transportation - Staff	0	0		0		4. 00
5. 00	Volunteer Service Coordination					0	5. 00
		0				0	•
6. 00	Administrative and General			1	J U	0	6. 00
7.00	I NPATI ENT CARE SERVI CE			1		0	7 00
7.00	Inpatient - General Care	0			0		7. 00
8.00	Inpatient - Respite Care	0	0	1	0	0	8. 00
	VI SI TI NG SERVI CES	1		ı	1		
9.00	Physi ci an Servi ces	0	1		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	11. 00
12.00	Physi cal 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	l o		0	0	16. 00
17. 00	Di etary Counseling	0	0		0	0	17. 00
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	Ö	•	0	0	20.00
21. 00	Other	0	Ö		o o	Ö	21. 00
21.00	OTHER HOSPICE SERVICE COSTS	, , ,			<u> </u>		21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0	1	0	0	22. 00
23. 00	Anal gesi cs	0	0	•		0	23. 00
24. 00	Sedatives / Hypnotics	0				0	24.00
		0				0	
25. 00	Other - Specify	0	1				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	I maging 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	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	0	0		0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0	0	35. 00
36.00	Volunteer Program Costs	0	0		0	0	36. 00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0	1	0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	l n	l n		o n	0	39. 00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000	_	
10.00	Join C 300C Mai Cipi i Oi	0.00000	0.00000	0.00000	3. 333000	0.00000	1 .0.00

			110001.00		10 077 007 2011	2/25/2016 9:4	46 am
					Hospi ce I		
		RECONCI LI ATI ON					
			& GENERAL				
			(ACC. COST)				
	T	6A	6. 00				
	GENERAL SERVICE COST CENTERS						_
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0					2. 00
3.00	Plant Operation and Maintenance	0					3. 00
4.00	Transportation - Staff	0					4. 00
5.00	Volunteer Service Coordination						5. 00
6.00	Administrative and General	-26, 428	101, 153				6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	64, 902				7. 00
8.00	Inpatient - Respite Care	0	0				8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0				9. 00
10.00	Nursing Care	o	19, 237				10.00
11. 00	Nursing Care-Continuous Home Care	O	0				11.00
12.00	Physical Therapy	O	0				12.00
13.00	Occupational Therapy	o	0				13.00
14. 00	Speech/ Language Pathology	0	0				14. 00
15. 00	Medical Social Services	0	7, 817				15. 00
16. 00	Spiritual Counseling	0	8, 351				16. 00
17. 00	Di etary Counsel i ng	0	0	1			17. 00
18. 00	Counseling - Other	0	0				18. 00
19. 00	Home Health Aide and Homemaker	0	846				19.00
20.00	HH Aide & Homemaker - Cont. Home Care	O	0	1			20.00
21. 00	Other	o	0	1			21. 00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>					1 21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0				22. 00
23. 00	Anal gesi cs	o	0	1			23. 00
24. 00	Sedatives / Hypnotics	0	0	1			24. 00
25. 00	Other - Specify	0	0	l .			25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0	•			26.00
27. 00	Patient Transportation	0	0	•			27. 00
28. 00	Imaging Services	0	0	•			28. 00
29. 00	Labs and Diagnostics	0	0				29. 00
30. 00	Medical Supplies		0	1			30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0				31. 00
32. 00	Radiation Therapy	0	0	1			32.00
33. 00	Chemotherapy	0	0				33. 00
	1	0	0	1			
34. 00	Other	U	0				34. 00
25 00	HOSPICE NONREIMBURSABLE SERVICE	O	0				35. 00
35. 00	Bereavement Program Costs	1		1			
36. 00	Volunteer Program Costs	0	0	•			36. 00
37. 00	Fundrai si ng	0	0	1			37. 00
38. 00	Other Program Costs	0	0	1			38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		26, 428	1			39. 00
40.00	Unit Cost Multiplier	1	0. 261268	1			40. 00

 MMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-5

 Hospice CCN: 151561
 To 09/30/2014
 Date/Time Prepared: 2/25/2016 9: 46 am

						2/25/2016 9:40	<u> 6 am</u>
					Hospi ce I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Hospice Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		Bal ance (1)			BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	4. 00	4A	
1.00	Administrative and General		0	4, 251	30, 779	35, 030	1. 00
2.00	Inpatient - General Care	81, 859	0	0	0	81, 859	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	24, 263	0	0	0	24, 263	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	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	9, 859	0	0	0	9, 859	10.00
11.00	Spiritual Counseling	10, 533	0	0	0	10, 533	11. 00
12.00	Di etary Counsel i ng	O	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	1, 067	0	0	0	1, 067	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	o	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0	0	0	0	17. 00
18. 00	Anal gesi cs	o	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	o	0	0	0	0	19. 00
20.00	Other - Specify	o	0	0	o	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	o	0	0	o	0	21. 00
22. 00	Patient Transportation	o	0	0	o	0	22. 00
23. 00	I maging Services	o	0	0	o	0	23. 00
24.00	Labs and Diagnostics	o	0	0	o	0	24. 00
25. 00	Medical Supplies	o	0	0	o	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	o	0	0	o	0	26. 00
27. 00	Radiation Therapy	o	0	0	o	0	27. 00
28. 00	Chemotherapy	o	0	o	o	ol	28. 00
29. 00	Other	o	0	o	o	ol	29. 00
30.00	Bereavement Program Costs	o	0	o	o	ol	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32. 00	Fundrai si ng	o	0	ol	o	0	32. 00
33. 00	Other Program Costs	0	0	o	o	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	127, 581	0	4, 251	30, 779	162, 611	34. 00
35. 00			_	., == 1	,	0. 000000	
		1					

 MMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-5

 Hospice CCN: 151561
 To 09/30/2014
 Date/Time Prepared: 2/25/2016 9: 46 am
 Health Financial Systems CAMERON I ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						2/25/2016 9:4	o alli
					Hospi ce I		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10. 00	
1.00	Administrative and General	8, 762	7, 816	o C	0	0	1. 00
2.00	Inpatient - General Care	20, 475	C) C	0	0	2. 00
3.00	Inpatient - Respite Care	0	C	0	0	0	3. 00
4.00	Physician Services	0	C	0	0	0	4. 00
5.00	Nursing Care	6, 069	C	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	C	0	0	0	6. 00
7.00	Physi cal Therapy	0	C	0	0	0	7. 00
8.00	Occupational Therapy	0	C	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	C	0	0	0	9. 00
10.00	Medical Social Services	2, 466	C	0	0	0	10.00
11.00	Spiritual Counseling	2, 635	C	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	C	0	0	0	12.00
13.00	Counseling - Other	0	C	0	0	0	13.00
14.00	Home Health Aide and Homemaker	267	C	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C	0	0	0	15. 00
16.00	Other	0	C	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C	0	0	0	17. 00
18.00	Anal gesi cs	0	C	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	C	0	0	0	19. 00
20.00	Other - Specify	0	C	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	C	0	0	0	21. 00
22.00	Patient Transportation	0	C	0	0	0	22. 00
23.00	I maging Services	0	C	0	0	0	23. 00
24.00	Labs and Diagnostics	0	C	0	0	0	24. 00
25.00	Medical Supplies	0	C	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	C	0	0	0	26. 00
27.00	Radi ati on Therapy	0	l c) c	0	0	27. 00
28.00	Chemotherapy	0	C) c	0	0	28. 00
29.00	Other	0	l c) c	0	0	29. 00
30.00	Bereavement Program Costs	0	l c) c	0	0	30.00
31.00	Volunteer Program Costs	0	l c) c	0	0	31.00
32.00	Fundrai si ng	0	C) c	0	0	32. 00
33.00	Other Program Costs	0	[c	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	40, 674	7, 816	o C	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00
		•	•	•		•	•

 DMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-5 Part I Date/Time Prepared: 2/25/2016 9: 46 am

 Heal th Financial
 Systems
 CAMERON I

 ALLOCATION OF GENERAL SERVICE
 COSTS TO HOSPICE COST CENTERS

						2/25/2016 9: 4	6 am
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	8, 355	0	240	0	-	
2.00	Inpatient - General Care	0	0		0	0	
3.00	Inpatient - Respite Care	0	0	(0	0	3. 00
4.00	Physi ci an Servi ces	0	0	(0	0	
5.00	Nursi ng Care	0	0	(0	0	1
6.00	Nursing Care-Continuous Home Care	0	0	(0	0	6. 00
7.00	Physi cal Therapy	0	0	(0	0	7. 00
8.00	Occupational Therapy	0	0	(0	0	8. 00
9.00	Speech/ Language Pathology	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	
18. 00	Anal gesi cs	0	0		0	0	
19. 00	Sedatives / Hypnotics	0	0		0	0	
20.00	Other - Specify	0	0		0	0	
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	
22. 00	Patient Transportation	0	0	(0	0	
23. 00	I maging Services	0	0	(0	0	
24. 00	Labs and Diagnostics	0	0	(0	0	
25. 00	Medical Supplies	0	0		0	0	
26. 00	Outpatient Services (including E/R Dept.)	0	0	(0	0	
27. 00	Radiation Therapy	0	0		0	0	
28. 00	Chemotherapy	0	0	(0	0	
29. 00	Other	0	0	(0	0	
30.00	Bereavement Program Costs	0	0	(0	0	1
31. 00	Volunteer Program Costs	0	0	(0	0	1
32. 00	Fundrai si ng	0	0	(0	0	
33. 00	Other Program Costs	0	0		0	0	
34.00	Total (sum of lines 1 thru 33) (2)	8, 355	0	240	0	0	1 0 00
35. 00	Unit Cost Multiplier (see instructions)		l		Ţ	1	35.00

 DMMUNITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 151315
 Period: From 10/01/2013
 Worksheet K-5 Part I Date/Time Prepared: 2/25/2016 9: 46 am

						2/25/2016 9: 4	5 am
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	60, 203	l control of the cont				1. 00
2.00	Inpatient - General Care	102, 334	· 0	102, 334	38, 628	140, 962	2.00
3.00	Inpatient - Respite Care	C) 0	0	0	0	3.00
4.00	Physi ci an Servi ces	C	0	0	0	0	4.00
5.00	Nursing Care	30, 332	2 0	30, 332	11, 449	41, 781	5.00
6.00	Nursing Care-Continuous Home Care	C	0	0	0	0	6.00
7.00	Physi cal Therapy	C	0	0	0	0	7.00
8.00	Occupational Therapy	C	0	0	0	0	8.00
9.00	Speech/ Language Pathology	C	0	0	0	0	9.00
10.00	Medical Social Services	12, 325	0	12, 325	4, 652	16, 977	10.00
11. 00	Spiritual Counseling	13, 168	0	13, 168	4, 970	18, 138	11.00
12.00	Di etary Counsel i ng	C	0	0	0	0	12.00
13.00	Counseling - Other	C	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	1, 334	· 0	1, 334	504	1, 838	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	l c	0	0	0	0	15.00
16.00	Other	l c	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	l c	0	0	0	0	17.00
18.00	Anal gesi cs	l c	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	l c	0	0	0	0	19.00
20.00	Other - Specify		0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	l c	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	23.00
24.00	Labs and Diagnostics		o	0	0	0	24.00
25. 00	Medical Supplies		o	0	0	0	25.00
26. 00	Outpatient Services (including E/R Dept.)		o	0	0	0	26.00
27. 00	Radi ati on Therapy		ol o	0	0	o	27.00
28. 00	Chemotherapy		ol o	0	0	0	28. 00
29. 00	Other		ol o	0	0	0	29. 00
30. 00	Bereavement Program Costs		ol o	0	0	0	30. 00
31. 00	Volunteer Program Costs			0	0	0	31. 00
32. 00	Fundrai si ng			0	0	0	32. 00
33. 00	Other Program Costs	1	ا م	l o	0	Ö	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	219, 696	ما م	219, 696		219, 696	34. 00
	Unit Cost Multiplier (see instructions)	1		2.,,0,0	0. 377465		35. 00
55.50	1	į.	1	1	3. 3. 7 100		20.00

Health Financial Systems	CAMERON MEMORIAL C	OMMUNI TY	In Lie	eu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST STATISTICAL BASIS	CENTERS	Provi der CCN: 15131	Peri od: From 10/01/2013	Worksheet K-5
STATISTICAL BASIS		Hospi ce CCN: 15156		Date/Time Prepared:

2/25/2016 9:46 am

40,674

0. 250131 36. 00

35.00

Hospi ce I CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE BLDG & FLXT MVBLE EQUIP Cost Center Description EMPL OYEE (SQUARE FEET) **BENEFITS** (SQUARE FEET) & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5A 5.00 4.00 1.00 Administrative and General 95 9.5 100, 875 35, 030 1 00 0 2.00 Inpatient - General Care 0 0 81, 859 2.00 Inpatient - Respite Care 3.00 0 0 3.00 0 0 4 00 Physici an Services 4 00 0 0 0 5.00 Nursing Care 24, 263 5.00 6.00 Nursing Care-Continuous Home Care 0 0 6.00 0 0 7.00 Physical Therapy 0 7.00 Occupational Therapy 0 0 8.00 8 00 0 9.00 Speech/ Language Pathology 0 Ω 9.00 10.00 Medical Social Services 0 0 9, 859 10.00 Spiritual Counseling 0 0 10, 533 11.00 11.00 0 0 12.00 Dietary Counseling 0 12.00 13.00 Counseling - Other 0 0 0 13.00 Home Health Aide and Homemaker 1,067 14.00 14.00 0 0 0 0 15.00 HH Aide & Homemaker - Cont. Home Care 15.00 0 16.00 Other 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 17.00 18.00 Anal gesi cs 0 0 0 18.00 0 Sedatives / Hypnotics 0 19.00 19.00 0 20.00 Other - Specify 0 20.00 0 21.00 Durable Medical Equipment/Oxygen 0 21.00 Patient Transportation 22.00 22.00 OI 23.00 Imaging Services 0 0 23.00 0 24.00 Labs and Diagnostics 0 24.00 Medical Supplies 25.00 25.00 Outpatient Services (including E/R Dept.) 0 0 26.00 0 26.00 0 Radiation Therapy 0 27.00 27.00 0 28.00 Chemotherapy 28.00 0 0 29. 00 0ther 0 29.00 0 0 30.00 Bereavement Program Costs 30.00 0 0 31.00 Volunteer Program Costs 0 31.00 0 32.00 Fundrai si ng 0 0 32.00 0 33.00 Other Program Costs 0 33.00 0 0 95 95 Total (sum of lines 1 thru 33) (2) 162, 611 34.00 34.00 100,875

0

0.000000

4, 251

44. 747368

30, 779

0.305120

35.00

Total cost to be allocated

36.00 Unit Cost Multiplier (see instructions)

		оор. оо		077 007 2011	2/25/2016 9: 4	6 am	
				Hospi ce I			
	Cost Center Description		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
'		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(POUNDS OF	SERVIC)	(==,	` ′	
		,	LAUNDR)				
		7.00	8.00	9.00	10.00	11. 00	
1.00	Administrative and General	95	C) (0	210	1. 00
2.00	Inpatient - General Care	0	C) (0	0	2. 00
3.00	Inpatient - Respite Care	0	C) (0	0	3. 00
4.00	Physi ci an Servi ces	0	C) (0	0	4. 00
5.00	Nursi ng Care	0	C) (0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	() (0	0	6. 00
7.00	Physi cal Therapy	0	() (0	0	7. 00
8.00	Occupational Therapy	0	(0	0	8. 00
9.00	Speech/ Language Pathology	0	() (o	0	9. 00
10.00	Medical Social Services	0	l c		o	0	10.00
11. 00	Spiritual Counseling	0	l c		o	0	11. 00
12.00	Di etary Counsel i ng	0	l c		o	0	12.00
13.00	Counseling - Other	0			o	0	13.00
14.00	Home Health Aide and Homemaker	0			o	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0			o	0	15. 00
16.00	Other	0			o	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0			o	0	17. 00
18. 00	Anal gesi cs	0			o	0	18. 00
19. 00	Sedatives / Hypnotics	0			o	0	19. 00
20.00	Other - Specify	0			o	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0			o	0	21. 00
22. 00	Patient Transportation	0	1 0		o	0	22. 00
23. 00	I maging Services	0			0	0	23. 00
24. 00	Labs and Diagnostics	0			o	0	24. 00
25. 00	Medical Supplies	0			o	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0			0	0	26. 00
27. 00	Radi ati on Therapy	0				0	27. 00
28. 00	Chemotherapy	0	1		-	0	28. 00
29. 00	Other	0	1		-	0	29. 00
30.00	Bereavement Program Costs	0				0	30.00
31. 00	Volunteer Program Costs	0			-	0	31. 00
32. 00	Fundrai si ng	0			-	0	32. 00
33. 00	Other Program Costs					0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	95				210	ı
35. 00	Total cost to be allocated	7, 816				8, 355	35. 00
	Unit Cost Multiplier (see instructions)	82. 273684	l .	0. 000000	0. 000000	•	
30.00	John Coost Wurtipiter (See Histractions)	02.273004	1 0.000000	1 0.00000	0.000000	37.703714	1 30.00

Health Financial Systems	CAMERON MEMORIAL COMMU	UNI TY	In Lieu of Form CMS-2552-10		
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	ovider CCN: 151315		Worksheet K-5	
STATISTICAL BASIS	Hos	ospi ce CCN: 151561	From 10/01/2013 To 09/30/2014	Part II Date/Time Prepared:	

Cost Center Description
NURSING ADMINISTRATION SERVICES & SUPPLY (COSTED HR) REQUIS.) SUPPLY (COSTED HR) REQUIS.) SERVICES & SUPPLY (COSTED HR) REQUIS.) SERVICES & SUPPLY (COSTED HR) REQUIS.) SERVICES & SUPPLY (TIME SPENT)
ADMINISTRATION SERVICES & SUPPLY (COSTED REQUIS.) TIME SPENT)
Courseling Cou
HR REQUIS.
13.00
1.00
1.00
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 0 5.00 6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 7.00 Physical Therapy 0 0 0 0 0 8.00 Occupational Therapy 0 0 0 0 0 9.00 Speech/ Language Pathology 0 0 0 0 0 10.00 Medical Social Services 0 0 0 0 11.00 Spiritual Counseling 0 0 0 0 12.00 Dietary Counseling - Other 0 0 0 14.00 Home Health Aide and Homemaker 0 0 0 0 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 16.00 Other 0 0 0 16.00 Other 0 0 0 17.00 0 0 0 18.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 19.
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 0 6.00 7.00 Physical Therapy 0 0 0 0 0 0 6.00 7.00 Physical Therapy 0 8.00 9.00 0 0 0 0 9.00 0 0 9.00 0 9.00 0 9.00 0 9.00 0 0 9.00 0 0 9.00 0 0 10.00 0 10.00 0 10.00 0 11.00 0 0 0 11.00 0 0 0 0 0 11.00 0 0 0 0 0 </td
5.00 Nursing Care 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 Pathology 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 9.00 11.00 Spiritual Counseling 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 11.00 13.00 Counseling - Other 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 16.00
6.00 Nursing Care-Continuous Home Care 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 Pathology 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 15.00 16.00 Other 0 0 0 0 16.00
7.00 Physical Therapy 0 0 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 9.00 10.00 Medical Social Services 0 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 0 0 0 0 0 13.00 Counseling 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 0 0 15.00 16.00 Other
8.00 Occupational Therapy 0 0 0 0 0 0 0 9.00 9.00 9.00 10.00 Medical Social Services 0 0 0 0 0 0 0 10.00 11.00 Spiritual Counseling 0 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 0 12.00 13.00 Counseling 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 16.00
9.00 Speech / Language Pathology 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 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 14.00 14.00 Halde & Homemaker 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 16.00 16.00 0 0 0 16.00
9.00 Speech/ Language Pathology 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 14.00 14.00 Halde & Homemaker 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 16.00 16.00 0 0 0 16.00
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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
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
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 0 15.00 16. 00 Other 0 0 0 0 0 16.00
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 0 15. 00 16. 00 Other 0 0 0 0 0 16. 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
16. 00 Other 0 0 0 16. 00
18.00 Anal gesi cs 0 0 0 0 18.00
19.00 Sedatives / Hypnotics 0 0 0 19.00
20.00 Other - Specify 0 0 0 0 20.00
21.00 Durable Medical Equipment/0xygen 0 0 0 21.00
22.00 Patient Transportation 0 0 0 0 22.00
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 25. 00
26.00 Outpatient 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 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 1,244 0 0 34.00
35.00 Total cost to be allocated 0 240 0 0 35.00
36.00 Unit Cost Multiplier (see instructions) 0.000000 0.192926 0.000000 0.000000 36.00

Health Financial Systems		CAMERON MEMORIAL COMMUNITY			In Lieu of Form CMS-2552-10			
COMPUTATION OF TOTAL HOSPICE SHARED COSTS			Provi der CCN: 15		Peri od:	Worksheet K-5		
			Hospi ce (CCN: 151561	From 10/01/2013 To 09/30/2014			
					Hospi ce I			
Cost Center Description					ge Total Hospice			
		1,	I, col. 11 Rati		Charges	Ancillary		
			line			Costs (cols. 1		
					Records)	x 2)		
			0	1. 00	2. 00	3. 00		
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSI CAL THERAPY		66. 00	•	90 0	0	1.00	
2.00	OCCUPATI ONAL THERAPY		67. 00				2.00	
3.00	SPEECH PATHOLOGY		68. 00				3.00	
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 4628	67 0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00	
6.00	LABORATORY		60.00	0. 2929	42 0	0	6.00	
6. 01	BLOOD LABORATORY		60. 01				6. 01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0. 5444	09 0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00	
9.00	RADI OLOGY-THERAPEUTI C		55.00				9.00	
10.00	CHEMI CAL DEPENDENCY		76. 00	2. 9887	75 0	o	10.00	
10. 01	ONCOLOGY		76. 01	0. 4871	77 0	0	10. 01	
11. 00	Totals (sum of lines 1-10)					0	11.00	
	•	,			•	·		

Health Financial Systems CAMERON MEMO			OMMUNI TY		In Li€	In Lieu of Form CMS-2552-10		
CALCUL	CALCULATION OF HOSPICE PER DIEM COST		Provider CCN: 151315		Peri od:	Worksheet K-6		
					From 10/01/2013			
			Hospice C	CCN: 151561	To 09/30/2014			
						2/25/2016 9:4	<u>6 am </u>	
					Hospi ce I			
		Ti t	le XVIII	Title XIX	Other	Total		
			1. 00	2. 00	3. 00	4. 00		
1.00	Total cost (see instructions)					219, 696	1. 00	
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					2, 126	2. 00	
3.00	Average cost per diem (line 1 divided by line 2)					103. 34	3. 00	
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line		1, 710				4. 00	