payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPLRES 05-31-2019

HOSPITAL AND I	HOSPI TAL	HEALTH C	CARE C	COMPLEX	COST	REPORT	CERTI FI CATI ON	Provi der	CCN:	15-1315	Peri o	d:	Worksheet S
AND SETTLEMEN	T SUMMARY												Parts I-III
											lo	09/30/2017	Date/Time Prepared:
													2/22/2018 3:52 pm

					2/22/2018 3:	52 pm
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 2/22/201	8 Time:	3: 52 pi
use only	2. [] Manually submitted co	ost report				
	3. [0] If this is an amended 4. [F] Medicare Utilization.			resubmitted this co	st report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No.	this Provider CCN 12.	NPR Date: Contractor's Vendo [0]If line 5, col number of time	umn 1 is 4:	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY (15-1315) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
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	-127, 765	412, 491	0	-106, 046	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	25, 794	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10. 00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	-101, 971	412, 491	0	-106, 046	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.

From 10/01/2016 To 09/30/2017 Part I Date/Time Prepared: 2/22/2018 11:52 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 99915 05/01/1997 14.00 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) 10/01/2016 09/30/2017 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 §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 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	MEMORI A	AL COMMUNITY		In L	ieu of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ГА	Provi der CC		eriod: rom 10/01/201		eet S-2	
			T-		17 Date/T	me Prep	
				Urban/Rural	S Date of		32 dili
26.00 Enter your standard geographic classification (not wa	ge) sta	atus at the bed	inning of the	1. 00	2.	00	26. 00
cost reporting period. Enter "1" for urban or "2" for	rural.		· · ·				
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or					2		27. 00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the			H status in		0		35. 00
effect in the cost reporting period.	Tiulibei	or perrous so	on status in				
				Begi nni ng: 1. 00	Endi 2.		
36.00 Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number				36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	ls MDH status		0		37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for th	e MDH t	ransitional na	vment in	N			37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" fo				.,			07.01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	of MDH	l status. If li	ne 37 is				38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	peri od	ds in excess of	one and				
enter subsequent dates.				Y/N	Y		
39.00 Does this facility qualify for the inpatient hospital	paymen	nt adjustment f	for low volume	1. 00 N	2.		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i)							
for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column							
instructions) 40.00 Is this hospital subject to the HAC program reduction	adi ust	ment? Enter "Y	" for ves or	N N		ı	40. 00
"N" for no in column 1, for discharges prior to Octob	er 1. E	Enter "Y" for y					.0.00
no in column 2, for discharges on or after October 1.	(see i	nstructions)			V XVIII	XIX	
Prospective Payment System (PPS)-Capital				1.	00 2.00	3.00	
45.00 Does this facility qualify and receive Capital paymen	t for d	li sproporti onat	e share in acc	cordance	N N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce	ption f	for extraordi na	ıry circumstand	es	N N	N I	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.							
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS c					N N	N	47. 00
48.00 Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no.		N N	N	48. 00
56.00 Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	N		56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting p							57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont							
for yes or "N" for no in column 2. If column 2 is "Y	", comp	olete Worksheet					
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reimb			ıns' services a	ns	N		58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes			D+ I		N		59. 00
or so pic costs craimed on title too of worksheet A: 11 yes	, compt	OLO WKSL. D-Z,	NAHE 413.85	Worksheet A	A Pass-T		37.00
			Y/N	Line #	Qual i fi Cri teri		
			1 00	2.00	2	20	
60.00 Are you claiming nursing and allied health education			1. 00 N	2. 00	3.	50	60. 00
any programs that meet the criteria under §413.85? (see ins	structions) IME	Direct GME	IME	Di rec	t GME	
	1 00	2.00	2.00				
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4. 00	5.		61. 00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)							
61.01 Enter the average number of unweighted primary care		0.00	0.00				61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see							
instructions) 61.02 Enter the current year total unweighted primary care		0. 00	0.00				61. 02
FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.00	1			U 1. UZ
and primary care FTEs added under section 5503 of ACA). (see instructions)							
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0. 00	0.00				61. 03
determining compliance with the 75% test. (see							
i nstructi ons)							

HOSPI TAL	nancial Systems AND HOSPITAL HEALTH CARE COMPL			AL COMMUNITY Provider CO	CN: 15-1315 F	Peri od:	eu of Form CMS-2 Worksheet S-2	
					F	From 10/01/2016 Fo 09/30/2017	Part I	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
sur cur	ter the number of unweighted p rgery allopathic and/or osteop rrent cost reporting period. (so ter the difference between the	athic FTEs in the ee instructions).		0.00				61. 0 61. 0
pri 61. 1.06 Ent use	d/or general surgery FTEs and imary care and/or general surgon. 04 minus line 61.03). (see inster the amount of ACA §5503 aword for cap relief and/or FTEs	ery FTE counts (line structions) ard that is being that are nonprimary		0. 00) O. C	00		61.0
car	re or general surgery. (see in:	structions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2. 00	3.00	4. 00	
spe for col pro unw	the FTEs in line 61.05, speciecialty, if any, and the number each new program. (see instrium 1, the program name. Enterogram code. Enter in column 3, weighted count. Enter in column E unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE				0. 00	0. 00	61. 1
1.20 Of pro res i ns Ent 3,	the FTEs in line 61.05, speci- ogram specialty, if any, and the sidents for each expanded prog- structions) Enter in column 1, ter in column 2, the program co- the IME FTE unweighted count.	ne number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0. 00	0. 00	61. 2
							1.00	
	A Provisions Affecting the Hea ter the number of FTE residents					iod for which	0.00	62. C
2. 01 Ent	ur hospital received HRSA PCRE ter the number of FTE resident ring in this cost reporting pe	s that rotated from a riod of HRSA THC prog	n Teachi gram. (s	see instruction		your hospital	0.00	62. C
3.00 Has	aching Hospitals that Claim Re s your facility trained residen " for yes or "N" for no in col	nts in nonprovider se	ettings	during this co			N	63. 0
, ,	101 yes 01 N 101 110 111 001	ami i. ii yes, compre	700 11110	ss or through	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3. 00	
	ction 5504 of the ACA Base Yea				1			
4.00 Ent in res set res	riod that begins on or after J ter in column 1, if line 63 is the base year period, the numl sident FTEs attributable to ro ttings. Enter in column 2 the sident FTEs that trained in you (column 1 divided by (column	yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	y trair n-primar all nor I non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0.0	0.00	0. 000000	64. C
1		Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	3. 00	4. 00		4

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/22/2018 11:52 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in 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 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-131	5 Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Pro 2/22/2018 11:	epared:
		1.00	
Long Term Care Hospital PPS 10.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 11.00 Is this a LTCH co-located within another hospital for part or all of the cost report "Y" for yes and "N" for no.	rting period? Enter	N N	80. 00 81. 00
TEFRA Providers 15.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. 00 86. 00
17.00 Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv) for yes or "N" for no.)(II)? Enter "Y"	N	87. 00
, c. , se c	V 1.00	XI X 2. 00	
Title V and XIX Services 10.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y"		Υ	00.00
10.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" yes or "N" for no in the applicable column. 11.00 Is this hospital reimbursed for title V and/or XIX through the cost report either		N N	90.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see	e	N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 13.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? En "Y" for yes or "N" for no in the applicable column.	ter N	N	93. 00
24.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94. 00
15.00 Filine 94 is "Y", enter the reduction percentage in the applicable column. 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. 00 96. 00
applicable column. 17.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 18.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents postepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in		0. 00	
column 1 for title V, and in column 2 for title XIX. 18.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on V C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.		Y	98. 01
Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column		Y	98. 02
For title V, and in column 2 for title XIX. 18.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (vice in the control of the column 2 for title XIX. 10.10 For title V, and in column 2 for title XIX.		N	98. 03
Does title V, and III column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, in column 2 for title XIX.	and	N	98. 04
Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a		Y	98. 05
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	98.06
Rural Providers 05.00 Does this hospital qualify as a CAH?	Y		105. 00
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of par for outpatient services? (see instructions)			106. 00
07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is	lf		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e 42 N		108. 00
Physical	•	Respiratory 4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	0 3.00 N	4.00 Y	109. 00

for yes or "N" for no for each therapy.				
			1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or "complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, line applicable.	'N" for no. If	yes,	N	110. 00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-1315	Peri od:				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	CCN: 15-1315	From 10/01/ To 09/30/		Part I Date/Ti	me Pro	epared
		1.00	1	2.0	20	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beaution for tele-health services.	g period? Enter , enter the in column 2.	N		2.0	1	111. 0
			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 psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.	2 is "E", enter term care (incl the definition	in column udes	N		0	115. 0
l16.00 Is this facility classified as a referral center? Enter "Y" for yes or ' l17.00 Is this facility legally-required to carry malpractice insurance? Enter no.		"N" for	N Y			116. C
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter occurrence.	1 if the policy	/is	1			118. 0
ordin made. Enter 2 in the porrey is deed rende.	Premi ums	Losse	S	Insur	ance	
					/Time Pro/2018 11: 2.00 00 3.00 0 surance	
	1. 00	2.00)	3. 0	00	
18.01 List amounts of malpractice premiums and paid losses:	245, 3	357	0			0 118. 0
		1. 00		2.0	00	
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 19.00 DO NOT USE THIS LINE	r than the cost centers	N				118. (
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless pr §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 insenter in column 2, "Y" for yes or "N" for no.	"Y" for yes or the Outpatien			N		120. (
21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	ces charged to	Y				121. (
22.00 Does the cost report contain healthcare related taxes as defined in §190 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enthe Worksheet A line number where these taxes are included.						122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "I	N" for no. If	N				125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the cer	tification date	3				126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	ification date					127.
28.00 If this is a Medicare certified liver transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	ification date					128.
29.00 of this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	fication date i	n				129.
30.00 If this is a Medicare certified pancreas transplant center, enter the condate in column 1 and termination date, if applicable, in column 2.	erti fi cati on					130.
31.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.	certi fi cati on					131.
32.00 If this is a Medicare certified islet transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	ification date					132.
33.00 If this is a Medicare certified other transplant center, enter the certiin column 1 and termination date, if applicable, in column 2.	ification date					133.
34.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	r in column 1					134.
40.00 Are there any related organization or home office costs as defined in Cl chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		Y				140.

 Heal th Financial
 Systems
 CAMERON MED

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
 CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10 Worksheet S-2 Part I Date/Time Prepared: 2/22/2018 11: 52 am Provider CCN: 15-1315 Peri od: From 10/01/2016 To 09/30/2017 1.00 2.00 3.00

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the 17 this facility is part of a chain organization, enter on lines 141 through home office and enter the home office contractor name and contractor number.

141.00 Name:
142.00 Street:
143.00 City:

2.00
Contractor of a chain organization, enter on lines 141 through home office and enter the home office contractor name and contractor number.

Contractor's Name:
P0 Box:
State: Contractor's Number: 141. 00 142. 00 Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00

					1. 00	2. 00	
145.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for no lude Medicare utilizat	in column 1. If c	olumn 1 i				145. 00
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the pre column 1. (See CMS Pu			lf	N		146. 00
lyes, enter the approval date (IIIII/C	u/yyyy) iii corullii 2.						
						1. 00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of				_		N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method					N Title VIV	149. 00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for						
or charges? Enter "Y" for yes or "							
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER					.,		158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC		IN.	N N		N N	N N	161. 00
101. 00 CWITC			IV		IN	IN	101.00
						1. 00	_
Mul ti campus					'		
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more campu		fferent		N	165. 00
	Name	County	State	Zip Co		FTE/Campus	_
166.00 f ine 165 is yes, for each	0	1. 00	2. 00	3.00	4. 00	5.00	0 166, 00
campus enter the name in column						0.0	0 100.00
O, county in column 1, state in column 2, zip code in column 3,							
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
O, county in column 1, state in column 2, zip code in column 3,							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						1. 00	
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT					ct		1/7.00
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 Is this provider a meaningful user	under §1886(n)? Ente	r "Y" for yes or "	N" for no			Y	
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10	under §1886(n)? Ente 5 is "Y") and is a mea	r "Y" for yes or " ningful user (line	N" for no			Y	
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Ente 5 is "Y") and is a mea IT assets (see instruc	r "Y" for yes or " ningful user (line tions)	N" for no 167 is "	Y"), en	nter the	Y	0168.00
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the Home 168.01 If this provider is a CAH and is reception under §413.70(a) (6) (ii)?	under §1886(n)? Ente 5 is "Y") and is a mea IT assets (see instruc ot a meaningful user, 'Enter "Y" for yes or	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i	N" for no 167 is " qualify nstructio	Y"), er for a h	nter the nardship	Y	0168. 00 168. 01
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the Hosen 168.01 If this provider is a CAH and is reacception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful user 169.00 If this provid	under §1886(n)? Enter 5 is "Y") and is a mea IT assets (see instruc oot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i	N" for no 167 is " qualify nstructio	Y"), er for a h	nter the nardship	Y	0168. 00 168. 01
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the Hamiltonian 168.01 if this provider is a CAH and is not seem to see the column 168.01 if this provider is a CAH and is not seem to see the column 168.01 if this provider is a CAH and is not seem to see the column 168.01 in the column 16	under §1886(n)? Enter 5 is "Y") and is a mea IT assets (see instruc oot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i	N" for no 167 is " qualify nstructio	Y"), er for a h	nter the nardship , enter the	Y N O. C	0168. 00 168. 01
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the Hosen 168.01 If this provider is a CAH and is reacception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful user 169.00 If this provid	under §1886(n)? Enter 5 is "Y") and is a mea IT assets (see instruc oot a meaningful user, Enter "Y" for yes or ser (line 167 is "Y")	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i	N" for no 167 is " qualify nstructio	Y"), er for a h	nter the nardship , enter the Beginning	Y N O. C Endi ng	0168. 00 168. 01
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the Hamber 168.01 if this provider is a CAH and is reception under §413.70(a)(6)(ii)? 169.00 if this provider is a meaningful utransition factor. (see instructions)	under §1886(n)? Enters is "Y") and is a mea IT assets (see instruction of a meaningful user, 'Enter "Y" for yes or ser (line 167 is "Y") ins)	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (N" for no 167 is " qualify nstructio line 105	Y"), er for a h	nter the nardship , enter the Beginning 1.00	Y N 0. C Endi ng 2. 00	0168. 00 168. 01 00169. 00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the Health 168.01 if this provider is a CAH and is nexception under §413.70(a)(6)(ii)? 169.00 if this provider is a meaningful utransition factor. (see instruction 170.00 is the columns 1 and 2 the EHR between the columns 1 and 2 the EHR between the columns 2 the EHR between the columns 2 the EHR between the columns 3 the columns 3 the EHR between the columns 2 the EHR between the columns 2 the EHR between the columns 3 the columns 3 the EHR between the columns 4 the EHR between the columns 5 the columns 6 the columns 7 the columns 7 the columns 7 the columns 7 the columns 8 the columns 8 the columns 8 the columns 8 the columns 1 t	under §1886(n)? Enters is "Y") and is a mea IT assets (see instruction of a meaningful user, 'Enter "Y" for yes or ser (line 167 is "Y") ins)	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (N" for no 167 is " qualify nstructio line 105	Y"), er for a h	nter the nardship , enter the Beginning	Y N O. C Endi ng	0168. 00 168. 01 00169. 00
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the Hamber 168.01 if this provider is a CAH and is reception under §413.70(a)(6)(ii)? 169.00 if this provider is a meaningful utransition factor. (see instructions)	under §1886(n)? Enters is "Y") and is a mea IT assets (see instruction of a meaningful user, 'Enter "Y" for yes or ser (line 167 is "Y") ins)	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (N" for no 167 is " qualify nstructio line 105	Y"), er for a h	nter the nardship , enter the Beginning 1.00	Y N 0. C Endi ng 2. 00	0168. 00 168. 01 00169. 00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 167.00 Is this provider a meaningful user reasonable cost incurred for the Health Information Technology (HIT 168.01 If this provider is a CAH (line 10 reasonable cost incurred for the exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful utransition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR between the columns 1 and 2 the EHR between the columns 3 the EHR between the columns 2 the EHR between the columns 3 the EHR between the columns 3 the columns 3 the EHR between the columns 4 the EHR	under §1886(n)? Enter to see instruction assets (see instruction assets (see instruction assets). The see instruction are an ingful user, the see instruction are also see (line 167 is "Y") ins).	r "Y" for yes or " ningful user (line tions) does this provider "N" for no. (see i and is not a CAH (N" for no 167 is " qualify nstructio line 105 porting	Y"), er for a h	nter the nardship , enter the Beginning 1.00	Y N 0. 0 Endi ng 2. 00 09/30/2017	167. 00 0168. 00 168. 01 169. 00 170. 00

Heal th	Financial Systems CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet S-2	2 epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente	1.00 er all dates in t	2.00 he	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.00
	proporting period. It yes, enter the date of the change in e	701 UIII1 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, milable in	Y	A		4. 00 5. 00
5.00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report to		IN IN			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the Legal operator of the program?		ne provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	· ·	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	available in fferent from N reconciliation. 2: If yes, is the provider is N instructions. ed and/or renewed during the ed graduate medical education ions. d or renewed in the current N				10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11. 00
					1. 00	
10.00	Bad Debts				.,	40.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	Bed Complement				N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see ins [.] t A	tructi ons. Par	t B	15. 00
		Y/N	Date	Y/N	Date	
	DCAD Data	1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	12/19/2021	Y	12/19/2017	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 yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

	Financial Systems CAMERON MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	N: 15-1315	Peri od:	u of Form CM Worksheet S	
				From 10/01/2016 To 09/30/2017	Part II Date/Time P	repared:
		Descri	ption	Y/N	2/22/2018 1 Y/N	1: 52 am
		0		1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0
		Y/N	Date	Y/N	Date	
1. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 0
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP Capital Related Cost	PT CHILDRENS HO	OSPI TALS)			
2. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 0
3. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 0
4.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.0
5. 00						
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26. 0
7. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? I1	f yes, submit	N	27. 0
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into duri	ing the cost	t reporting	Υ	28.0
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or I		ot Service F	Reserve Fund)	Υ	29. (
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		debt? If yes	s, see	N	30. 0
1. 00	instructions. Has debt been recalled before scheduled maturity without issinstructions.	suance of new o	debt? If yes	s, see	N	31. (
2. 00	Purchased Services Have changes or new agreements occurred in patient care serv	vicas furnisha	d through co	ontractual	Υ	32. 0
3. 00	arrangements with suppliers of services? If yes, see instructly line 32 is yes, were the requirements of Sec. 2135.2 appl	ctions.	-		Y	33. (
0. 00	no, see instructions. Provider-Based Physicians			tive brading. II	·	
4. 00	Are services furnished at the provider facility under an arillf yes, see instructions.	rangement with	provi der-ba	ased physicians?	Υ	34. (
5. 00	If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	Υ	35. (
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date	
	Home Office Costs			1.00	2. 00	
6. 00	Were home office costs claimed on the cost report?			N		36.0
	If line 36 is yes, has a home office cost statement been prollf yes, see instructions.	epared by the I	nome office?			37. C
8. 00	If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end			F		38. 0
9. 00	If line 36 is yes, did the provider render services to other see instructions.			5,		39. 0
0. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	lf yes, see			40. 0
		1. (20	2.	00	
	Cost Report Preparer Contact Information	1. (2.		
1. 00		KYLE		SMI TH		41.0
12. 00		BLUE & CO				42.0
	preparer.			1		ll l

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lie	u of Form C	MS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	UESTI ONNAI RE	Provi der	CCN: 15-1315	iod: nm 10/01/2016 09/30/2017		Prep	ared:
				3. 00				
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the tit held by the cost report preparer in columns respectively.		NIOR MANAG	ER				41. 00
42. 00	Enter the employer/company name of the cost preparer.	t report						42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respect							43. 00

| Peri od: | Worksheet S-3 | From 10/01/2016 | Part | | To 09/30/2017 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON

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

					T	09/30/2017	Date/Time Prep 2/22/2018 11:	
							I/P Days / 0/P	72 aiii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		23	8, 395	70, 224. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			23	8, 395	70, 224. 00	0	7. 00
	beds) (see instructions)							
8.00	I NTENSI VE CARE UNIT	31. 00		2	730	4, 944. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00						12.00
13.00	NURSERY	43. 00		0.5	0.405	75 4/0 00	0	13.00
14.00	Total (see instructions)			25	9, 125	75, 168. 00	0	14.00
15. 00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16.00
17. 00	SUBPROVIDER - IRF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00 20. 00
20.00	NURSING FACILITY							20.00
21. 00 22. 00	OTHER LONG TERM CARE	101. 00					o	21.00
23. 00	HOME HEALTH AGENCY	101.00					U	23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116. 00		0	0			23.00
24. 00	HOSPICE (non-distinct part)	30.00		U	1			24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		25			U	27. 00
28. 00	Observation Bed Days			25			o	28. 00
29. 00	Ambul ance Trips						U	29. 00
30. 00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see l'istruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 00	Total ancillary labor & delivery room			0	Ī			32. 00
JZ. UI	outpatient days (see instructions)							JZ. U I
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
		1	1		I .			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1315

Peri od: Worksheet S-3 From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

33.01

2/22/2018 11:52 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 103 75 2, 926 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) 33 261 2 00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 315 5.00 315 Hospital Adults & Peds. Swing Bed NF 199 6.00 C 6.00 7.00 Total Adults and Peds. (exclude observation 1,418 75 3, 440 7.00 beds) (see instructions) INTENSIVE CARE UNIT 19 8.00 79 206 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 406 13.00 14.00 Total (see instructions) 1, 497 94 4,052 0.00 363.60 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 1,027 1, 176 5, 407 0.00 8. 30 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 2 29 24 00 0 0.00 24.00 0 24. 10 HOSPICE (non-distinct part) 0 C 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 26, 00 0.00 FEDERALLY QUALIFIED HEALTH CENTER 0 O 0.00 26.25 C 26.25 27.00 Total (sum of lines 14-26) 0.00 374.19 27.00 28.00 Observation Bed Days 173 1, 336 28.00 29.00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 25 32.00 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

| Period: | Worksheet S-3 | From 10/01/2016 | Part | To 09/30/2017 | Date/Time Prepared: Provider CCN: 15-1315

					То	09/30/2017	Date/Time Prep 2/22/2018 11:	
		Full Time Equivalents			Di scha	rges		
	Component	Nonpai d Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	1	13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	434	34	1, 256	1. 00
2. 00 3. 00 4. 00 5. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				15	97 0 0		2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT							6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY							9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00		0	434	34	1, 256	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
22. 00 23. 00 24. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0.00						22. 00 23. 00 24. 00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00						24. 10 25. 00 26. 00
26. 00 26. 25 27. 00 28. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0. 00 0. 00 0. 00						26. 25 27. 00 28. 00
29. 00 30. 00 31. 00 32. 00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)							29. 00 30. 00 31. 00 32. 00
	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0			32. 01 33. 00 33. 01

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-	2552-10
HOME F	EALTH AGENCY STATISTICAL DATA			CN: 15-1315 CCN: 15-7117	Peri od: From 10/01/2016 To 09/30/2017		pared:
					Home Health	PPS	<u> </u>
					Agency I		T
					1.	00	
0.00	County	T:	T' 11 \0.0111	T 11 VIV	STEUBEN	T	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	0.00	1. 00	0.00	
1.00	Home Health Aide Hours	0	C	1	0 0		
2.00	Unduplicated Census Count (see instructions)	0. 00	72. 00		0.00 0.00 0.00 0.00 0.00		2. 00
					,p. 0, 000 (. u	mo Equ. va. o.r.)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C)	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.0		l .	
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			3.		l .	1
7. 00	Nursing Supervisor			0.		l .	1
8.00	Physical Therapy Service			1. '			
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 0		l .	1
11. 00	Occupational Therapy Supervisor			0.			1
12.00	Speech Pathology Service			0.0			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (1
15. 00	Medical Social Service Supervisor			0.			1
16.00	Home Health Aide			1. !			1
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (1
10.00	HOME HEALTH AGENCY CBSA CODES			0.1	0.00	0.00	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 first code).	Full Ep	oi sodes				
			With Outliers	LUPA Epi sode		Total (cols.	
		0utliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	268 46, 462	15 2, 916		31 7 32 1, 361	321 56, 571	1
23. 00	Physical Therapy Visits	521	2, 910	1	8 13	l .	1
24. 00	Physical Therapy Visit Charges	105, 314	3, 079	1, 6		112, 704	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	29 5, 759	12 2, 383	1	0 1 0 198	42 8, 340	1
27. 00	Speech Pathology Visits	17	2, 303	i	0 0		1
28. 00	Speech Pathology Visit Charges	3, 376	C	1	0 0	-,	1
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	8 1, 973	C	1	0 0	8 1, 973	1
31. 00	Home Health Aide Visits	1, 973	10	1	3 0		1
32.00	Home Health Aide Visit Charges	3, 627	526	1!	58 0	4, 311	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	912	52		42 21	1, 027	33.00
34. 00	Other Charges	O	C		0 0	О	
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	166, 511	8, 904	7, 6	32 4, 228		
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	68			14 1	83	36. 00
	outlier)						
37.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	2, 429	1 C	0.	003		37. 00 38. 00
30.00	Trotal Mon-Routine Medical Supply Chaiges	2,429	C	'I 9'	001	J 3, 332	1 30.00

	Financial Systems	5.474	CAMERON MEMORI				eu of Form CMS-2	
HOSPI I	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provi der C	UN: 15-1315	Peri od: From 10/01/2016	Worksheet S-9 PARTS I THROU	
				Hospi ce CC	N: 15-1561	To 09/30/2017	Date/Time Pre	pared:
						Hospi ce I	2/22/2018 11:	52 am_
		Unduplicated				поѕргсе г		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1 00	0.00	Facility				
	DART I FNROLLMENT DAVC FOR O	1.00	2.00	3.00	4.00	5. 00	6. 00	
1. 00	PART I - ENROLLMENT DAYS FOR CO Hospice Continuous Home Care	JST REPORTING F	PERTODS BEGINNI	NG BEFORE OCTO	BER 1, 2015 T		I	1.00
2.00	Hospice Continuous Home Care			•				2.00
3.00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4. 00
5. 00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015	_	•	
6.00	Number of patients receiving							6. 00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							0.00
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.	·		
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
	DART III FNROILMENT RAVO FOR	OOCT DEPORTING	DEDLODG BEOLA	1.00	2.00	3.00	4. 00	
10. 00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTING	PERIODS BEGIN	INTING ON OR AFT	ER OCTOBER I	, 2015 0 0	1 0	10.00
11. 00	Hospice Routine Home Care			1, 320	1	50 615		11.00
12. 00	Hospice Inpatient Respite Care			1, 320	1	0 0		1
13. 00	Hospice General Inpatient Care					0 13		13.00
14. 00	Total Hospice Days			1, 320	1	50 628		14. 00
	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE			R OCTOBER 1, 201		1
	Hospice Inpatient Respite Care			C	l .	0 0		15. 00
16. 00	Hospice General Inpatient Care			0		0 0	0	16. 00

	Financial Systems CAMERON MEMORIAL COMMUNITY TAL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet S-10					
0351	AL UNCOMPENSATED AND THIDISENT CARE DATA PROVIDER	CCN. 15-1315	From 10/01/2016						
			To 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am				
				1. 00					
	Uncompensated and indigent care cost computation								
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colum	n 8)	0. 408307	1.0				
. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			2, 229, 375	2.0				
. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3. 0				
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments	ai d?		4.0					
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medic	cai d		1, 454, 424	5.0				
. 00	Medicaid charges Medicaid cost (line 1 times line 6)		12, 313, 258 5, 027, 589						
. 00	Difference between net revenue and costs for Medicaid program (line 7)	minus sum of li	nes 2 and 5: if	1, 343, 790					
	< zero then enter zero)			., ,					
	Children's Health Insurance Program (CHIP) (see instructions for each I	i ne)		_					
0.00	Net revenue from stand-alone CHLP			0	9. 0 10. 0				
1. 00				0	11.0				
2. 00	,	minus line 9;	if < zero then	0					
	enter zero)								
3. 00	Other state or local government indigent care program (see instructions). Net revenue from state or local indigent care program (Not included on			0	13. C				
4. 00			0						
00	10)		0						
5. 00			0						
6. 00	Difference between net revenue and costs for state or local indigent ca 13; if < zero then enter zero)	ne 15 minus line	0	16. 0					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and st	tate/local indi	gent care program	ns (see					
	instructions for each line)								
7.00				0					
8. 00 9. 00			s (sum of lines	0 1, 343, 790					
7. 00	8, 12 and 16)	rt care program	is (sum of filles	1, 545, 770	17.0				
		Uni nsured		Total (col. 1					
		patients 1.00	pati ents 2.00	+ col . 2) 3.00					
	Uncompensated Care (see instructions for each line)	1.00	2.00	3.00					
0.00		169, 0	94 25, 542	194, 636	20.0				
	(see instructions)			0.4 50.4					
1. 00	Cost of patients approved for charity care and uninsured discounts (see instructions)	e 69, 0	25, 542	94, 584	21. C				
2. 00	,		0 0	0	22. C				
	chari ty care								
3. 00	Cost of charity care (line 21 minus line 22)	69, 0	25, 542	94, 584	23.0				
				1. 00					
4. 00	Does the amount on line 20 column 2, include charges for patient days I	peyond a Length	of stay limit	N N	24.0				
	imposed on patients covered by Medicaid or other indigent care program	?	•						
	If line 24 is yes, enter the charges for patient days beyond the indige	ent care progra	m's length of	0	25.0				
5. 00	stay limit								
6. 00	Total bad debt expense for the entire hospital complex (see instruction								
6. 00	Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in	nstructions)		469, 844	27. 0				
6. 00 7. 00 7. 01	Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instruction).	nstructions)		722, 837	27. 0 27. 0				
6. 00 7. 00 7. 01 8. 00	Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instruction). Non-Medicare bad debt expense (line 26 minus line 27.01)	nstructions) ructions))	722, 837 6, 601, 937	27. 0 28. 0				
6. 00 7. 00 7. 01	Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instruction). Non-Medicare bad debt expense (line 26 minus line 27.01)	nstructions) ructions))	722, 837	27. 0 27. 0 28. 0 29. 0				

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNITY		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 10/01/2016 To 09/30/2017	Date/Time Pre	narod:
					10 09/30/2017	2/22/2018 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00				col . 4)	
	CENEDAL CEDVICE COCT CENTEDS	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		6, 040, 550	6, 040, 55	-485, 863	5, 554, 687	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 760, 756			3, 990, 083	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 668, 521			6, 668, 521	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 647, 323	6, 254, 469			10, 401, 225	
7.00	00700 OPERATION OF PLANT	765, 147	1, 729, 829		6 32, 915	2, 527, 891	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	33, 385	33, 38	5 0	33, 385	
9.00	00900 HOUSEKEEPI NG	629, 272	388, 051			1, 017, 323	
10. 00	01000 DI ETARY	425, 392	378, 367	803, 75		175, 433	
11.00	01100 CAFETERI A	0	0		589, 751	589, 751	
13.00	01300 NURSI NG ADMI NI STRATI ON	630, 555	47, 421			677, 976	1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	170, 592	90, 665			261, 257	1
	01600 MEDI CAL RECORDS & LI BRARY	438, 790 429, 972	2, 411, 560 236, 992			2, 850, 350 666, 964	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	427, 772	230, 772	000, 70	4 0	000, 704	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 079, 957	1, 387, 240	3, 467, 19	7 352, 957	3, 820, 154	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		195, 897	195, 897	1
43.00	04300 NURSERY	0	0)	54, 870		43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 775, 382	1, 289, 688	3, 065, 07		2, 378, 012	1
51. 00	05100 RECOVERY ROOM	0	0	1	0 687, 058	687, 058	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	807, 576	169, 557			371, 782	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 588, 994	894, 461			2, 483, 455	
60.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	902, 585	1, 753, 047	1	2 0	2, 655, 632	
64. 00 65. 00	06500 RESPIRATORY THERAPY	39, 433	872, 234		9	0 751, 358	
65. 01	06501 SLEEP LAB	37, 433	072, 234	711,00	186, 746	186, 746	
66. 00	06600 PHYSI CAL THERAPY	847, 890	32, 656	880, 54		880, 546	
69. 00	06900 ELECTROCARDI OLOGY	0	367, 084			340, 647	
69. 01	06901 CARDI AC REHAB	67, 574	4, 071			71, 645	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2	1, 093, 243	1, 093, 24	5 -651, 273	441, 972	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 651, 273	651, 273	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	
76. 00	03020 CHEMI CAL DEPENDENCY	101, 970	69, 666			171, 636	
76. 01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS] 0	1, 096, 544	1, 096, 54	4 0	1, 096, 544	76. 01
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 (0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89. 00
90.00	09000 CLINIC	145, 896	25, 252	171, 14	8 0	171, 148	
90. 01	09001 CLI NI C- MCDONALD	484, 294	956, 475	1			
91.00	09100 EMERGENCY	1, 736, 514	405, 140	2, 141, 65	4 1, 627	2, 143, 281	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS				_		
101.00	10100 HOME HEALTH AGENCY	711, 392	70, 750	782, 14	2 -143, 502	638, 640	101. 00
112 00	SPECIAL PURPOSE COST CENTERS		1 (07 02)	1 (07 02	1 (07 02)	0	113. 00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	0	1, 697, 836 0		6 -1, 697, 836 0 0		114. 00
	11600 HOSPI CE	86, 579	29, 734			146, 375	
118.00			38, 255, 244				
110.00	NONREI MBURSABLE COST CENTERS	10,010,001	00, 200, 211	00,700,02	070,010	07, 100, 070	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0)	0 0	0	194. 00
	07951 MOB	0	21, 039				194. 01
	07952 COMMUNI TY HEALTH	77, 410	7, 185	84, 59	5 0		194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	1	0		194. 03
	07954 EDUCATI ON	94, 461	99, 784				194. 04
	07955 MARKETI NG 07956 GUEST MEALS	136, 032	395, 731	531, 76	3 -104, 094 38, 575	427, 669	194. 05
	07957 OUTSI DE LAUNDRY	0	0		30, 373		194. 00
	07958 CANCER CENTER		0		0		194. 07
	07959 URGENT CARE	1, 302, 332	280, 828	1, 583, 16	-160, 782	1, 422, 378	
	07960 RHC	602, 353	105, 325			695, 802	
194. 11	07961 OBGYN	70, 328	10, 685	i .			194. 11
194. 12	07962 TRINE STUDENT HEALTH	14, 879	814	15, 69	3 0	15, 693	194. 12
	07963 OCCUPATI ONAL HEALTH	112, 718	40, 111			152, 829	
	07964 I MMUNI ZATI ON CLINI C	57, 430	1, 160				194. 14
200.00	TOTAL (SUM OF LINES 118 through 199)	20, 981, 024	39, 217, 906	60, 198, 93	0	60, 198, 930	J200. 00

Provider CCN: 15-1315

| Period: | Worksheet A | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared: 2/22/2018 11:52 am

				2/22/2018 11	1: 52 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	-633, 910			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-167, 257		l control of the cont	2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-394, 171			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-1, 877, 961			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			9. 00
10.00	01000 DI ETARY	-13, 741			10. 00
11. 00	01100 CAFETERI A	-305, 753			11. 00
13. 00	1	0			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	261, 257		14. 00
15. 00	I I	-86, 222			15. 00
16. 00		-401	666, 563		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			
30. 00		-1, 074, 034			30. 00
31. 00	I I	0		l control of the cont	31.00
43.00		0	54, 870		43. 00
	ANCILLARY SERVICE COST CENTERS	1			
50.00	· · · · · · · · · · · · · · · · · · ·	-633, 019		l control of the cont	50.00
51. 00	· · · · · · · · · · · · · · · · · · ·	0		l control of the cont	51. 00
52. 00	· · · · · · · · · · · · · · · · · · ·	0			52. 00
54. 00		0	_,,	•	54. 00
60. 00		-7, 911	2, 647, 721		60.00
64. 00		0			64. 00
65. 00	06500 RESPI RATORY THERAPY	0	,		65. 00
65. 01	06501 SLEEP LAB	0	186, 746		65. 01
66. 00	I I	0	880, 546		66. 00
69. 00		0		•	69. 00
69. 01	06901 CARDI AC REHAB	0	,		69. 01
71. 00		0			71. 00
72. 00		0			72. 00
73. 00		0			73. 00
76. 00	I I	0			76. 00
76. 01		0	1, 096, 544		76. 01
	OUTPATIENT SERVICE COST CENTERS	_	_		
88. 00	I I	0		•	88. 00
89. 00	I I	0		1	89. 00
90.00	I I	0	171, 148		90.00
90. 01	09001 CLINIC- MCDONALD	-1, 054, 459			90. 01
91.00		0	2, 143, 281		91.00
92. 00	`				92. 00
101 0	OTHER REIMBURSABLE COST CENTERS		(20 (40		101 00
101.00	0 10100 HOME HEALTH AGENCY	0	638, 640	<u> </u>	101. 00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300 NTEREST EXPENSE		1 0		112 00
		0		•	113.00
	0 11400 UTILIZATION REVIEW-SNF	0			114. 00
	0 11600 HOSPI CE	0			116.00
118.00	9 /	-6, 252, 139	50, 906, 731		118. 00
100 0	NONREI MBURSABLE COST CENTERS	1	0		190. 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		
	0 07950 DAYCARE-I NFANT/TODDLER	0			194. 00
	1 07951 MOB	0			194. 01
	2 07952 COMMUNITY HEALTH	0			194. 02
	3 07953 ASSISTED LIVING/CAMERON WOODS	0			194. 03
	4 07954 EDUCATI ON	0	,		194. 04
	5 07955 MARKETI NG	0			194. 05
	6 07956 GUEST MEALS	0	1,		194. 06
	7 07957 OUTSI DE LAUNDRY	0	0		194. 07
	8 07958 CANCER CENTER	0	1		194. 08
	9 07959 URGENT CARE	0			194. 09
	0 07960 RHC	0			194. 10
	1 07961 OBGYN		81, 013		194. 11
	2 07962 TRINE STUDENT HEALTH	0			194. 12
	3 O7963 OCCUPATIONAL HEALTH	0			194. 13
	4 07964 I MMUNI ZATI ON CLINI C	6 252 120			194. 14
200. 00	TOTAL (SUM OF LINES 118 through 199)	-6, 252, 139	53, 946, 791	I	200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2016 To 09/30/2017 Date/Time Prepared: Provider CCN: 15-1315

					2/22/2018 11:52 am
		Increases			
	Cost Center	Li ne #	Salary	Other 5.00	
	2.00 A - LABOR AND DELIVERY	3. 00	4. 00	5. 00	
. 00	ADULTS & PEDIATRICS	30.00	453, 614	95, 240	1.00
. 00	NURSERY	43.00	45, 349	9, 521	2.00
. 00	EMERGENCY	91.00	1, 345	282	3. 00
	0	<u> </u>	500, 308	105, 043	
	B - PROPERTY INSURANCE		<u> </u>	· · ·	
. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	89, 727	1. 00
	0		0	89, 727	
	C - CAFERTERIA	1			
. 00	CAFETERI A	11.00	312, 128	277, 623	1.00
00	GUEST MEALS	194.06	20, 416	1 <u>8, 1</u> 59	2. 00
	U LATEREST EVRENCE		332, 544	295, 782	
00	D - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	1, 609, 358	1. 0
. 00	CAP REL COSTS-BEDG & TTAT	2.00	o	26, 663	2. 00
. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	61, 815	3. 00
	0		 _ 	1, 697, 836	
	E - DEPRECIATION EXPENSE	<u>'</u>	·,	, , , , , , , , , , , , , , , , , , , ,	
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 202, 664	1. 00
	0		0	2, 202, 664	
	F - ICU				
. 00	INTENSIVE CARE UNIT	31.00	11 <u>7, 5</u> 18	7 <u>8, 3</u> 79	1.00
	0		117, 518	78, 379	
00	G - ADVERTISING COST	F 00	20. 200	04.77/	1.00
. 00	ADMI NI STRATI VE & GENERAL	5.00	22, 329	8 <u>4, 7</u> 76	1.00
	H - PROPERTY TAX		22, 329	84, 776	
. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	17, 716	1. 0
. 00	0			$-\frac{17,715}{17,716}$	1.00
	I - EDUCATION COSTS		<u> </u>	177710	
. 00	ADMINISTRATIVE & GENERAL	5. 00	94, 461	72, 284	1. 00
	0 — — — — —		94, 461	72, 284	
	J - SLEEP LAB				
. 00	SLEEP LAB	65. 01	0	186, 746	1. 00
00		0.00		0	2. 00
	K - UTILITIES		0	186, 746	
. 00	OPERATION OF PLANT	7.00	0	32, 915	1. 00
00	OFERATION OF FLANT	0.00	0	32, 913	2. 0
			 _	32, 915	2.00
	L - PUBLIC RELATIONS	<u> </u>	-1		
. 00	MARKETI NG	194. 05	0	3, 011	1. 00
	0 — — — — —			3, 011	
	M - HOME HEALTH SALARY				
. 00	HOME HEALTH AGENCY	101.00	1 <u>9, 9</u> 41	<u>0</u>	1. 00
	0		19, 941	0	
	N - RECOVERY ROOM	54.00	(07.050		
. 00	RECOVERY ROOM	51.00	687, 058	0	1.00
	O - IMPLANTABLE DEVICES		687, 058	U	
00	I MPL. DEV. CHARGED TO	72.00	٥	651, 273	1. 0
00	PATI ENTS	72.00	٩	031, 273	1.0
	0 = = =	+		651, 273	
	P - HOME HEALTH ADMIN		'		
00	ADMINISTRATIVE & GENERAL	5. 00	113, 440		1. 0
	0		113, 440	0	
_	Q - URGENT CARE				
00	ADMI NI STRATI VE & GENERAL	5.00	160, 782	<u>0</u>	1.0
	D HOSDI CE DECLACO		160, 782	0	
00	R - HOSPI CE RECLASS	11/ 00	E0 003		1.0
	HOSPICE	116.00	50, 003	0	1.00
00		1	50, 003	U	
00	S - DR MCDONALD PECLASS				
	S - DR. MCDONALD RECLASS	194 01	20 400	5 017	1 0
. 00	S - DR. MCDONALD RECLASS MOB TOTALS	194.01	29, 499 29, 499	<u>5, 9</u> 17 5, 917	1.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 10/01/2016 | To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: | 2/22/2018 | 11:52 am Provider CCN: 15-1315

						 2/22/2018 11:52 am
		Decreases				
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - LABOR AND DELIVERY	7.00	8.00	9.00	10.00	
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	500, 308	105, 043	0	1. 00
2. 00	DEEL VENT NOOM & ENDON NOOM	0.00	0	0	o	2. 00
3.00		0.00	O	C	o	3. 00
	0		500, 308	105, 043	B	
	B - PROPERTY INSURANCE					
1. 00	ADMI NI STRATI VE & GENERAL			8 <u>9, 7</u> 27		1.00
	0			89, 727		
1 00	C - CAFERTERI A DI ETARY	10.00	222 E44	295, 782	<u>.</u>	1 00
1. 00 2. 00	DIETARY	10. 00 0. 00	332, 544	295, 782	0	1.00
2.00			332, 544	295, 782		2.00
	D - INTEREST EXPENSE		002,011	270, 702		
1.00	INTEREST EXPENSE	113.00	0	1, 697, 836	9	1.00
2.00		0.00	O	C		2. 00
3.00		0.00	0	0	<u> </u>	3. 00
	0		0	1, 697, 836		
	E - DEPRECIATION EXPENSE		ما		ا ما	1.00
1. 00	CAP REL COSTS-BLDG & FIXT			2, 202, 664		1. 00
	F - ICU		U	2, 202, 664	-	
1.00	ADULTS & PEDIATRICS	30.00	117, 518	78, 379	0	1. 00
1.00	0		117, 518			1.00
	G - ADVERTISING COST		1177010	, 6, 6, 7		
1.00	MARKETI NG	194. 05	22, 329	84, 776	0	1. 00
	0 — — — — —		22, 329	84, 776		
	H - PROPERTY TAX					
1.00	ADMI NI STRATI VE & GENERAL		•	1 <u>7, 7</u> 16		1.00
	0 FRUGATION COSTS		0	17, 716		
1 00	I - EDUCATION COSTS EDUCATION	194. 04	94, 461	72, 284		1. 00
1. 00	n EDUCATION	194.04	94, 461	7 <u>2, 2</u> 04 72, 284		1.00
	J - SLEEP LAB		74, 401	72, 204	1	
1.00	RESPIRATORY THERAPY	65.00	0	160, 309	0	1. 00
2.00	ELECTROCARDI OLOGY	69.00	o	26, 437		2. 00
	0			186, 746		
	K - UTILITIES					
1.00	MOB	194. 01	0	21, 039	1	1.00
2. 00	RHC	194.10		11,876		2. 00
	U L - PUBLIC RELATIONS		0	32, 915		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3, 011	0	1. 00
1.00	0		— — ŏ	$-\frac{3,011}{3,011}$		1.00
	M - HOME HEALTH SALARY		-1	-,		
1.00	HOSPI CE	116.00	19, 941	C	0	1.00
	0 — — — — —		19, 941	o		
	N - RECOVERY ROOM					
1.00	OPERATING ROOM	<u>50.</u> 00	68 <u>7, 0</u> 58	0		1. 00
	0		687, 058	C)	
1 00	O - IMPLANTABLE DEVICES	71 00	ما	/F1 070		1.00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	٥	651, 273	0	1.00
	0	+		651, 273		
	P - HOME HEALTH ADMIN		<u> </u>	001,7270		
1.00	HOME HEALTH AGENCY	101.00	113, 440	C	0	1.00
	0 — — — — —		113, 440	0		
	Q - URGENT CARE					
1. 00	URGENT CARE	194.09	160, 782		<u> </u>	1.00
	D HOSPI OF DEGLACE		160, 782	C	ין	
1 00	R - HOSPICE RECLASS	101 00	E0 000			1 00
1.00	HOME HEALTH AGENCY	101.00	5 <u>0, 0</u> 03 50, 003		0 0	1.00
	S - DR. MCDONALD RECLASS		ou, 003		,	
1.00	CLINIC- MCDONALD	90. 01	29, 499	5, 917	' o	1. 00
	TOTALS		29, 499			60
500.00	Grand Total: Decreases		2, 127, 883	5, 524, 069		500.00
		'			. '	1

Provider CCN: 15-1315

					o 09/30/2017	Date/Time Prep 2/22/2018 11:	pared:
				Acqui si ti ons		2/22/2010 11.	32 aiii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 317, 868	0	C	0	0	1. 00
2.00	Land Improvements	0	0	C	0	0	2. 00
3.00	Buildings and Fixtures	56, 605, 523	1, 875, 903	C	1, 875, 903	1, 714, 694	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, 241, 107	2, 134, 333	(2, 134, 333	471, 216	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	75, 164, 498	4, 010, 236	C	4, 010, 236	2, 185, 910	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	75, 164, 498	4, 010, 236		4, 010, 236	2, 185, 910	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		4.00	Assets				
	DART I ANALYSIS OF CHANGES IN CARLTAL ASSE	6. 00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1 00
1.00	Land	1, 317, 868	0				1. 00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	56, 766, 732	0				3. 00
4.00	Building Improvements	0	U				4. 00
5. 00 6. 00	Fixed Equipment	10 004 224	0				5. 00 6. 00
7. 00	Movable Equipment	18, 904, 224	0				7. 00
7. 00 8. 00	HIT designated Assets	76, 988, 824	0				7. 00 8. 00
9. 00	Subtotal (sum of lines 1-7) Reconciling Items	70, 988, 824	0				9. 00
9. 00 10. 00	Total (line 8 minus line 9)	76, 988, 824	0				9. 00 10. 00
10.00	Tiotal (Time o milius Time 4)	10, 900, 824	υĮ				10.00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	'I TAL		
	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 WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 040, 550	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 760, 756		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	6, 040, 550	1, 760, 756		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 040, 550		·		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 760, 756				2. 00
	1	1	7 004 004	I .			

0 0

6, 040, 550 1, 760, 756 7, 801, 306

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)

Health Financial Systems	CA	AMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COS	TS CENTERS		Provider CC	F	Period: From 10/01/2016 To 09/30/2017		
		COMF	PUTATION OF RAT	108	ALLOCATION OF		<u> </u>
Cost Center Descr	i pti on (Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
				(col. 1 - col. 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ON OF CAPITAL COSTS CENT						
1.00 CAP REL COSTS-BLDG & FI		58, 084, 600	0	58, 084, 600		0	1.00
2.00 CAP REL COSTS-MVBLE EQU	1	18, 904, 224	0	18, 904, 224		0	2.00
3.00 Total (sum of lines 1-2	2)	76, 988, 824	0	76, 988, 824		0	3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY O	F CAPITAL	
Cost Center Descr	i pti on	Taxes		Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
DADT LLL BEGGNOLLLATI		6.00	7. 00	8. 00	9. 00	10.00	
	ON OF CAPITAL COSTS CENT				F 44 / 470		1 00
1. 00 CAP REL COSTS-BLDG & FI		0	0		5, 416, 173	0	1.00
2.00 CAP REL COSTS-MVBLE EQU 3.00 Total (sum of lines 1-2	l l	0	0	(2, 045, 395		2.00
3.00 Total (sum of lines 1-2	2)	U	U	IMMARY OF CAPI	7, 461, 568	1, 787, 419	3. 00
			30	INIMARY OF CAPI	IAL		
Cost Center Descr	i pti on	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	ON OF CAPITAL COSTS CENT		00	·	-		
1. 00 CAP REL COSTS-BLDG & FI		-602, 839		17, 716		4, 920, 777	1.00
2. 00 CAP REL COSTS-MVBLE EQU		-9, 988		47.74	,	3, 822, 826	2.00
3.00 Total (sum of lines 1-2	2)	-612, 827	89, 727	17, 716	0	8, 743, 603	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10 Provider CCN: 15-1315 Peri od: From 10/01/2016 To 09/30/2017 Worksheet A-8 Date/Time Prepared: 2/22/2018 11:52 am Expense Classification on Worksheet A 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 -602, 839	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	A	-9, 988	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	A	-23, 155	ADMINISTRATIVE & GENERAL	5. 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
6. 00	expenses (chapter 8) Rental of provider space by	В	-11, 386	CAP REL COSTS-MVBLE EQUIP	2. 00	9	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service		0		0.00	0	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	-2, 600, 435			0	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	
12.00	Related organization transactions (chapter 10)	A-8-1	-554, 600		0.00	0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and quests	, в	-287 489	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee	1	207, 107	5711 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0.00	Ö	15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients	В	-86 222	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and	В		MEDICAL RECORDS & LIBRARY	16. 00	0	
19. 00	abstracts Nursing and allied health		0		0.00	0	
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-14, 984 0	CAFETERI A	11. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
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
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Ω	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	Α		CLINIC- MCDONALD	90. 01	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for	А	-18, 814	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
33. 00	Depreciation and Interest LOBBYING EXPENSES	A	-4.009	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
		- 1	., 507	,	2.00	,	

					0 77 007 2017	2/22/2018 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
		5 1 (0 1 (0)					
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 01	EMPLOYEE CHRISTMAS PARTY	A		ADMINISTRATIVE & GENERAL	5. 00		00.0.
33. 02		A		ADMINISTRATIVE & GENERAL	5. 00		33. 02
33. 03	MEALS ON WHEELS	В	-13, 741	DI ETARY	10. 00	0	33. 03
33. 04	RENTAL INCOME OFFSET - CANCER	В	-31, 071	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 04
	CENTER						
33. 05	ATM SURCHARGE REVENUE	В	-449	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	OP EDUCATION	В	-240	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 06
33.07	DIETICIAN CONSULTATIONS	В	-3, 280	CAFETERI A	11. 00	0	33. 07
33.09	HAF EXPENSE	В	-1, 234, 617	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	PHYSICIAN INCOME GUARANTEE	A	-468, 056	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
	OFFSET						
33. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 12
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-6, 252, 139				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

					2/22/2018 11:	52 am		
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount			
				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2.00	3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:							
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	393, 931	1. 00		
2.00	5. 00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	30, 300	2.00		
3.00	7. 00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3, 300	3.00		
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	490, 618	617, 687	4. 00		
5.00	0		0	490, 618	1, 045, 218	5. 00		

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

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, ,		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
 B. THTERRELATIONSHIT TO RELAT	ED ORGANIZATION(3) AND/OR HO	WE OTTTOE.			

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

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

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

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

Heal th	Financial Syste	ems		CA	MERON MEMORIAL	COMMUNI TY			Į. Li	n Lie	u of Form CN	S-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI	ONS AND HOME	Provi der	CCN:	15-1315	Peri od:		Worksheet A	8-1
OFFICE	COSTS								From 10/01/ To 09/30/		Date/Time F 2/22/2018	
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REC	QUI RED AS A	A RESULT OF TRA	NSACTI ONS	WI TH	I RELATED C	ORGANI ZATI ONS	S OR (CLAIMED	
	HOME OFFICE CO	STS:										
1.00	-393, 931	0										1.00
2.00	-30, 300	0										2.00
3.00	-3, 300	0										3.00
4.00	-127, 069	9										4. 00
5.00	-554, 600											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropr	iate) are tran	sferred in	deta	ail to Wor	ksheet A, co	l umn	6, lines as	
appropr	i ate. Posi ti ve	amounts increas	se cost a	and negativ	ve amounts decr	ease cost.	For	related or	ganization o	r hom	e office co	st which
has not	been posted to	o Worksheet A,	col umns	1 and/or 2	the amount a	llowable s	houl	d be indic	ated in colu	ımn 4	of this par	ī.
											•	

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
The Corretory by virtue of the out	pority granted under section 1914(b)(1) of the Social Security Act, requires that you f	iurni ch

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.
- 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.

Provider CCN: 15-1315

| Peri od: | From 10/01/2016 | To 09/30/2017 | Date/Ti me Prepared:

						To 09/30/2017	7 Date/Time Pro 2/22/2018 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				· ·	·		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	60.00	LABORATORY	18, 000	7, 9	10, 089	0	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	893, 313	851, 70	09 41, 604		0	2. 00
3.00	50.00	OPERATING ROOM	633, 019	633, 0°	19	0	0	3. 00
4.00	30.00	ADULTS & PEDIATRICS	222, 325	222, 32	25 0	0	0	4. 00
5.00	90. 01	CLINIC- MCDONALD	885, 471	885, 47	71 (0	0	5. 00
6.00	0.00		0		0	ol o	0	6. 00
7. 00	0.00		0		0		0	1
8. 00	0.00		0		0		Ō	8.00
9. 00	0.00		0		0		0	9. 00
10. 00	0. 00		0		0		0	10.00
200.00	0.00		2, 652, 128	2, 600, 43	51, 693		1 0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		I denti fi er			CE Memberships &	Component	of Malpractice	
			2	Li mi t	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1.00	60.00	LABORATORY	0		0 0	0	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	0		0	0	0	2. 00
3.00	50. 00	OPERATING ROOM	0		0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0		0	0	0	4. 00
5.00	90. 01	CLINIC- MCDONALD	0		0	0	0	5. 00
6.00	0. 00		0		0	0	0	6. 00
7.00	0.00		0		0	0	0	7. 00
8.00	0.00		0		0	0	0	8. 00
9.00	0.00		0		0	ol o	0	9. 00
10.00	0.00		0		0		0	10.00
200.00			0		0		0	1
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	60.00	LABORATORY	0		0 (7, 911		1. 00
2.00	30. 00	ADULTS & PEDIATRICS	0		0	851, 709		2. 00
3.00	50.00	OPERATING ROOM	0		0	633, 019		3. 00
4.00	30.00	ADULTS & PEDIATRICS	0		0	222, 325		4. 00
5.00	90. 01	CLINIC- MCDONALD	0		0	885, 471		5. 00
6.00	0.00		0		0			6. 00
7. 00	0.00		0		0			7. 00
8. 00	0.00		0		0			8.00
9. 00	0. 00		Ö		o o	ol o		9. 00
10. 00	0.00		Ö		o o	1		10.00
200.00			0		o c	1		200.00
200.00	1		1	ı	-1	2,000,100	I	

	ABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY E SUPPLIERS	Provider CCN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet A-8 Parts I-VI Date/Time Pre 2/22/2018 11:	pared:			
			Respi ratory Therapy	Cost	52 aiii			
				1. 00				
	PART I - GENERAL INFORMATION							
1. 00 2. 00	Total number of weeks worked (excluding aides) (see instructions 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			
F 00	nor therapist was on provider site (see instructions)	ni ata (asa i natruati ana)		0	F 00			
5. 00 6. 00	Number of unduplicated offsite visits - supervisors or thera Number of unduplicated offsite visits - therapy assistants (by therapy	0	5. 00 6. 00			
	assistant and on which supervisor and/or therapist was not p							
7. 00	instructions) Standard travel expense rate			3. 25	7. 00			
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 2,062.00	2. 00 3. 00 18, 960. 75 0.	4. 00 00 0. 00	5. 00	9. 00			
10. 00	AHSEA (see instructions) 2,002.00		00 0.00	0.00				
11. 00	Standard travel allowance (columns 1 and 2, 32.27	32. 27 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)	o	0		12. 00			
12. 01	Number of travel hours (offsite)				12. 01			
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		13. 00 13. 01			
13.01	Number of infres driven (offsite)				13.01			
				1. 00				
14. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, line 10)			133, 061	 14. 00			
15. 00	Therapists (column 2, line 9 times column 2, line 10)			1, 223, 537				
16. 00	Assistants (column 3, line 9 times column 3, line10)			0	16. 00			
17. 00	Subtotal allowance amount (sum of lines 14 and 15 for respiration of the subtotal allowance amount (sum of lines 14 and 15 for respiration of lines 15 for lines 15 for respiration of lines 15	atory therapy or lines 14	-16 for all	1, 356, 598	17. 00			
18. 00	Aides (column 4, line 9 times column 4, line 10)			0	18. 00			
19. 00	Trainees (column 5, line 9 times column 5, line 10)			0	19. 00			
20. 00	Total allowance amount (sum of lines 17-19 for respiratory that the sum of columns 1 and 2 for respiratory therapy or columns 1.			1, 356, 598	20.00			
	occupational therapy, line 9, is greater than line 2, make no							
21 00	the amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 17 of the complete lines 21-23).	divided by sum of columns	1 and 2 line 0	0.00	21. 00			
21.00	for respiratory therapy or columns 1 thru 3, line 9 for all of	3	s I aliu 2, IIIIe 9	0.00	21.00			
22. 00	Weighted allowance excluding aides and trainees (line 2 times	s line 21)		0	22. 00			
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL	FXPENSE COMPUTATION - PR	POVIDER SITE	1, 356, 598	23. 00			
	Standard Travel Allowance	EXI ENGL COM CTATION TO	OVI DER OTTE					
24. 00	Therapists (line 3 times column 2, line 11)			11, 779				
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or sum of lines 24	and 25 for all others)		0 11, 779	1			
27. 00	Standard travel expense (line 7 times line 3 for respiratory		3 and 4 for all	1, 186				
20.00	others)	at the provider site (sum	of lines 24 and	10.0/5	20.00			
28. 00	Total standard travel allowance and standard travel expense (27)	at the provider site (sui	1 01 TITIES 26 and	12, 965	28. 00			
	Optional Travel Allowance and Optional Travel Expense							
29. 00 30. 00	Therapists (column 2, line 10 times the sum of columns 1 and Assistants (column 3, line 10 times column 3, line 12)	2, line 12)		0	29. 00 30. 00			
31. 00	Subtotal (line 29 for respiratory therapy or sum of lines 29	and 30 for all others)		0	31.00			
32. 00	Optional travel expense (line 8 times columns 1 and 2, line		y or sum of	0	32. 00			
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (line:	28)		0	33. 00			
34. 00	Optional travel allowance and standard travel expense (sum o			0	34.00			
35. 00	Optional travel allowance and optional travel expense (sum o		W. 050 OUTOURS DR	0	35. 00			
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL I Standard Travel Expense	EXPENSE COMPUTATION - SER	VICES OUTSIDE PRO	OVI DER SI IE				
36. 00	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			
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6)							
57.00	Optional Travel Allowance and Optional Travel Expense			0	39. 00			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2	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			
43. 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	es 44, 45,				
44 ∩∩	or 46, as appropriate. Standard travel allowance and standard travel expense (sum o	f lines 38 and 39 - see i	nstructions)	Ω	44. 00			
	, and a second common			0	,			

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider Co	CN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet A-8 Parts I-VI Date/Time Pre 2/22/2018 11:	pared:
					Respi ratory Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ir	structions)	1.00	45. 00
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47. 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)	16. 25	398. 75	0.0	0.00	16. 25	47.00
48. 00	Overtime rate (see instructions)	96. 80	0.00				48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	1, 573. 00	0.00	0.0	0.00		49. 00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100. 00	0. 00	0.0	0.00	100.00	50. 00
51. 00	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	0.00	2, 080. 00	51. 00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	64. 53	0.00	0.0	0.00		52. 00
	(see instructions)						
53. 00	Overtime cost limitation (line 51 times line 52)	134, 222	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1, 573	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1, 049	0		0 0		55. 00
56. 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	524	0		0 0	524	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			1.00	
57. 00	Salary equivalency amount (from line 23)					1, 356, 598	
58. 00 59. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service			,		0	58. 00 59. 00
50.00	Overtime allowance (from column 5, line 56)	es (ITOIII TITIES	44, 45, 01 40	')		524	60.00
51. 00	Equipment cost (see instructions)					0	61.00
	Supplies (see instructions)					0	
53. 00 54. 00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	vour records)				1, 357, 122 654, 441	
	Excess over limitation (line 64 minus line 63	,	, enter zero)			034, 441	1
100 00	LINE 33 CALCULATION	611	4 105.6			44 770	1400 00
100. 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 LINE 34 CALCULATION				others	11, 779 1, 186 12, 965	100. 01
101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				ımns 1-3, line		102. 00 102. 01
	13 for all others Line 35 = sum of lines 31 and 32	·				0	102. 02

Period: Worksheet B
From 10/01/2016 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS CAMERON MEMORIAL COMMUNITY Provider CCN: 15-1315

					o 09/30/2017	Date/Time Pre	
			CAPI TAL REI	ATED_COSTS		2/22/2018 11:	52 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE DENEEL TO	Subtotal	
		Allocation			BENEFITS DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4. 00	4A	
GEI	NERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	48	
1.00 00	100 CAP REL COSTS-BLDG & FIXT	4, 920, 777	4, 920, 777				1. 00
	200 CAP REL COSTS-MVBLE EQUIP	3, 822, 826		3, 822, 826			2.00
	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL	6, 274, 350 8, 523, 264	25, 391 435, 341	15, 972 366, 684		10, 540, 914	4. 00 5. 00
	700 OPERATION OF PLANT	2, 524, 591	442, 312		1 ' ' 1	3, 542, 607	7. 00
	800 LAUNDRY & LINEN SERVICE	33, 385				107, 838	•
	900 HOUSEKEEPI NG 000 DI ETARY	1, 017, 323 161, 692	20, 399 168, 783			1, 239, 977 464, 599	9. 00 10. 00
	100 CAFETERI A	283, 998			1	517, 116	
13. 00 01:	300 NURSING ADMINISTRATION	677, 976		22, 090	189, 810	924, 992	13. 00
	400 CENTRAL SERVICES & SUPPLY	261, 257	134, 097			531, 061	14. 00
	500 PHARMACY 600 MEDICAL RECORDS & LIBRARY	2, 764, 128 666, 563	49, 705 0			2, 977, 186 825, 961	15. 00 16. 00
	PATIENT ROUTINE SERVICE COST CENTERS	333,333		27/700	1277 100	0207701	10.00
	000 ADULTS & PEDIATRICS	2, 746, 120			,	4, 605, 965	30.00
	100 INTENSIVE CARE UNIT 300 NURSERY	195, 897 54, 870	50, 781 18, 075			313, 997 97, 966	31. 00 43. 00
	CILLARY SERVICE COST CENTERS	34,070	10,073	11, 370	13,031	71, 700	43.00
	OOO OPERATING ROOM	1, 744, 993				2, 834, 657	50. 00
	100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM	687, 058				1, 392, 122	
	400 RADI OLOGY-DI AGNOSTI C	371, 782 2, 483, 455		·		701, 446 3, 540, 503	
	000 LABORATORY	2, 647, 721	119, 379			3, 113, 892	60. 00
	400 I NTRAVENOUS THERAPY	0	0	1	-	0	64.00
	500 RESPI RATORY THERAPY 501 SLEEP LAB	751, 358 186, 746	57, 882 0			857, 521 257, 132	65. 00 65. 01
66. 00 066	600 PHYSI CAL THERAPY	880, 546	_			1, 561, 534	
69. 00 069	900 ELECTROCARDI OLOGY	340, 647	6, 154			350, 672	69. 00
	901 CARDIAC REHAB 100 MEDICAL SUPPLIES CHARGED TO PATIENT	71, 645 441, 972	31, 372 0	1		143, 093 441, 973	69. 01 71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	651, 273			i i	651, 273	•
73. 00 07:	300 DRUGS CHARGED TO PATIENTS	0	0	C	o	0	73. 00
	020 CHEMI CAL DEPENDENCY	171, 636				202, 331	76. 00
	480 ONCOLOGY TPATIENT SERVICE COST CENTERS	1, 096, 544	477, 687	300, 494	. 0	1, 874, 725	76. 01
88. 00 088	800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		_	0	89. 00
	000 CLINIC 001 CLINIC- MCDONALD	171, 148 350, 894	21, 173 0	l		249, 558 591, 697	90. 00 90. 01
	100 EMERGENCY	2, 143, 281	410, 725			3, 335, 507	91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
	HER REIMBURSABLE COST CENTERS 100 HOME HEALTH AGENCY	638, 640	0	39, 768	170, 946	849, 354	101 00
	ECIAL PURPOSE COST CENTERS	030, 040		37, 700	170, 740	047, 334	101.00
	300 INTEREST EXPENSE						113. 00
	400 UTILIZATION REVIEW-SNF 600 HOSPICE	146, 375	0	8, 149	35, 111	189, 635	114.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	50, 906, 731	4, 866, 553			49, 828, 804	
	NREI MBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 950 DAYCARE-I NFANT/TODDLER	0	24, 960	1	0	40, 661	
194. 00 07		35, 416	0		8, 880	44, 296	194. 00 194. 01
	952 COMMUNITY HEALTH	84, 595	Ö	C	23, 302	107, 897	
	953 ASSISTED LIVING/CAMERON WOODS	0	0	C	0		194. 03
	954 EDUCATI ON 955 MARKETI NG	27, 500 427, 669		18, 409	0 34, 227	27, 500 509, 569	
	956 GUEST MEALS	38, 575	27, 204	10, 407	6, 146	44, 721	
	957 OUTSI DE LAUNDRY	0	0	1	o		194. 07
	958 CANCER CENTER 959 URGENT CARE	1 422 279	0	170, 199	0 343, 629	0 1, 936, 206	194. 08
194. 09 07		1, 422, 378 695, 802	0	118, 817		995, 939	
194. 11 079	961 OBGYN	81, 013	0	c	21, 170	102, 183	194. 11
	962 TRINE STUDENT HEALTH	15, 693	0	22.020	4, 479	20, 172	•
	963 OCCUPATIONAL HEALTH 964 IMMUNIZATION CLINIC	152, 829 58, 590	0 0	22, 930 3, 276		209, 689 79, 154	•
200.00	Cross Foot Adjustments	33,370		, 2, 2		0	200. 00
201.00	Negative Cost Centers	E2 04/ 701	0 4 000 777	2 000 000	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	53, 946, 791	4, 920, 777	3, 822, 826	6, 315, 713	53, 946, 791	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2016 Part I To 09/30/2017 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

2/22/2018 11:52 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 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 10, 540, 914 5 00 5 00 7.00 00700 OPERATION OF PLANT 860, 304 4, 402, 911 7.00 00800 LAUNDRY & LINEN SERVICE 26, 188 40, 902 174, 928 8.00 8.00 9.00 00900 HOUSEKEEPI NG 301, 122 18, 256 46, 702 1, 606, 057 9.00 01000 DI ETARY 737, 362 10.00 10.00 112,826 151, 053 147 8.737 61, 162 11.00 01100 CAFETERI A 125, 579 76, 451 1,046 0 11.00 13 00 01300 NURSING ADMINISTRATION 224,630 31, 428 C 0 13.00 01400 CENTRAL SERVICES & SUPPLY 128, 966 120,010 14.00 14 00 0 11, 468 0 15.00 01500 PHARMACY 722, 995 44, 484 0 15, 018 0 15.00 200, 580 16.00 01600 MEDICAL RECORDS & LIBRARY 42, 635 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 448 887 03000 ADULTS & PEDIATRICS 1, 118, 549 622, 196 33.808 688 862 31.00 03100 INTENSIVE CARE UNIT 76, 253 45, 447 1,868 16, 929 48, 500 31.00 23, 791 87, 102 43 00 43.00 04300 NURSERY 16, 176 5,842 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 688.382 418, 650 31,806 118, 229 0 05100 RECOVERY ROOM 338,070 273, 721 77, 272 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 170, 343 130, 294 1,660 17, 475 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 859.793 14, 853 54.00 317, 935 118.775 0 54.00 60.00 06000 LABORATORY 756, 193 106, 839 398 77, 545 0 60.00 64.00 06400 I NTRAVENOUS THERAPY C 0 64.00 06500 RESPIRATORY THERAPY 208, 245 51, 802 21 15, 837 65.00 0 65.00 06501 SLEEP LAB 21, 571 65.01 62, 443 100, 137 2.327 Λ 65.01 06600 PHYSI CAL THERAPY 66.00 379, 211 233, 897 3,819 55, 155 0 66.00 06900 ELECTROCARDI OLOGY 85, 159 5, 508 69.00 0 0 69.00 o 06901 CARDI AC REHAB 34.749 28.077 0 69.01 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 107.331 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 158, 158 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 03020 CHEMI CAL DEPENDENCY o 76 00 49, 135 0 0 76 00 03480 ONCOLOGY 0 76.01 455, 268 427, 508 0 76.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 90.00 09000 CLI NI C 60,604 18, 949 0 0 0 90.00 09001 CLINIC- MCDONALD 90. 01 143, 691 147, 818 1, 444 73, 722 0 90.01 91 00 09100 EMERGENCY 810 011 367, 580 27, 826 91.00 242, 738 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 206, 261 56, 577 0 15, 837 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 46, 052 0 116.00 11.593 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 1, 483, 459 9, 540, 882 3, 905, 923 173, 567 737, 362 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 9,874 22, 338 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 194.00 0 C 0 194. 01 07951 MOB 10, 757 C 131 6,826 0 194 01 194. 02 07952 COMMUNI TY HEALTH 26, 202 0 194. 02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 194. 04 6,678 0 0 194. 05 194. 05 07955 MARKETI NG 123, 746 26, 190 0 0 194.06 07956 GUEST MEALS 10,860 0 0 0 194.06 C 194. 07 07957 OUTSI DE LAUNDRY o 0 194. 07 0 194. 08 07958 CANCER CENTER 0 194, 08 0 0 194.09 07959 URGENT CARE 470, 198 242, 139 1, 230 76, 999 0 194, 09 194. 10 07960 RHC 241, 859 169, 039 38, 773 0 194. 10 C 194. 11 07961 OBGYN 24, 815 0 194. 11 0 C 0 194. 12 07962 TRI NE STUDENT HEALTH 4, 899 0 0 0 194, 12 194. 13 07963 OCCUPATI ONAL HEALTH 50, 922 0 0 0 194. 13 32, 622 o 194. 14 07964 IMMUNIZATION CLINIC 19, 222 0 0 194. 14 4,660 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 10, 540, 914 4, 402, 911 202.00 174. 928 1, 606, 057 737, 362 202. 00

Provider CCN: 15-1315

Cost Contan Decarintian	CAFETERIA	MIDELNE	CENTRAL	DUADMACY	2/22/2018 11:	52 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
	11. 00	13.00	SUPPLY 14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	781, 354					11.00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	28, 895 16, 727		808, 232			13. 00 14. 00
15. 00 01500 PHARMACY	18, 340	1	4, 465	3, 782, 488		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	36, 820	1	111	0	1, 106, 107	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	152, 645		33, 927	0 0	10, 565	30. 00 31. 00
43. 00 04300 NURSERY	7, 820 2, 209		2, 032 0	0	1, 263 2, 063	43. 00
ANCI LLARY SERVI CE COST CENTERS	2,207	0,000	<u> </u>	<u> </u>	2,003	43.00
50. 00 05000 OPERATING ROOM	62, 313	192, 795	105, 867	0	30, 212	50. 00
51. 00 05100 RECOVERY ROOM	37, 697	116, 566	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	15, 044		12, 417	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	84, 090 69, 046	l	11, 961 257, 717	0	234, 321 307, 383	54. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	07, 040		237,717	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 333	Ö	6, 615	Ö	35, 610	65. 00
65. 01 06501 SLEEP LAB	0	o	0	О	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	49, 163	0	2, 922	0	123, 427	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	828	0	63, 949	69.00
69. 01 06901 CARDIAC REHAB 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 787 0	٥	114 122, 402	0	31, 906 0	69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	ا	180, 367	Ö	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	0	3, 782, 488	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	8, 521	o	1, 150	O	1, 368	76. 00
76. 01 03480 0NCOLOGY	0	0	6	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	ol	0	ol	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90. 00 09000 CLI NI C	9, 643	29, 776	5, 629	o	40, 041	90.00
90. 01 09001 CLI NI C- MCDONALD	20, 619		2, 345	O	36, 222	90. 01
91. 00 09100 EMERGENCY	103, 832	321, 177	43, 141	0	159, 123	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
101. 00 10100 HOME HEALTH AGENCY	29, 105	o	1, 623	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	=:, :==	-1	., 5=5	-,		
113.00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0.020		220		0	114. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 030 765, 679		328 795, 967	0 3, 782, 488	1, 077, 453	116. 00
NONREI MBURSABLE COST CENTERS	703,077	1,207,743	175, 761	3, 702, 400	1, 077, 433	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0	0		194. 00
194. 01 07951 MOB	1, 859	0	0	0	26, 591	
194. 02 07952 COMMUNITY HEALTH 194. 03 07953 ASSISTED LIVING/CAMERON WOODS	3, 647 0	0	571 0	0		194. 02 194. 03
194. 04 07954 EDUCATION	0	- 1	0	0		194. 03
194. 05 07955 MARKETI NG	7, 855	- 1	94	o		194. 05
194.06 07956 GUEST MEALS	2, 314	О	0	О	0	194. 06
194. 07 07957 OUTSI DE LAUNDRY	0	0	0	0		194. 07
194. 08 07958 CANCER CENTER	0	0	0 F 4/3	0		194. 08
194. 09 07959 URGENT CARE 194. 10 07960 RHC	0		5, 463 4, 478	0		194. 09 194. 10
194. 11 07961 OBGYN	0		675	o o		194. 10
194. 12 07962 TRI NE STUDENT HEALTH	0	0	144	ō		194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	0	646	0		194. 13
194. 14 07964 IMMUNIZATION CLINIC	0	0	194	0	0	194. 14
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	^		0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	781, 354	1, 209, 945	808, 232	3, 782, 488	1, 106, 107	
		. '				•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315

			Ť	o 09/30/2017 Date/Time P 2/22/2018 1	
Cost Center Description	Subtotal	Intern &	Total	272272010	1. 02 um
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
1. 00 00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		-			2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0 107 517	, .	0 107 517		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	8, 187, 517 538, 269		8, 187, 517 538, 269		30. 00 31. 00
43. 00 04300 NURSERY	242, 012	1	242, 012		43. 00
ANCILLARY SERVICE COST CENTERS		1			
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	4, 482, 911 2, 235, 448	1 1	4, 482, 911 2, 235, 448		50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 095, 174	1 1	1, 095, 174		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 182, 231	0	5, 182, 231		54.00
60. 00 06000 LABORATORY	4, 689, 013	1	4, 689, 013 0		60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 176, 984	1 1	1, 176, 984		64. 00 65. 00
65. 01 06501 SLEEP LAB	443, 610	1	443, 610		65. 01
66. 00 06600 PHYSI CAL THERAPY	2, 409, 128	1 1	2, 409, 128		66. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	506, 116 241, 726	1 1	506, 116 241, 726		69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	671, 706	1 1	671, 706		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	989, 798	1	989, 798		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CHEMICAL DEPENDENCY	3, 782, 488 262, 505	1	3, 782, 488 262, 505		73. 00 76. 00
76. 01 03480 ONCOLOGY	2, 757, 507	1	2, 757, 507		76. 01
OUTPATIENT SERVICE COST CENTERS	_				
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0		88. 00 89. 00
90. 00 09000 CLI NI C	414, 200	1 -1	414, 200		90.00
90. 01 09001 CLI NI C- MCDONALD	1, 017, 558	1	1, 017, 558		90. 01
91. 00 09100 EMERGENCY	5, 410, 935	0 0	5, 410, 935		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		<u> </u>			92. 00
101.00 10100 HOME HEALTH AGENCY	1, 158, 757	0	1, 158, 757		101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE					112 00
114.00 11400 UTILIZATION REVIEW-SNF					113. 00 114. 00
116. 00 11600 HOSPI CE	255, 638	0	255, 638		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	48, 151, 231	0	48, 151, 231		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72, 873	B O	72, 873		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0		194. 00
194. 01 07951 MOB	90, 460	1	90, 460		194. 01
194. 02 07952 COMMUNITY HEALTH 194. 03 07953 ASSISTED LIVING/CAMERON WOODS	138, 317		138, 317 0		194. 02 194. 03
194. 04 07954 EDUCATI ON	34, 178		34, 178		194. 04
194. 05 07955 MARKETI NG	667, 454	1	667, 454		194. 05
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	57, 895 0	1	57, 895 0		194. 06 194. 07
194. 08 07958 CANCER CENTER	0	1	Ö		194. 08
194. 09 07959 URGENT CARE	2, 732, 235	1	2, 732, 235		194. 09
194. 10 07960 RHC 194. 11 07961 OBGYN	1, 450, 088 129, 736	1	1, 450, 088 129, 736		194. 10 194. 11
194. 12 07962 TRINE STUDENT HEALTH	25, 215	1	25, 215		194. 11
194. 13 07963 OCCUPATI ONAL HEALTH	293, 879	1	293, 879		194. 13
194.14 07964 IMMUNIZATION CLINIC 200.00 Cross Foot Adjustments	103, 230	1	103, 230 0		194. 14 200. 00
201.00 Negative Cost Centers			0		200.00
202.00 TOTAL (sum lines 118 through 201)	53, 946, 791	0	53, 946, 791		202. 00

| Peri od: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

			To	09/30/2017	Date/Time Pre	
		CAPITAL RELATED COSTS			2/22/2018 11:	oz alli
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	25, 391	15, 972	41, 363	41, 363	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	0	435, 341 442, 312		802, 025 787, 691	7, 971 1, 508	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	45, 703		74, 453	1, 300	8. 00
9. 00 00900 HOUSEKEEPI NG	0	20, 399		33, 231	1, 240	9. 00
10. 00 01000 DI ETARY	0	168, 783		274, 958	183	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	85, 424 35, 116		139, 161 57, 206	615 1, 243	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	134, 097		218, 452	336	14. 00
15. 00 01500 PHARMACY	0	49, 705		80, 973	865	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	29, 968	29, 968	847	16. 00
30. 00 03000 ADULTS & PEDIATRICS	0	695, 225	437, 340	1, 132, 565	4, 762	30.00
31.00 03100 INTENSIVE CARE UNIT	0	50, 781	31, 944	82, 725	232	31. 00
43. 00 04300 NURSERY	0	18, 075	11, 370	29, 445	89	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	467, 789	294, 268	762, 057	2, 145	50. 00
51. 00 05100 RECOVERY ROOM	0	305, 849		498, 246	1, 354	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	145, 587		237, 170	606	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	355, 253		578, 729	3, 132	54. 00 60. 00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	119, 379 0	75, 096 0	194, 475 0	1, 779 0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	57, 882	36, 411	94, 293	78	65. 00
65. 01 06501 SLEEP LAB	0	0	70, 386	70, 386	0	65. 01
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	261, 351 6, 154	164, 405 3, 871	425, 756 10, 025	1, 671 0	66. 00 69. 00
69. 01 06901 CARDI AC REHAB	0	31, 372		51, 107	133	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 PATI ENTS 76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0	0	201	73. 00 76. 00
76. 01 03480 ONCOLOGY	0	477, 687	300, 494	778, 181	0	76. 01
OUTPATIENT SERVICE COST CENTERS		_		-1		
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00 09000 CLI NI C	0	21, 173	-	34, 492	288	90.00
90. 01 09001 CLI NI C- MCDONALD	0	0	103, 901	103, 901	896	90. 01
91. 00 09100 EMERGENCY	0	410, 725	258, 371	669, 096	3, 425	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				U		92. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	39, 768	39, 768	1, 119	101. 00
SPECIAL PURPOSE COST CENTERS	1		T T			440.00
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	0	0	8, 149	8, 149	230	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 866, 553	3, 473, 494	8, 340, 047	36, 948	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	24, 960	15, 701	40, 661	0	190. 00
194. OO 07950 DAYCARE-I NFANT/TODDLER	0	24, 700	15, 701	40, 001		194. 00
194. 01 07951 MOB	0	0	0	0		194. 01
194. 02 07952 COMMUNITY HEALTH	0	0	0	0		194. 02 194. 03
194.03 07953 ASSISTED_LIVING/CAMERON_WOODS 194.04 07954 EDUCATION	0	0	0	0		194. 03
194. 05 07955 MARKETI NG	0	29, 264	18, 409	47, 673		194. 05
194. 06 07956 GUEST MEALS	0	0	0	0		194. 06
194. 07 07957 0UTSLDE_LAUNDRY 194. 08 07958 CANCER_CENTER	0	0	0	0		194. 07 194. 08
194. 09 07959 URGENT CARE	0	0	170, 199	170, 199		194. 09
194. 10 07960 RHC	0	0	118, 817	118, 817	1, 187	194. 10
194. 11 07961 OBGYN	0	0	0	0		194. 11 194. 12
194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH		0	22, 930	22, 930		194. 12
194.14 07964 IMMUNIZATION CLINIC	0	Ö	3, 276	3, 276		194. 14
200.00 Cross Foot Adjustments		_	_	0	_	200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0	0 4, 920, 777	0 3, 822, 826	0 8, 743, 603		201. 00 202. 00
	١	1,720,111	5, 522, 520	3, , 13, 003	11, 303	,_02. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2016 Part II To 09/30/2017 Date/Time Prepared:

In Lieu of Form CMS-2552-10

2/22/2018 11:52 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 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 809, 996 5 00 5 00 7.00 00700 OPERATION OF PLANT 66, 109 855, 308 7.00 00800 LAUNDRY & LINEN SERVICE 2,012 7, 946 8.00 84, 411 8.00 9.00 00900 HOUSEKEEPI NG 23, 139 3, 546 22.534 83.690 9.00 01000 DI ETARY 313, 680 10.00 10.00 8.670 29.343 71 455 11.00 01100 CAFETERI A 9,650 14, 851 505 3, 187 0 11.00 13 00 01300 NURSING ADMINISTRATION 17, 261 6, 105 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 9, 910 23, 313 598 14.00 14 00 0 0 15.00 01500 PHARMACY 55, 557 8, 641 0 783 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 15.413 8, 282 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 23.390 03000 ADULTS & PEDIATRICS 85.952 120, 870 16.314 293.048 31.00 03100 INTENSIVE CARE UNIT 5,859 8, 828 902 882 20, 632 31.00 43 00 43.00 04300 NURSERY 1,828 3, 142 2,819 4,539 ANCILLARY SERVICE COST CENTERS 50 00 52, 898 50.00 05000 OPERATING ROOM 81, 327 15, 348 6, 161 0 05100 RECOVERY ROOM 25, 978 53, 173 4,027 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 13,090 25, 311 801 911 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 66,069 61, 762 7, 167 6.189 0 54.00 60.00 06000 LABORATORY 58, 108 20, 754 192 4,041 0 60.00 64.00 06400 I NTRAVENOUS THERAPY C 0 64.00 06500 RESPIRATORY THERAPY 16,002 10,063 10 825 65.00 0 65.00 4, 798 06501 SLEEP LAB 65.01 19, 453 1.123 1.124 Λ 65.01 06600 PHYSI CAL THERAPY 66.00 29, 140 45, 437 1,843 2,874 0 66.00 06900 ELECTROCARDI OLOGY 6,544 1, 070 69.00 0 0 0 69.00 0 06901 CARDI AC REHAB 2.670 5. 454 0 69.01 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 8, 248 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 153 C 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 73.00 03020 CHEMI CAL DEPENDENCY 76 00 3.776 0 0 76 00 03480 ONCOLOGY 0 76.01 34, 984 83,048 0 76.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 0 90.00 09000 CLI NI C 4,657 3, 681 0 0 0 90.00 09001 CLINIC- MCDONALD 90. 01 11,042 28, 715 697 3, 842 0 90.01 91 00 09100 EMERGENCY 71, 406 0 91.00 62.244 13.428 12.649 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 15, 850 10, 991 0 825 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 3,539 0 116.00 2, 252 SUBTOTALS (SUM OF LINES 1 through 117) 77, 302 118.00 313, 680 118. 00 733, 150 83, 754 758, 764 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 759 4, 339 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 C 194. 01 07951 MOB 0 194.01 827 C 63 356 194. 02 07952 COMMUNI TY HEALTH 0 0 194. 02 2,013 0 194.03 07953 ASSISTED LIVING/CAMERON WOODS C 0 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 194. 04 513 0 194. 05 07955 MARKETI NG 9.509 5.088 0 0 0 194 05 194.06 07956 GUEST MEALS 835 0 0 0 194.06 C 194. 07 07957 OUTSI DE LAUNDRY o 0 194. 07 0 0 194. 08 07958 CANCER CENTER 0 194, 08 0 0 0 194.09 07959 URGENT CARE 36, 132 47,038 594 4, 012 0 194, 09 194. 10 07960 RHC 18, 585 32, 837 0 2,020 0 194. 10 1, 907 194. 11 07961 OBGYN 0 194. 11 0 0 C 194. 12 07962 TRI NE STUDENT HEALTH 376 r 0 0 0 194, 12 194. 13 07963 OCCUPATI ONAL HEALTH 3, 913 0 0 194. 13 6, 337 o 194. 14 07964 IMMUNIZATION CLINIC 1, 477 905 0 0 194. 14 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers \cap 0 201.00 TOTAL (sum lines 118 through 201) 809, 996 313, 680 202. 00 202.00 855, 308 84.411 83.690

Provider CCN: 15-1315

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2016 | Part II |
| To 09/30/2017 | Date/Time Prepared: | 2/22/2018 | 11:52 am

			10	09/30/2017	2/22/2018 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u> </u>
· ·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LIBRARY	
CENEDAL CEDIMACE COCT CENTEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 O0700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 LAUNDRY & LINEN SERVICE						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	167, 969					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	6, 212	88, 027				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 596		256, 205			14. 00
15. 00 01500 PHARMACY	3, 943	ő	1, 415	152, 177		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	7, 915	0	35	0	62, 460	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	,,,,,	<u> </u>		<u> </u>	02, 100	10.00
30. 00 03000 ADULTS & PEDIATRICS	32, 811	34, 348	10, 755	0	597	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 681	1, 758	644	o	71	31.00
43. 00 04300 NURSERY	475		0	o	116	1
ANCILLARY SERVICE COST CENTERS			<u>'</u>			1
50. 00 05000 OPERATING ROOM	13, 396	14, 026	33, 559	0	1, 706	50.00
51.00 05100 RECOVERY ROOM	8, 104	8, 480	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 234	3, 383	3, 936	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 077	0	3, 791	0	13, 232	54.00
60. 00 06000 LABORATORY	14, 843	0	81, 695	0	17, 358	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	286	0	2, 097	0	2, 011	65. 00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	10, 569	0	926	0	6, 970	
69. 00 06900 ELECTROCARDI OLOGY	0	0	262	0	3, 611	69. 00
69. 01 06901 CARDI AC REHAB	814	0	36	0	1, 802	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	38, 801	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	57, 175	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	152, 177	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	1, 832	0	365	0	77	76. 00
76. 01 03480 0NC0L0GY	0	0	2	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS	0	٥		ام	0	00 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	2, 073	2, 166	0 1, 785	0	2, 261	89. 00 90. 00
90. 01 09001 CLI NI C - MCDONALD	4, 433	2, 100	743	ol Ol	2, 261	1
91. 00 09100 EMERGENCY	22, 321	23, 367	13, 675	0	8, 985	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	22, 321	25, 507	13, 073	J	0, 703	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	6, 257	0	515	O	0	101. 00
SPECIAL PURPOSE COST CENTERS		-1		-1		
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
116. 00 11600 HOSPI CE	1, 726	o	104	О	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	164, 598	88, 027	252, 316	152, 177	60, 842	118. 00
NONREI MBURSABLE COST CENTERS]
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0	0	0	194. 00
194. 01 07951 MOB	400	0	0	0	1, 502	194. 01
194. 02 07952 COMMUNI TY HEALTH	784	0	181	0		194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194. 03
194. 04 07954 EDUCATI ON	0	0	0	0	0	194. 04
194. 05 07955 MARKETI NG	1, 689	0	30	0	0	194. 05
194.06 07956 GUEST MEALS	498	0	0	0	0	194. 06
194. 07 07957 OUTSI DE LAUNDRY	0	0	0	0	0	194. 07
194. 08 07958 CANCER CENTER	0	0	0	0	0	194. 08
194. 09 07959 URGENT CARE	0	0	1, 732	0	0	194. 09
194. 10 07960 RHC	0	0	1, 419	0		194. 10
194. 11 07961 OBGYN	0	0	214	0		194. 11
194. 12 07962 TRI NE STUDENT HEALTH	0	0	46	0		194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	0	205	o		194. 13
194. 14 07964 I MMUNI ZATI ON CLINI C	0	0	62	0	0	194. 14
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	167, 969	88, 027	256, 205	152, 177	62, 460	202. 00

| Peri od: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

			Ţ	o 09/30/2017 Date/Time Pre 2/22/2018 11:	
Cost Center Description	Subtotal	Intern &	Total	272272010 11.	UZ UIII
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1 755 410	ما	1 755 410		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	1, 755, 412 124, 214	0	1, 755, 412 124, 214		30. 00 31. 00
43. 00 04300 NURSERY	42, 952	o	42, 952		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 0PERATI NG ROOM	982, 623	0	982, 623		50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	599, 362 288, 442	0	599, 362 288, 442		51. 00 52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	758, 148	o	758, 148		54. 00
60. 00 06000 LABORATORY	393, 245	O	393, 245		60.00
64. 00 06400 I NTRAVENOUS THERAPY	125 ((5	0	125 (45		64. 00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	125, 665 96, 884	0	125, 665 96, 884		65. 00 65. 01
66. 00 06600 PHYSI CAL THERAPY	525, 186	Ö	525, 186		66.00
69. 00 06900 ELECTROCARDI OLOGY	21, 512	O	21, 512		69. 00
69. 01 06901 CARDI AC REHAB	62, 016	0	62, 016		69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	47, 049 69, 328	0	47, 049 69, 328		71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	152, 177	o	152, 177		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	6, 251	0	6, 251		76. 00
76. 01 03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	896, 215	0	896, 215		76. 01
88. 00 08800 RURAL HEALTH CLINIC	0	ol	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	О	0		89. 00
90. 00 09000 CLI NI C	51, 403	0	51, 403		90.00
90. 01 09001 CLI NI C- MCDONALD 91. 00 09100 EMERGENCY	156, 314 900, 596	0	156, 314 900, 596		90. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	700, 370	O	700, 370		92.00
OTHER REIMBURSABLE COST CENTERS					
101. 00 10100 HOME HEALTH AGENCY	75, 325	0	75, 325		101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
116. 00 11600 HOSPI CE	16, 000	0	16, 000		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	8, 146, 319	0	8, 146, 319		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	45, 759	0	45, 759		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	О	0		194. 00
194. 01 07951 MOB	3, 206	0	3, 206		194. 01
194. 02 07952 COMMUNITY HEALTH 194. 03 07953 ASSISTED LIVING/CAMERON WOODS	3, 131	0	3, 131 0		194. 02 194. 03
194. 04 07954 EDUCATI ON	513	o	513		194. 04
194. 05 07955 MARKETI NG	64, 213	0	64, 213		194. 05
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	1, 373 0	0	1, 373 0		194. 06 194. 07
194. 08 07958 CANCER CENTER	0	0	0		194. 07
194. 09 07959 URGENT CARE	261, 957	o	261, 957		194. 09
194. 10 07960 RHC	174, 865	0	174, 865		194. 10
194. 11 07961 0BGYN 194. 12 07962 TRINE_STUDENT_HEALTH	2, 376 451	0	2, 376 451		194. 11 194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	33, 607	o	33, 607		194. 12
194.14 07964 IMMUNIZATION CLINIC	5, 833	O	5, 833		194. 14
200.00 Cross Foot Adjustments	0	0	0		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 8, 743, 603	0	0 8, 743, 603		201. 00 202. 00
202.00 TOTAL (Sum Tilles 110 till ough 201)	0, 740, 000	ı Yı	5, 745, 505	l	1-02.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1315 Peri od: Worksheet B-1 From 10/01/2016 09/30/2017 Date/Time Prepared: 2/22/2018 11:52 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 114.344 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 141, 212 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 590 590 20, 981, 024 4.00 00500 ADMINISTRATIVE & GENERAL 4, 038, 335 43, 405, 877 5 00 13, 545 -10, 540, 914 5 00 10 116 7.00 00700 OPERATION OF PLANT 10, 278 12, 758 765, 147 3, 542, 607 7.00 1, 062 1, 062 8.00 00800 LAUNDRY & LINEN SERVICE 107, 838 8.00 0 9.00 00900 HOUSEKEEPI NG 474 474 629, 272 1, 239, 977 9.00 01000 DI ETARY 464, 599 10.00 3 922 3. 922 92.848 10 00 11.00 01100 CAFETERI A 1, 985 1, 985 312, 128 0 517, 116 11.00 01300 NURSING ADMINISTRATION 630, 555 0 13.00 816 816 924, 992 13.00 0 01400 CENTRAL SERVICES & SUPPLY 170, 592 14.00 3. 116 531, 061 14.00 3.116 2, 977, 186 15.00 01500 PHARMACY 1, 155 1, 155 438, 790 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 107 429, 972 825, 961 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 16, 155 2, 416, 053 30.00 03000 ADULTS & PEDIATRICS 16, 155 0 4, 605, 965 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 180 1, 180 117, 518 0 313, 997 31 00 04300 NURSERY 420 420 45, 349 97, 966 43.00 43.00 ANCILLARY SERVICE COST CENTERS 2, 834, 657 05000 OPERATING ROOM 50.00 10, 870 10,870 1, 088, 324 0 50.00 05100 RECOVERY ROOM 0 51.00 7, 107 7, 107 687, 058 1, 392, 122 51.00 3, 383 05200 DELIVERY ROOM & LABOR ROOM 3, 383 307, 268 701, 446 52.00 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 8, 255 8, 255 1, 588, 994 3, 540, 503 54.00 60.00 06000 LABORATORY 2,774 2, 774 902, 585 3, 113, 892 60.00 64.00 06400 INTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 1, 345 1, 345 39, 433 0 857, 521 65.00 257, 132 65.01 06501 SLEEP LAB 2,600 C 65.01 06600 PHYSI CAL THERAPY 66.00 6,073 6,073 847, 890 1, 561, 534 66.00 06900 ELECTROCARDI OLOGY 143 69.00 143 0 0 0 350, 672 69.00 69.01 06901 CARDI AC REHAB 729 729 67.574 143, 093 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 441, 973 71 00 0 C 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 651, 273 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 73.00 03020 CHEMI CAL DEPENDENCY 101, 970 202, 331 76.00 76.00 03480 ONCOLOGY 76. 01 11, 100 11, 100 0 1, 874, 725 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER o 0 89 00 C 0 0 89 00 90.00 09000 CLI NI C 492 492 145, 896 0 249, 558 90.00 90.01 09001 CLINIC- MCDONALD 3,838 454, 795 0 591, 697 90.01 91.00 09100 EMERGENCY 9, 544 1, 737, 859 0 3, 335, 507 91.00 9,544 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 1, 469 567, 890 0 849, 354 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 189, 635 116. 00 301 116, 641 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 39, 287, 890 118. 00 113, 084 -10, 540, 914 118.00 128, 308 18, 740, 738 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 580 580 40, 661 190. 00 0 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 C 0 0 194.00 194. 01 07951 MOB 0 0 29, 499 44, 296 194, 01 Ω 0 194. 02 07952 COMMUNI TY HEALTH 0 0 77, 410 107, 897 194. 02 0 194. 03 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 C 0 194. 04 07954 EDUCATI ON 0 27, 500 194. 04 C 0 194. 05 07955 MARKETI NG 113, 703 509, 569 194. 05 680 680 194.06 07956 GUEST MEALS 0 20, 416 44, 721 194. 06 C 0 0 0 0 194. 07 07957 OUTSLDE LAUNDRY 0 0 194. 07 0 194. 08 07958 CANCER CENTER 0 194. 08 C 0 194. 09 07959 URGENT CARE 6, 287 1, 141, 550 1, 936, 206 194. 09 0 194. 10 07960 RHC 602, 353 995, 939 194. 10 4, 389 0 194. 11 07961 OBGYN 0 0 70, 328 102, 183 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 20, 172 194. 12 14.879 194. 13 07963 OCCUPATIONAL HEALTH 847 112, 718 209, 689 194. 13 194. 14 07964 IMMUNIZATION CLINIC 121 57, 430 79, 154 194. 14 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th Fina	ncial Systems	CAMERON MEMORIAL COMMUNITY			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS					Period: From 10/01/2016 Fo 09/30/2017		pared:
		CAPITAL REL	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 920, 777	3, 822, 826	6, 315, 71	3	10, 540, 914	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	43. 034851	27. 071538	0. 301020)	0. 242845	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			41, 36	3	809, 996	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00197	1	0. 018661	205. 00

	Financial Systems	CAMERON MEMORI				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider CO		Period: From 10/01/2016 Fo 09/30/2017	Worksheet B-1 Date/Time Pre 2/22/2018 11:	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	J. um
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	T	1	I			
	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 5. 00	00400 CAF NCE COSTS-WOOL LEGGT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	114, 319 1, 062					4. 00 5. 00 7. 00 8. 00
	00900 HOUSEKEEPI NG	474	17, 498	5, 882	2		9.00
	01000 DI ETARY	3, 922	l t	32		00.000	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 985 816	1	224		22, 282 824	1
	01400 CENTRAL SERVICES & SUPPLY	3, 116	1	42	-	624 477	14.00
	01500 PHARMACY	1, 155	1	5!		523	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 107	0	(0	1, 050	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	16, 155	12, 667	1, 64	13, 337	4, 353	30.00
	03100 INTENSIVE CARE UNIT	1, 180	1	62		4, 333	1
	04300 NURSERY	420	1	319		63	1
	ANCILLARY SERVICE COST CENTERS	,	,				
	05000 OPERATING ROOM 05100 RECOVERY ROOM	10, 870 7, 107	1	433		1, 777 1, 075	50. 00 51. 00
	05200 DELIVERY ROOM & LABOR ROOM	3, 383	1	64		429	
	05400 RADI OLOGY-DI AGNOSTI C	8, 255	1			2, 398	1
	06000 LABORATORY	2, 774	1	284		1, 969	60.00
	06400 I NTRAVENOUS THERAPY	1 245		(0	64.00
	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	1, 345 2, 600	1	58 79		38 0	65. 00 65. 01
	06600 PHYSI CAL THERAPY	6, 073	l .	202		1, 402	1
	06900 ELECTROCARDI OLOGY	143	1	(0	
	06901 CARDI AC REHAB	729	l .			108	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	1			0	73. 00
	03020 CHEMI CAL DEPENDENCY	0				243	
	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	11, 100	0	(0	0	76. 01
	08800 RURAL HEALTH CLINIC	0	0		ol lo	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		o	0	1
	09000 CLI NI C	492		(۷ ۱	275	
	09001 CLINIC- MCDONALD 09100 EMERGENCY	3, 838 9, 544		270 889		588 2, 961	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 544	10, 420	00.		2, 701	92.00
	OTHER REIMBURSABLE COST CENTERS]
	10100 HOME HEALTH AGENCY	1, 469	0	58	3 0	830	101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		1] 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11600 H0SPI CE	301			o o		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	101, 415	65, 032	5, 433	3 14, 276	21, 835	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	0		lo lo	0] 190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	1				194. 00
	07951 MOB	0	49	2!	5 0		194. 01
	07952 COMMUNITY HEALTH	0	_				194. 02
	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION	0	1				194. 03 194. 04
	07955 MARKETI NG	680					194. 05
	07956 GUEST MEALS	0	0	(o o		194. 06
	07957 OUTSI DE LAUNDRY	0	0				194. 07
	07958 CANCER CENTER 07959 URGENT CARE	6, 287	1	282			194. 08 194. 09
	07960 RHC	4, 389		142			194. 10
194. 11	07961 OBGYN	0	0				194. 11
	07962 TRI NE STUDENT HEALTH	0					194. 12
	07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC	847 121	1				194. 13 194. 14
200.00	Cross Foot Adjustments			ĺ		o o	200. 00
201.00	Negative Cost Centers				_		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 402, 911	174, 928	1, 606, 05	737, 362	781, 354	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	38. 514254	2. 668945	273. 046073	51. 650462	35. 066601	203. 00

35. 066601 203. 00

Heal th Finar	icial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 10/01/2016 Fo 09/30/2017	Date/Time Pre 2/22/2018 11:	
	Cost Center Description	OPERATION OF	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	
204. 00	Cost to be allocated (per Wkst. B, Part II)	855, 308	84, 411	83, 69	313, 680	167, 969	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	7. 481766	1. 287892	14. 22815	21. 972541	7. 538327	205. 00

	Financial Systems	CAMERON MEMORIA		011 45 4045 5		U OT FORM CMS-2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 10/01/2016	Worksheet B-1
				Т	o 09/30/2017	Date/Time Prepared: 2/22/2018 11:52 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	27 227 2010 11. 32 dill
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LIBRARY (TIME SPENT)	
		HR)	REQUIS.)		(TIME SIENT)	
		13.00	14. 00	15. 00	16.00	
1 00	GENERAL SERVI CE COST CENTERS			T	1	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
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 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	232, 023	0.040.000			13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	2, 918, 389 16, 123)	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	o	400	•		
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	90, 534	122, 503	III		30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	4, 633 1, 316	7, 336 0			
43.00	ANCI LLARY SERVI CE COST CENTERS	1,310	0	/	1, 250	43.00
50.00	05000 OPERATING ROOM	36, 971	382, 268	3 (18, 424	50.00
51.00	05100 RECOVERY ROOM	22, 353	0	1	_	
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	8, 916 0	44, 834 43, 188	1	-	52. 00 54. 00
60.00	06000 LABORATORY	0	930, 579		1	60.00
64. 00	06400 I NTRAVENOUS THERAPY	O	0		1	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	23, 885	1	21, 716	
65. 01	06501 SLEEP LAB	0	10 553		1	65. 01
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	10, 552 2, 990	1	75, 269 38, 998	
69. 01	06901 CARDI AC REHAB	O	410	1	19, 457	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	441, 972		_	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	651, 273	100	1	72. 00 73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0	4, 153			76.00
76. 01	03480 ONCOLOGY	O	23			
	OUTPATIENT SERVICE COST CENTERS				_	
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	-	
90. 00	09000 CLINIC	5, 710	20, 327	1	-	
90. 01	09001 CLINIC- MCDONALD	0	8, 468			90. 01
91. 00	09100 EMERGENCY	61, 590	155, 775	i c	97, 037	91. 00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS					92. 00
101.00	10100 HOME HEALTH AGENCY	0	5, 861		0	101. 00
	SPECIAL PURPOSE COST CENTERS		-,			
	11300 I NTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE		1, 186		0	114. 00 116. 00
118. 00	l l	232, 023	2, 874, 106	1		
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	
	07950 DAYCARE-I NFANT/TODDLER	0	0		0 16, 216	
	207952 COMMUNITY HEALTH	o	2, 060		0	194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0) (0	194. 03
	07954 EDUCATI ON	0	0	1	0	194. 04
	07955 MARKETI NG 07956 GUEST MEALS	0	338		0	194. 05 194. 06
	707957 OUTSI DE LAUNDRY	0	0		o o	194. 07
	07958 CANCER CENTER	0	0) (0	194. 08
	07959 URGENT CARE	0	19, 726		0	194. 09
	0 07960 RHC 07961 0BGYN	0	16, 169		0 1, 258	194. 10 194. 11
	207962 TRI NE STUDENT HEALTH		2, 436 520) 1, 258) 0	194. 11
	07963 OCCUPATI ONAL HEALTH	O	2, 333		o o	194. 13
	07964 IMMUNIZATION CLINIC	0	701		0	194. 14
200.00	,					200.00
201. 00 202. 00		1, 209, 945	808, 232	3, 782, 488	1, 106, 107	201. 00 202. 00
202.00	Part I)	1,207,743	300, 232	3, 702, 400	1, 100, 107	
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 214763	0. 276945	37, 824. 880000	1. 639814	203. 00

Heal th Finar	ncial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		eri od:	Worksheet B-1	
					rom 10/01/2016 o 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
		(DIRECT NRSING	(COSTED		(TIME SPENT)		
		HR)	REQUIS.)				
		13.00	14.00	15.00	16.00		
204. 00	Cost to be allocated (per Wkst. B, Part II)	88, 027	256, 205	152, 177	62, 460		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 379389	0. 087790	1, 521. 770000	0. 092598		205. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1315	
		From 10/01/2016 Part I
		To 00/30/2017 Date/Time Prepared:

					To 09/30/2017	Date/Time Pre 2/22/2018 11:	
			Title	: XVIII	Hospi tal	Cost	
	·				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						
30.00	03000 ADULTS & PEDI ATRI CS	8, 187, 517		8, 187, 51	7 0	0	30.00
	03100 INTENSIVE CARE UNIT	538, 269		538, 26		0	31. 00
	04300 NURSERY	242, 012		242, 01		0	43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	2 12/012		2.270.	<u>-</u>		10.00
50.00	05000 OPERATING ROOM	4, 482, 911		4, 482, 91	1 0	0	50.00
51. 00	05100 RECOVERY ROOM	2, 235, 448		2, 235, 44		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 095, 174		1, 095, 17	-	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 182, 231		5, 182, 23		0	54.00
60.00	06000 LABORATORY	4, 689, 013		4, 689, 01		0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	4,007,013				0	64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 176, 984	0		-	0	65. 00
65. 01	06501 SLEEP LAB	443, 610	0	443, 61		0	65. 00
	06600 PHYSI CAL THERAPY		0	·		0	ı
66. 00	06900 ELECTROCARDI OLOGY	2, 409, 128	Ü	2, 409, 12			66. 00 69. 00
69. 00		506, 116		506, 11		0	
	06901 CARDI AC REHAB	241, 726		241, 72		0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	671, 706		671, 70		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	989, 798		989, 79		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	3, 782, 488		3, 782, 48		0	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	262, 505		262, 50		0	76. 00
76. 01	03480 ONCOLOGY	2, 757, 507		2, 757, 50	7 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0		•	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLI NI C	414, 200		414, 20		0	90. 00
	09001 CLI NI C- MCDONALD	1, 017, 558		1, 017, 55	8 0	0	90. 01
	09100 EMERGENCY	5, 410, 935		5, 410, 93	5 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 380, 886		2, 380, 88	6	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 158, 757		1, 158, 75	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	255, 638		255, 63	8	0	116. 00
200.00		50, 532, 117	0	50, 532, 11	7 0	0	200. 00
201.00	Less Observation Beds	2, 380, 886		2, 380, 88	6	0	201. 00
202.00	Total (see instructions)	48, 151, 231	0	48, 151, 23	1 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: 15-1315	Period: Worksheet C From 10/01/2016 Part I
		To 09/30/2017 Date/Time Prepared

						To 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am
				Title	XVIII	Hospi tal	Cost	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
							Ratio	
	_		6. 00	7. 00	8. 00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS				_		
30.00		ADULTS & PEDIATRICS	6, 977, 139		6, 977, 13	9		30. 00
31. 00		INTENSIVE CARE UNIT	432, 414		432, 41			31. 00
43.00		NURSERY	407, 000		407, 00	0		43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	2, 177, 846	13, 202, 102			0. 000000	
51. 00		RECOVERY ROOM	441, 592	3, 042, 009			0. 000000	1
52. 00		DELIVERY ROOM & LABOR ROOM	657, 035	146, 157			0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	1, 328, 528	27, 502, 253			0. 000000	54.00
60.00		LABORATORY	1, 767, 027	11, 339, 741	13, 106, 76		0. 000000	
64.00		INTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	
65.00		RESPI RATORY THERAPY	1, 294, 644	944, 224			0. 000000	
65. 01		SLEEP LAB	0	1, 099, 933			0. 000000	
66. 00		PHYSI CAL THERAPY	649, 963	3, 718, 986			0. 000000	
69. 00		ELECTROCARDI OLOGY	175, 778	1, 769, 416			0. 000000	
		CARDI AC REHAB	10, 583	380, 379			0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	473, 864	2, 068, 503			0. 000000	
		IMPL. DEV. CHARGED TO PATIENTS	489, 634	855, 038			0. 000000	
		DRUGS CHARGED TO PATIENTS	1, 484, 190	7, 856, 978			0. 000000	
76.00		CHEMI CAL DEPENDENCY	0	73, 532			0. 000000	
76. 01		ONCOLOGY	0	6, 608, 615	6, 608, 61	5 0. 417259	0. 000000	76. 01
		TIENT SERVICE COST CENTERS				_		
		RURAL HEALTH CLINIC	0	0		0		88. 00
		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
		CLI NI C	0	497, 298			0. 000000	
90. 01		CLINIC- MCDONALD	0	140, 972			0. 000000	
		EMERGENCY	463, 423	14, 404, 731			0. 000000	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART	113, 382	1, 760, 014	1, 873, 39	6 1. 270893	0. 000000	92. 00
		REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY	0	849, 564	849, 56	4		101. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114. 00
		HOSPI CE	0	324, 471				116. 00
200.00		Subtotal (see instructions)	19, 344, 042	98, 584, 916	117, 928, 95	8		200. 00
201.00		Less Observation Beds						201. 00
202.00)	Total (see instructions)	19, 344, 042	98, 584, 916	117, 928, 95	8		202. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Prepared: 2/22/2018 11:52 am

			To 09/30/2017	Date/Time Prepared 2/22/2018 11:52 am	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					_
30. 00 03000 ADULTS & PEDIATRICS				30. 0	
31.00 03100 INTENSIVE CARE UNIT				31. (00
43. 00 04300 NURSERY				43. 0	00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50.0	
51.00 05100 RECOVERY ROOM	0. 000000			51. (
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. (
60. 00 06000 LABORATORY	0. 000000			60. (
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. (00
65. 01 06501 SLEEP LAB	0. 000000			65. (01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. (00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. (00
69. 01 06901 CARDI AC REHAB	0. 000000			69. (01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. (00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. (00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. (00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			76. (00
76. 01 03480 ONCOLOGY	0. 000000			76. (01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC				88. 0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. (
90. 00 09000 CLI NI C	0. 000000			90. (
90. 01 09001 CLINIC- MCDONALD	0. 000000			90. (
91. 00 09100 EMERGENCY	0. 000000			91. (
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. (00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY				101. (00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE				113. (
114.00 11400 UTILIZATION REVIEW-SNF				114. (
116. 00 11600 H0SPI CE				116. (
200.00 Subtotal (see instructions)				200. (
201.00 Less Observation Beds				201. (
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: 15-1315	Period: Worksheet C From 10/01/2016 Part I
		To 09/30/2017 Date/Time Prepared

					To 09/30/2017	Date/Time Pre 2/22/2018 11:	
			Ti tl	e XIX	Hospi tal	PPS	_
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	•				
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 187, 517		8, 187, 51	7 0	8, 187, 517	30. 00
31.00	03100 INTENSIVE CARE UNIT	538, 269		538, 26	9 0	538, 269	31. 00
43.00	04300 NURSERY	242, 012		242, 01		242, 012	
	ANCILLARY SERVICE COST CENTERS	<u> </u>			<u>'</u>	· · · · · · · · · · · · · · · · · · ·	1
50.00	05000 OPERATING ROOM	4, 482, 911		4, 482, 91	1 0	4, 482, 911	50. 00
51.00	05100 RECOVERY ROOM	2, 235, 448		2, 235, 44	8 0	2, 235, 448	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 095, 174		1, 095, 17		1, 095, 174	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 182, 231		5, 182, 23		5, 182, 231	
60.00	06000 LABORATORY	4, 689, 013		4, 689, 01		4, 689, 013	
64. 00	06400 I NTRAVENOUS THERAPY	0				0	64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 176, 984	0		-	1, 176, 984	65. 00
65. 01	06501 SLEEP LAB	443, 610	0	443, 61		443, 610	
66. 00	06600 PHYSI CAL THERAPY	2, 409, 128	0	2, 409, 12		2, 409, 128	
69. 00	06900 ELECTROCARDI OLOGY	506, 116	O	506, 11		506, 116	
69. 01	06901 CARDI AC REHAB	241, 726		241, 72		241, 726	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	671, 706		671, 70		671, 706	
	07200 IMPL. DEV. CHARGED TO PATIENTS	989, 798		989, 79		989, 798	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 782, 488		3, 782, 48		3, 782, 488	
76. 00	03020 CHEMI CAL DEPENDENCY	262, 505		262, 50		262, 505	
	03480 ONCOLOGY	2, 757, 507		2, 757, 50		2, 757, 507	
76.01	OUTPATIENT SERVICE COST CENTERS	2, 737, 307		2, 757, 50	7 0	2, 737, 307	76.01
88. 00	08800 RURAL HEALTH CLINIC	O			o	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89.00
90.00	09000 CLINIC	414, 200		414, 20	- 1	414, 200	90.00
	09001 CLI NI C MCDONALD	1, 017, 558		1, 017, 55		1, 017, 558	
	09100 EMERGENCY						
		5, 410, 935		5, 410, 93		5, 410, 935	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 380, 886		2, 380, 88	D	2, 380, 886	92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1 150 757		4 450 75	7	1 150 757	101 00
101.00	SPECIAL PURPOSE COST CENTERS	1, 158, 757		1, 158, 75	/	1, 158, 757	101.00
112 00	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	255 (20		255 (2)			114. 00
	11600 HOSPI CE	255, 638	^	255, 63		255, 638	
200.00		50, 532, 117	0	,,		50, 532, 117	
201.00	l I	2, 380, 886	_	2, 380, 88		2, 380, 886	
202.00	Total (see instructions)	48, 151, 231	0	48, 151, 23	1 0	48, 151, 231	J202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1315	Period: Worksheet C From 10/01/2016 Part I
		To 09/30/2017 Date/Time Prepared:

					Го 09/30/2017	Date/Time Pre 2/22/2018 11:	
			Titl	e XIX	Hospi tal	PPS	
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		6, 977, 139		6, 977, 13			30. 00
31. 00		432, 414		432, 41			31. 00
43. 00		407, 000		407, 000			43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00		2, 177, 846	13, 202, 102				
51. 00	05100 RECOVERY ROOM	441, 592	3, 042, 009			0. 000000	
52. 00		657, 035	146, 157			0. 000000	
54. 00		1, 328, 528	27, 502, 253			0. 000000	
60.00	06000 LABORATORY	1, 767, 027	11, 339, 741			0. 000000	
64. 00		0	0		0. 000000	0. 000000	
65. 00		1, 294, 644	944, 224			0. 000000	
65. 01	06501 SLEEP LAB	0	1, 099, 933			0. 000000	
66. 00		649, 963	3, 718, 986			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	175, 778	1, 769, 416			0. 000000	
69. 01	06901 CARDI AC REHAB	10, 583	380, 379			0. 000000	
71. 00		473, 864	2, 068, 503			0. 000000	
72. 00		489, 634	855, 038			0. 000000	
73. 00		1, 484, 190	7, 856, 978			0. 000000	
76. 00	03020 CHEMI CAL DEPENDENCY	0	73, 532			0. 000000	
76. 01	03480 ONCOLOGY	0	6, 608, 615	6, 608, 61	0. 417259	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0	0		0. 000000	0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000	0. 000000	
90.00		0	497, 298			0. 000000	
90. 01	09001 CLINIC- MCDONALD	0	140, 972			0. 000000	
91. 00		463, 423	14, 404, 731			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	113, 382	1, 760, 014	1, 873, 39	1. 270893	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS		0.10 5/4	0.0.57			
101. 0	0 10100 HOME HEALTH AGENCY	0	849, 564	849, 56	1		101. 00
440.0	SPECIAL PURPOSE COST CENTERS						440.00
	0 11300 I NTEREST EXPENSE						113.00
	0 11400 UTILIZATION REVIEW-SNF		004 474	204 47			114.00
	0 11600 HOSPI CE	10 244 242	324, 471	· ·			116. 00
200. 0		19, 344, 042	98, 584, 916	117, 928, 95	3		200.00
201. 0		10 244 242	00 504 047	117 000 05			201. 00
202. 0	Total (see instructions)	19, 344, 042	98, 584, 916	117, 928, 95	기		202. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Prepared: 2/22/2018 11:52 am
		T' 11 1/11/	11 1 1	DDC

			10 09/30/2017	2/22/2018 11: 52 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. 291478			50.00
51.00 05100 RECOVERY ROOM	0. 641706			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 363527			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 179746			54.00
60. 00 06000 LABORATORY	0. 357755			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 525705			65. 00
65. 01 06501 SLEEP LAB	0. 403306			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 551420			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 260188			69. 00
69. 01 06901 CARDI AC REHAB	0. 618285			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 264205			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 736089			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 404927			73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	3. 569942			76. 00
76. 01 03480 ONCOLOGY	0. 417259			76. 01
OUTPATIENT SERVICE COST CENTERS	T			
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. 832901			90.00
90. 01 09001 CLI NI C- MCDONALD	7. 218157			90. 01
91. 00 09100 EMERGENCY	0. 363928			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 270893			92. 00
OTHER REIMBURSABLE COST CENTERS				101 00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				110.00
113. 00 11300 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	COMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICAID ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-1315	From 10/01/2016	Worksheet C Part II Date/Time Prepared:

				1	o 09/30/2017	Date/lime Pre 2/22/2018 11:	
			Ti +I	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	oost odified beschiptron	(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		1, 33.1 20)		col . 2)		7 1110 01112	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	4, 482, 911	982, 623	3, 500, 288	0	0	50. 00
51.00	05100 RECOVERY ROOM	2, 235, 448	599, 362	1, 636, 086	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 095, 174	288, 442	806, 732	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 182, 231	758, 148	4, 424, 083	0	0	54.00
60.00	06000 LABORATORY	4, 689, 013	393, 245	4, 295, 768	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1, 176, 984	125, 665	1, 051, 319	0	0	65. 00
65. 01	06501 SLEEP LAB	443, 610	96, 884	346, 726	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	2, 409, 128	525, 186	1, 883, 942	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	506, 116	21, 512	484, 604	0	0	69. 00
69. 01	06901 CARDI AC REHAB	241, 726	62, 016	179, 710	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	671, 706	47, 049	624, 657	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	989, 798	69, 328	920, 470	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 782, 488	152, 177	3, 630, 311	0	0	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	262, 505	6, 251	256, 254	0	0	76. 00
76. 01	03480 ONCOLOGY	2, 757, 507	896, 215	1, 861, 292	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	414, 200	51, 403	362, 797	0	0	90.00
90. 01	09001 CLINIC- MCDONALD	1, 017, 558	156, 314	861, 244	0	0	90. 01
91.00	09100 EMERGENCY	5, 410, 935	900, 596	4, 510, 339	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 380, 886	510, 464	1, 870, 422	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 158, 757	75, 325	1, 083, 432	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
116.00	11600 H0SPI CE	255, 638	16, 000	239, 638	0	0	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	41, 564, 319	6, 734, 205	34, 830, 114	0	0	200. 00
201.00	Less Observation Beds	2, 380, 886	510, 464	1, 870, 422	0		201. 00
202.00	Total (line 200 minus line 201)	39, 183, 433	6, 223, 741	32, 959, 692	0) 0	202. 00

Health Financial Systems	CAMERON	MEMORI AL	COMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICALD ONLY	O CHARGE RATIOS NET	0F	Provi der CCN: 15-1315	From 10/01/2016	Worksheet C Part II Date/Time Prepared:

					10 07/30/2017	2/22/2018 11	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,				
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATI NG ROOM	4, 482, 911					50.00
51. 00	05100 RECOVERY ROOM	2, 235, 448					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 095, 174					52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 182, 231					54.00
60.00	06000 LABORATORY	4, 689, 013	1				60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.0000			64. 00
65.00	06500 RESPI RATORY THERAPY	1, 176, 984					65. 00
65. 01	06501 SLEEP LAB	443, 610					65. 01
66. 00	06600 PHYSI CAL THERAPY	2, 409, 128	4, 368, 949				66. 00
69. 00	06900 ELECTROCARDI OLOGY	506, 116	1, 945, 194	0. 26018	8		69. 00
69. 01	06901 CARDI AC REHAB	241, 726	390, 962	0. 61828	5		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	671, 706		0. 26420	5		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	989, 798	1, 344, 672	0. 73608	9		72. 00
	07300 DRUGS CHARGED TO PATIENTS	3, 782, 488	9, 341, 168	0. 40492	7		73. 00
		262, 505					76. 00
76. 01	03480 ONCOLOGY	2, 757, 507	6, 608, 615	0. 41725	9		76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000			89. 00
90.00	09000 CLI NI C	414, 200	497, 298	0. 83290	1		90. 00
90. 01	09001 CLINIC- MCDONALD	1, 017, 558	140, 972	7. 21815	7		90. 01
91.00	09100 EMERGENCY	5, 410, 935			8		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 380, 886	1, 873, 396	1. 27089	3		92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 158, 757	849, 564	1. 36394	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
116.00	11600 H0SPI CE	255, 638	324, 471	0. 78786	1		116. 00
200.00	Subtotal (sum of lines 50 thru 199)	41, 564, 319	110, 112, 405				200.00
201.00	Less Observation Beds	2, 380, 886	0				201. 00
202.00	Total (line 200 minus line 201)	39, 183, 433	110, 112, 405				202. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	Y SERVICE CAPITAL COSTS	Provider CCN: 15-1315		Worksheet D
			From 10/01/2016	Part II

APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 10/01/2016 To 09/30/2017	Part II Date/Time Pre	pared: 52 am
		Ti tl e	xVIII	Hospi tal	Cost	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(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		T				
50.00 05000 OPERATING ROOM	982, 623				43, 534	1
51.00 05100 RECOVERY ROOM	599, 362	3, 483, 601			17, 845	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	288, 442	803, 192	1		1, 391	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	758, 148		1		11, 953	54. 00
60. 00 06000 LABORATORY	393, 245	13, 106, 768			17, 945	
64.00 06400 I NTRAVENOUS THERAPY	0	0	0. 000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	125, 665	2, 238, 868	0. 056129	415, 872	23, 342	65. 00
65. 01 06501 SLEEP LAB	96, 884	1, 099, 933	0. 088082		0	65. 01
66. 00 06600 PHYSI CAL THERAPY	525, 186	4, 368, 949			19, 363	66. 00
69. 00 06900 ELECTROCARDI OLOGY	21, 512	1, 945, 194	0. 011059	166, 405	1, 840	69. 00
69. 01 06901 CARDI AC REHAB	62, 016	390, 962	0. 15862	1, 259	200	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 049	2, 542, 367	0. 01850	320, 578	5, 933	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	69, 328	1, 344, 672	0. 051558	212, 806	10, 972	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	152, 177	9, 341, 168	0. 01629°	1 487, 672	7, 945	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	6, 251	73, 532	0. 08501°	1 0	0	76. 00
76. 01 03480 ONCOLOGY	896, 215	6, 608, 615	0. 135613	3 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	ol ol	0	89. 00
90. 00 09000 CLI NI C	51, 403	497, 298	0. 10336	5 0	0	90.00
90. 01 09001 CLINIC- MCDONALD	156, 314	140, 972	1. 108830	ol o	0	90. 01
91. 00 09100 EMERGENCY	900, 596	14, 868, 154	0.060572	11, 529	698	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	510, 464		1		25, 743	92.00
200.00 Total (lines 50 through 199)	6, 642, 880		1	3, 713, 309		1
, , ,			•			'

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2016	

]	o 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am_
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description				Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_	_	1		_	4
	05000 OPERATING ROOM	0	0	(0	0	00.00
	05100 RECOVERY ROOM	0	0	(0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
	06000 LABORATORY	0	0	(0	0	60. 00
	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64. 00
	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
	06501 SLEEP LAB	0	0	(0	0	65. 01
	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	06901 CARDI AC REHAB	0	0	(0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
	03020 CHEMI CAL DEPENDENCY	0	0	(0	0	76. 00
76. 01	03480 ONCOLOGY	0	0	() 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS	1 .		1			
	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	89. 00
	09000 CLI NI C	0	0	(0	0	90.00
	09001 CLINIC- MCDONALD	0	0	(0	0	90. 01
	09100 EMERGENCY	0	0	(0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0	0	92. 00
200.00	Total (lines 50 through 199)	0	1 0		ן 0	0	200. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2016	

THROUG	H COSTS				Fo 09/30/2017	Date/Time Pre	
			Ti +l c	xVIII	Hospi tal	2/22/2018 11: Cost	52 alli
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
		Eddodti on oost	4)	col. 2, 3 and		7)	
			.,	4)		.,	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		•			
50.00	05000 OPERATING ROOM	0	0	(15, 379, 948	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0) (3, 483, 601	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0) (803, 192	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) (28, 830, 781	0.000000	54.00
60.00	06000 LABORATORY	0	0)	13, 106, 768	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0) (0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0) (2, 238, 868	0.000000	65.00
65. 01	06501 SLEEP LAB	0	0)	1, 099, 933	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0) (4, 368, 949	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0) (1, 945, 194	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	0	0) (390, 962	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) (2, 542, 367	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (1, 344, 672	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (9, 341, 168	0.000000	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0	0)	73, 532	0.000000	76. 00
76. 01	03480 ONCOLOGY	0	0	(6, 608, 615	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0) (0	0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0	0.000000	89. 00
	09000 CLI NI C	0	0) (497, 298	0.000000	90. 00
	09001 CLINIC- MCDONALD	0	0) (140, 972	0.000000	90. 01
91.00	09100 EMERGENCY	0	0) (14, 868, 154	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0) (1, 873, 396	0.000000	92. 00
200.00	Total (lines 50 through 199)	0	0	(108, 938, 370		200. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND	CILLARY SERVICE OTHER PASS	Provider CO	CN: 15-1315	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2016	Part IV	
				To 09/30/2017	Date/Time Pre	
					2/22/2018 11:	52 am_
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	

		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	681, 395		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	103, 717	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	3, 873	0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	454, 553	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	598, 094	0	0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	415, 872	0	0	0	65. 00
65. 01 06501 SLEEP LAB	0. 000000	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	161, 078	0	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	166, 405	0	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 000000	1, 259	0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	320, 578	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	212, 806	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	487, 672	o	0	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000	0	o	0	0	76. 00
76. 01 03480 ONCOLOGY	0. 000000	0	o	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	o	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0	o	0	0	90.00
90. 01 09001 CLI NI C- MCDONALD	0. 000000	0	o	0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	11, 529	l o	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	94, 478		0	0	92. 00
200.00 Total (lines 50 through 199)		3, 713, 309		0		200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-, -,	-1	-1	_	

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1315	Peri od:	Worksheet D

To 09/30/2017 Date/Time Prepared: 2/22/2018 11:52 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 291478 3, 392, 146 0 50.00 51.00 05100 RECOVERY ROOM 0.641706 199, 697 0 0 0 0 0 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1 363527 2, 184 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.179746 0 6, 678, 583 0 54.00 60.00 06000 LABORATORY 0. 357755 3, 179, 673 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.525705 523, 825 0 65.00 65. 01 06501 SLEEP LAB 0.403306 15, 736 0 65.01 06600 PHYSI CAL THERAPY 66.00 0.551420 1, 153, 272 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0. 260188 522, 176 69 00 0 69.01 06901 CARDI AC REHAB 0.618285 142, 584 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 264205 380, 263 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS ol 72.00 0.736089 232, 459 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0 2, 599, 070 0.404927 13, 040 Ω 76.00 03020 CHEMI CAL DEPENDENCY 3.569942 0 43, 929 0 76.00 03480 ONCOLOGY 0. 417259 2, 487, 045 0 76.01 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 09000 CLI NI C 0.832901 90.00 90.00 226, 157 0 0 09001 CLINIC- MCDONALD 67, 792 90. 01 90.01 7. 218157 0 0 0 09100 EMERGENCY 0.363928 0 2, 931, 776 91.00 91.00 3, 145 Ω 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 270893 0 1,006,178 505 0 92.00 200.00 Subtotal (see instructions) 25, 784, 545 16, 690 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 0 0 Only Charges 0 202. 00 202.00 Net Charges (line 200 - line 201) 25, 784, 545 16, 690

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1315	Peri od: From 10/01/2016	Worksheet D Part V Date/Time Prepared

					From 10/01/2016 To 09/30/2017	Part V Date/Time Pro 2/22/2018 11:	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subj ect To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	988, 736		1			50. 00
	05100 RECOVERY ROOM	128, 147	0	1			51. 00
	05200 DELIVERY ROOM & LABOR ROOM	2, 978	0	1			52. 00
	05400 RADI OLOGY-DI AGNOSTI C	1, 200, 449		1			54. 00
	06000 LABORATORY	1, 137, 544	0)			60.00
	06400 I NTRAVENOUS THERAPY	0	0)			64. 00
	06500 RESPI RATORY THERAPY	275, 377	0)			65. 00
	06501 SLEEP LAB	6, 346	0)			65. 01
	06600 PHYSI CAL THERAPY	635, 937	0)			66. 00
	06900 ELECTROCARDI OLOGY	135, 864	0)			69. 00
	06901 CARDI AC REHAB	88, 158	0)			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	100, 467	0)			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	171, 111	0	1			72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 052, 434	5, 280)			73. 00
	03020 CHEMI CAL DEPENDENCY	156, 824	0)			76. 00
76. 01	03480 ONCOLOGY	1, 037, 742	0)			76. 01
	OUTPATIENT SERVICE COST CENTERS	_					
	08800 RURAL HEALTH CLINIC	0	0)			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)			89. 00
	09000 CLI NI C	188, 366	0)			90. 00
	09001 CLINIC- MCDONALD	489, 333)			90. 01
	09100 EMERGENCY	1, 066, 955					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 278, 745		•			92. 00
200.00		10, 141, 513	7, 067	'			200. 00
201.00		0					201. 00
	Only Charges						1
202.00	Net Charges (line 200 - line 201)	10, 141, 513	7, 067	'			202. 00

Health Financial Systems	CA	MERON MEMORIAL CO	OMMUNI TY		In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VA	ACCINE COST P	Provider CCN:		Peri od: From 10/01/2016	Worksheet D Part V
		C	Component CCN:	: 15-Z315	To 09/30/2017	Date/Time Prepared:

			,	CCN: 15-Z315	To 09/30/2017	2/22/2018 11:	
			Titl∈		Swing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		_		_1		
	05000 OPERATI NG ROOM	0. 291478	l .	1	0	0	
	05100 RECOVERY ROOM	0. 641706	0)	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	1. 363527	0)	0	0	02.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 179746)	0	0	54. 00
	06000 LABORATORY	0. 357755	l .)	0	0	60.00
	06400 I NTRAVENOUS THERAPY	0. 000000			0 0	0	64. 00
	06500 RESPI RATORY THERAPY	0. 525705)	0	0	65. 00
	06501 SLEEP LAB	0. 403306	l e)	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0. 551420)	0	0	66. 00
	06900 ELECTROCARDI OLOGY	0. 260188	l e)	0	0	69. 00
	06901 CARDI AC REHAB	0. 618285)	0	0	1 0 / 1 0 1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 264205	0)	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 736089	0)	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 404927	0)	0	0	73. 00
	03020 CHEMI CAL DEPENDENCY	3. 569942)	0	0	1 . 0. 00
76. 01	03480 ONCOLOGY	0. 417259	0)	0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0. 000000	l e			0	00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
	09000 CLI NI C	0. 832901	0)	0	0	90.00
	09001 CLI NI C- MCDONALD	7. 218157	0)	0	0	90. 01
91.00	09100 EMERGENCY	0. 363928	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 270893	0		0 0	0	92. 00
200.00	Subtotal (see instructions)		0		0 0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0)	0 0	0	202. 00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1315	Peri od: From 10/01/2016	Worksheet D Part V	
		Component	CCN: 15-Z315	To 09/30/2017	Date/Time Prep 2/22/2018 11:	
		Title	e XVIII	Swing Beds - SNF	Cost	
	Co:	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				

Cost Center Descrip	pti on Cost	t Cost		
	Rei mbur	rsed Reimbursed		
	Servi	ces Services No	it	
	Subj ect	t To Subject To		
	Ded. & C	oins. Ded. & Coins	S.	
	(see in	st.) (see inst.)		
	6. 00	7.00		
ANCILLARY SERVICE COST C	ENTERS			
50.00 05000 OPERATI NG ROOM		0	0	50.00
51.00 05100 RECOVERY ROOM		0	0	51.00
52.00 05200 DELIVERY ROOM & LA	BOR ROOM	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI	IC	0	0	54.00
60. 00 06000 LABORATORY		o	0	60.00
64. 00 06400 I NTRAVENOUS THERAP	Υ	o	0	64. 00
65. 00 06500 RESPIRATORY THERAP	Υ	ol	o	65. 00
65. 01 06501 SLEEP LAB		o	0	65. 01
66. 00 06600 PHYSI CAL THERAPY		ol	o	66.00
69. 00 06900 ELECTROCARDI OLOGY		ol	o	69. 00
69. 01 06901 CARDI AC REHAB		ol	o	69. 01
71.00 07100 MEDICAL SUPPLIES CH	HARGED TO PATIENT	ol	o	71. 00
72. 00 07200 I MPL. DEV. CHARGED	¥	o	0	72. 00
73. 00 07300 DRUGS CHARGED TO PA		o	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY		ol		76. 00
76. 01 03480 0NC0L0GY		o	0	76. 01
OUTPATIENT SERVICE COST	CENTERS	<u>~</u>	<u> </u>	7 7 5 7 5 7
88. 00 08800 RURAL HEALTH CLINIC		0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED		o	0	89. 00
90. 00 09000 CLI NI C		ol		90.00
90. 01 09001 CLI NI C- MCDONALD		o	0	90. 01
91. 00 09100 EMERGENCY		ol .		91.00
92. 00 09200 OBSERVATION BEDS (1	NON-DISTINCT PART	ő		92.00
200.00 Subtotal (see insti		ol o	o l	200.00
,	b. Services-Program	ő	<u> </u>	201. 00
Only Charges	2. 23. 1. 303 11 ogi am	Ĭ		[
202.00 Net Charges (line 2	200 - line 201)	o	0	202. 00

Health Financial Systems	CAMERON MEMORI.	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2016 To 09/30/2017		namad.
				To 09/30/2017	Date/Time Pre 2/22/2018 11:	pareu: 52 am
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	•	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 755, 412	120, 811	1, 634, 60	1 4, 262	383. 53	30.00
31.00 INTENSIVE CARE UNIT	124, 214		124, 21	4 206	602. 98	31.00
43. 00 NURSERY	42, 952		42, 95	2 406	105. 79	43.00
200.00 Total (lines 30 through 199)	1, 922, 578		1, 801, 76	7 4, 874		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	75	28, 765				30.00
31.00 INTENSIVE CARE UNIT	19	11, 457				31. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	94	40, 222				200. 00

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 10/01/2016 To 09/30/2017	Date/Time Pre	
		Ti tI	e XIX	Hospi tal	2/22/2018 11: PPS	52 am
Cost Center Description		Total Charges (from Wkst. C,	to Charges	Program	Capital Costs (column 3 x	
	(from Wkst. B, Part II, col.	Part I, col. 8)	(col . 1 ÷ col 2)	. Charges	column 4)	
	26) 1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	982, 623	15, 379, 948	0. 06389	28, 623	1, 829	50.00
51.00 05100 RECOVERY ROOM	599, 362	3, 483, 601	0. 17205	5, 804	999	51.00

Health Financial Systems	CAMERON MEMORIA	L COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Peri od: From 10/01/2016 To 09/30/2017	Worksheet D Part III Date/Time Pre 2/22/2018 11:	pared: 52 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School N	ursing School	Allied Healt	n Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 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	0	31.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) n	ninus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	4, 26	0.00	75	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	20	0.00	19	31. 00
43. 00 04300 NURSERY		0	40	0.00	0	43. 00
200.00 Total (lines 30 through 199)		0	4, 87	4	94	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2016	

				Т	o 09/30/2017	Date/Time Pre 2/22/2018 11:	
				e XIX	Hospi tal	PPS	
	Cost Center Description				Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS		_	1	_		4
	05000 OPERATI NG ROOM	0	0		0	0	1 00.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
	06501 SLEEP LAB	0	0		0	0	65. 01
	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	06901 CARDI AC REHAB	0	0		0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	03020 CHEMI CAL DEPENDENCY	0	0		0	0	76. 00
76. 01	03480 ONCOLOGY	0	0		0	0	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0			0	00.00
		0	0			0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00 90. 00
	09001 CLINIC MCDONALD	0	0			0	90.00
		0	0			0	
	09100 EMERGENCY		0			0	91.00
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			0	92. 00 200. 00
200.00	Total (lines 50 through 199)	ı Y	ı	1	ין	U	₁ 200.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1315	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2016 Part IV

	11 00313			-	Го 09/30/2017	Date/Time Pre 2/22/2018 11:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
		4.00	F 00	4)	7.00	0.00	
	ANOLLI ADV. CEDVI OF LOCK OFNITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	1 0		J	15 270 040	0.000000	F0 00
	05000 OPERATING ROOM	0	0		15, 379, 948		
	05100 RECOVERY ROOM	0	0		3, 483, 601	l .	
	05200 DELIVERY ROOM & LABOR ROOM	0			803, 192	l .	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		28, 830, 781		
	06000 LABORATORY	0	0		13, 106, 768	l .	
	06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	
	06500 RESPIRATORY THERAPY	0	0		2, 238, 868	l .	
	06501 SLEEP LAB	0	0	(1, 099, 933		
	06600 PHYSI CAL THERAPY	0	0		4, 368, 949	l .	
	06900 ELECTROCARDI OLOGY	0	0	(1, 945, 194		
	06901 CARDI AC REHAB	0	0		390, 962		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 542, 367		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 344, 672		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(9, 341, 168		
	03020 CHEMI CAL DEPENDENCY	0	0	(73, 532		
76. 01	03480 ONCOLOGY	0	0) (6, 608, 615	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	(0	0.000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0.000000	
	09000 CLI NI C	0	0) (497, 298		
	09001 CLI NI C- MCDONALD	0	0) (140, 972	l .	
	09100 EMERGENCY	0	0	(14, 868, 154	l .	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		1, 873, 396		
200.00	Total (lines 50 through 199)	0	0	(108, 938, 370		200. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 1		Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prep	pared:
		Title XI	Y	Hospi tal	2/22/2018 11: PPS	52 am
Cost Center Description	Outpati ent		npati ent	Outpatient	Outpati ent	
	B 11 6 6					

				'	0 09/30/201/	2/22/2018 11:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS				T		
50. 00	05000 OPERATING ROOM	0. 000000	28, 623		0	0	50. 00
51. 00	05100 RECOVERY ROOM	0. 000000	5, 804		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 635	0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	17, 461	0	0	0	54.00
60.00	06000 LABORATORY	0. 000000	23, 224	0	0	0	60. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	17, 015	0	0	0	65. 00
65. 01	06501 SLEEP LAB	0. 000000	0	0	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0. 000000	8, 542	0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 653	C	0	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 000000	139	C	0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12, 663	C	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	19, 507	C	0	0	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0. 000000	0	C	0	0	76. 00
76. 01	03480 ONCOLOGY	0. 000000	0	C	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	C	0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0	C	0	0	90.00
90. 01	09001 CLINIC- MCDONALD	0. 000000	0	C	0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	6, 091	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	11, 145	0	0	0	92.00
200.00	Total (lines 50 through 199)		160, 502	C	0	0	200. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-25	52-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1315	Period: Worksheet D-1 From 10/01/2016	
		To 09/30/2017 Date/Time Prepa	
	Title XVIII	Hospital Cost	

		Title XVIII	Hospi tal	2/22/2018 11:	52 am
	Cost Center Description	II tie XVIII	l llospi tai	Cost	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 776	1. 00
2.00	0 Inpatient days (including private room days, excluding swing-bed and newborn days)				2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	vate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 926	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period	3 7			
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	315	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	adys) through becember	or or the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	199	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	- th- D (ldi		1 102	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 103	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	315	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 (,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exer auring eming zeu	aayo,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT		C +1+		17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 o	the cost		17. 00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	137. 32	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	155. 02	20. 00
	reporting period	-			
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng poriod (line	8, 187, 517 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	riig perrou (Triie		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	X line 18)	21 of the cost reporti	ag poriod (line	0	24. 00
24.00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ig perrou (Trile		24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	30, 849	25. 00
27 00	x line 20)			F02 211	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		592, 211 7, 595, 306	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21		7, 0, 0, 0, 0	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	30. 00 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 min		tions)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00				7, 595, 306	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 782. 10	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 965, 656	39. 00
40.00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 965, 656	41.00

	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1315	Peri od: From 10/01/2016	Worksheet D-1	
					To 09/30/2017	Date/Time Pre	
			Ti +I	e XVIII	Hospi tal	2/22/2018 11: Cost	52 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
	·	Inpatient Cost	Inpatient Day	/sDiem (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	0 0.0			42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	538, 269	20	2, 612. 9	79	206, 424	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00							46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	c+ D 2 col 2	lino 200)			1. 00 1, 480, 728	48. 00
	Total Program inpatient costs (sum of lines			ons)		3, 652, 808	
17.00	PASS THROUGH COST ADJUSTMENTS	11 till oagi. 10) (0.10)		0,002,000	
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sun	n of Parts I and	0	50.00
51. 00		ationt ancillar	v sorvicos (f	from Wkst D o	rum of Darte II	0	51.00
31.00	and IV)	attent ancitial	y services (i	ITOIII WKSt. D, S	Sull Of Parts II		31.00
52. 00	Total Program excludable cost (sum of lines					0	
53.00	Total Program inpatient operating cost exclu		lated, non-ph	nysician anesth	netist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)			/I !	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount ((Tine 56 minus	11 ne 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the		
	market basket		•	•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see instructions)						
	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)						62. 00 63. 00
63.00	0 Allowable Inpatient cost plus incentive payment (see instructions) 0 PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00							
	instructions)(title XVIII only)	Ü					
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	period (See	561, 362	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	561, 362	66. 00
	CAH (see instructions)				3,		
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67. 00
68 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after D	ecember 31 of	f the cost reno	orting period	0	68. 00
00. 00	(line 13 x line 20)		ecciliber 51 01	the cost repe	iring perrou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N		•			I	70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-					70. 00 71. 00
72. 00							72. 00
73. 00	0 Medically necessary private room cost applicable to Program (line 14 x line 35)						73. 00
74. 00 75. 00	Total Program general inpatient routine serv	•		*	Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	TOUTTHE SELVICE	CUSIS (IIUIII	WOLKSHEEL D, F	art ii, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)						78. 00 79. 00
	Total Program routine service costs for comp				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1 227	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			1, 336 1, 782. 10	
	Observation bed cost (line 87 x line 88) (se	•	2)			2, 380, 886	
		,				•	

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/22/2018 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 755, 412	8, 187, 517	0. 21440	1 2, 380, 886	510, 464	90.00
91.00 Nursing School cost	0	8, 187, 517	0.00000	2, 380, 886	0	91.00
92.00 Allied health cost	0	8, 187, 517	0.00000	2, 380, 886	0	92.00
93.00 All other Medical Education	0	8, 187, 517	0.00000	2, 380, 886	0	93.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1315	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prep 2/22/2018 11:5	
	Title XIX	Hospi tal	PPS	
Cost Contar Description				

DART 1 ALL PROVIDER CAMPMANTS MARKET 1 ALL PROVIDER CAMPMANTS	-		Title XIX	Hospi tal	2/22/2018 11: PPS	52 am_
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	TI LIE XIX	nospi tai	113	
IMPATEENT DAYS					1. 00	
Impatient days (including private room days and swing-bed days, excluding neaborn)						
Impatient days (including private room days, excluding saring-bed and nekeron days) 1, 200 2, 00	1 00		s excluding newborn)		4 776	1 00
do not complete this line. 4. 05 Sell-private room days (excluding saing-bed and observation bed days) 1. Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 199 8.00 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 11. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 12. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 13. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 14. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 15. 00 Swing-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to the Program (excluding private room days) 16. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 17. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XI						
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	Financial Systems	CAMERON MEMORI		CN. 1E 101E		u of Form CMS-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1315	Peri od: From 10/01/2016	Worksheet D-1	
					To 09/30/2017	Date/Time Pre 2/22/2018 11:	
		T		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per		Program Cost (col. 3 x col.	
				col . 2)		4)	
42.00	MUDCEDY (+; +1 c V e VIV colv)	1. 00 242, 012	2.00	3. 00 596. 0	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		400	590. (09	0	42.00
43.00	INTENSIVE CARE UNIT	538, 269	206	2, 612.	96 19	49, 646	1
44.00	CORONARY CARE UNIT						44. 00 45. 00
45. 00 46. 00							46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			77, 086	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		260, 895	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst D sun	n of Parts I and	40, 222	50.00
30.00		atrent routine	Services (11011	r wkst. D, sun	ii or rai ts r and	40, 222	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	13, 076	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				53, 298	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	sician anesth	netist, and	207, 597	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	argot amount (1	ino 56 minus	lino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (i	The 50 millius	Title 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	ndated by the m	narket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	i iisti ucti oiis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64. 00
	instructions) (title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the c	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
(7.00	CAH (see instructions)		. D 21 -				/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i becember 31 C	or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	48)		n	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70.00	Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		rne 70 ÷ rrne	2)			71. 00 72. 00
73. 00							73. 00
74. 00 75. 00	Total Program general inpatient routine serv	•			Part II column		74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (Irom w	Wiksheet B, F	Part II, Corumn		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	rovi der record	ls)			79. 00
	Total Program routine service costs for comp		cost limitation	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00							81. 00 82. 00
83. 00							83. 00
84.00	Program inpatient ancillary services (see in						84. 00
85. 00 86. 00							85. 00 86. 00
23.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						33.00
87.00	Total observation bed days (see instructions	•	Line 2)			1, 336	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 788. 84 2, 389, 890	1
_ /. 00	(30)					_,,,,	,

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/22/2018 11:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 755, 412	8, 187, 517	0. 21440	1 2, 389, 890	512, 395	90.00
91.00 Nursing School cost	0	8, 187, 517	0.00000	2, 389, 890	0	91.00
92.00 Allied health cost	0	8, 187, 517	0.00000	2, 389, 890	0	92.00
93.00 All other Medical Education	0	8, 187, 517	0.00000	2, 389, 890	0	93. 00

Heal th Fina	ncial Systems CAMERON MEMORIAL CO	MMUNI TY		In Lie	eu of Form CMS-:	2552-10
		ovider C	CN: 15-1315	Peri od:	Worksheet D-3	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LNDA	TIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS O ADULTS & PEDIATRICS		ı	1 (02 052		30.00
	O I NTENSI VE CARE UNI T			1, 603, 053 165, 900		31.00
	O NURSERY			105, 900		43.00
	LLARY SERVICE COST CENTERS					43.00
	O OPERATING ROOM		0. 2914	78 681, 395	198, 612	50.00
	O RECOVERY ROOM		0. 6417			
	O DELIVERY ROOM & LABOR ROOM		1. 3635			
	O RADI OLOGY-DI AGNOSTI C		0. 1797			
60.00 0600	O LABORATORY		0. 3577	55 598, 094	213, 971	60.00
64. 00 0640	O I NTRAVENOUS THERAPY		0.0000	00	0	
65. 00 0650	O RESPI RATORY THERAPY		0. 5257	05 415, 872	218, 626	65.00
65. 01 0650	1 SLEEP LAB		0. 4033	06 0	0	65. 01
	O PHYSI CAL THERAPY		0. 5514	20 161, 078	88, 822	66. 00
	0 ELECTROCARDI OLOGY		0. 2601			
	1 CARDI AC REHAB		0. 6182			
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2642			
	O IMPL. DEV. CHARGED TO PATIENTS		0. 7360			
	O DRUGS CHARGED TO PATIENTS		0. 4049		197, 472	
	O CHEMI CAL DEPENDENCY		3. 5699		1	
	0 ONCOLOGY		0. 4172	59 0	0	76. 01
	ATIENT SERVICE COST CENTERS			20	_	
	O RURAL HEALTH CLINIC		0.0000		0	
	O FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	O CLINIC		0. 8329		0	90.00
	1 CLI NI C- MCDONALD O EMERGENCY		7. 2181 0. 3639		0	
	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART		1. 2708			
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1.2/08	3, 713, 309		
201. 00	Less PBP Clinic Laboratory Services-Program only charges (1	ine 61)		3, 713, 309		200.00
202. 00	Net charges (line 200 minus line 201)	1116 01)		3, 713, 309	l	202.00
202.00	inct charges (Title 200 illithus Title 201)		I	3, 713, 307	I	1202.00

Heal th	Financial Systems 0	CAMERON MEMORIAL COMMUNITY		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Peri od:	Worksheet D-3	
				From 10/01/2016		
		Component	CCN: 15-Z315	To 09/30/2017	Date/Time Pre 2/22/2018 11:	
		Ti +Lo	XVIII	Swing Beds - SNF		32 alli
	Cost Center Description	Title	Ratio of Cos		Inpatient	
	cost center bescription		To Charges	Program	Program Costs	
			10 charges		(col. 1 x col.	
				onal goo	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			0		30. 00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 29147	1, 033	301	50.00
51.00	05100 RECOVERY ROOM		0. 64170	06	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 36352	27 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 17974		2, 313	
60.00	06000 LABORATORY		0. 35775		17, 370	
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY		0. 52570		11, 414	65. 00
65. 01	06501 SLEEP LAB		0. 40330		0	
66. 00	06600 PHYSI CAL THERAPY		0. 55142			
69. 00	06900 ELECTROCARDI OLOGY		0. 26018		1, 803	
69. 01	06901 CARDI AC REHAB		0. 61828		890	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 26420		3, 642	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 73608		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 40492		24, 118	
76. 00	03020 CHEMI CAL DEPENDENCY		3. 56994		0	
76. 01	03480 ONCOLOGY		0. 41725	9 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.00000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90.00	09000 CLINIC		0. 83290		0	90.00
90. 01	09001 CLI NI C- MCDONALD		7. 21815		0	90. 01
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 36392 1. 27089		0 8, 108	
200.00		through 00)	1.27089	370, 579	179, 316	
200.00	1 1 1			370, 579		200.00
201.00		iraiii oni y charges (Title 01)		370, 579		201.00
202.00	The charges (The 200 millions The 201)	l	I	370, 377	l	1202.00

111 41-	Figure 1 Contains	CAMEDON MEMODIAL	COMMUNITY		1 1 :-	6 F CMC	2552 10
	Financial Systems ONT ANCILLARY SERVICE COST APPORTIONMENT	CAMERON MEMORIAL	Provider C	CN: 15-1315	Period: From 10/01/2016	worksheet D-3	
					To 09/30/2017		
			Ti tl	e XIX	Hospi tal	PPS	
	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	
	NPATIENT ROUTINE SERVICE COST CENTERS			1		l	
	D3000 ADULTS & PEDIATRICS				63, 358		30.00
	03100 NTENSIVE CARE UNIT				5, 683		31.00
	04300 NURSERY				5, 349		43. 00
	ANCILLARY SERVICE COST CENTERS			0.0044	70 00 (00	0.040	
	D5000 OPERATING ROOM			0. 2914			
	D5100 RECOVERY ROOM			0. 64170			
	D5200 DELIVERY ROOM & LABOR ROOM			1. 36352			
	D5400 RADI OLOGY-DI AGNOSTI C			0. 17974		3, 139	
	D6000 LABORATORY			0. 35775			
	06400 INTRAVENOUS THERAPY			0.00000			
	06500 RESPIRATORY THERAPY			0. 52570			
	06501 SLEEP LAB			0. 40330		0	
	D6600 PHYSI CAL THERAPY D6900 ELECTROCARDI OLOGY			0. 55142 0. 26018		· ·	
	06901 CARDI AC REHAB			0. 26018			
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 61828			
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 26420		3, 340	1
	07300 DRUGS CHARGED TO PATIENTS			0. 73000		_	
	D3020 CHEMI CAL DEPENDENCY			3. 56994			1
	03480 ONCOLOGY			0. 4172!			
	DUTPATIENT SERVICE COST CENTERS			0.4172	0	0	70.01
	D8800 RURAL HEALTH CLINIC			0.00000	00 0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	
	09000 CLINIC			0. 83290		ĺ	1
	D9001 CLINIC- MCDONALD			7. 2181		0	
	D9100 EMERGENCY			0. 36392			
	D9200 OBSERVATION BEDS (NON-DISTINCT PART			1. 27089		· ·	
200.00	Total (sum of lines 50 through 94 and	1 96 through 98)		1.2700	160, 502		200. 00
201.00	Less PBP Clinic Laboratory Services-P		(Line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)		(160, 502	l	202.00
	, g.: (<u></u>			1	1 117 002	Į.	

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	•	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/22/2018 11:52 am

			0 09/30/2017	2/22/2018 11:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			10 110 500	
1.00	Medical and other services (see instructions)	tions)		10, 148, 580 0	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	LI OIIS)		0	
4. 00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			10, 148, 580	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	07)		0	
	Customary charges		,		
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services on a		0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
18.00	Total customary charges (see instructions)	: € : 10	11) (0	18.00
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y IT Time 18 exceeds Time	II) (See	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifling 11 avcaeds line	18) (500	0	20. 00
20.00	instructions)	y IT TITLE IT EXCEEDS TITLE	10) (300	O	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instruc	ctions)		10, 250, 066	21. 00
22.00	Interns and residents (see instructions)	•		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	- (All !+!)		45, 981	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for		nd 221 (coo	4, 533, 853 5, 670, 232	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	orus the sum of filles 22 ar	iu 23] (See	5, 670, 232	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			5, 670, 232	30.00
31.00	Primary payer payments			3, 066	31.00
32.00	Subtotal (line 30 minus line 31)			5, 667, 166	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			684, 080	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		444, 652 541, 019	
	Subtotal (see instructions)	uctions)		6, 111, 818	
38. 00	MSP-LCC reconciliation amount from PS&R			0, 111, 010	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruction	ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			6, 111, 818	1
40. 01	Sequestration adjustment (see instructions)			122, 236	
40. 02	Demonstration payment adjustment amount after sequestration			0 E E77 001	1
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			5, 577, 091 0	1
42.00	Balance due provider/program (see instructions)			412, 491	42.00
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2 ch	apter 1.	412, 491	1
00	§115. 2			O	55
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	1
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		l	0	94. 00

Health Financial Systems CAME
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2016 | Part I | Date/Time Prepared: Provider CCN: 15-1315

				10 09/30/2017	2/22/2018 11:5	
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I=	1. 00	2.00	3.00	4. 00	
1.00	Total interim payments paid to provider		3, 263, 05		5, 500, 891	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	03/22/2017	103, 10		76, 200	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3.05				0	0	3. 05
0 50	Provi der to Program					0.50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 51				0	0	3. 51
3. 52				0	0	3. 53
3. 54				o	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		103, 10		76, 200	3. 99
0. ,,	3. 50-3. 98)		100, 10		, 0, 200	0. ,,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 366, 15	О	5, 577, 091	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			<u> </u>	1	
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TENTATI VE TO TROVIDER			o	0	5. 02
5. 03				o	Ö	5. 03
	Provider to Program				_	
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
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
/ 01	the cost report. (1)				410 401	. 01
6. 01	SETTLEMENT TO PROVIDER			0	412, 491	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		127, 76 3, 238, 38		0 5, 989, 582	6. 02 7. 00
7.00	inclai medicale program frability (see Histructions)		J, Z30, 38	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8.00	Name of Contractor					8. 00
	·			•	· '	

		Component	CN: 15-Z315	0 09/30/201/	2/22/2018 11:	
		Title	XVIII Sv	ving Beds - SNF		<u> </u>
			t Part A		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		704, 105		0	
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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03			0		0	
3.04			0		0	
3. 05	Drawi dan ta Draggam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADDUST WEIGHTS TO TROOKE WI		l ő		0	
3. 52			Ö		0	
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)		704, 105		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1				1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03	Provider to Program] 0		0	5. 03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTITY E TO TROOTONIII		0		Ö	
5. 52			Ō		0	
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
. 01	the cost report. (1)		05 704			/ 01
6. 01	SETTLEMENT TO PROVIDER		25, 794 0		0	
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		729, 899		0	
7.00	Tiotal medicale program frability (see Histructions)		127, 699	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS	-2552-10
CALCUL					Worksheet E- Part II	1
				To 09/30/2017		
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1. 00	Total hospital discharges as defined in AARA			14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 s		-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col.					3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 s	·	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, co					5. 00
6.00	Total hospital charity care charges from Wkst					6. 00
7. 00	CAH only - The reasonable cost incurred for t	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8. 00	Calculation of the HIT incentive payment (see					8. 00
9. 00	Sequestration adjustment amount (see instruct					9. 00
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10. 00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					4
	30.00 Initial/interim HIT payment adjustment (see instructions)					30. 00
	Other Adjustment (specify)					31. 00
32. 00	Balance due provider (line 8 (or line 10) mir	nus line 30 and l	ine 31) (see instruction	s)		32.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1315 Component CCN: 15-Z315	Peri od: From 10/01/2016 To 09/30/2017	Date/Time Prepared:
				2/22/2018 11:52 am

				2/22/2018 11:	52 am_
		Title XVIII S	wing 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)		566, 976	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,		181, 109	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc				
4. 00	Per diem cost for interns and residents not in approved teaching p	orogram (see		0. 00	4. 00
г оо	instructions)		24.5	0	F 00
5.00	Program days	+:>	315	0	5.00
6.00	Interns and residents not in approved teaching program (see instru Utilization review - physician compensation - SNF optional method			U	6. 00 7. 00
7. 00 8. 00	, , , , , , , , , , , , , , , , , , , ,	oni y	740 005	0	8.00
9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		748, 085	0	9.00
10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		740 005	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	748, 085	0	11.00
11.00	professional services)	e to physician	٥	U	11.00
12. 00	Subtotal (line 10 minus line 11)		748, 085	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (ex	clude coinsurance	3, 290	0	13. 00
10.00	for physician professional services)	ter dae eer risur ariee	0,270	o o	10.00
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)		744, 795	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	Rural community hospital demonstration project (§410A Demonstration	on) payment	0		16. 55
	adjustment (see instructions)	, , ,			
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	18. 00
	Total (see instructions)		744, 795	0	19. 00
19. 01	Sequestration adjustment (see instructions)		14, 896	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
	Interim payments		704, 105	0	20. 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 2	•	25, 794	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance w	vith CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstration				
200.00	Is this the first year of the current 5-year demonstration period	under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D 1 D+ II line			201 00
201.00	66 (title XVIII hospital))	D-1, Pt. 11, Tille			201. 00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from Wks	st D-3 col 3 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	31. D 3, COI. 3, TIME			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
2011.00	Computation of Demonstration Target Amount Limitation (N/A in first	st vear of the current	5-vear demonst	rati on	2011.00
	peri od)	,	,		
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen	nt			
207.00	Program reimbursement under the §410A Demonstration (see instructi	ons)			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	ol. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ns)			209. 00
210. 00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 p	olus line 210) (see			215. 00
	instructions)				

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Pre 2/22/2018 11:	pared:
	Title XVIII	Hospi tal	Cost	

				2/22/2018 11:	52 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE I	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 652, 808	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructio	ns)		0	2. 00
3.00	Organ acqui si ti on			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			3, 652, 808	4.00
5.00	Pri mary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 689, 336	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable 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			ol	9. 00
10.00	Total reasonable charges			ol	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)	1.3	3		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	vifline 14 exceeds li	ne 6) (see	0	15. 00
	instructions)	,) (
16.00	Excess of reasonable cost over customary charges (complete only	y if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)	, ,			
17.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4	, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 689, 336	19. 00
20.00	Deductibles (exclude professional component)			409, 724	20.00
21.00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 279, 612	22. 00
23.00	Coinsurance			329	23. 00
24.00	Subtotal (line 22 minus line 23)			3, 279, 283	24. 00
25.00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		38, 757	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)	, ,		25, 192	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		18, 666	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	,		3, 304, 475	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration	,		0	29. 99
30.00	Subtotal (see instructions)			3, 304, 475	
30. 01	Seguestration adjustment (see instructions)			66, 090	
30. 02	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration			00,070	30. 02
	Interim payments			3, 366, 150	
32. 00	Tentative settlement (for contractor use only)			3, 300, 130	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02	31 and 32)		-127, 765	
34. 00	Protested amounts (nonallowable cost report items) in accordan		chanter 1	-127, 703	34. 00
5 1. 00	§115. 2	33 til 3m3 l ub. 13-2,	5aptor 1,		5 1. 00
	19				1

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	,	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-1315	Peri od: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/22/2018 11:52 am

PPS				10 09/30/2017	2/22/2018 11:	
Input tent			Title XIX	Hospi tal		
PART VII - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES 1.00					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 0 1.00				1. 00	2. 00	
Inpati ent hospital (SNE/NE services 0 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
2.00 Medical and other services 0 2.00		COMPUTATION OF NET COST OF COVERED SERVICES				
3.00 Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services		0		1. 00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
1.00	3.00	Organ acquisition (certified transplant centers only)		0		3. 00
0.00		Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
Subtotal (line 4 less sum of lines 5 and 6)		, , , , , , , , , , , , , , , , , , , ,		0		1
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 74, 390 8 & 00						
Reasonable Charges 74, 390 8, 00 9,00 Ancillary service charges 74, 390 8, 00 10,00 Ancillary service charges 160, 502 0 9, 00 10,00 Incentive from target amount computation 0 11,00 11,00 Incentive from target amount computation 234, 892 0 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00	7. 00			0	0	7.00
Routine service charges						
9.00 Ancillary service charges 160,502 0 9.00 10.00 Incentive from target amount computation 0 11.00 11.00 Incentive from target amount computation 0 11.00 12.00 Total reasonable charges (sum of lines 8 through 11) 234,892 0 12.00 12.00 COUSTOMARY CHARGES 0 0 0 12.00 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 14.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0 0 0 0 0 14.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0 0 0 0 0 0 0 15.00 Total customary charges (see instructions) 0 0 0 0 0 0 0 16.00 Total customary charges (see instructions) 0 0 0 0 0 0 0 16.00 Total customary charges (see instructions) 0 0 0 0 0 0 0 16.00 Total customary charges (see instructions) 0 0 0 0 0 0 0 0 0	0.00			74 200		0.00
10.0 Organ acquisition charges, net of revenue 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00		· ·			0	1
11.00 Incentive from target amount computation 234,892 0 11.00 COSTOMARY CHARGES					Ü	
12.00 Total reasonable charges (sum of lines 8 through 11) 234,892 0 12.00				_		
CUSTOMARY CHARGES 0 0 13.00				<u>۷</u>	0	
13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis shad 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) 15.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00	12.00			234, 072	0	12.00
basis 14.00 Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.0	13 00		services on a charge	0	0	13 00
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PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 22. 00 23. 00 0utlier payments 0 0 23. 00 24. 00 25. 00 24. 00 25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 28. 00 29. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00				-	-	
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chapter 1, §115.2	43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
		chapter 1, §115.2				l

Health Financial Systems

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

Provider CCN: 15-1315

| Peri od: | Worksheet G | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared: 2/22/2018 11:52 am

oni y)					2/22/2018 11:	52 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4.00	
	CURRENT ASSETS				_	
1.00	Cash on hand in banks	23, 340		0	0	
2. 00 3. 00	Temporary investments Notes receivable	202, 744	. (0	
4. 00	Accounts receivable	10, 814, 638		1	0	
5. 00	Other recei vabl e	110, 766			Ö	
6.00	Allowances for uncollectible notes and accounts receivable	0	1	0	0	
7.00	Inventory	1, 827, 074	. (0	0	7. 00
8.00	Prepai d expenses	981, 327		0	0	
9. 00	Other current assets	1, 098, 890	1	0	0	
10.00	Due from other funds	0		0	0	1
11. 00	Total current assets (sum of lines 1-10)	15, 058, 779) (0	0	11. 00
12. 00	FIXED ASSETS Land	1, 317, 868	3	0	0	12.00
13. 00	Land improvements	1, 317, 606			1	
14. 00	Accumulated depreciation		1			
15. 00	Bui I di ngs	56, 786, 732		o o	Ö	
16.00	Accumulated depreciation	-13, 307, 611	1	0	0	
17.00	Leasehold improvements	0) (0	0	17. 00
18. 00	Accumul ated depreciation	0) (0	0	18. 00
19. 00	Fi xed equipment	0) (0	0	
20. 00	Accumulated depreciation	0) (0	0	
21. 00	Automobiles and trucks	0	1	0	0	
22. 00	Accumulated depreciation	10 004 224	1	0	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	18, 884, 224 -11, 384, 058	1	0	0	
25. 00	Mi nor equi pment depreci abl e	-11, 364, 036			0	
26. 00	Accumulated depreciation				Ö	
27. 00	HIT designated Assets	Ö		o o	Ō	
28. 00	Accumul ated depreciation	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)	52, 297, 155	5 (0	0	30.00
	OTHER ASSETS				_	
31.00	Investments	21, 457, 454			1	
32. 00 33. 00	Deposits on leases	0		1	0	
34. 00	Due from owners/officers Other assets	3, 931, 812	1	1	0	1
35. 00	Total other assets (sum of lines 31-34)	25, 389, 266		1	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	92, 745, 200	1	o o	l	
	CURRENT LIABILITIES	, ,	•			
37.00	Accounts payable	3, 920, 268	3 (0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 769, 879		0	0	
39. 00	Payroll taxes payable	0	1	0	0	
40. 00	Notes and Loans payable (short term)	1, 022, 282	. (0	0	
41.00	Deferred income	0		0	0	
42. 00 43. 00	Accel erated payments Due to other funds	0			0	42.00
44. 00	Other current liabilities	776, 828			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	7, 489, 257	1			
10.00	LONG TERM LIABILITIES	7, 107, 207		<u> </u>		10.00
46. 00	Mortgage payable	0) (0	0	46. 00
47. 00	Notes payable	1, 133, 788	3	0	0	
48. 00	Unsecured Loans	0) (0	1	
49. 00	Other long term liabilities	44, 408, 061		0	1	
50.00	Total long term liabilities (sum of lines 46 thru 49)	45, 541, 849	1			
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	53, 031, 106) (0	0	51.00
52.00	General fund balance	39, 714, 094				52.00
53.00	Specific purpose fund					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		1	0	_	56.00
57.00	Plant fund balance - invested in plant				0	
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)	39, 714, 094	. .	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	92, 745, 200		o o	ő	
	59)					

Provider CCN: 15-1315

| Peri od: | From 10/01/2016 | To 09/30/2017 | Date/Ti me Prepared:

					То	09/30/2017	Date/Time Prep 2/22/2018 11:5	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	11.00	40, 241, 284	0.00		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-434, 997					2. 00
3.00	Total (sum of line 1 and line 2)		39, 806, 287			0		3.00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00 7. 00
8.00		0			0			8. 00
9. 00		o o			0		0	9. 00
10.00	Total additions (sum of line 4-9)		o			0		10.00
11. 00	Subtotal (line 3 plus line 10)		39, 806, 287			0		11.00
12.00	FOUNDATI ON	92, 193			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 17. 00					0		0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)		92, 193		U	0	١	18. 00
19. 00	Fund balance at end of period per balance		39, 714, 094			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8. 00
9. 00			Ö					9. 00
10.00	Total additions (sum of line 4-9)	О	آ		0			10.00
11.00	Subtotal (line 3 plus line 10)	O			0			11.00
12. 00	FOUNDATI ON		0					12.00
13. 00			0					13. 00
14. 00			0					14. 00 15. 00
15. 00 16. 00		+	0					16. 00
17. 00			o					17. 00
	I .	1	٩		- 1			
18. 00	Total deductions (sum of lines 12-17)	ol			0			18.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

Health Financial Systems C.
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1315

				То	09/30/2017	Date/Time Pre 2/22/2018 11:	
	Cost Center Description	l r	npati ent		Outpati ent	Total	52 aiii
	oddt denten besentptron		1. 00	+	2.00	3. 00	
	PART I - PATIENT REVENUES				2.00	0.00	
	General Inpatient Routine Services						1
1.00	Hospi tal		7, 384, 13	9		7, 384, 139	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			О		0	5. 00
6.00	Swing bed - NF			О		0	6. 00
7.00	SKILLED NURSING FACILITY						7. 00
8.00	NURSING FACILITY						8. 00
9.00	OTHER LONG TERM CARE						9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 384, 13	9		7, 384, 139	10.00
	Intensive Care Type Inpatient Hospital Services	· · · · · · · · · · · · · · · · · · ·	,			, ,	
11. 00	INTENSIVE CARE UNIT		432, 41	4		432, 414	11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL INTENSIVE CARE UNIT						14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)						15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	nes	432, 41	4		432, 414	16. 00
	11-15)		•				
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 816, 55	3		7, 816, 553	17. 00
18. 00	Ancillary services		10, 950, 68	4	80, 607, 866	91, 558, 550	18. 00
19.00	Outpati ent servi ces		576, 80	5	16, 803, 015	17, 379, 820	19. 00
20.00	RURAL HEALTH CLINIC			0	0	O	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	o	Ō	21.00
22.00	HOME HEALTH AGENCY				849, 564	849, 564	22. 00
23.00	AMBULANCE SERVICES						23. 00
24.00	CMHC						24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25. 00
26.00	HOSPI CE			0	324, 471	324, 471	26. 00
27.00	PROFESSI ONAL FEES		1, 049, 57	4	2, 212, 758	3, 262, 332	27. 00
27. 01	OTHER REVENUE		8, 75	4	4, 808, 245	4, 816, 999	27. 01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst.	20, 402, 37	0	105, 605, 919	126, 008, 289	28. 00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)				60, 198, 930		29. 00
30.00	ADD (SPECIFY)			0			30. 00
31. 00				0			31. 00
32.00				0			32. 00
33.00				0			33. 00
34.00				0			34.00
35.00				0			35. 00
36.00	Total additions (sum of lines 30-35)				0		36. 00
37. 00	DEDUCT (SPECIFY)			0			37. 00
38. 00				0			38. 00
39. 00				0			39. 00
40.00				0			40. 00
41. 00				0			41. 00
42.00	Total deductions (sum of lines 37-41)				0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)((transfer			60, 198, 930		43. 00
	to Wkst. G-3, line 4)						

	Financial Systems	CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315 Period: Worksheet G- From 10/01/2016	3
		To 09/30/2017 Date/Time Pr	
			:52 am
		1.00	
1. 00	Total patient revenues (from Wkst. G-2, Pa	1.00 art I, column 3, line 28) 126,008,28	9 1.00
2. 00	Less contractual allowances and discounts		
3.00	Net patient revenues (line 1 minus line 2)		
4.00	Less total operating expenses (from Wkst.		
5. 00	Net income from service to patients (line		
0.00	OTHER I NCOME	o mindo intro iy	
6.00	Contributions, donations, bequests, etc		6.00
7.00	Income from investments		7.00
8.00	Revenues from telephone and other miscella	aneous communication services	8.00
9.00	Revenue from television and radio service		9.00
10.00	Purchase di scounts		0 10.00
11.00	Rebates and refunds of expenses		0 11.00
12.00	Parking Lot receipts		0 12.00
13.00	Revenue from Laundry and Linen service		0 13.00
14.00	Revenue from meals sold to employees and g		0 14.00
15. 00	Revenue from rental of living quarters		0 15.00
16. 00	Revenue from sale of medical and surgical	· ·	0 16.00
17. 00	Revenue from sale of drugs to other than p		0 17.00
18.00	Revenue from sale of medical records and a		0 18.00
19.00	Tuition (fees, sale of textbooks, uniforms		19.00
20.00	Revenue from gifts, flowers, coffee shops,		0 20.00
21. 00 22. 00	Rental of vending machines Rental of hospital space		0 21.00
23. 00	Governmental appropriations		0 23.00
24. 00	OTHER INCOME	1, 017, 69	
24. 01	CONTRI BUTI ONS	53, 23	
24. 02	LOSS ON DISPOSAL OF PROPERTY	-105, 54	
24. 03	CONTRIBUTION TO FOUNDATION	-90, 18	•
24. 04	CHANGE IN ASSETS FOUNDATION	166, 70	
24. 05	INVESTMENT INCOME	2, 192, 78	
24. 06	OP REVENUE, GROUPED IN OTHER	24, 12	1
	1	3, 258, 81	
26. 00	Total (line 5 plus line 25)	-434, 99	
27. 00	OTHER EXPENSES (SPECIFY)	· ·	0 27.00
28. 00	Total other expenses (sum of line 27 and s	subscripts)	0 28.00
29 00	Net income (or loss) for the period (line	26 minus line 28) -434, 99	7 29.00

638, 640

0

0

638, 640

23.50

24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

-143, 502

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23. 50

Heal th	Financial Systems		CAMERON MEMORIA	L COMMUNITY		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE			Provi der C	CN: 15-1315	Peri od: From 10/01/2016	Worksheet H-1 Part I	
				HHA CCN:	15-7117	To 09/30/2017	Date/Time Pre	pared:
						Home Health	2/22/2018 11: PPS	52 am
			C: +- D-		1	Agency I		
			Capital Rela	ited Costs				
		Net Expenses	BI dgs &	Movable	Plant	Transportati on	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1.00	2. 00	3.00	4. 00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS		0					1.00
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable	0		0			0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	О	0		0	0	3. 00
4.00	Transportation	133,000	0	0	1	0 0	122 000	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	132, 900	0	0		0 0	132, 900	5. 00
6.00	Skilled Nursing Care	258, 215	l l	0	1	0 0	258, 215	1
7. 00 8. 00	Physical Therapy Occupational Therapy	152, 448 28, 088	0	0	1	0 0	152, 448 28, 088	•
9.00	Speech Pathology	2, 350	0	0		0 0	2, 350	9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	19, 941 44, 698	0	0		0 0		10.00
12. 00	Supplies (see instructions)	0	0	0		0 0	0	1
13. 00 14. 00	Drugs DME	0	0	0	1	0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES		0			0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0	1	0 0	0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21. 00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
23. 50	Tel emedi ci ne	o o	Ö	0	1	0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	638,640 Admi ni strati ve		0		0 0	638, 640	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6. 00					
1.00	Capital Related - Bldg. &							1. 00
2. 00	Fixtures Capital Related - Movable							2.00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	132, 900						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	67, 854	326, 069					6.00
7.00	Physical Therapy	40, 061	192, 509					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	7, 381 618	35, 469 2, 968					8. 00 9. 00
10. 00	Medical Social Services	5, 240						10.00
11.00	Home Heal th Ai de	11, 746						11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0 0	0					12. 00 13. 00
14. 00		0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16.00	Respiratory Therapy	0	- 1					16.00
17. 00 18. 00	Private Duty Nursing Clinic	0 0	0					17. 00 18. 00
19. 00	Health Promotion Activities	0	0					19. 00
20.00	Day Care Program Home Delivered Meals Program	0	0					20.00
22. 00	Homemaker Service	0	0					22. 00
23. 00 23. 50	1 3/	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		638, 640					24. 00
		,	·					

llool +b	Financial Cystems		CAMEDON MEMODI	AL COMMUNITY		la li o	u of Form CMC	2552 10
	Financial Systems LLOCATION - HHA STATISTICAL BAS	21.0	CAMERON MEMORI	Provider C	CN: 15 1215	Peri od:	eu of Form CMS-2 Worksheet H-1	2552-10
C031 A	ELECCATION - HIM STATISTICAL DAS	51.5		HHA CCN:	15-7117	From 10/01/2016 To 09/30/2017	Part II	
						Home Health Agency I	PPS	<u> </u>
		Capital Rel	ated Costs			Agency		
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)				(ACCUM. COST)	
		1.00	0.00	(SQUARE FEET)		54.00		
	CENEDAL CEDALCE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	1 0		ı	I	0		1.00
1.00	Fixtures					0		1.00
2.00	Capital Related - Movable		0			0		2.00
2.00	Equi pment							2.00
3.00	Plant Operation & Maintenance	0	0		,	0		3. 00
4.00	Transportation (see	0	0	l o)	0		4. 00
	instructions)							
5.00	Administrative and General	0	0	O		0 -132, 900	505, 740	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0			1	0 0	258, 215	
7.00	Physi cal Therapy	0		0)	0 0	152, 448	
8.00	Occupational Therapy	0	0	0		0 0	28, 088	
9.00	Speech Pathology	0	0	0	1	0 0	2, 350	
10. 00	Medical Social Services	0	0	0	1	0 0	19, 941	
11. 00	Home Health Aide	0	0	0	1	0 0	44, 698	
12.00	Supplies (see instructions)	0	0	0	1	0	0	12.00
13.00	Drugs	0	0	0	1	0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0		1	0 0	0	14. 00
15. 00	Home Dialysis Aide Services	l 0	0	0	d .	0 0	0	15. 00
16. 00	Respiratory Therapy				1	0 0	0	1
17. 00	Private Duty Nursing		0				0	
18. 00	Clinic		0			0 0	0	1
19. 00	Health Promotion Activities		0			0 0	0	
20. 00	Day Care Program	0	0			0 0	0	
21. 00	Home Delivered Meals Program	0	0			0 0	0	
22. 00	Homemaker Service	0	0		,	0 0	Ö	
23. 00	All Others (specify)	0	0	O)	0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0	1	0 0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	0)	0 -132, 900	505, 740	24. 00
25. 00	Cost To Be Allocated (per	0	0	0)	0	132, 900	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 262783	26. 00

HHA CCN:

Home Health PPS

15-7117

						Agency I	PPS	
			CAPITAL REL	ATED COSTS		rigerio y		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4. 00	4A	5. 00	
1. 00 2. 00	Administrative and General Skilled Nursing Care	0 326, 069	0	39, 768 0	170, 946 0	210, 714 326, 069	51, 171 79, 184	1. 00 2. 00
3.00	Physical Therapy	192, 509	0	О	0	192, 509		3.00
4.00	Occupational Therapy	35, 469	0	0	0	35, 469	8, 613	4.00
5.00	Speech Pathology	2, 968	0	0	0	2, 968	721	5.00
6.00	Medical Social Services	25, 181	0	0	0	25, 181	6, 115	6.00
7.00	Home Health Aide	56, 444	0	0	0	56, 444		7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0	0	0	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	0	0	0		12. 00
13. 00	Private Duty Nursing	Ö	o o	o	0	0	o	13. 00
14.00	Clinic	0	0	0	0	0	o	14.00
15.00	Health Promotion Activities	0	0	0	0	0	O	15.00
16. 00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00 19. 00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify) Telemedicine	0	0	0	0	0	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)	638, 640	0	39, 768	170, 946	849, 354	206, 261	20. 00
21. 00	Unit Cost Multiplier: column	000,010		077 700	1,0,710	0. 000000	200, 201	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	goot contor bood ptron	PLANT	LINEN SERVICE				ADMI NI STRATI ON	
4 00		7. 00	8. 00	9. 00	10 00			
1.00	Administrative and General	E/ E77			10.00	11. 00	13. 00	4 00
2.00	Chilled Numeing Come	56, 577	0	15, 837	0	11. 00 29, 105	0	1. 00
3 00	Skilled Nursing Care	56, 577 0	0				0	2. 00
3.00 4.00	Physi cal Therapy	56, 577 0 0	0		0		0 0 0	2. 00 3. 00
3. 00 4. 00 5. 00	Physical Therapy Occupational Therapy	56, 577 0 0 0 0	0		0		0	2. 00
4.00	Physi cal Therapy	56, 577 0 0 0 0 0	0 0 0		0		0 0 0	2. 00 3. 00 4. 00
4. 00 5. 00	Physical Therapy Occupational Therapy Speech Pathology	56, 577 0 0 0 0 0 0	0 0 0 0		0		0 0 0 0	2. 00 3. 00 4. 00 5. 00
4. 00 5. 00 6. 00 7. 00 8. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	56, 577 0 0 0 0 0 0 0	0 0 0 0 0 0		0 0 0 0 0 0		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	56, 577 0 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	56, 577 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	56, 577 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	56, 577 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	56, 577 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	56, 577 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	56, 577 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	29, 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	29, 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	29, 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 837 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	29, 105 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

⁽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.

1, 158, 757

19.50

20.00

21.00

365, 027

0. 459888

19.00 19.50

20.00

21.00

Tel emedi ci ne

6 decimal places.

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

⁽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	COMMUNI TY	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO	HHA COST CENTERS STATISTICAL	Provider CCN: 15-1315	Peri od:	Worksheet H-2
BASIS			From 10/01/2016	
		HHA CCN: 15-7117	To 09/30/2017	Date/Time Prepared:
				2/22/2018 11:52 am
			Home Health	PPS

						Home Health	PPS	
						Agency I		
		CAPITAL REL	LATED COSTS					
	C+ C+	DIDC & FLVT	MVDLE FOULD	EMDL OVEE	D	ADMINI CEDATI VE	ODEDATION OF	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
				(GROSS		(ACCOM. COST)	(SQUARE FEET)	
				SALARI ES)				
		1.00	2. 00	4. 00	5A	5. 00	7. 00	
1. 00	Administrative and General	0	1, 469	567, 890			1, 469	1. 00
2. 00	Skilled Nursing Care	0	.,,	007,070			0	2. 00
3.00	Physical Therapy	0	0				ol	3. 00
4.00	Occupational Therapy	0	0	l o			o	4. 00
5.00	Speech Pathology	0	0	O			o	5. 00
6.00	Medical Social Services	0	0	0	·		o	6.00
7.00	Home Health Aide	0	0	l c	ıl c		o	7. 00
8.00	Supplies (see instructions)	0	0	0	· C	o	o	8. 00
9.00	Drugs	0	0	0	(o	o	9.00
10.00	DME	0	0	0) c	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0) c	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	CI i ni c	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	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18. 00	Homemaker Service	0	0	0		0	0	18. 00
19. 00	All Others (specify)	0	0	0		0	0	19. 00
19. 50	Tel emedi ci ne	0	1 4/0			040 254	1 4(0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	0	1, 469 39, 768		1	849, 354 206, 261	1, 469 56, 577	20. 00 21. 00
22. 00	Unit cost multiplier	0. 000000	27. 071477	0. 301020	1	0. 242845	38. 513955	
22.00	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	22.00
	oost conten besen per on	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	ADMINI STRATION	SERVICES &	
		(POUNDS OF	SERVIC)	()	(/		SUPPLY	
		LAUNDR)	ŕ			(DIRECT NRSING	(COSTED	
						HR)	REQUIS.)	
		8. 00	9. 00	10.00	11. 00	13. 00	14. 00	
1. 00	Administrative and General	0	58	0			5, 861	1. 00
2.00	Skilled Nursing Care	0	0	0		1	0	2. 00
3.00	Physi cal Therapy	0	0	0		0	0	3. 00
4.00	Occupational Therapy	0	0	0		0	0	4. 00
5.00	Speech Pathology	0	0				U	5. 00
6.00	Medical Social Services	0	0			0	U	6. 00
7. 00 8. 00	Home Health Aide	0	0				0	7. 00 8. 00
9. 00	Supplies (see instructions) Drugs	0	0			1	0	9. 00
10.00	DME		0				0	10. 00
11. 00	Home Dialysis Aide Services	0	0				0	11. 00
12. 00	Respiratory Therapy	0	0			ol ol	Ö	12. 00
13. 00	Private Duty Nursing	0	0	l o		o	o	13.00
14.00	Clinic	0	0	l c	ıl c	o	o	14.00
15.00	Health Promotion Activities	0	0	l c	ıl c	o	o	15.00
16.00	Day Care Program	0	0	0		ol ol	o	16.00
17. 00	Home Delivered Meals Program	0	0	0	(o o	o	17.00
18.00	Homemaker Service	0	0	0	(ol ol	o	18.00
19.00	All Others (specify)	0	0	0	(o o	o	19. 00
	Tel emedi ci ne	0	0	0	(o o	o	19. 50
20. 00		0	58	0	830		5, 861	
21. 00	Total cost to be allocated	0	15, 837	0	29, 105		1, 623	
22. 00	Unit cost multiplier	0. 000000	273. 051724	0.000000	35. 066265	0. 000000	0. 276915	22. 00

	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provi der CCN	N: 15-1315	Peri od:	Worksheet H-2	!
BASIS				HHA CCN:	15-7117	From 10/01/2016 To 09/30/2017	Part II Date/Time Pre 2/22/2018 11:	pared: 52 am
						Home Health	PPS	
	C+ C+	DHADMACV	MEDICAL			Agency I		
	Cost Center Description	PHARMACY (COSTED	MEDICAL RECORDS &					
		REQUIS.)	LI BRARY					
		KLQUI 3.)	(TIME SPENT)					
		15. 00	16.00					-
1.00	Administrative and General	0	0					1. 00
2.00	Skilled Nursing Care	0	o					2. 00
3.00	Physi cal Therapy	0	O					3. 00
4.00	Occupational Therapy	0	О					4.00
5.00	Speech Pathology	0	О					5. 00
6.00	Medical Social Services	0	o					6. 00
7.00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respi ratory Therapy	0	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
	Day Care Program	0	0					16. 00
	Home Delivered Meals Program	0	0					17. 00
18.00	Homemaker Service	0	0					18.00
	All Others (specify)	0	0					19.00
19. 50	Tel emedi ci ne	0	0					19. 50
20.00	Total (sum of lines 1-19)	0	0					20.00
21. 00	Total cost to be allocated	0 000000	0 000000					21. 00 22. 00
22.00	Unit cost multiplier	0. 000000	0. 000000					1 22. UC

	Financial Systems		CAMERON MEMORI				u of Form CMS-2	
APPORT	FIONMENT OF PATIENT SERVICE COST	-S		Provider C	CN: 15-1315 15-7117	Period: From 10/01/2016 To 09/30/2017		
				HHA CCN.	15-7117	10 09/30/2017	2/22/2018 11:	
				Titl€	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I 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	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4. 00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
00	Cost Per Visit Computation	1 0 00	F04 (00	ı	F04 (4	20 4 500	205.00	
. 00 2. 00	Skilled Nursing Care	2. 00 3. 00	1		591, 62		l e	
3. 00	Physical Therapy Occupational Therapy	4.00	1				l e	1
. 00	Speech Pathology	5. 00	1				ł	
5. 00	Medical Social Services	6. 00			45, 68		l e	1
5. 00	Home Health Aide	7. 00	102, 413		102, 4	1, 660	61. 69	6.0
. 00	Total (sum of lines 1-6)		1, 158, 757	C				7. 0
			1		Program Visi			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	cost center bescription	COST LIMITES	CBSA NO. (1)	Part A	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	I	99915		J 24	24	I	1
3. 00 9. 00	Skilled Nursing Care Physical Therapy		99915		•	21 57		8. 0 9. 0
0.00	Occupational Therapy		99915		•	42		10.0
11.00	Speech Pathology		99915	i c	•	17		11.0
12.00	Medical Social Services		99915	C		8		12. 0
13. 00	Home Heal th Aide		99915	C		32		13. 0
14. 00	Total (sum of lines 8-13)	F WI+ II 2	F:::::::::::::::::::::::::::::::::::	Classas			D-+: - (I 2	14. 00
	Cost Center Description	Part I, col.	Facility Costs (from Wkst.		Total HHA Costs (cols.	Total Charges 1 (from HHA	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	- (01. 4)	
			, , ,	Part (II)	,			
		0	1. 00	2.00	3. 00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 8.00	0		\	0 0	0. 000000	15 0
16. 00		9.00	1		l	0 0	l .	1
0. 00	COST OF Brugs	7.00	Program Visits		Cost of	0	0.00000	10.0
					Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Deductibles & Coinsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6.00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							1
	Cost Per Visit Computation	1	1 004	ı		100 000		
. 00	Skilled Nursing Care	0	· ·			0 123, 880		1.0
2. 00 3. 00	Physical Therapy Occupational Therapy	0	557 42			0 105, 396 0 8, 950		2. 0
. 00	Speech Pathology		17			0 2,775	l	4.0
5. 00	Medical Social Services	0	8	ł control de la control de		0 11, 076	l e	5. 0
5. 00	Home Health Aide	0	82			0 5, 059		6.0
7. 00	Total (sum of lines 1-6)	0	1, 027			0 257, 136		7. 0
	Cost Center Description	(00	7.00	0.00	0.00	10.00	11.00	
	Limitation Cost Computation	6. 00	7.00	8. 00	9. 00	10.00	11.00	
3. 00	Skilled Nursing Care				I			8.0
9. 00	Physical Therapy							9. 0
10.00	Occupational Therapy							10.0
11.00	Speech Pathology							11.0
12.00	Medical Social Services							12.0
13.00	Home Health Aide	1						13. 0
4. 00	Total (sum of lines 8-13)							14.0

Heal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		Provider CC HHA CCN:	15-7117	Peri od: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/22/2018 11:	pared:
				Title	XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	ırges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies Cost of Drugs	0	0 420	0		0 0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	123, 880						1.00
2.00	Physi cal Therapy	105, 396						2. 00
3.00	Occupational Therapy	8, 950						3.00
4. 00 5. 00	Speech Pathology Medical Social Services	2, 775						4. 00 5. 00
6.00	Home Health Aide	11, 076						6.00
7. 00	Total (sum of lines 1-6)	5, 059 257, 136						7.00
7.00	Cost Center Description	237, 130						7.00
	oost denter bescriptron	12. 00						
	Limitation Cost Computation		'					
8.00	Skilled Nursing Care							8. 00
9.00	Physi cal Therapy							9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11. 00
12.00	Medical Social Services							12.00
13.00	Home Heal th Aide							13.00
14. 00	Total (sum of lines 8-13)	I						14. 00

Heal th	Financial Systems		CAMERON MEMORI.	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTI	ONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-1315	Peri od:	Worksheet H-3	
				HHA CCN:	15-7117	From 10/01/2016 To 09/30/2017	Part II Date/Time Pre 2/22/2018 11:	pared: 52 am
				Title	xVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
F	PART II - APPORTIONMENT OF COST	Γ OF HHA SERVI	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 551420	0		Ocol. 2, line 2	. 00	1.00
2.00	Occupati onal Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 264205	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 404927	0)	0 col. 2, line 1	6. 00	5. 00

	· · · · · · · · · · · · · · · · · · ·	ORIAL COMMUNITY			u of Form CMS-2	
ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-1315	Peri od: From 10/01/2016	Worksheet H-4 Part I-II	
		HHA CCN:	15-7117	To 09/30/2017	Date/Time Pre	
		Title	× XVIII	Home Health	2/22/2018 11: PPS	52 a
		ii ti e	XVIII	Agency I	113	
					t B	
			Part A	Not Subject to Deductibles &		
				Coi nsurance	Coi nsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR Reasonable Cost of Part A & Part B Services	CUSTOMARY CHARGE	S			1
00	Reasonable cost of services (see instructions)			0 0	0	1
00	Total charges			0 420	0	2
00	Customary Charges	nt for complete	I	0 0	0	١,
00	Amount actually collected from patients liable for payme on a charge basis (from your records)	nt for services		0 0	0	3
00	Amount that would have been realized from patients liabl	e for payment		0 0	0	4.
	for services on a charge basis had such payment been mad	e in accordance				
00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 00000	0. 000000	5
00	Total customary charges (see instructions)		0.0000	0 420		
00	Excess of total customary charges over total reasonable	cost (complete		0 420	0	7
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (comple	te only if line		0 0	0	8
00	1 exceeds line 6)	te only it time				"
00	Primary payer amounts			0 0		9
				Part A Services	Part B Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	0 191, 040	
. 00	Total PPS Reimbursement - Full Episodes with Outliers			0	4, 768	
. 00	Total PPS Reimbursement - LUPA Episodes			0	5, 348	13
. 00	Total PPS Reimbursement - PEP Episodes			0	1, 860	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Out Total PPS Outlier Reimbursement - PEP Episodes	liers		0	802 0	
. 00	Total Other Payments			0	Ö	
. 00	DME Payments			0	0	
. 00	Oxygen Payments			0	0	
. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude	coi neurance)		0	0 0	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	corrisar arice)		0		
. 00	Excess reasonable cost (from line 8)			0	0	
. 00	Subtotal (line 22 minus line 23)	`		0		
. 00	Coinsurance billed to program patients (from your record Net cost (line 24 minus line 25)	S)		0	0 203, 818	
	Reimbursable bad debts (from your records)			0	203, 010	27
. 00		see instructions)				28
. 00	Total costs - current cost reporting period (line 26 plu	s line 27)		0		
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	_	
. 99	Demonstration payment adjustment amount before sequestra			0	0	1
. 00	Subtotal (see instructions)			0		
. 01	Sequestration adjustment (see instructions)			0	.,	
. 02	Demonstration payment adjustment amount after sequestrat	i on		0		
	Interim payments (see instructions) Tentative settlement (for contractor use only)			0	199, 742 0	
	Balance due provider/program (line 31 minus lines 31.01,	32, and 33)		0		

Health Financial Systems CAMERON MEMORIA
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10

Peri od: From 10/01/2016 To 09/30/2017 Provider CCN: 15-1315 Worksheet H-5 TO PROGRAM BENEFICIARIES Date/Time Prepared: 2/22/2018 11:52 am HHA CCN: 15-7117

Inpatient Part A					Home Health Agency I	PPS	
Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 199,742 1.00 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 110 1			Inpatien	t Part A		t B	
Total interim payments paid to provider 0 199,742 1.00 2.00 199,742 1.00 2.00 2.00 199,742 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2			mm/dd/yyyy		mm/dd/yyyy	Amount	
Interin payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	1.00		1. 00				4 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			-		
3.02 3.03 3.04 3.05 3.03 3.04 3.05 Provider to Program Provider to Program Provider to Program 0		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)					
3.03 0 0 0 3.03 3.04 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.05 3.							
3.04 0					-		
3.05 Provider to Program							
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3.51 0		Provider to Program			- 1		
3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99							
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3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3.01-3.49 minus sum of lines			-		
(transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR							
To BE COMPLETED BY CONTRACTOR	4.00	(transfer to Wkst. H-4, Part II, column as appropriate,			0	199, 742	4. 00
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0		TO BE COMPLETED BY CONTRACTOR					
0	5. 00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
Solution Solution	E 01	Program to Provider					E 01
5.03 Provider to Program O							
0							
5.51		Provider to Program					
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)					-		
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 0 199,742 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5 01 5 40 minus sum of lines			-		
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)			O		
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
0 1.00 2.00	7.00	notal medicale program frability (see instructions)			Contractor	NPR Date	7.00
			()			
	8. 00	Name of Contractor					8. 00

Provider CCN: 15-1315 Peri od: From 10/01/2016 To 09/30/2017 Worksheet 0 Date/Time Prepared: 2/22/2018 11:52 am Hospi ce CCN: 15-1561

						2/22/2018 11:	o2 am_
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		C	0	0	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP*				Ö	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*				0	0	3. 00
4. 00	ADMINISTRATIVE & GENERAL*	0	10 00	10 005	0		4. 00
		0	10, 085	10, 085	U	10, 085	
5.00	PLANT OPERATION & MAINTENANCE*	0	(9	U	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	(0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	C	0	0	0	7. 00
8.00	DI ETARY*	0	51	51	0	51	8.00
9.00	NURSING ADMINISTRATION*	0	C	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	C	0	0	0	10.00
11. 00	MEDI CAL RECORDS*	l ol	C	ol o	0	0	11.00
12. 00	STAFF TRANSPORTATION*	o	17, 774	17, 774	0	17, 774	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	11, 305	,	11, 305	0	11, 305	13. 00
14. 00	PHARMACY*	11, 303		0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0			0	0	15. 00
		0	(0	0	
16.00	OTHER GENERAL SERVICE*	U	C	٥	U	U	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS	,					
25. 00	INPATIENT CARE-CONTRACTED**	0	C	0	0	0	25.00
26. 00	PHYSI CI AN SERVI CES**	0	C	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	C	0	0	0	27.00
28.00	REGI STERED NURSE**	70, 444	1, 825	72, 269	o	72, 269	28.00
29.00	LPN/LVN**	o	C	o	0	0	29.00
30.00	PHYSI CAL THERAPY**	1, 077	C	1, 077	0	1, 077	30.00
31. 00	OCCUPATIONAL THERAPY**	0		0	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**			á ő	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	24, 567	(24, 567	0	24, 567	33. 00
34. 00	SPIRITUAL COUNSELING**				0	5, 182	34. 00
		5, 182	(1 0, .02	U	•	
35. 00	DI ETARY COUNSELI NG**	0	(0	0	0	35. 00
36. 00	COUNSELING - OTHER**	0	() 0	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	4, 065	C	4, 065	0	4, 065	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	C	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION**	0	C	0	0	0	39. 00
40.00	I MAGING SERVI CES**	0	C	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	C	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	o	C	o	0	0	42.00
43.00	OUTPATIENT SERVICES**		(0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY**	ا			0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0		o o	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0			0	0	46. 00
46.00		l ol)	U	U	40.00
	NONREI MBURSABLE COST CENTERS				ام	0	
60.00	BEREAVEMENT PROGRAM *	0	C	1	0	0	60.00
61. 00	VOLUNTEER PROGRAM *	0	C	ή "	0	0	61. 00
62. 00	FUNDRAI SI NG*	0	C	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	C	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	C	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	C	0	0	0	65.00
66.00	RESI DENTI AL CARE*	l ol	C	ol	ol	0	66.00
67. 00	ADVERTI SI NG*	أم	(ا ما	n	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	اً ما	r	ا م	n	0	68. 00
69. 00	THRIFT STORE*	ا	(0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*				٥	0	70. 00
70.00			(j j	S S	0	
	OTHER NONREIMBURSABLE (SPECIFY)*	11/ /40	20 725	1 44 37	O ₁		71.00
100.00	7 IUIAL	116, 640	29, 735	146, 375	0	146, 375	100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				2/22/2018 11	1:52 am
		AD ILICTMENTS	TOTAL (L E	Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
		6. 00	± col. 6) 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	CAP REL COSTS-BLDG & FIXT*		ol		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*				3. 00
4. 00	ADMINISTRATIVE & GENERAL*		10, 085		4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0		5. 00
6. 00	LAUNDRY & LINEN SERVICE*	0	ol		6. 00
7. 00	HOUSEKEEPI NG*	0	ol ol		7. 00
8. 00	DI ETARY*	0	51		8. 00
9. 00	NURSING ADMINISTRATION*	0	ol		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	ol		10.00
11.00	MEDICAL RECORDS*	0	ol ol		11.00
12.00	STAFF TRANSPORTATION*	0	17, 774		12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	0	11, 305		13.00
14.00	PHARMACY*	0	ol		14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	ol ol		15. 00
16.00	OTHER GENERAL SERVICE*	0	ol		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED**	0	0		25. 00
26.00	PHYSICIAN SERVICES**	0	0		26. 00
27.00	NURSE PRACTITIONER**	0	0		27. 00
28.00	REGI STERED NURSE**	0	72, 269		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	1, 077		30.00
31.00	OCCUPATI ONAL THERAPY**	0	0		31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32. 00
33.00	MEDICAL SOCIAL SERVICES**	0	24, 567		33. 00
34.00	SPIRITUAL COUNSELING**	0	-,		34. 00
35. 00	DI ETARY COUNSELI NG**	0	0		35. 00
36. 00	COUNSELING - OTHER**	0	0		36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	4, 065		37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0		38. 00
39. 00	PATI ENT TRANSPORTATION**	0	0		39. 00
40.00	I MAGI NG SERVI CES**	0	0		40. 00
41.00	LABS & DI AGNOSTI CS**	0	0		41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44. 00	PALLIATIVE CHEMOTHERAPY**	0	0		44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS		y U		46. 00
(0.00	BEREAVEMENT PROGRAM *				/ / 00
60. 00 61. 00	VOLUNTEER PROGRAM *	0	1		60.00
	FUNDRAI SI NG*		1		
62. 00 63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*				62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM*				64. 00
65. 00	OTHER PHYSICIAN SERVICES*				65.00
66. 00	RESIDENTIAL CARE*				66. 00
67. 00	ADVERTI SI NG*				67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*				68.00
69. 00	THRIFT STORE*				69. 00
70.00	NURSING FACILITY ROOM & BOARD*				70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)*		-		71.00
100.00			146, 375		100.00
	ofer the emplints in column 7 to Wket O.E. co		140, 373		1100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Hospi ce CCN: 15-1561 Peri od: Worksheet 0-2 From 10/01/2016 09/30/2017 Date/Time Prepared: To

2/22/2018 11:52 am

Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col . CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 0 26.00 0 26.00 NURSE PRACTITIONER 27.00 0 C 0 27.00 0 0 28.00 REGISTERED NURSE 69, 757 1,807 71, 564 71, 564 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 1,066 0 1,066 30.00 1,066 OCCUPATIONAL THERAPY 31.00 0 C 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 24, 327 24, 327 24, 327 33.00 SPIRITUAL COUNSELING 34.00 0 5, 131 5, 131 5, 131 34.00 35.00 DIETARY COUNSELING 35.00 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 4.025 4, 025 37.00 4.025 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 0 0 0 39.00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 LABS & DIAGNOSTICS 0 0 41.00 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 0 44.00 PALLIATIVE CHEMOTHERAPY 0 45.00 C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 Ω 46.00 100.00 TOTAL 104, 306 1,807 106, 113 106, 113 100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED				25. 00
26.00	PHYSI CI AN SERVI CES	0	0		26. 00
27.00	NURSE PRACTITIONER	0	0		27. 00
28.00	REGI STERED NURSE	0	71, 564		28. 00
29.00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	1, 066		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32. 00
33.00	MEDICAL SOCIAL SERVICES	0	24, 327		33. 00
34.00	SPIRITUAL COUNSELING	0	5, 131		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4, 025		37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38. 00
39.00	PATI ENT TRANSPORTATION	0	0		39. 00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	106, 113	10	00.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

INPATIENT CARE

Hospi ce CCN: 15-1561

1,047

From 10/01/2016 09/30/2017 Date/Time Prepared: To

1, 047 100. 00

2/22/2018 11:52 am Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 26.00 NURSE PRACTITIONER 0 27.00 0 27.00 0 28.00 REGISTERED NURSE 687 18 705 705 28.00 29.00 LPN/LVN 0 29.00 0 0 30.00 PHYSI CAL THERAPY 11 11 11 30.00 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 240 240 240 33.00 SPIRITUAL COUNSELING 34.00 51 0 51 51 34.00 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 40 37.00 37.00 40 0 40 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 39.00 I MAGING SERVICES 40.00 40.00 0 0 0 0 0 0 LABS & DIAGNOSTICS 0 41.00 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 44.00 PALLIATIVE CHEMOTHERAPY 45.00 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 C 0 0 0 46.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	705	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	11	30. 00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	240	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	51	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	40	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	1, 047	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

100.00 TOTAL

Health Financial Systems CAMERON MEMORI COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Peri od:	worksheet 0-5	
EXPENSES FOR ALLOCATION	Hospi ce CC		From 10/01/2016 To 09/30/2017	Date/Time Pre 2/22/2018 11:	pared: 52 am
			Hospi ce I	2, 22, 2010 111	
Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
		EXPENSES (see		(sum of cols.	
		instructions)		1 + 2)	
			WKST B PART I		
			(see		
		1.00	instructions)	2.00	
CENEDAL CEDVICE COST CENTEDS		1.00	2. 00	3. 00	
GENERAL SERVI CE COST CENTERS 1.00 CAP REL COSTS-BLDG & FLXT			0 0	0	1.00
2.00 CAP REL COSTS-BLDG & FTXT		1	0 8, 149	1	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT			0 35, 111	35, 111	3.00
4.00 ADMINISTRATIVE & GENERAL		10, 08			4.00
5.00 PLANT OPERATION & MAINTENANCE		1	0 11, 593		5.00
6.00 LAUNDRY & LINEN SERVICE			0 11, 373	11, 343	6.00
7. 00 HOUSEKEEPI NG		1	0 0	0	7.00
8. 00 DI ETARY		5	-	51	8.00
9. 00 NURSING ADMINISTRATION		•	0	0	9.00
10. 00 ROUTI NE MEDI CAL SUPPLI ES		1	0 328		
11. 00 MEDI CAL RECORDS		1	0 0	0	11.00
12. 00 STAFF TRANSPORTATION		17, 77	-	17, 774	12. 00
13. 00 VOLUNTEER SERVI CE COORDI NATI ON		11, 30		11, 305	•
14. 00 PHARMACY			0	0	14.00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES			o	0	15. 00
16. 00 OTHER GENERAL SERVICE			o o	·	16. 00
17. 00 PATIENT/RESIDENTIAL CARE SERVICES			0		17. 00
LEVEL OF CARE					
50. 00 HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE		106, 11	3	106, 113	51.00
52.00 HOSPICE INPATIENT RESPITE CARE			О	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE		1, 04	7	1, 047	53.00
NONREI MBURSABLE COST CENTERS					
60. 00 BEREAVEMENT PROGRAM			0	0	60.00
61. 00 VOLUNTEER PROGRAM			0	0	61.00
62. 00 FUNDRAI SI NG			0	0	62.00
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS		1	0	0	63. 00
64. 00 PALLIATIVE CARE PROGRAM		1	0	0	64. 00
65. 00 OTHER PHYSI CI AN SERVI CES		•	0	0	65. 00
66. 00 RESI DENTI AL CARE		l .	0	0	66.00
67. 00 ADVERTI SI NG		1	0	0	67.00
68 OO TIELEHENTIH/TELEMONITOPING		1	f 11		

68. 00

69. 00 70. 00 0 0

71.00 0

99. 00

255, 638 100. 00

109, 263

146, 375

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71. 00 OTHER NONREIMBURSABLE (SPECIFY)
99. 00 NEGATIVE COST CENTER

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC	CE GENERAL SERVICE COSTS Provider CCN	V: 15-1315 Peri od: W	Worksheet 0-6

Hospice CCN: 15-1561 From 10/01/2016 Part I Date/Time Prepared: 2/22/2018 11:52 am

							2/22/2018 11:	52 am_
						Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL B	LDG &	CAP REL MVBL	E EMPLOYEE	SUBTOTAL	
			FIX		EQUI P	BENEFI TS		
						DEPARTMENT		
		0	1. 00		2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	0		0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	8, 149			8, 1	19		2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	35, 111		0		0 35, 111		3. 00
4. 00	ADMINISTRATIVE & GENERAL	64, 167		0		0 00,	64, 167	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	11, 593		0		0 0	11, 593	5. 00
6. 00	LAUNDRY & LINEN SERVICE	11,070		0			0	6. 00
7. 00	HOUSEKEEPI NG			0		0	Ö	7. 00
8. 00	DI ETARY	51		0		0	51	8.00
9. 00	NURSING ADMINISTRATION	31		0			0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	328		0		0	328	10.00
	MEDICAL RECORDS	320		0		0		•
11.00		17 774		0		0	0	11.00
12.00	STAFF TRANSPORTATION	17, 774		0		0	17, 774	12.00
13.00	VOLUNTEER SERVICE COORDINATION	11, 305		0		0	11, 305	13.00
14. 00	PHARMACY	0		0		0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0		0		0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0		0	0	17. 00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	106, 113				34, 769	140, 882	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0		0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 047		0	8, 1	19 342	9, 538	53.00
	NONREI MBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0 0	0	61. 00
62.00	FUNDRAI SI NG	0		0		0 0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o		0		0 0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	l ol		0		0 0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	o		0		0 0	o	65. 00
66. 00	RESI DENTI AL CARE	0		0		0 0	0	66. 00
67. 00	ADVERTI SI NG	أم		0		0 0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	أم		0		0 0	0	68. 00
69. 00	THRI FT STORE			0		0 0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			O			0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			Ω		0	0	71.00
99. 00	NEGATIVE COST CENTER			0				99. 00
	TOTAL	255, 638		0	8, 1	19 35, 111	255, 638	
100.00	TOTAL	255,050		U	0, 1	50, 111	255,050	1.00.00

			11000100		0 077 007 2017	2/22/2018 11:	52 am
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	64, 167					4. 00
5.00	PLANT OPERATION & MAINTENANCE	3, 885	15, 478	3			5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0) () i		6. 00
7.00	HOUSEKEEPI NG	0	0		o		7. 00
8.00	DI ETARY	17	0		o	68	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0		o		9.00
10.00	ROUTINE MEDICAL SUPPLIES	110	0		o		10.00
11. 00	MEDI CAL RECORDS	o	0		ol		11. 00
12. 00	STAFF TRANSPORTATION	5, 957	0		o		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	3, 789	0		o		13.00
14. 00	PHARMACY	0	0		o		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00		0	0		o		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		o		17. 00
	LEVEL OF CARE	1		•	-1		
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	47, 213					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0) (ol	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3, 196	15, 478	s c	ol	68	53.00
	NONREI MBURSABLE COST CENTERS	<u> </u>		•			1
60.00	BEREAVEMENT PROGRAM	0	0)	0		60.00
61. 00	VOLUNTEER PROGRAM	0	0		O		61.00
62. 00	FUNDRAI SI NG	0	0		O		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		o		64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66. 00	RESI DENTI AL CARE	0	0) (o	0	66. 00
67. 00	ADVERTI SI NG	0	0		O		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		O		68. 00
69.00	THRI FT STORE	0	0		0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0) (ol ol	0	71. 00
99. 00	NEGATIVE COST CENTER	0	0) (ol ol	0	99. 00
100.00	TOTAL	64, 167	15, 478	s c	o	68	100. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE COSTS	Provider CCN: 15-1315	Peri od: From 10/01/2016	Worksheet 0-6 Part I

Hospi ce CCN: 15-1561 To 09/30/2017 Date/Time Prepared: 2/22/2018 11:52 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI ON MEDI CAL RECORDS TRANSPORTATI ON SERVI CE COORDI NATI ON **SUPPLIES** 9. 00 11. 00 12.00 10.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 0 0 0 0 0 ROUTINE MEDICAL SUPPLIES 438 10.00 10.00 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 23, 731 12.00 VOLUNTEER SERVICE COORDINATION 15, 094 13.00 13.00 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 0 HOSPICE ROUTINE HOME CARE 0 51.00 435 23, 500 14, 947 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 52.00 0 0 53.00 HOSPICE GENERAL INPATIENT CARE 231 147 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 n 60.00 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 0 0 0 0 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 66.00 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 71.00 0 0 99.00 NEGATIVE COST CENTER 99.00 0 100.00 TOTAL 438 23, 731 15, 094 100. 00

			nospi ce coi	N. 13-1301 1	0 07/30/2017	2/22/2018 11:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14.00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMINI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10. 00
11.00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12. 00
13.00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY	o					14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0				15. 00
16.00	OTHER GENERAL SERVICE	ol		1 0			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE			•			1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	C)	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE	o	0	ol c		226, 977	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	0	ol c	0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	o	0	ol c	0	28, 661	53. 00
	NONREI MBURSABLE COST CENTERS						Ī
60.00	BEREAVEMENT PROGRAM	0		C)	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	61. 00
62.00	FUNDRAI SI NG	0				0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		[c		0	63. 00
64.00	PALLIATIVE CARE PROGRAM	O		[c		0	64. 00
65.00	OTHER PHYSICIAN SERVICES	O		[c		0	65. 00
66.00	RESI DENTI AL CARE	O	0	l c	0	0	66. 00
67.00	ADVERTI SI NG	O				0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	o		[c		0	68. 00
69. 00	THRI FT STORE	o		c		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0) c	0	0	71. 00
99. 00	NEGATI VE COST CENTER	o	0) c	0	0	99. 00
100.00	TOTAL	o	0	c	0	255, 638	100.00

Health Financ	ial Systems		CAMERO	ON MEMORIAL	COMMUNI TY		In Lie	u of Form CMS-2552-	10
COST ALLOCAT STATI STI CAL I	ON - HOSPITAL-BASED HOSPICE BASIS	GENERAL S	SERVI CE	COSTS	Provi der Hospi ce (15-1315 15-1561	10/01/2016	Worksheet 0-6 Part II Date/Time Prepared 2/22/2018 11:52 am	

			Hospi ce CCN	: 15-1561 T	09/30/2017	Date/Time Pre 2/22/2018 11:	
					Hospi ce I	272272010 111	<u> </u>
	Cost Center Descriptions	CAP REL BLDG & CA FIX (SQUARE FEET) (D	EQUI P	BENEFITS DEPARTMENT (GROSS	RECONCI LI ATI ON	ADMI NI STRATI VE & GENERAL (ACCUMULATED COSTS)	
		1.00	2. 00	SALARI ES) 3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	44	4.00	
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		301				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	34, 091			3. 00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-64, 167	191, 471	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	11, 593	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	51	8. 00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	328	1
11. 00	MEDI CAL RECORDS	0	0	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION	0	0	0	0	17, 774	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	11, 305	13. 00
14. 00	PHARMACY	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0	0	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	
51. 00	HOSPI CE ROUTI NE HOME CARE		_	33, 759	0	140, 882	1
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	301	332	0	9, 538	53. 00
(0.00	NONREI MBURSABLE COST CENTERS		ما		ام		,,,,,,,
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62. 00 63. 00	FUNDRAL SI NG		0	0	U	0	62.00
64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM		0	0	U O	0	63. 00 64. 00
65. 00	OTHER PHYSICIAN SERVICES		0	0	U O	0	65.00
66. 00	RESI DENTI AL CARE		0	0	U O	0	66.00
67. 00	ADVERTISING		0	0	O O	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	0	O O	0	68. 00
69. 00	THRIFT STORE		0	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		o o	U	0	U	70.00
	OTHER NONREIMBURSABLE (SPECIFY)		0	Ō	0	0	1
99. 00	NEGATIVE COST CENTER		4	U	٩	U	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		8, 149	35, 111		64 167	100.00
	UNIT COST MULTIPLIER	0. 000000	27. 073090	1. 029920		0. 335126	
101.00	John . SSST MOETTIETEN	3. 000000	27.07070	1.02//20	ļ	0. 000120	1.01.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	 From 10/01/2016 To 09/30/2017	Worksheet 0-6 Part II Date/Time Prepared: 2/22/2018 11:52 am
			Hospi co I	

STATISTICAL BASIS			Hospi ce CCI	Hospi ce CCN: 15-1561 T		Date/Time Prepared: 2/22/2018 11:52 am	
					Hospi ce I	2/22/2010 11.	52 diii
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	
		5. 00	6. 00	7. 00	8. 00	HRS.) 9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	301 0 0 0 0 0 0 0 0 0 0	0		13 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
50. 00 51. 00 52. 00 53. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0 301	0	l .	0 0 13	0 0 0	50. 00 51. 00 52. 00 53. 00
100.0	VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0. 000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 99. 00 100. 00 101. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNI	ΤΥ	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS Provide Hospice	er CCN: 15-1315 e CCN: 15-1561	Peri od: From 10/01/2016 To 09/30/2017	Worksheet 0-6 Part II Date/Time Prepared: 2/22/2018 11:52 am

SIAIIS	TITCAL BASIS		Hospi ce CCI	N: 15-1561	To 09/30/2017	Date/Time Pre 2/22/2018 11:	
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	Hospi ce I VOLUNTEER	PHARMACY	<u> </u>
	cost center bescriptions	MEDI CAL	RECORDS	TRANSPORTATIO	N SERVI CE	(CHARGES)	
			(PATIENT DAYS)	(MILEACE)	COORDI NATI ON (HOURS OF		
		(PATIENT DAYS)		(MI LEAGE)	SERVICE)		
		10.00	11. 00	12. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	CAP REL COSTS-BLDG & FLXT					ı	1.00
2.00	CAP REL COSTS-MVBLE EQUIP					ı	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					i	3. 00
4. 00 5. 00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE					i	4. 00 5. 00
6. 00	LAUNDRY & LINEN SERVICE					i	6.00
7. 00	HOUSEKEEPI NG					ı	7. 00
8. 00	DI ETARY					i	8.00
9. 00	NURSING ADMINISTRATION					i	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2, 098				i	10.00
11. 00	MEDI CAL RECORDS	, , , ,	0			i	11. 00
12.00	STAFF TRANSPORTATION			25, 47	8	ı	12. 00
13.00	VOLUNTEER SERVICE COORDINATION				0 16, 206	i	13.00
14.00	PHARMACY				o o	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15. 00
16. 00	OTHER GENERAL SERVICE				0 0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	
51.00	HOSPICE ROUTINE HOME CARE	2, 085	0	,	1	0	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	13	0	24	8 158	0	53. 00
60. 00	BEREAVEMENT PROGRAM				ol ol	0	60.00
61. 00	VOLUNTEER PROGRAM			i .	0	0	
62. 00	FUNDRAI SI NG				0	Ö	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				o o	0	1
64. 00	PALLIATIVE CARE PROGRAM				0	0	
65.00	OTHER PHYSICIAN SERVICES				o o	0	65. 00
66.00	RESI DENTI AL CARE				0 0	0	66. 00
67.00	ADVERTI SI NG				0 0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG				0 0	0	
69. 00	THRI FT STORE				0	0	
70. 00	NURSING FACILITY ROOM & BOARD					ı	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	0	
99.00	NEGATIVE COST CENTER	400	^	20.70	1 15 004		99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	438	0.00000	23, 73			100.00
101.00	UNIT COST MULTIPLIER	0. 208770	0. 000000	0. 93143	1 0. 931383	0. 000000	1101.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: 1 Hospice CCN:	From 10/01/2016 To 09/30/2017	Worksheet 0-6 Part II Date/Time Prepared: 2/22/2018 11:52 am

						2/22/2018 11:	52 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	'	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		,	,	DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
							1
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMINI STRATI ON						9.00
10. 00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16.00	OTHER GENERAL SERVICE		0				16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			C)		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0)			50. 00
51.00	HOSPICE ROUTINE HOME CARE	0	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	l o	ol c			52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	Ó	ol c			53.00
	NONREI MBURSABLE COST CENTERS			•	•		
60.00	BEREAVEMENT PROGRAM		0				7 60. 00
61. 00	VOLUNTEER PROGRAM		O				61.00
	FUNDRAI SI NG		Ó				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		Ó				63.00
	PALLIATIVE CARE PROGRAM		0				64. 00
65. 00	OTHER PHYSICIAN SERVICES		Ö				65. 00
66. 00	RESI DENTI AL CARE	0	Ö	ó			66.00
67. 00	ADVERTI SI NG		Ö				67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG						68. 00
	THRI FT STORE						69.00
	NURSING FACILITY ROOM & BOARD	1	١	Ί			70.00
			0				1
	OTHER NONREIMBURSABLE (SPECIFY)	0		ή	'		71. 00
	NEGATIVE COST CENTER		_				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0 000000	0 00000	0 000000			100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.000000	Y .		101. 00

Health Financial Systems		CAMERON MEMORIAL	_	COMMUNI TY		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVLEVEL OF CARE		RVICE COSTS BY	Provi der Co	CN: 15-1315	Peri od:	Worksheet 0-7	7		
			Hospi ce CCI	N: 15-1561	From 10/01/2016 To 09/30/2017				
					Hospi ce I				
				Charges by LOC (from Provider Records)					
	Cost Center Descriptions	From Wkst. C, Co	ost to Chargo	HCHC	HRHC	HI RC			
	cost center bescriptions	Part I. Col. 9	Ratio	TICHE	TIKHO	HIKC			
		line	Ratio						
		0	1.00	2.00	3. 00	4. 00			
	ANCILLARY SERVICE COST CENTERS				<u> </u>	•			
1.00	PHYSI CAL THERAPY	66. 00	0. 551420		0 0	0			
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. 404927		0	0	1		
5. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5.00		
6. 00	LABORATORY	60. 00	0. 357755		0	0	1		
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 264205		0	0	, , , , ,		
3. 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	3. 569942		0 0	0			
10. 01	ONCOLOGY	76. 01	0. 417259		0 0	0	1		
11. 00	Totals (sum of lines 1-11)						11.00		
		Charges by LOC		Shared Serv	ice Costs by LOC				
		(from Provider							
	Cost Center Descriptions	Records) HGIP	CHC (col 1 v	UDUC (col 1	xHIRC (col. 1 x	UCLD (col. 1 v	,		
	cost center bescriptions	ndi P	col. 2)	col. 3)	col. 4)	col. 5)	·		
		5. 00	6.00	7.00	8.00	9.00			
	ANCILLARY SERVICE COST CENTERS								
1. 00	PHYSI CAL THERAPY	0	0		0 0	0	1.00		
2. 00	OCCUPATI ONAL THERAPY						2.00		
3.00	SPEECH PATHOLOGY						3.00		
4. 00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00		
5. 00	DURABLE MEDICAL EQUIP-RENTED						5. 00		
5. 00	LABORATORY	0	0		0 0	0	6.00		
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	7.00		
8. 00	OTHER OUTPATIENT SERVICE COST CENTER						8. 00		
	DADLOLOGY THEDADELITIO	1		I		1	1 ~ ~		

9. 00 RADI OLOGY-THERAPEUTI C 10. 00 CHEMI CAL DEPENDENCY 10. 01 ONCOLOGY

11.00 Totals (sum of lines 1-11)

Health Financial Systems	CAMERON MEMORIAL	N MEMORIAL COMMUNITY			In Lieu of Form CMS-2552-10		
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Ī	Provider CCN:	15-1315	Peri od: From 10/01/2016	Worksheet 0-8		
		Hospi ce CCN:	15-1561		Date/Time Prepared:		

		nospi ce con	. 10 1001	077 007 2017	2/22/2018 11:	
				Hospi ce I		
	· · · · · · · · · · · · · · · · · · ·		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)		0	0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			226, 977	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				2, 085	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				108. 86	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	1, 320	150		9. 00
10.00	Program cost (line 8 times line 9)		143, 695	16, 329		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7, col. 8,			0	11. 00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	12.00
13. 00	Total average cost per diem (line 11 divided by line 12)				0. 00	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	0	0		14.00
15. 00	Program cost (line 13 times line 14)		0	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			28, 661	16. 00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				13	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				2, 204. 69	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	0	0		19. 00
20. 00	Program cost (line 18 times line 19)		0	0		20. 00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				255, 638	
22. 00						22. 00
23. 00	Average cost per diem (line 21 divided by line 22)				121. 85	23. 00