## PART II - CERTIFICATION

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY (15-1315) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	299, 899	413, 346	0	-129, 820	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	73, 017	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	372, 916	413, 346	0	-129, 820	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.

	In-State	in-state	Out-or	Out-or	wear car a	Uther	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	paid days	eligible			
		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	0	0	0	0	0	0	24. 00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	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.							
-	:	•	•	•	•	•	·

	Financial Systems CAMERON AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL COMMUNITY Provider CC		eriod: rom 10/01/2	015		et S-2 me Pre	pared:
			·		Urban/Rura	I S	Date of 2.0		
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ige) sta "2" fo	atus at the end or rural. If ap	of the cost	1.00	2	2. 0	0	26. 00 27. 00
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		C	)		35. 00
	jornout in the cost roporting porroa.				Begi nni ng	g:	Endi ı		
36. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1. 00		2.0	0	36. 00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	S.	•			C	)		37. 00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37. 01
	<pre>instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.</pre>								38. 00
					Y/N		Y/I		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ent∈ µui remer	er in column 1 nts in accordan	"Y" for yes ce with 42	1. 00 N		2. 0 N		39. 00
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	adjust er 1. [	tment? Enter "Y Enter "Y" for y	" for yes or	N	V	N	VIV	40.00
						1. 0		XI X 3. 00	
45.00	Prospective Payment System (PPS)-Capital  Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	it for (	di sproporti onat	e share in acc	cordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete WkstPt. III.	. L, P1	t. III and Wkst	. L-1, Pt. I t	hrough	N	N	N	46. 00
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment Teaching Hospitals				10.	N N	N N	N N	47. 00 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.  If line 56 is yes, is this the first cost reporting p  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  "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th ", comp	r "N" for no in nis cost report olete Worksheet	column 1. If ing period? E	column 1 Enter "Y"				57. 00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer	nt for physicia	ns' services a	ıs	N			58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N			59. 00
60. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				ctions)	N			60.00
		Y/N	I ME	Direct GME	IME		Di rect	GME	
		1.00	2. 00	3. 00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00		0.00	61.00
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00					61. 01
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0.00					61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	0.00					61. 03
	<pre>instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).</pre>		0. 00	0.00					61. 04
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00					61.05

	ncial Systems			AL COMMUNITY			u of Form CMS-2	
HOSPITAL ANI	D HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ιΤΑ	Provi der CC		eriod: rom 10/01/2015 o 09/30/2016	Worksheet S-2 Part I Date/Time Pre 2/22/2017 4:50	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
(1 0) Fatara			1. 00	2. 00	3. 00	4. 00	5. 00	(1.0(
used	the amount of ACA §5503 aw for cap relief and/or FTEs or general surgery. (see in	that are nonprimary		0.00	0.00	}		61. 06
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2. 00	3.00	4.00	
speci for e colum progr unwei	he FTEs in line 61.05, specialty, if any, and the numbe each new program. (see instraint 1, the program name, enter am code, enter in column 3, ghted count and enter in connweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61. 10
progr resi d i nstr enter 3, th	ne FTEs in line 61.05, speci cam specialty, if any, and t dents for each expanded prog- cuctions) Enter in column 1, in column 2, the program c de IME FTE unweighted count crect GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61. 20
							1.00	
ACA P	Provisions Affecting the Hea	Ith Resources and Sei	rvi ces i	Administration	(HRSA)		11.00	
	the number of FTE resident			in this cost	reporting peri	od for which	0.00	62. 00
62.01 Enter durin	hospital received HRSA PCRE the number of FTE resident g in this cost reporting pe ling Hospitals that Claim Re	s that rotated from a riod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0.00	62. 01
63.00 Has y	our facility trained reside for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		period? Enter	N	63. 00
					Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1. 00	2.00	3.00	
Secti	on 5504 of the ACA Base Yea	r FTE Residents in No	onprovi	der Settings				
64.00 Enter in th resid setti resid	ed that begins on or after Join column 1, if line 63 is the base year period, the number to root the first attributable to root ongs. Enter in column 2 the lent FTEs that trained in you column 1 divided by (column	uly 1, 2009 and before yes, or your facilite ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	re June ty train n-priman all non d non-pn n column	30, 2010.  ned residents ry care nprovider rimary care n 3 the ratio	0.00			64. 00
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	Si te 3. 00	4.00	5. 00	
is ye train year assoc FTEs progr resid the p colum unwei resid rotat non-p colum unwei resid your 5, th	rin column 1, if line 63 is, or your facility led residents in the base period, the program name liated with primary care for each primary care for each primary care am in which you trained lents. Enter in column 2, program code, enter in an 3, the number of ghted primary care FTE lents attributable to ions occurring in all provider settings. Enter in an 4, the number of ghted primary care lent FTEs that trained in hospital. Enter in column her atio of (column 3 led by (column 3 + column (see instructions)				0.00	0.00	0. 000000	65. 00

	AL COMMUNITY			Li eu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		eriod: rom 10/01/2 o 09/30/2		Worksheet S- Part I Date/Time Pr	epared:
			V		2/22/2017 4: XI X	50 pm
95.00 If line 94 is "Y", enter the reduction percentage in the ap	nlicable colum	2	1. 00 0. 00		2. 00 0. 00	95, 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.	s or "N" for n	o in the	N		N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colum	<u>1.</u>	0.00		0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C 106.00 of this facility qualifies as a CAH, has it elected the all		nod of payment	Y N			105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	N			107. 00
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N			108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respiratory 4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N		Υ Υ	109. 00
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	OA Demo)for		N	110. 00
				1. 00	2.00 3.00	
Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 int for long te	is "E", enter i rm care (includ	n column des	N	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y"				N		116. 00
117.00 ls this facility legally-required to carry malpractice insu no.  118.00 ls the malpractice insurance a claims-made or occurrence po		,		Y 1		117. 00
claim-made. Enter 2 if the policy is occurrence.		. ,				110.00
		Premi ums	Losses		Insurance	
		1.00	2.00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		207, 234		0		0 118. 01
			1. 00		2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.	center other dule listing c	than the ost centers	N			118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y ualifies for t	' for yes or ne Outpatient	N		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl	antable device	s charged to	Y			121. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t	Enter "Y" for	yes or "N"	Y			121. 00 122. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.	Enter "Y" for	yes or "N"				
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes or "N" for no.	Enter "Y" for he Worksheet A	yes or "N" line number				
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter the contact of th	Enter "Y" for he Worksheet A for yes and "N" nter the certi	yes or "N" line number	N			122. 00
Enter in column 2, "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column	Enter "Y" for he Worksheet A for yes and "N" nter the certi-	yes or "N" line number  for no. If	N			122. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	Enter "Y" for he Worksheet A for yes and "N" nter the certif 2. ter the certif 2.	yes or "N" line number  for no. If fication date cation date	N			122. 00 125. 00 126. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	Enter "Y" for he Worksheet A  for yes and "N"  nter the certification of	yes or "N" line number  for no. If fication date cation date	N			122. 00 125. 00 126. 00 127. 00 128. 00
Enter in column 2, "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified lung transplant center, enter certified lung transplant center certified lung transplant center certified lung transplant center certified lung transplant	Enter "Y" for he Worksheet A for yes and "N" nter the certif 2. ter the certif 2. ter the certif 2. er the certific	yes or "N" line number  for no. If fication date cation date cation date	N			122. 00 125. 00 126. 00 127. 00 128. 00 129. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.	Enter "Y" for he Worksheet A  for yes and "N"  nter the certification of	yes or "N" line number  for no. If fication date cation date cation date cation date titification	N			122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.	Tenter "Y" for he Worksheet A  or yes and "N"  nter the certification of	yes or "N" line number  for no. If fication date cation date cation date cation date in tification ertification	N			122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	CAMERON MEMORIA X IDENTIFICATION DATA	Provider CCN	l: 15-1315			u of Form CMS Worksheet S- Part I Date/Time Pr	2 repared:
						2/22/2017 4:	50 pm
					1. 00	2. 00	_
33.00 If this is a Medicare certified of	her transplant center, ent	ter the certific	ation dat	е			133. 00
in column 1 and termination date,							
34.00 If this is an organ procurement or		ne OPO number ir	n column 1				134. 00
and termination date, if applicabl	e, in column 2.						
40.00 Are there any related organization	or home office costs as o	defined in CMS F	Pub. 15-1.		Υ		140. 00
chapter 10? Enter "Y" for yes or '				ts	•		1.10.0
are claimed, enter in column 2 the							
1. 00	2.00				3. 00		
If this facility is part of a chair				name an	d address	of the	
home office and enter the home off 41.00 Name:	Contractor name and co	ontractor number		ctor's Nu	mber:		141. 0
42. 00 Street:	PO Box:		Contra	5 toi 5 ive	illiber.		142. 0
43. 00 Ci ty:	State:		Zip Cod	de:			143. 0
	·						
						1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet A	۱?				Y	144. 0
					1. 00	2.00	_
45.00 f costs for renal services are cl	aimed on Wkst A line 74	are the costs	for		N N	2.00	145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in clude Medicare utilization	column 1. If co	olumn 1 is		IV		143.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	n column 1. (See CMS Pub. 1			lf	N		146. 0
						1.00	-
47.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for r	10.			N	147. 0
48.00 Was there a change in the order of						N	148. 00
49.00 Was there a change to the simplifi	ed cost finding method? Er					N	149. 0
	•	Part A	Part B		itle V	Title XIX	_
Does this facility contain a provi	der that qualifies for an	1.00	2.00	cation o	3.00 f the Lowe	4.00	
or charges? Enter "Y" for yes or '							
55. 00 Hospi tal	•	N	N		N	N	<u> </u>
56.00 Subprovider - IPF		N	N		N	N	156. 0
57. 00 Subprovi der – IRF		N	N		N	N	157. 0
58. OO SUBPROVI DER 59. OO SNF		N	N		N	N	158. 0 159. 0
60.00HOME HEALTH AGENCY		N N	N N		N	N N	160. 0
61. OO CMHC		14	N		N	N	161. 0
011 00 0mm							10110
						1. 00	
Multicampus							
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	county		ferent CE Zip Code	BSAs?  CBSA	N FTE/Campus	165. 0
	0	1. 00	2.00	3.00	4. 00	5. 00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (	00 166. 0
						1 00	
Health Information Technology (HI	() incentive in the America	an Recovery and	Rei nvestm	ent Act		1. 00	
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	under §1886(n)? Enter "Y O5 is "Y") and is a meaning	/" for yes or "N gful user (line	l" for no.		- the	N	167. 0 0168. 0
reasonable cost incurred for the H 68.01 If this provider is a CAH and is r			qualify f	nr a har	ishi n	Y	168. 0
exception under §413.70(a)(6)(ii)?					asiii p	'	100.0
69.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y") and				enter the	0.0	00169.0

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	OSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Per					
			From 10/01/2015			
			To 09/30/2016	Date/Time Pre 2/22/2017 4:5	pared: O pm	
			Begi nni ng	Endi ng		
			1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170. 00			
			1. 00	2. 00		
171.00 If line 167 is "Y", does this provide	r have any days for indiv	iduals enrolled in	N	C	171. 00	
section 1876 Medicare cost plans repo						
"Y" for yes and "N" for no in column	<ol> <li>If column 1 is yes, er</li> </ol>	nter the number of sectio	n			
1876 Medicare days in column 2. (see	instructions)					

Heal th	Financial Systems CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Period: From 10/01/2015	Worksheet S-2	
				Го 09/30/2016		
				Y/N	Date 0.1	) piii
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format.	l for all NO re	esponses. Enter	all dates in t	the	
	COMPLETED BY ALL HOSPITALS					
4 00	Provider Organization and Operation			T N	l	1 00
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1. 00
	1. specific grant and the same containing the	_ (	Y/N	Date	V/I	
2.00	The the good dee to be a set of set of the first to the f	22 1.5	1.00 N	2. 00	3. 00	2, 00
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		IN			2.00
3.00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	ng management	Y			3. 00
	contracts, with individuals or entities (e.g., chain home of	offices, drug				
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		) / (D)	-	5 .	
			1. 00	7ype 2. 00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	
4.00	Column 1: Were the financial statements prepared by a Cert	tified Public	Y	А		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differentiations.		N			5. 00
	Those of the fired inflancial statements? If yes, submit fed	CONCLETE A LEON.		Y/N	Legal Oper.	
				1. 00	2.00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If was is th	ne provider is	N		6. 00
0.00	the legal operator of the program?	11 yes, 13 ti	ic provider 13			0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	auring the	N		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 of		ho current	N		10.00
10.00	cost reporting period? If yes, see instructions.	or renewed in t	The Current	IN.		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
40.00	Bad Debts					10.00
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection;			st reporting	Y N	12. 00 13. 00
	period? If yes, submit copy.	3	Ü			
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see inst	ructi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instr	ructi ons.	N	15. 00
			t A		t B	
		1. 00	2. 00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	01/04/2017	Y	01/04/2017	16. 00
	date of the PS&R Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	leither column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	,	1	1	1	•	1

Heal th	Financial Systems CAMERON MEMORI.	AL COMMUNITY		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S- Part II Date/Time Pr 2/22/2017 4:	epared:
		Descri	pti on	Y/N	Y/N	JU PIII
			)	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. 00
		Y/N	Date 2.00	Y/N 3.00	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21. 00
21.00	records? If yes, see instructions.	IV.				21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
00.00	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see		ala mada dum	ing the cost	N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	• • •		N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	Υ	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	Υ	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into dur	ing the cost	reporting	Υ	28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		bt Service R	eserve Fund)	Υ	29. 00
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi ces furni she	d through co	ntractual	Y	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	•		Υ	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	Υ	35. 00
	physicians during the cost reporting period? If yes, see in	ISTI UCTI OIIS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off					38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.			
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compon	ents? IT yes	,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1	00	2.0	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH		41. 00
42. 00	Enter the employer/company name of the cost report	BLUE & CO				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEANI	OCO. COM	43. 00

Heal th	Financial Systems CAMERON M	EMORI A	MORIAL COMMUNITY In Lieu of Form (				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Ξ	Provider CCN: 15-1315		riod: om 10/01/2015 09/30/2016		pared:
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	ı S	ENIOR MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and	3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42. 00
	preparer.						
43.00	Enter the telephone number and email address of the co	st					43.00
	report preparer in columns 1 and 2, respectively.						

						10 077 307 2010	2/22/2017 4:5	
							I/P Days / 0/P	<u>Б</u>
							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, 41	8 76, 680. 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, 41	76, 680. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		2	73	2 5, 136. 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)							12.00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			25	9, 15	0 81, 816. 00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24.00	HOSPI CE	116. 00		0		0		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0		0		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)						1	
33. 00	LTCH non-covered days						1	33. 00

 Heal th Financial
 Systems
 CAMERON

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared:

				1	0 09/30/2016	2/22/2017 4:5	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7.00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 185	59	3, 195			1.00
2.00	HMO and other (see instructions)	586	330				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	287	0	296			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	240			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 472	59	3, 731			7. 00
8. 00	INTENSIVE CARE UNIT	69	37	214			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		0	434			13.00
14. 00	Total (see instructions)	1, 541	96	4, 379		350. 62	
15. 00	CAH visits	1, 341	70	4, 3/7	0.00	350.02	15.00
16. 00	SUBPROVIDER - IPF	U	o o	0			16.00
17. 00	SUBPROVIDER - IPF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00							20.00
	OTHER LONG TERM CARE	1, 699	1 222	6, 079	0.00	0.00	
22. 00	HOME HEALTH AGENCY	1, 699	1, 223	6, 079	0. 00	9. 28	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0.00	2.2/	23. 00
24. 00	HOSPI CE	0	0	0	0. 00	2. 26	
24. 10	HOSPICE (non-distinct part)	U	0	Ü			24. 10
25. 00	CMHC - CMHC	0	0	0	0.00	0.00	25. 00
26. 00	RURAL HEALTH CLINIC	0	0	0		0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27. 00	Total (sum of lines 14-26)				0. 00	362. 16	
28. 00	Observation Bed Days		144	1, 124			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33.00

					To	09/30/2016	Date/Time Prep 2/22/2017 4:50	
		Full Time			Di sch	arges	272272017 1.00	р п
		Equi val ents						
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers		_			Pati ents	
		11. 00	12. 00		13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	492	30	1, 344	1. 00
2. 00 3. 00 4. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				225	148 0 0		2. 00 3. 00 4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)							6. 00 7. 00
8. 00 9. 00	INTENSIVE CARE UNIT							8. 00 9. 00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)	0. 00		0	492	30	1, 344	14.00
15. 00	CAH visits							15. 00
16.00	SUBPROVIDER - I PF							16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER							17. 00 18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	0. 00						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00						23. 00
24. 00	HOSPI CE	0. 00						24. 00
24. 10	HOSPICE (non-distinct part)	0.00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	0. 00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
	Total (sum of lines 14-26)	0. 00						27. 00
28. 00	Observation Bed Days	0.00						28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)	}						30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							•
33. 00	LTCH non-covered days							33. 00

Heal th	Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-1315 CCN: 15-7117	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-4 Date/Time Pre	pared:
					Home Health	2/22/2017 4: 5 PPS	U pm
					Agency I		
					1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours		0		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00	108.00	0. (	0.00	0. 00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal		Starr	Joint dot	10 tu	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00			0.00	3.00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			1. (		1. 04 3. 13	4. 00 5. 00
6. 00	Direct Nursing Service			3.		3. 77	6. 00
7.00	Nursi ng Supervi sor			0.0		0.00	
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. (		2. 22 0. 00	8. 00 9. 00
10.00	Occupational Therapy Service			0.		0. 41	10.00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. (		0. 00 0. 04	11. 00 12. 00
13.00	Speech Pathology Supervisor			0. (	0.00	0.00	1
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. (		0. 00 0. 00	1
16.00	Home Health Aide			1.	93 0.00	1. 93	16. 00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (			ł
10.00	HOME HEALTH AGENCY CBSA CODES			0.1	0.00	0.00	18.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			50031			20. 00
	contains the first code).						
20. 01		Full Ep	i sodes	99915			20. 01
			With Outliers	LUPA Epi sode	es PEP Only	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	413 72, 900	37 7, 193		80 2 69 389	532 95, 451	21. 00 22. 00
23. 00	Physical Therapy Visits	845	7, 193	I	9 5	95, 451 859	ı
24. 00	Physical Therapy Visit Charges	173, 470	0		_	176, 344	
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	155 30, 780	0	1	1 0 99 0	156 30, 979	
27. 00	Speech Pathology Visits	13	0	)	0 0	13	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	2, 582 21	0	1	0 0	2, 582 21	28. 00 29. 00
30. 00	Medical Social Service Visit Charges	4, 947	0		0 0	4, 947	30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	152 7, 989	0	1	3 0 58 0	155 8, 147	31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	1, 599	37	1	93 7	1, 736	
34. 00	29, and 31) Other Charges		0		0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	292, 668	7, 193	17, 1			1
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	104			31 1	136	36. 00
	outlier)	104			'	130	30.00
37.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	8, 829	1 734	2, 0.	0 23 0	1 11, 586	37.00
30.00	Trotal Mon-Routine Medical Supply Charges	0,029	734	·I 2, 0.	20	11,500	1 30.00

Hoal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		Inlic	u of Form CMS-2	2552 10
	AL-BASED HOSPICE IDENTIFICATION	DATA	CAMERON WEWORT	Provider C Hospice CC		Period: From 10/01/2015 To 09/30/2016	Worksheet S-9 PARTS I THROU	GH IV pared:
						Hospi ce I	2/22/2017 4.5	о рііі
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
1. 00 2. 00 3. 00 4. 00 5. 00	PART I - ENROLLMENT DAYS FOR CO Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days							1. 00 2. 00 3. 00 4. 00 5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			,
6. 00	Number of patients receiving hospice care							6. 00
7. 00	Total number of unduplicated Continuous Care hours billable to Medicare							7. 00
8. 00	Average Length of Stay (line 5 / line 6)							8. 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 cols. 1 through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,			
11. 00 12. 00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care			2, 938	1	0 0 55 140 1 0 0 0	0 3, 233 5	11. 00
	Total Hospice Days			2.949	1	0 56 140	3 245	14.00
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					14.00
15. 00	Hospice Inpatient Respite Care			0		0 0		15. 00
	Hospice General Inpatient Care			c	1	0 0		ı

∐oal +h	Financial Systems	CAMERON MEMORIAL	COMMUNITY		In Lie	u of Form CMS-2	2552 10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	CAMERON MEMORIAL	Provi der CO	N. 15 1215	Peri od:	Worksheet S-10	
позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	JN. 19-1319	From 10/01/2015 To 09/30/2016		pared:
						2,22,201, 110	<u> </u>
						1. 00	
	Uncompensated and indigent care cost comp	outati on					
1.00	Cost to charge ratio (Worksheet C, Part I	line 202 column 3 d	ivided by li	ne 202 column	1 8)	0. 424872	1.00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					960, 536	2.00
3.00	Did you receive DSH or supplemental payme	ents from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include a			from Medicaio	l?		4. 00
5.00	If line 4 is "no", then enter DSH or supp	olemental payments fr	om Medicaid			383, 039	5. 00
6.00	Medicaid charges					5, 874, 870	
7. 00	Medicaid cost (line 1 times line 6)					2, 496, 068	
8. 00	Difference between net revenue and costs	for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5; if	1, 152, 493	8. 00
	< zero then enter zero)	)	6	- \			
0.00	Children's Health Insurance Program (CHIP	(See Instructions	ror each iin	e)		0	0.00
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges					0	9. 00 10. 00
11. 00	Stand-alone CHIP cost (line 1 times line	10)				0	
12. 00	Difference between net revenue and costs		(Lino 11 mi	nus lino 0: i	f < zoro thon	0	
12.00	enter zero)	Tor Stand-arone Chir	(TITIE IT IIII	ilus IIIIe 7, I	i < Zero tileli	U	12.00
	Other state or local government indigent	care program (see in	structions f	or each line)			
13. 00	Net revenue from state or local indigent					0	13. 00
14. 00	Charges for patients covered under state	. 5 .			,	0	14.00
	10)	3	. 5 .				
15.00	State or local indigent care program cost	(line 1 times line	14)			0	15. 00
16. 00		for state or local i	ndigent care	program (lir	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)						
	Uncompensated care (see instructions for					_	
17. 00	3					0	
18. 00	Government grants, appropriations or tran				( 6.11	0	18. 00
19. 00		HIP and state and Loc	al indigent	care programs	s (sum of lines	1, 152, 493	19. 00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1.00	2. 00	3. 00	
20. 00	Charity care charges for the entire facil	ity (see instruction	s)	527, 4		604, 683	20. 00
21. 00				224, 08		256, 913	
22. 00			ĺ		0 0	0	22. 00
23.00	Cost of charity care (line 21 minus line	22)		224, 08	32, 829	256, 913	23. 00
						1.00	
24. 00	Does the amount in line 20 column 2 inclu			nd a Length o	of stay limit	N	24. 00
imposed on patients covered by Medicaid or other indigent care program?							
25. 00	If line 24 is "yes," charges for patient				th of stay limit	0	
26. 00						5, 266, 382	
27. 00				- 1: 27)		505, 806	
28. 00	Non-Medicare and non-reimbursable Medicar				20)	4, 760, 576	
29. 00 30. 00			xpense (IIne	i times iine	: 20)	2, 022, 635 2, 279, 548	
	Total unreimbursed and uncompensated care		line 30)			2, 279, 548 3, 432, 041	
31.00	Total uni erinbur seu anu uncompensateu care	cost (Title 17 prus	11116 30)			3, 432, 041	31.00

RECEASE FOR THE AND ADJUSTIMENTS OF TRIAL BALANCE O	I EN ENGES	Trovider co	F	rom 10/01/2015 o 09/30/2016		pared:
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	2/22/2017 4: 5 Reclassi fi ed	O pm
cost contest person		0 11101	+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2. 00	3.00	4. 00	<u>col. 4)</u> 5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT		5, 513, 317	5, 513, 317	-379, 166	5, 134, 151	1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		1, 664, 180			3, 666, 837	2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	5, 655, 092			5, 655, 092	4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	3, 484, 995 474, 765	5, 420, 984 2, 111, 673	8, 905, 979 2, 586, 438		9, 377, 881 2, 600, 408	5. 00 7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	474, 765	2, 111, 673 44, 482			2, 600, 406 44, 482	8.00
9. 00 00900 HOUSEKEEPI NG	644, 972	396, 194			1, 041, 166	9. 00
10. 00   01000   DI ETARY	425, 236	442, 139	867, 375	-765, 858	101, 517	10. 00
11. 00   01100   CAFETERI A	0	0	C	,	722, 030	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	644, 685	37, 811	682, 496		682, 496	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	176, 664 441, 705	55, 242 2, 031, 220	231, 906 2, 472, 925		231, 906 2, 472, 925	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	389, 441	317, 390			706, 831	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	221, 111	311, 313		-1		
30. 00 03000 ADULTS & PEDIATRICS	1, 945, 730	1, 756, 091	3, 701, 821	435, 998	4, 137, 819	30. 00
31. 00   03100   INTENSIVE CARE UNIT	0	0	C		200, 809	31.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	<u> </u>	70, 319	70, 319	43. 00
50. 00 05000 OPERATING ROOM	1, 653, 568	1, 195, 286	2, 848, 854	-674, 051	2, 174, 803	50. 00
51. 00   05100   RECOVERY   ROOM	0	0	2,010,001		674, 051	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	830, 565	58, 749	889, 314		172, 426	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 457, 927	408, 982	1, 866, 909		1, 866, 909	54.00
60. 00   06000   LABORATORY	898, 722	1, 679, 167	2, 577, 889	0	2, 577, 889	60.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	41 240	0 821, 788	0/2 127	177 170	(05.050	64.00
65. 00   06500   RESPI RATORY   THERAPY 65. 01   06501   SLEEP   LAB	41, 349	821, 788 N	863, 137	-177, 178 198, 631	685, 959 198, 631	65. 00 65. 01
66. 00 06600 PHYSI CAL THERAPY	697, 628	57, 191	754, 819		754, 819	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	326, 109			304, 656	69. 00
69. 01   06901   CARDI AC REHAB	67, 819	4, 143			71, 962	69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	1, 440, 002	1, 440, 002		1, 056, 015	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0	0		383, 987	383, 987 0	72. 00 73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	14, 211	17, 038	31, 249	0	31, 249	76.00
76. 01 03480 0NC0L0GY	0	1, 249, 834			1, 249, 834	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0	0	C		0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC	138, 142	0 24 101	144 222		144 222	89. 00 90. 00
91. 00   09100   EMERGENCY	1, 702, 354	26, 191 662, 138	164, 333 2, 364, 492		164, 333 2, 374, 254	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 702, 001	002, 100	2,001,172	7, 702	2,071,201	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	691, 381	83, 184	774, 565	-107, 587	666, 978	101. 00
SPECIAL PURPOSE COST CENTERS		1 540 041	1 540 041	-1, 540, 941	0	112 00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	o	1, 540, 941 0	1, 540, 941 C			113.00
116. 00 11600 HOSPI CE	119, 276	33, 706			152, 818	
118.00 SUBTOTALS (SUM OF LINES 1-117)	16, 941, 135	35, 050, 264			52, 408, 242	
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	00 515	141 040	12.070		194. 00
194. 01 07951 MOB 194. 02 07952 COMMUNI TY HEALTH	51, 353 72, 542	90, 515 12, 438			127, 898 84, 980	
194. 03 07953 ASSI STED LIVING/CAMERON WOODS	72, 342	12, 430	04, 700			194. 03
194. 04 07954 EDUCATI ON	66, 888	79, 564	146, 452	-108, 938	37, 514	
194. 05 07955 MARKETI NG	173, 313	493, 215	666, 528		490, 517	
194. 06 07956 GUEST MEALS	0	0	0	43, 828	43, 828	
194. 07 07957 OUTSI DE LAUNDRY	0	0		0		194. 07
194. 08 07958  CANCER CENTER 194. 09 07959  URGENT CARE	1, 195, 740	0 281, 312	1, 477, 052	-161, 752	1, 315, 300	194. 08 194. 09
200.00 TOTAL (SUM OF LINES 118-199)	18, 500, 971	36, 007, 308				
		, , , , , , , , , , , , , , , , , ,	, ., , ,	, 9	,, ,	

| Period: | Worksheet A | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: 2/22/2017 4:50 pm

				2/22/2017 4: 50	0 pm
	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	-638, 923		l e	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-178, 572			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-200, 767			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 794, 229			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	1,,		9. 00
10.00	01000 DI ETARY	-13, 482	1		10.00
11. 00	01100 CAFETERI A	-330, 442	•	1	11. 00
13. 00	01300 NURSING ADMINISTRATION	0			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	,		14. 00
15. 00	01500 PHARMACY	-90, 325			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-368	706, 463		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	-1, 044, 450			30. 00
31. 00	03100 INTENSIVE CARE UNIT	0			31.00
43. 00	04300 NURSERY	0	70, 319		43. 00
	ANCILLARY SERVICE COST CENTERS		,		
50. 00	05000 OPERATING ROOM	-562, 658	1		50. 00
51. 00	05100 RECOVERY ROOM	0	,	1	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-2, 688	1	1	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	.,,	1	54. 00
60. 00	06000 LABORATORY	-11, 056	1		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0		l l	65. 00
65. 01	06501 SLEEP LAB	0	198, 631	l e	65. 01
66. 00	06600 PHYSI CAL THERAPY	0			66. 00
69. 00	06900 ELECTROCARDI OLOGY	0		1	69. 00
69. 01	06901 CARDI AC REHAB	0	1		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	,		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0		1	76. 00
76. 01	03480 ONCOLOGY	0	1, 249, 834		76. 01
	OUTPATIENT SERVICE COST CENTERS	_	_		
88. 00	08800 RURAL HEALTH CLINIC	0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1		89. 00
90.00	09000 CLI NI C	0	1		90.00
91.00	09100 EMERGENCY	0	2, 374, 254		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
404 04	OTHER REIMBURSABLE COST CENTERS			, I	101 00
101.00	10100 HOME HEALTH AGENCY	0	666, 978	3	101. 00
112 00	SPECIAL PURPOSE COST CENTERS				1112 00
	11300 I NTEREST EXPENSE	0			113.00
	11400 UTILIZATION REVIEW-SNF	0			114. 00 116. 00
	11600 HOSPI CE	4 071 200		1	
118. 00	,	-4, 871, 260	47, 536, 982		118. 00
100.00	NONREIMBURSABLE COST CENTERS     19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN		1 0		100 00
	07950 DAYCARE-I NFANT/TODDLER				190.00
		0			194. 00
	107951 MOB	0	,		194. 01
	2 07952 COMMUNITY HEALTH 3 07953 ASSISTED LIVING/CAMERON WOODS	0			194. 02 194. 03
		_	1		
	107954 EDUCATION	0			194. 04
	5 07955 MARKETI NG		490, 517		194. 05 194. 06
	507956 GUEST MEALS		43, 828		194. 06
	7 07957  OUTSI DE LAUNDRY		0	l .	194. 07
	3 07958 CANCER CENTER 9 07959 URGENT CARE		1	1	194. 08
200.00		-4, 871, 260	1,,		200.00
∠∪∪. ∪(	PI TOTAL (SUM OF LINES 110-199)	-4,0/1,200	49, 637, 019	1	<sub> </sub> 200.00

Peri od: Worksheet A-6 From 10/01/2015 To 09/30/2016 Date/Time Prepared:

						2/22/2017 4:50
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	- LABOR AND DELIVERY					
	OULTS & PEDIATRICS	30.00	594, 739	42, 068		
	JRSERY	43.00	65, 674	4, 645		
D EM	MERGENCY	91.00	<u>9, 1</u> 17	645		
0			669, 530	47, 358		
В	- PROPERTY INSURANCE					
CA	AP REL COSTS-BLDG & FLXT	1.00	0	80, 027		
0			Ō	80, 027		
C	- CAFERTERI A					
CA	AFETERI A	11. 00	353, 980	368, 050		
) GU	JEST MEALS	194. 06	21, 487	22, 341		
0			375, 467	390, 391		
D	- INTEREST EXPENSE	<u>'</u>				
CA	AP REL COSTS-BLDG & FIXT	1.00	0	1, 502, 543		
	AP REL COSTS-MVBLE EQUIP	2.00	o	38, 398		
0		— — <del>—                                 </del>		1, 540, 941		
F	- DEPRECIATION EXPENSE			1,010,711		
	AP REL COSTS-MVBLE EQUIP	2.00	0	1, 964, 259		
0	<u> </u>		<del> </del> _	1, 964, 259		
F	- ICU	<u> </u>	<u> </u>	1, 704, 237		
	ITENSIVE CARE UNIT	31.00	105, 548	95, 261		
	TIENSTVE CAILE UNIT		105, 548	<del>95, 2</del> 61		
0	- ADVERTISING COST		103, 346	73, 201		
		F 00	27, 897	155 571		
AD	<u>DMI NI STRATI VE &amp; GENERAL</u>			15 <u>5, 5</u> 71		
0	DDODEDTY TAY		27, 897	155, 571		
H	- PROPERTY TAX	4 00		0. 500		
) CA	AP REL_COSTS-BLDG_&_FLXT	1.00	0	<u>2, 523</u>		
0	ERWALTI ON AGOTO		O	2, 523		
	- EDUCATION COSTS					
) AD	OMINISTRATIVE & GENERAL	5.00	6 <u>6, 8</u> 88	<u>42, 0</u> 50		
0			66, 888	42, 050		
	- SLEEP LAB	,				
	LEEP LAB	65. 01	0	198, 631		
)		0.00	0	0		
0			0	198, 631		
K	- UTILITIES					
) OP	PERATION_OF_PLANT	7. 00	0	13, 970		
0				13, 970		
L	- PUBLIC RELATIONS					
) MA	ARKETI NG	194. 05	0	7, 457		
0				7, 457		
М	- MSW					
) HO	DME HEALTH AGENCY	101.00	5, 514	0		
0	_ — — — — –		5, 514	0		
N	- RECOVERY ROOM	<u> </u>		- 1		
_	COVERY ROOM	51.00	674, 051	0		
0		<u> </u>	674, 051	<u>0</u>		
0	- IMPLANTABLE DEVICES		07.17.00.1			
	MPL. DEV. CHARGED TO	72. 00	o	383, 987		
	ATI ENTS	72.00	٩	303, 707		
10	<u> </u>	+		383, 987		
D	- HOME HEALTH	L	9	303, 707		
	OMINISTRATIVE & GENERAL	5.00	107, 751	0		
IAD	WI NI SI KATI VE & GENERAL			0		
0	LIDCENT CADE		107, 751	U		
	- URGENT CARE	F 001	1/4 750			
) AD	OMI NI STRATI VE & GENERAL	5.00	161, 752	<del>0</del>		
0	U0001 05 050: : : :		161, 752	0		
	- HOSPICE RECLASS					
) HO	OSPICE	116.00	<u>5, 3</u> 50	<u>0</u>		
	TALS		5, 350			
OO ICE	and Total: Increases		2, 199, 748	4, 922, 426		50

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1315

						2/22/2017 4	1:50 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - LABOR AND DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	669, 530	47, 358			1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	•	0	0		3. 00
	0		669, 530	47, 358			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8 <u>0, 0</u> 27			1. 00
	0		0	80, 027			
	C - CAFERTERIA						
1.00	DI ETARY	10.00	375, 467	390, 391	0		1.00
2.00		0.00	0	0			2.00
	0		375, 467	390, 391			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	1, 540, 941	11		1.00
2.00		0.00	0	0	11		2. 00
				1, 540, 941			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 964, 259	9		1.00
				1, 964, 259			
	F - ICU	<u> </u>	-				
1.00	ADULTS & PEDIATRICS	30.00	105, 548	95, 261	0		1.00
	0		105, 548	95, 261			
	G - ADVERTISING COST		1007010	707201			
1.00	MARKETING	194. 05	27, 897	155, 571	0		1.00
1.00	0			15 <u>5, 5</u> 71			1.00
	H - PROPERTY TAX		21,071	133, 371			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	2, 523	13		1.00
1.00	n delicitati			2, 523			1.00
	I - EDUCATION COSTS		<u> </u>	2, 523			
1. 00	EDUCATION COSTS	194. 04	66, 888	42, 050	0		1 1 00
1.00	DOCATION	194.04	66, 888	4 <u>2, 0</u> 50 42, 050			1. 00
	J - SLEEP LAB		00, 000	42, 030			
1 00	RESPIRATORY THERAPY	/F 00	ما	177 170	0		1 00
1.00		65.00	0	177, 178			1.00
2.00	ELECTROCARDI OLOGY	<u>69.</u> 00		2 <u>1, 4</u> 53			2. 00
	0		U	198, 631			
4 00	K - UTILITIES	404.04		40.070			
1.00	MOB	1 <u>94.</u> 01	0	13,970	0		1.00
	0		0	13, 970			
	L - PUBLIC RELATIONS	- aal			1		
1.00	ADMI NI STRATI VE & GENERAL		•		0		1. 00
	0		0	7, 457			
	M - MSW						
1.00	HOSPICE	116. 00	5, 514	0			1. 00
	0		5, 514	0			
	N - RECOVERY ROOM						
1.00	OPERATI NG ROOM	5000	67 <u>4, 0</u> 51	0	0		1. 00
	0		674, 051	0			
	O - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	383, 987	0		1.00
	PATI ENT						
	0		0	383, 987			
	P - HOME HEALTH						
1.00	HOME HEALTH AGENCY	101.00	107, 751	0	0		1.00
	0		107, 751				
	Q - URGENT CARE						
1.00	URGENT CARE	194. 09	161, 752	0	0		1.00
			161, 752				
	R - HOSPICE RECLASS		=	-			
1.00	HOME HEALTH AGENCY	101.00	5, 350	0	0		1.00
50	TOTALS		5, 350	<u>-</u>			1.50
500 00	Grand Total: Decreases		2, 199, 748	4, 922, 426			500.00
ວບບ. 00	orana rotar: Decreases		2, 199, /48	4, 922, 426			500

					rom 10/01/2015 o 09/30/2016		
				Acqui si ti ons		2,22,231, 113	<u>Б</u>
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
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	52, 431, 702	10, 439, 365	C	10, 439, 365	6, 265, 544	3. 00
4.00	Building Improvements	0	0	C	0	0	4. 00
5.00	Fixed Equipment	0	0	C	0	0	5. 00
6.00	Movable Equipment	15, 299, 796	1, 941, 311	C	1, 941, 311	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	69, 049, 366	12, 380, 676	C	12, 380, 676	6, 265, 544	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	69, 049, 366	12, 380, 676	C	12, 380, 676	6, 265, 544	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 317, 868	0				1.00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	56, 605, 523	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	17, 241, 107	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	75, 164, 498	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	75, 164, 498	0				10. 00

Heal th	Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 15-1315	Peri od:	Worksheet A-7	
					From 10/01/2015 To 09/30/2016	Part II   Date/Time Pre	narod:
					10 04/30/2010	2/22/2017 4:5	
	·		SU	IMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	5, 513, 317	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 513, 317	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5, 513, 317				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 664, 180	1, 664, 180				2. 00
0 00	T 1 1 ( C1: 4 0)		- 4 40-				

0 1, 664, 180 1, 664, 180

5, 513, 317 1, 664, 180 7, 177, 497

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	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 10/01/2015 To 09/30/2016	Worksheet A-7 Part III Date/Time Pre 2/22/2017 4:50	pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)	•		
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	56, 605, 523				0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	18, 558, 975		18, 558, 97		0	2. 00
3.00 Total (sum of lines 1-2)	75, 164, 498		75, 164, 49			3. 00
	ALLOCA <sup>2</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6.00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS O		1	0 2 510 507	0	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 3, 518, 597 0 1, 801, 237		1. 00 2. 00
3.00 Total (sum of lines 1-2)	0	0		0 1, 801, 237 0 5, 319, 834	0	3.00
3.00   Total (Suiii of Titles 1-2)	U	U CI	I JMMARY OF CAPI		U	3.00
		30	DIVINIART OF CAFT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DART III DECONOLILIATION OF CARLTAL COCTO OF	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	894, 081	90.027	2.52	2 0	4 40E 220	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	22, 848			0 0 1, 664, 180	4, 495, 228 3, 488, 265	2.00
3.00 Total (sum of lines 1-2)	916, 929					
3. 00   Total (Suill Of TITIES 1-2)	710, 929	1 00,027	1 2, 32	J <sub> </sub> 1,004,160	1, 703, 493	3.00

Peri od: Worksheet A-From 10/01/2015 Provider CCN: 15-1315

				T	o 09/30/2016		
				Expense Classification on	Worksheet A	2/22/2017 4:50	O pm
				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 -608_462	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-15, 550	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)	_					
6. 00	Rental of provider space by suppliers (chapter 8)	В	-12, 127	CAP REL COSTS-MVBLE EQUIP	2.00	9	6. 00
7. 00	Tel ephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 620, 852			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-365, 286			0	12. 00
12.00	transactions (chapter 10)		0		0.00	0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-310, 952	CAFETERI A	0. 00 11. 00		
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than	В	-90, 325	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-368	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19. 00
	books, etc.)		_				
20. 00 21. 00	Vending machines Income from imposition of	В	-15, 930 0	CAFETERI A	11. 00 0. 00	0	20. 00 21. 00
200	interest, finance or penalty		· ·		0.00		200
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00		29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	0	503t Genter Dereteu	07.00		30.00
30. 99	Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)	1					
31. 00	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	_	_26 140	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
	Depreciation and Interest	A					
33. 00 33. 01	LOBBYING EXPENSES EMPLOYEE CHRISTMAS PARTY	A A	-1, 629 -14 583	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 00 33. 01
	1 - LOTEL OTHER TRIVIT	1 0 1	14, 303	P.S. W. OTTOWN VE & GENERAL	3.00	<u> </u>	

					0 77 007 2010	2/22/2017 4:50	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33. 02	PHYSICIAN RECRUITMENT	A	-159, 520	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	MEALS ON WHEELS	В	-13, 482	DI ETARY	10.00	0	33. 03
33.04	REIMBURSEMENT FOUNDATION	В	-71, 147	ADMINISTRATIVE & GENERAL	5.00	0	33. 04
	DEVELOPMENT						
33. 05	RENTAL INCOME OFFSET - CANCER	В	-30, 461	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 05
	CENTER						
33.06	ATM SURCHARGE REVENUE	В	-877	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	OP EDUCATION	В	-1, 270	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33.09	DIETICIAN CONSULTATIONS	В	-3, 560	CAFETERI A	11.00	0	33. 09
33. 10	HAF EXPENSE	В	-703, 636	ADMINISTRATIVE & GENERAL	5.00	0	33. 10
33. 12	PHYSICIAN INCOME GUARANTEE	l A	-805, 095	ADMINISTRATIVE & GENERAL	5.00	0	33. 12
	OFFSET						
50.00	TOTAL (sum of lines 1 thru 49)		-4, 871, 260				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.

Health Financial Systems			CAMERON MEMOR	RIAL COMMUNITY	In Lieu of Form CMS-2552-		
	STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	3-1
	OFFICE	COSTS			From 10/01/2015		
					To 09/30/2016		
						2/22/2017 4:5	O pm
		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 ADJUSTA	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
		HOME OFFICE COSTS:					
	1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	199, 497	1.00
	2.00	5. 00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	37, 742	2.00
	3.00	7. 00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3, 300	3.00
			l .	1	1		

0 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.

RENT PAID TO CMO

316, 443

316, 443

441, 190

681, 729

4.00

5.00

			Related Organization(s) and	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
, ,		Ownershi p		Ownershi p				
1. 00	2. 00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME 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:

2. 00 CAP REL COSTS-MVBLE EQUIP

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

4.00

5.00

Heal th	Health Financial Systems			CAMERON MEMORIAL COMMUNITY				In Lieu of Form CMS-2552-				2552-10	
STATEME OFFICE		SERVICES FROM	RELATED	ORGANI ZATI ONS ANI	D HOME	Provi der	CCN:	15-1315	Period: From 10	/01/2015	Worksheet	A-8-	-1
UITTCL										/30/2016	Date/Ti me 2/22/2017		
	Net	Wkst. A-7 Ref.											
	Adjustments												
	(col. 4 minus												
	col. 5)*												
	6. 00	7. 00											
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REC	QUI RED AS A RESUL	T OF TRA	NSACTI ONS	WI TH	RELATED C	RGANI ZAT	TIONS OR (	CLAI MED		
	HOME OFFICE CO	STS:											
1.00	-199, 497	0	1										1.00
2.00	-37, 742	0	1										2.00
3.00	-3, 300	0											3.00
4.00	-124, 747	9											4.00
5.00	-365, 286												5.00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriate) a	are trans	sferred in	deta	il to Wor	ksheet A	, column	6, lines a	 S	
				and negative amour									whi ch
has not	been posted to	o Worksheet A,	col umns	1 and/or 2, the a	amount al	lowable sh	houl d	l be indic	ated in	column 4	of this pa	rt.	

nas not	been posted to norrestice n,	cordinate transfer 2, the dispart arrowable should be that cated the cordinate terms part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	<b>3.</b>		
	6. 00		
В	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	
TI C			

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.

						0 09/30/2016	2/22/2017 4:5	
	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	11, 056		0	0	1. 00
2. 00	30.00	ADULTS & PEDIATRICS	852, 293	812, 765	39, 528	0	0	2. 00
3. 00	50.00	OPERATING ROOM	562, 658	562, 658		0	0	3. 00
4. 00	52. 00	DELIVERY ROOM & LABOR ROOM	2, 688	2, 688	0	0	0	4. 00
5. 00	30.00	ADULTS & PEDIATRICS	231, 685	231, 685	0	0	0	5. 00
6. 00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0.00		0	0	0	0	0	10.00
200. 00			1, 667, 324	1, 620, 852	46, 472		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00		LABORATORY	0		-	0		
2. 00		ADULTS & PEDIATRICS	0		0	0	0	
3. 00		OPERATING ROOM	0	0	0	0	0	0.00
4. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4. 00
5. 00		ADULTS & PEDIATRICS	0	0	0	0	0	0.00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	,
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	1
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		LABORATORY	15.00			11, 056		1. 00
2.00		ADULTS & PEDIATRICS		1	-	812, 765		2.00
3.00		OPERATING ROOM			0	562, 658	•	3. 00
4.00		DELIVERY ROOM & LABOR ROOM			0	2, 688	•	4.00
5.00		ADULTS & PEDIATRICS			0	231, 685		5.00
6.00	0.00				0	231,000	1	6.00
7.00	0.00					0		7.00
8. 00	0.00				0	0		8.00
9.00	0.00					0		9.00
10.00	0.00				0	0		10.00
200.00	0.00					1, 620, 852		200.00
200.00	ı		1	1	1	1,020,032	I	1 200. 00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	CAMERON MEMORIA FURNISHED BY	Provider CO	CN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016 Respi ratory Therapy		-3 pared:		
					Therapy	1.00			
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruct	tions)			52	1.00		
2.00	Line 1 multiplied by 15 hours per week  Number of unduplicated days in which supervis	e instructions)	780 366	2. 00					
4. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see insti		0	1					
5. 00 6. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)		0	5. 00 6. 00					
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					3. 25 0. 00			
0.00	optional travel expense rate per inite	Supervi sors	Therapi sts	Assi stants		Trai nees	0.00		
9. 00	Total hours worked	1. 00 1, 782. 00	2. 00 17, 366. 50	3.00	4. 00 00 0. 00	5.00	9. 00		
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	62. 88 31. 44	62. 88 31. 44	•	0.00	0.00	10. 00 11. 00		
12. 00 12. 01 13. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 00 12. 01 13. 00		
13. 01	Number of miles driven (offsite)						13. 01		
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00			
14. 00 15. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					112, 052 1, 092, 006	1		
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 and 14 and 15 and 1	line10)	ratory therapy	or lines 14	-16 for all	1, 204, 058	16. 00		
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 00		
19. 00 20. 00	7 Trainees (column 5, line 9 times column 5, line 10)								
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3,	lines 21-23. ainees (line 17	divided by su				21. 00		
22. 00 23. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)					0 1, 204, 058			
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVEL	EXPENSE COMP	UTATION - PR	OVI DER SITE	, , , , , , ,			
	Therapists (line 3 times column 2, line 11)					11, 507			
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	II others)		0 11, 507			
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory	y therapy or s	um of lines	3 and 4 for all	1, 190	27. 00		
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provid	er site (sum	of lines 26 and	12, 697	28. 00		
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2. line 12 )			0	29. 00		
30.00	Assistants (column 3, line 10 times column 3,	line 12)				0	30. 00		
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)				y or sum of	0	31. 00 32. 00		
33.00	Standard travel allowance and standard travel			۵ ( ) ( )		12, 697	33.00		
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAS Standard Travel Expense	expense (sum o	of lines 31 an	d 32)	VICES OUTSIDE PRO	OVI DER SITE	34. 00 35. 00		
36.00	Therapists (line 5 times column 2, line 11)					0			
37. 00 38. 00 39. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum		0 0	38. 00					
	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	Expense							
40. 00 41. 00									
42. 00 43. 00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	n of columns 1-3	3, line 13.01)			0	42. 00 43. 00		
	Total Travel Allowance and Travel Expense - ( or 46, as appropriate.				lowing three line				
44. 00	Standard travel allowance and standard travel	expense (sum o	of lines 38 an	d 39 - see i	nstructions)	0	44. 00		

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	CAMERON MEMORIAI FURNISHED BY	Provider CO	CN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 2/22/2017 4:5	-3 pared:
					Respi ratory Therapy	Cost	
					тист ару		
15.00	Optional travel allowance and standard travel	expense (sum o	flinos 20 an	ud 42 - soo ir	etructions)	1. 00	45. 00
	Optional travel allowance and optional travel				,	0	
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	DART W. OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION  Overtime hours worked during reporting	588. 75	0.00	0.0	0.00	588. 75	   47 00
7.00	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	333.73	0.00	0.0	0.00	000.70	17. 0
0 00	column of line 56)	04.22	0.00		0.00		40.00
8. 00 9. 00	Overtime rate (see instructions) Total overtime (including base and overtime	94. 32 55, 530. 90	0. 00 0. 00	1			48. 00 49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT		0.00				
0. 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
	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
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	62. 88	0.00	0.0	0.00		52. 0
2.00	(see instructions)	02. 00	0.00	0.0	0.00		32.00
3. 00	Overtime cost limitation (line 51 times line 52)	130, 790	0		0 0		53. 00
4. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	55, 531	0		0 0		54.00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	37, 021	0		0 0		55. 00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	18, 510	0		0 0	18, 510	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
7. 00 8. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	24 or 2E))			1, 204, 058 12, 697	57. 00 58. 00
9. 00	Travel allowance and expense - Offsite service			)		12, 047	59.00
	Overtime allowance (from column 5, line 56)	•				18, 510	
	Equipment cost (see instructions)					0	
	Supplies (see instructions) Total allowance (sum of lines 57-62)					0 1, 235, 265	1
	Total cost of outside supplier services (from	your records)				574, 045	
5. 00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative,	•			0	65. 0
	Line 26 = line 24 for respiratory therapy or					11, 507	
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	therapy or sum	or lines 3 a	ind 4 for all	otners	1, 190 12, 697	
01. 00	Line 27 = line 7 times line 3 for respiratory				others	1, 190	
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			101. 01 101. 02
01. 01 01. 02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						
01. 01 01. 02	Line 34 = Sum of Tines 27 and 31  LINE 35 CALCULATION  Line 31 = Tine 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			102. 0

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315 Peri od: Worksheet B From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/22/2017 4:50 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 4, 495, 228 00100 CAP REL COSTS-BLDG & FLXT 4, 495, 228 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 488, 265 3, 488, 265 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 454, 325 23, 195 15, 575 5, 493, 095 4.00 00500 ADMINISTRATIVE & GENERAL 7, 583, 652 9, 481, 808 5 00 397, 692 357 570 1 142 894 5 00 7.00 00700 OPERATION OF PLANT 2, 597, 108 404, 061 336, 794 140, 962 3, 478, 925 7.00 44, 482 8.00 00800 LAUNDRY & LINEN SERVICE 41, 751 28, 035 114, 268 8.00 9.00 00900 HOUSEKEEPI NG 1, 041, 166 18, 634 12, 513 191, 497 1, 263, 810 9.00 01000 DI ETARY 10.00 154, 186 14, 777 88.035 103, 536 360, 534 10 00 11.00 01100 CAFETERI A 391, 588 78, 037 52, 401 105, 099 627, 125 11.00 01300 NURSING ADMINISTRATION 32, 080 21, 541 191, 412 927, 529 13.00 682, 496 13.00 01400 CENTRAL SERVICES & SUPPLY 231, 906 122, 500 82, 258 52, 453 489, 117 14.00 14.00 30, 490 01500 PHARMACY 45, 407 2, 589, 643 15.00 15.00 2, 382, 600 131, 146 01600 MEDICAL RECORDS & LIBRARY 706, 463 29, 223 115, 628 851, 314 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 093, 369 635, 103 426, 472 722, 948 4.877.892 30.00 31.00 03100 INTENSIVE CARE UNIT 200 809 46, 390 31, 150 31, 338 309, 687 31 00 16, 512 04300 NURSERY 70, 319 11, 087 19, 499 117, 417 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 286, 953 50.00 1, 612, 145 427, 334 290, 826 2, 617, 258 50.00 05100 RECOVERY ROOM 51.00 674,051 279, 399 187, 615 200, 131 1, 341, 196 51.00 439, 855 05200 DELIVERY ROOM & LABOR ROOM 169, 738 132, 997 89, 307 47, 813 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 866, 909 324, 530 217, 921 432, 870 2, 842, 230 54.00 06000 LABORATORY 60. nn 2, 566, 833 109, 055 73, 230 266, 838 3, 015, 956 60.00 64.00 06400 INTRAVENOUS THERAPY 64.00  $\cap$ 06500 RESPIRATORY THERAPY 685, 959 65.00 52, 876 35, 506 12, 277 786, 618 65.00 267, 267 65.01 06501 SLEEP LAB 198, 631 68.636 65.01 06600 PHYSI CAL THERAPY 66.00 754,819 235, 172 157, 917 207, 131 1, 355, 039 66.00 06900 ELECTROCARDI OLOGY 304, 656 3, 775 69.00 5, 622 314, 053 69.00 69.01 06901 CARDI AC REHAB 71, 962 32, 237 21, 647 20, 136 145, 982 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1.056.015 1, 056, 015 71 00  $\cap$ 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 383, 987 C 0 0 383, 987 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 03020 CHEMI CAL DEPENDENCY 31, 249 35, 468 76.00 76.00 4.219 0 03480 ONCOLOGY 1, 979, 235 76. 01 1, 249, 834 436, 376 293, 025 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89 00 0 0 0 90.00 09000 CLI NI C 164, 333 19, 342 12, 988 41,015 237, 678 90.00 91.00 09100 EMERGENCY 2, 374, 254 375, 205 251, 949 508, 149 3, 509, 557 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 666, 978 0 38, 780 173, 333 879, 091 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 1114 00 116. 00 11600 HOSPI CE 152, 818 7, 946 35, 365 196, 129 116. 00 SUBTOTALS (SUM OF LINES 1-117) 4, 445, 693 5, 099, 756 46, 891, 683 118. 00 47, 536, 982 3, 285, 840 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 38, 113 190, 00 22, 802 15.311 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 194.00 194. 01 07951 MOB 127, 898 Ω 0 15, 247 143, 145 194. 01 194. 02 07952 COMMUNI TY HEALTH 106, 518 194. 02 84, 980 0 21, 538 Ω 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194. 03 194. 04 07954 EDUCATI ON 37, 514 194. 04 37, 514 17, 951 194. 05 07955 MARKETI NG 490, 517 43, 175 578, 376 194. 05 26, 733 194.06 07956 GUEST MEALS 50, 208 194. 06 43.828 C 0 6.380 194. 07 07957 OUTSIDE LAUNDRY 0 194. 07 0 0 194.08 07958 CANCER CENTER 0 194. 08 194. 09 07959 URGENT CARE 1, 791, 462 194. 09 169, 163 306, 999 1, 315, 300 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 49, 637, 019 4, 495, 228 3, 488, 265 5, 493, 095 49, 637, 019 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

2/22/2017 4:50 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 9, 481, 808 5 00 5 00 7.00 00700 OPERATION OF PLANT 821, 475 4, 300, 400 7.00 43, 394 00800 LAUNDRY & LINEN SERVICE 26, 982 184, 644 8.00 8.00 9.00 00900 HOUSEKEEPI NG 298, 422 19, 368 50, 202 1, 631, 802 9.00 01000 DI ETARY 615, 515 10.00 10.00 85.133 160, 256 220 9.372 71, 371 11.00 01100 CAFETERI A 148,082 81, 109 1,669 0 11.00 13 00 01300 NURSING ADMINISTRATION 219,016 33, 342 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 115, 495 127. 322 19 825 14.00 0 0 14, 058 15.00 01500 PHARMACY 611, 490 47, 194 0 0 15.00 201, 020 16.00 01600 MEDICAL RECORDS & LIBRARY 45, 233 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 495, 994 03000 ADULTS & PEDIATRICS 1, 151, 808 660, 109 40, 179 576.883 31.00 03100 INTENSIVE CARE UNIT 73, 126 48, 216 362 8, 651 38, 632 31.00 27, 726 92, 278 43 00 43.00 04300 NURSERY 17, 162 8, 391 ANCILLARY SERVICE COST CENTERS 50 00 50.00 05000 OPERATING ROOM 618,011 444, 157 24, 568 120.033 0 05100 RECOVERY ROOM 316, 695 290, 398 78, 580 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 103, 863 138, 232 2, 470 32, 802 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 17,003 54.00 671.133 337, 306 126, 882 0 54.00 60.00 06000 LABORATORY 712, 155 113, 348 342 78, 580 0 60.00 64.00 06400 I NTRAVENOUS THERAPY C 0 64.00 06500 RESPIRATORY THERAPY 185, 743 54, 958 20 18, 383 65.00 0 65.00 06501 SLEEP LAB 65.01 63, 109 106, 238 2.926 25, 232 Λ 65.01 66.00 06600 PHYSI CAL THERAPY 319, 964 244, 430 3, 992 81, 824 0 66.00 06900 ELECTROCARDI OLOGY 74, 157 5, 843 69.00 0 0 69.00 o 06901 CARDI AC REHAB 34, 471 0 69.01 69.01 33, 506 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 249, 356 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 90,670 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 73.00 C 0 73.00 03020 CHEMI CAL DEPENDENCY o 76 00 8 375 0 0 76 00 03480 ONCOLOGY 0 76.01 467, 355 453, 555 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 0 20, 104 90.00 09000 CLI NI C 56, 123 0 0 90.00 91.00 09100 EMERGENCY 828, 708 389, 976 32,060 272, 147 0 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 207, 579 60, 025 240 32, 802 0 101. 00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 116. 00 11600 HOSPI CE 46, 312 12, 299 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 8, 833, 554 3, 987, 080 184, 644 1, 578, 814 615, 515 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9,000 23, 699 0 0 0 190, 00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 194. 01 07951 MOB 33, 801 0 0 194. 01 0 194. 02 07952 COMMUNI TY HEALTH 0 25.152 C 0 194 02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194. 03 194. 04 07954 EDUCATI ON 8,858 0 0 194. 04 0 194. 05 07955 MARKETI NG 0 194. 05 0 136, 571 27, 785 0 0 194.06 194.06 07956 GUEST MEALS 11,856 r 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 C 194.08 07958 CANCER CENTER 0 0 0 194. 08 0 194, 09 194. 09 07959 URGENT CARE 423.016 261, 836 0 52. 988 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 1, 631, 802 202.00 TOTAL (sum lines 118-201) 9, 481, 808 4, 300, 400 184.644 615, 515 202. 00

			То	09/30/2016	Date/Time Pre 2/22/2017 4:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	O PIII
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13.00	SUPPLY 14.00	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15. 00	16. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 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 11. 00   01100   CAFETERI A	929, 356					10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	35, 622	1				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	20, 139		771, 898			14. 00
15. 00   01500   PHARMACY	22, 509		3, 536	3, 288, 430		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	39, 830	o	124	0	1, 137, 521	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	188, 812		31, 373	0	12, 952	30. 00
31. 00   03100   INTENSIVE CARE UNIT	8, 824		1, 798	0	1, 836	31. 00
43. 00   04300   NURSERY	3, 840	10, 133	0	0	2, 481	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	66, 750	176, 033	92, 413	ol	31, 220	50.00
51. 00   05100   RECOVERY   ROOM	43, 424		92, 413	0	31, 220	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 437		11, 203	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	93, 589		10, 747	Ö	253, 747	54.00
60. 00   06000   LABORATORY	83, 948		218, 867	O	340, 391	60.00
64.00 06400 INTRAVENOUS THERAPY	C	o	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 634		6, 211	0	33, 506	65. 00
65. 01   06501   SLEEP LAB	C	ή "Ι	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	51, 186		1, 781	0	121, 109	66.00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI AC   REHAB	4 404		871 374	0	69, 469	69.00
69. 01   06901   CARDI AC REHAB 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	4, 494 C	1	251, 059	0	39, 283 0	69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1	91, 378	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1	0	3, 288, 430	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	1, 062	o	652	0	0	76. 00
76. 01 03480 ONCOLOGY	C	o	919	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC	C	1	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	11 020	1 1	0	0	0	89. 00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	11, 030		4, 681	0	47, 614	90. 00 91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART	126, 474	333, 456	34, 519	٩	183, 913	91.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	37, 910	ol	1, 815	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				•		
113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		_		_	_	114. 00
116. 00 11600 HOSPI CE	9, 232		000	0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	859, 746	1, 209, 176	764, 701	3, 288, 430	1, 137, 521	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	С		0	n	0	190. 00
194. 00 07950  DAYCARE-I NFANT/TODDLER		1	0	0		194. 00
194. 01 07951 MOB	2, 410	1		o		194. 01
194. 02 07952 COMMUNI TY HEALTH	4, 494		1, 153	0		194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	C	o	0	0	0	194. 03
194. 04 07954 EDUCATI ON	C	0	0	0		194. 04
194. 05 07955 MARKETI NG	14, 012		373	0		194. 05
194. 06 07956 GUEST MEALS	3, 268	0	0	O		194. 06
194. 07 07957 OUTSI DE LAUNDRY			0	0		194. 07
194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE	45, 426	ή "Ι	4, 627	o o		194. 08 194. 09
200.00 Cross Foot Adjustments	45, 420	ή "	4, 027	٩	U	200.00
201.00 Negative Cost Centers	c	ol ol	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	929, 356	1, 215, 509	771, 898	3, 288, 430		
		·	·	,		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 CAMERON MEMORIAL COMMUNITY Provi der CCN: 15-1315 Cost Center Description Subtotal Intern & Total

Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS	I				1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00   00900   HOUSEKEEPI NG					9. 00
10. 00   01000   DI ETARY					10.00
11. 00   01100   CAFETERI A					11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00   01500   PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		'			1
30. 00 03000 ADULTS & PEDIATRICS	8, 533, 793	0	8, 533, 793		30.00
31.00 03100 INTENSIVE CARE UNIT	514, 422	0	514, 422		31. 00
43. 00   04300   NURSERY	279, 428	0	279, 428	1	43. 00
ANCILLARY SERVICE COST CENTERS	4 100 442	ا	4 100 442		
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	4, 190, 443 2, 184, 802	0 0	4, 190, 443 2, 184, 802		50. 00 51. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	762, 700		762, 700		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 352, 637	l o	4, 352, 637		54. 00
60. 00   06000   LABORATORY	4, 563, 587	Ö	4, 563, 587		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 087, 073	0	1, 087, 073		65. 00
65. 01   06501   SLEEP LAB	464, 772	0	464, 772		65. 01
66. 00   06600   PHYSI CAL THERAPY 69. 00   06900   ELECTROCARDI OLOGY	2, 179, 325		2, 179, 325		66. 00
69. 00   06900  ELECTROCARDI OLOGY 69. 01   06901  CARDI AC REHAB	464, 393 258, 110		464, 393 258, 110		69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 556, 430	-	1, 556, 430		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	566, 035	l o	566, 035		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 288, 430	0	3, 288, 430		73.00
76. 00 03020 CHEMI CAL DEPENDENCY	45, 557	0	45, 557		76. 00
76. 01 03480 ONCOLOGY	2, 901, 064	0	2, 901, 064		76. 01
OUTPATIENT SERVICE COST CENTERS					00.00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		88. 00 89. 00
90. 00   09000  CLINI C	406, 356		406, 356		90.00
91. 00 09100 EMERGENCY	5, 710, 810	l o	5, 710, 810		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		O			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	1, 219, 462	0	1, 219, 462		101. 00
SPECIAL PURPOSE COST CENTERS					112 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	264, 352	o	264, 352		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	45, 793, 981	l o	45, 793, 981		118. 00
NONREI MBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70, 812	0	70, 812		190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0		194. 00
194. 01 07951 MOB 194. 02 07952 COMMUNI TY HEALTH	186, 733	0	186, 733		194. 01
194.02 07952 COMMUNITY HEALTH 194.03 07953 ASSISTED LIVING/CAMERON WOODS	137, 317	0	137, 317		194. 02 194. 03
194. 04 07954 EDUCATION	46, 372		46, 372		194. 03
194. 05 07955 MARKETI NG	757, 117	l o	757, 117		194. 05
194. 06 07956 GUEST MEALS	65, 332	Ö	65, 332		194. 06
194. 07 07957 OUTSI DE LAUNDRY	0	0	0		194. 07
194. 08 07958 CANCER CENTER	0	0	0		194. 08
194. 09 07959 URGENT CARE	2, 579, 355	0	2, 579, 355		194. 09
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0 0	0		200. 00 201. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118-201)	49, 637, 019		49, 637, 019		201.00
202.00   101/12 (Sum 11103 110 201)	17,007,017	١	17,037,017	'	1-02.00

Heal th Financial Systems

CAMERON MEMORIAL COMMUNITY

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

Period:
From 10/01/2015
To 09/30/2016

Part II
Date/Time Prepared:
2/22/2017 4: 50 pm

CAPITAL RELATED COSTS

Cost Center Description

Directly BLDG & FIXT MVBLE EQUIP Subtotal EMPLOYEE

					077 007 2010	2/22/2017 4:5	O pm
			CAPITAL RELATED COSTS				
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	23, 195	15, 575	38, 770	38, 770	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	397, 692	357, 570	755, 262	8, 058	5. 00
7.00	00700 OPERATION OF PLANT	0	404, 061	336, 794	740, 855	995	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	41, 751		69, 786	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	18, 634	12, 513	31, 147	1, 352	9. 00
10.00	01000 DI ETARY	0	154, 186	103, 536	257, 722	104	10.00
11.00	01100 CAFETERI A	0	78, 037		130, 438		11. 00
13.00	01300 NURSING ADMINISTRATION	0	32, 080	1	53, 621	1, 351	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	122, 500		204, 758		14. 00
15. 00	01500 PHARMACY	0	45, 407	1	75, 897		15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	1	29, 223		1
	INPATIENT ROUTINE SERVICE COST CENTERS		_				
30.00	03000 ADULTS & PEDIATRICS	0	635, 103	426, 472	1, 061, 575	5, 104	30. 00
	03100   NTENSI VE CARE UNI T	o o		1	77, 540		31. 00
	04300 NURSERY	0	16, 512		27, 599		
10.00	ANCI LLARY SERVI CE COST CENTERS		10,012	11,007	21,077	100	10.00
50.00	05000 OPERATING ROOM	0	427, 334	286, 953	714, 287	2, 053	50.00
	05100 RECOVERY ROOM	0	279, 399		467, 014		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	132, 997	1	222, 304	338	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	324, 530		542, 451		
60. 00	06000 LABORATORY	0	109, 055	1	182, 285		1
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	52, 876	- 1	88, 382	87	65. 00
65. 01	06501 SLEEP LAB	0	02,070	68, 636	68, 636	0	65. 01
	06600 PHYSI CAL THERAPY	0	235, 172		393, 089		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	5, 622	1	9, 397	0	69. 00
	06901 CARDI AC REHAB	0	32, 237	1	53, 884	-	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	02, 20,		00,001	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		Ö	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0		Ö	0	0	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0		0	0	30	76.00
	03480 ONCOLOGY	0	436, 376	- 1	729, 401	0	1
70.01	OUTPATIENT SERVICE COST CENTERS		430, 370	273, 023	727, 401	0	70.01
88. 00	08800 RURAL HEALTH CLINIC	1	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0	0	89. 00
	09000 CLINIC	0	19, 342	- 1	32, 330		1
91. 00	09100 EMERGENCY	0	375, 205		627, 154		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	373, 203	231, 747	027, 134		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
101 00	10100 HOME HEALTH AGENCY	0	0	38, 780	38, 780	1 224	101. 00
	SPECIAL PURPOSE COST CENTERS			30,700	30, 700	1, 227	101.00
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11600 HOSPI CE	0	0	7, 946	7, 946	250	116. 00
118. 00	1	0			7, 731, 533		118. 00
110.00	NONREI MBURSABLE COST CENTERS		4, 443, 073	3, 203, 040	7, 731, 333	33, 773	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	22, 802	15, 311	38, 113	0	190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	22,002		0		194. 00
	07951 MOB			0	0		194. 01
	07952 COMMUNITY HEALTH			0	0		194. 01
	07953 ASSISTED LIVING/CAMERON WOODS			0	0		194. 02
	07954 EDUCATION				0		194. 03
	l		24 722	17 051	44 404		194. 04
	07955 MARKETI NG		26, 733	17, 951	44, 684		
	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY			0	0		194. 06 194. 07
					0		
	07958 CANCER CENTER			140 143	140 143		194. 08
	07959 URGENT CARE			169, 163	169, 163	2, 16/	194. 09
200.00	1 1				0	_	200. 00 201. 00
201.00			4 405 220	2 499 265	7 002 402		
202. 00	TOTAL (sum lines 118-201)	0	4, 495, 228	3, 488, 265	7, 983, 493	38,770	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2015 Part II To 09/30/2016 Date/Time Prepared:

2/22/2017 4:50 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 763 320 5 00 7.00 00700 OPERATION OF PLANT 66, 131 807, 981 7.00 2, 172 00800 LAUNDRY & LINEN SERVICE 8.00 8, 153 80, 111 8.00 9.00 00900 HOUSEKEEPI NG 24, 024 3, 639 21, 781 81, 943 9.00 01000 DI ETARY 295, 355 10.00 10.00 6.853 30, 110 95 471 11.00 01100 CAFETERI A 11, 921 15, 239 724 3,584 0 11.00 13 00 01300 NURSING ADMINISTRATION 17,631 6, 265 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 996 14 00 9, 298 23, 922 14.00 0 0 15.00 01500 PHARMACY 49, 227 8, 867 0 706 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16, 183 8, 499 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 24, 906 30.00 03000 ADULTS & PEDIATRICS 92.735 124, 023 17, 432 276, 817 31.00 03100 INTENSIVE CARE UNIT 5,887 9, 059 157 434 18, 538 31.00 43 00 43.00 04300 NURSERY 2, 232 3, 224 3,641 4,634 ANCILLARY SERVICE COST CENTERS 50 00 50.00 05000 OPERATING ROOM 49.751 83, 451 10,659 6.028 0 05100 RECOVERY ROOM 25, 495 54, 561 3, 946 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 8, 361 25, 972 1,072 1,647 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 7, 377 6, 372 54.00 54.028 63, 375 0 54.00 60.00 06000 LABORATORY 57, 330 21, 296 148 3, 946 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 14, 953 10, 326 923 65.00 0 65.00 5,080 06501 SLEEP LAB 65.01 19, 961 1, 270 1.267 Λ 65.01 66.00 06600 PHYSI CAL THERAPY 25, 758 45, 925 1,732 4, 109 0 66.00 06900 ELECTROCARDI OLOGY 5, 970 1, 098 69.00 0 0 0 69.00 6, 295 0 06901 CARDI AC REHAB 2.775 0 69.01 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 20,074 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 299 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 00 674 0 0 76 00 03480 ONCOLOGY 0 76.01 37,623 85, 216 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 0 0 0 90.00 09000 CLI NI C 4,518 3,777 0 0 0 90.00 91.00 09100 EMERGENCY 66, 713 73, 271 13, 910 13, 666 0 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 16, 711 11, 278 104 1, 647 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 3,728 2.311 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 711, 135 749, 113 80, 111 79, 282 295, 355 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 724 4, 453 0 0 0 190. 00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 194. 01 07951 MOB 0 0 194. 01 2.721 0 194. 02 07952 COMMUNITY HEALTH 0 2.025 C 0 194 02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 194. 03 194. 04 07954 EDUCATI ON 713 0 0 194. 04 0 194. 05 07955 MARKETI NG 0 0 194. 05 10.994 5, 220 οĺ 194.06 07956 GUEST MEALS 0 194.06 954 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 0 194.08 07958 CANCER CENTER 0 0 194. 08 0 194, 09 194. 09 07959 URGENT CARE 34.054 49. 195 0 2.661 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 81, 943 202.00 TOTAL (sum lines 118-201) 763, 320 807.981 80, 111 295, 355 202. 00

Provider CCN: 15-1315

			10	09/30/2016	2/22/2017 4:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11.00	13.00	14. 00	15. 00	16. 00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00   OO700 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	162, 648	1				11.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	6, 234		242 940			13. 00 14. 00
15. 00   01500   PHARMACY	3, 525 3, 939		242, 869 1, 113	140, 675		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	6, 971	0	39	140, 075	61, 731	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 7, 1	<u> </u>	37	<u> </u>	01,701	10.00
30. 00 03000 ADULTS & PEDIATRICS	33, 045	34, 853	9, 871	0	703	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 544	1, 631	566	0	100	31. 00
43. 00 04300 NURSERY	672	709	0	0	135	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	11, 682	12, 325	29, 077	0	1, 694	50.00
51. 00   05100   RECOVERY ROOM	7, 600		0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   54.00   05400   RADIOLOGY-DIAGNOSTIC	1, 652	1, 739	3, 525	0	12.770	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	16, 379 14, 692	0	3, 381 68, 864	0	13, 770 18, 472	54. 00 60. 00
64. 00   06400   NTRAVENOUS THERAPY	14, 092	0	08, 804	0	10, 472	64. 00
65. 00 06500 RESPIRATORY THERAPY	286	Ö	1, 954	0	1, 818	65. 00
65. 01   06501   SLEEP LAB	0	Ö	0	Ö	0	65. 01
66. 00   06600 PHYSI CAL THERAPY	8, 958	0	561	0	6, 572	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	274	0	3, 770	69. 00
69. 01   06901   CARDI AC   REHAB	786	0	118	0	2, 132	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	78, 991	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	28, 751	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	140, 675	0	73.00
76. 00   03020  CHEMI CAL DEPENDENCY 76. 01   03480  ONCOLOGY	186	0	205 289	0	0	76.00
OUTPATIENT SERVICE COST CENTERS		U U	209	<u> </u>	U	76. 01
88. 00 08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ő	0	o	0	89. 00
90. 00   09000   CLINIC	1, 930	2, 039	1, 473	o	2, 584	90.00
91. 00 09100 EMERGENCY	22, 134	23, 346	10, 861	0	9, 981	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	T					
101. 00 10100 HOME HEALTH AGENCY	6, 635	0	571	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	T					112 00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF	-					113. 00 114. 00
116. 00 11600 HOSPI CE	1, 616	0	120	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	150, 466	1	240, 604	140, 675	61, 731	
NONREI MBURSABLE COST CENTERS	100, 100	01,007	210,001	110,070	01,701	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	o	0	0	0	194. 00
194. 01 07951 MOB	422	443	329	0	0	194. 01
194. 02 07952 COMMUNI TY HEALTH	786	0	363	0		194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	0	1	0	0		194. 03
194. 04 07954 EDUCATI ON	0	1	0	0		194. 04
194. 05 07955 MARKETI NG	2, 452		117	0		194. 05
194. 06 07956  GUEST MEALS 194. 07 07957  OUTSI DE LAUNDRY	572		0	0		194. 06 194. 07
194.08 07958 CANCER CENTER			0	0		194. 07
194. 09 07959 URGENT CARE	7, 950	ا	1, 456	0		194. 06
200.00 Cross Foot Adjustments	,,,,,,		1, 430	٩	0	200. 00
201.00 Negative Cost Centers	0	ol	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	162, 648	85, 102	242, 869	140, 675	61, 731	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315 Peri od: Worksheet B From 10/01/2015 Part II 09/30/2016 Date/Time Prepared: 2/22/2017 4:50 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 681, 064 1, 681, 064 30.00 03100 INTENSIVE CARE UNIT 31.00 31 00 115 677 0 115 677 43.00 04300 NURSERY 42, 984 0 42, 984 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 921, 007 921, 007 50.00 05100 RECOVERY ROOM 51 00 568 046 Ω 568, 046 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 266, 610 0 266, 610 52.00 05400 RADI OLOGY-DI AGNOSTI C 710, 189 710, 189 54.00 54.00 60.00 06000 LABORATORY 368, 917 0 368, 917 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 64.00 0 06500 RESPIRATORY THERAPY 65.00 118, 738 0 118, 738 65.00 06501 SLEEP LAB 65.01 96, 214 96, 214 65.01 06600 PHYSI CAL THERAPY 488, 166 0 488, 166 66.00 66, 00 06900 ELECTROCARDI OLOGY 20, 509 0 20, 509 69.00 69.00 69. 01 06901 CARDI AC REHAB 66, 132 0 66, 132 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 99, 065 99, 065 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 36, 050 0 36, 050 72.00 0 73 00 140,675 140, 675 73 00 03020 CHEMI CAL DEPENDENCY 1,095 1,095 76.00 76.00 03480 ONCOLOGY 76. 01 852, 529 0 852, 529 76.01 OUTPATIENT SERVICE COST CENTERS 88 00 88.00 08800 RURAL HEALTH CLINIC 0 0 O 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 48, 941 0 48, 941 90.00 91.00 09100 EMERGENCY C 91.00 864,623 864, 623 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101. 00 76, 950 0 76, 950 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 15, 971 15 971 116. 00 11600 HOSPI CE 116, 00 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 7, 600, 152 0 7, 600, 152 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 43, 290 43, 290 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 194.00 194. 01 07951 MOB 4,023 0 4,023 194.01 194. 02 07952 COMMUNI TY HEALTH 3, 326 3, 326 194.02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 194. 03 C 194. 04 07954 EDUCATI ON 713 0 713 194.04 194. 05 07955 MARKETI NG 63, 772 63, 772 194. 05 194.06 07956 GUEST MEALS 1,571 0 1,571 194.06 194. 07 07957 OUTSI DE LAUNDRY 0 194 07 0 C 194.08 07958 CANCER CENTER 0 C 194. 08 194. 09 07959 URGENT CARE 194. 09 266, 646 266, 646 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 201. 00 0 202.00 TOTAL (sum lines 118-201) 7, 983, 493 7, 983, 493 202.00

From 10/01/2015 09/30/2016 Date/Time Prepared: 2/22/2017 4:50 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 114 344 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 132, 138 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 590 590 18, 500, 971 4.00 00500 ADMINISTRATIVE & GENERAL 3, 849, 283 40, 155, 211 5 00 13, 545 -9, 481, 808 5 00 10 116 7.00 00700 OPERATION OF PLANT 10, 278 12, 758 474, 765 3, 478, 925 7.00 1, 062 1, 062 8.00 00800 LAUNDRY & LINEN SERVICE 114, 268 8.00 00900 HOUSEKEEPI NG 474 474 644, 972 0 1, 263, 810 9.00 9.00 0 01000 DI ETARY 3 922 3.922 49, 769 360, 534 10 00 10.00 11.00 01100 CAFETERI A 1, 985 1, 985 353, 980 0 627, 125 11.00 01300 NURSING ADMINISTRATION 0 927, 529 13.00 816 816 644, 685 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 3. 116 176, 664 489, 117 14.00 3.116 441, 705 2, 589, 643 15.00 01500 PHARMACY 1, 155 1, 155 15.00 01600 MEDICAL RECORDS & LIBRARY 389, 441 16.00 16.00 1, 107 851, 314 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 155 16, 155 2. 434. 921 4. 877. 892 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 180 1, 180 105, 548 0 309, 687 31 00 65, 674 04300 NURSERY 420 117, 417 43.00 43.00 420 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 979, 517 50.00 10,870 10,870 2, 617, 258 50.00 0 51.00 05100 RECOVERY ROOM 7, 107 7, 107 674.051 1, 341, 196 51.00 3, 383 439, 855 05200 DELIVERY ROOM & LABOR ROOM 3, 383 161, 035 0 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 255 8, 255 1, 457, 927 2, 842, 230 54.00 60.00 06000 LABORATORY 2,774 898, 722 3, 015, 956 2,774 60.00 0 64.00 06400 INTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 1, 345 1, 345 41, 349 0 786, 618 65.00 267, 267 65.01 06501 SLEEP LAB 2,600 65.01 C 06600 PHYSI CAL THERAPY 66.00 5, 982 5, 982 697, 628 1, 355, 039 66.00 06900 ELECTROCARDI OLOGY 69.00 143 143 0 0 0 314, 053 69.00 69.01 06901 CARDI AC REHAB 820 820 67, 819 145, 982 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 C 1,056,015 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 383, 987 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 73.00 03020 CHEMI CAL DEPENDENCY 35, 468 76.00 76.00 14, 211 1<u>, 979, 235</u> 03480 ONCOLOGY 76. 01 11, 100 11, 100 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 o 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89 00 0 C 0 0 90.00 09000 CLI NI C 492 492 138, 142 0 237, 678 90.00 91.00 09100 EMERGENCY 9,544 9, 544 1, 711, 471 0 3, 509, 557 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 1, 469 583, 794 0 879, 091 101. 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 301 119, 112 196, 129 116. 00 SUBTOTALS (SUM OF LINES 1-117) -9, 481, 808 37, 409, 875 118. 00 113,084 124, 470 17, 176, 185 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 38, 113 190, 00 580 580 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 194.00 194. 01 07951 MOB 0 0 Ω 51, 353 143, 145 194. 01 194. 02 07952 COMMUNI TY HEALTH 0 0 106, 518 194. 02 C 72.542 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 C 0 0 194. 03  $\cap$ 194. 04 07954 EDUCATI ON 0 37, 514 194. 04 C 0 194. 05 07955 MARKETI NG 145, 416 578, 376 194. 05 680 680 194.06 07956 GUEST MEALS 50, 208 194. 06 0 C 21, 487 0 194. 07 07957 OUTSIDE LAUNDRY 0 0 194. 07 C 194.08 07958 CANCER CENTER 0 0 194. 08 194. 09 07959 URGENT CARE 0 6, 408 1, 033, 988 1, 791, 462 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 4, 495, 228 3, 488, 265 5, 493, 095 9, 481, 808 202. 00 Part I) 0. 236129 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 39 313195 26 398651 0 296908 204.00 Cost to be allocated (per Wkst. B, 38, 770 763, 320 204. 00 Part II) 0. 019009 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.002096 111)

		TION - STATISTICAL BASIS	CAMERON MEMORI	Provi der C	CN: 15-1315 F	Peri od:	Worksheet B-1	
						From 10/01/2015 o 09/30/2016	Date/Time Pre	pared:
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	2/22/2017 4: 5 CAFETERI A (FTES)	O pm
			7. 00	LAUNDR) 8. 00	9. 00	10.00	11. 00	
	GENER	AL SERVICE COST CENTERS	7.00	6.00	9.00	10.00	11.00	
1.00 2.00 4.00 5.00 7.00	00200 00400 00500	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT	105, 245					1. 00 2. 00 4. 00 5. 00 7. 00
8. 00 9. 00 10. 00 11. 00	00800 00900 01000	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	1, 062 474 3, 922	45, 372 12, 336 54	4, 527 26	14, 706	22, 750	8. 00 9. 00 10. 00
13. 00 14. 00 15. 00	01300	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	1, 985 816 3, 116 1, 155	0	198 0 55 1 39	0 0	22, 750 872 493 551	13. 00 14. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY TENT ROUTINE SERVICE COST CENTERS	1, 107		(		975	
30. 00 31. 00 43. 00	03000	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	16, 155 1, 180 420	89	24	923	4, 622 216 94	31.00
43.00	ANCI L	LARY SERVICE COST CENTERS		· ·			74	43.00
50. 00 51. 00 52. 00	05100 05200	OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	10, 870 7, 107 3, 383	0 607	91	0 0	1, 634 1, 063 231	51. 00 52. 00
54. 00 60. 00 64. 00	06000 06400	RADI OLOGY-DI AGNOSTI C   LABORATORY   I NTRAVENOUS THERAPY	8, 255 2, 774 0	84	218	0 0	2, 291 2, 055 0	60. 00 64. 00
65. 00 65. 01 66. 00	06501 06600	RESPI RATORY THERAPY   SLEEP LAB   PHYSI CAL THERAPY	1, 345 2, 600 5, 982	719 981	51 70 227	o	40 0 1, 253	65. 01 66. 00
69. 00 69. 01 71. 00	06901 07100	ELECTROCARDIOLOGY   CARDIAC REHAB   MEDICAL SUPPLIES CHARGED TO PATIENT	143 820 0			0	0 110 0	69. 01 71. 00
73. 00 76. 00	07300 03020	IMPL. DEV. CHARGED TO PATIENTS   DRUGS CHARGED TO PATIENTS   CHEMICAL DEPENDENCY	0 0	0 0	(	0	0 0 26	73. 00 76. 00
76. 01		ONCOLOGY OTHER SERVICE COST CENTERS	11, 100	0	(	0	0	76. 01
88. 00 89. 00 90. 00 91. 00	08800 08900 09000	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER CLINIC EMERGENCY	0 0 492 9, 544	0	(	0	0 0 270 3, 096	89. 00 90. 00
91.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9, 544	7,878	/55		3, 090	92.00
101. 00	10100	REIMBURSABLE COST CENTERS  HOME HEALTH AGENCY  AL PURPOSE COST CENTERS	1, 469	59	91	0	928	101. 00
	11300	INTEREST EXPENSE						113. 00
	11600	UTILIZATION REVIEW-SNF HOSPICE SUBTOTALS (SUM OF LINES 1-117) HIMBURSABLE COST CENTERS	301 97, 577		4, 380	) 0 14, 706		114. 00 116. 00 118. 00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN DAYCARE-INFANT/TODDLER	580		1			190. 00 194. 00
194. 01 194. 02	07951 07952	MOB COMMUNITY HEALTH	0		1	o	59	194. 01 194. 02
194. 04	07954	ASSISTED LIVING/CAMERON WOODS EDUCATION	0	0	(	0	0	194. 03 194. 04
		MARKETING GUEST MEALS	680	0	(	0		194. 05 194. 06
194. 08	07958	OUTSIDE LAUNDRY CANCER CENTER URGENT CARE Cross Foot Adjustments	0 0 6, 408	0 0	( ) ( ) ( )	0	0	194. 07 194. 08 194. 09 200. 00
201. 00	)	Negative Cost Centers Cost to be allocated (per Wkst. B,	4, 300, 400	184, 644	1, 631, 802	2 615, 515	929, 356	201. 00
203. 00 204. 00	1	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	40. 860848 807, 981		1		40. 850813 162, 648	1
205. 00		Part II) Unit cost multiplier (Wkst. B, Part II)	7. 677144	1. 765648	18. 100950	20. 083979	7. 149363	205. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNI	TY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi d	er CCN: 15-1315	Peri od: From 10/01/2015	Worksheet C Part I
			To 09/30/2016	Date/Time Prepared:

					To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDIATRICS	8, 533, 793		8, 533, 79	3 0	0	30. 00
31.00 03	3100 INTENSIVE CARE UNIT	514, 422		514, 42	2 0	0	31. 00
43.00 04	4300 NURSERY	279, 428		279, 42	8 0	0	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	4, 190, 443		4, 190, 44	3 0	0	50.00
51.00 0	5100 RECOVERY ROOM	2, 184, 802		2, 184, 80	2 0	0	51.00
52. 00 0!	5200 DELIVERY ROOM & LABOR ROOM	762, 700		762, 70	0	0	52. 00
54. 00 0!	5400 RADI OLOGY-DI AGNOSTI C	4, 352, 637		4, 352, 63	7 0	0	54.00
60.00 0	6000 LABORATORY	4, 563, 587		4, 563, 58	7 0	0	60.00
64.00 0	6400 INTRAVENOUS THERAPY	0			0	0	64. 00
65.00 0	6500 RESPIRATORY THERAPY	1, 087, 073	0	1, 087, 07	3 0	0	65. 00
65. 01 0	6501 SLEEP LAB	464, 772	0	464, 77	2 0	0	65. 01
66.00 0	6600 PHYSI CAL THERAPY	2, 179, 325	0	2, 179, 32	5 0	0	66. 00
69. 00 0	6900 ELECTROCARDI OLOGY	464, 393		464, 39	3 0	0	69. 00
69. 01 00	6901 CARDI AC REHAB	258, 110		258, 11	0	0	69. 01
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 556, 430		1, 556, 43	0	0	71. 00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	566, 035		566, 03	5 0	0	72. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	3, 288, 430		3, 288, 43	0	0	73. 00
76. 00 03	3020 CHEMI CAL DEPENDENCY	45, 557		45, 55	7 0	0	76. 00
76. 01 03	3480 ONCOLOGY	2, 901, 064		2, 901, 06	4 0	0	76. 01
OI	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00 08	8900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00 0	9000 CLI NI C	406, 356		406, 35	6 0	0	90. 00
91.00 0	9100 EMERGENCY	5, 710, 810		5, 710, 81	0 0	0	91. 00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 070, 408		2, 070, 40	8	0	92. 00
0	THER REIMBURSABLE COST CENTERS						1
101.00 10	0100 HOME HEALTH AGENCY	1, 219, 462		1, 219, 46	2	0	101. 00
	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113. 00
	1400 UTILIZATION REVIEW-SNF						114. 00
	1600 HOSPI CE	264, 352		264, 35			116. 00
200.00	Subtotal (see instructions)	47, 864, 389	0	47, 864, 38	9 0		200. 00
201.00	Less Observation Beds	2, 070, 408		2, 070, 40	8		201. 00
202.00	Total (see instructions)	45, 793, 981	0	45, 793, 98	1 0	0	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 d	er CCN: 15-1315	Peri od: From 10/01/2015	Worksheet C Part I
			To 09/30/2016	Date/Time Prepared:

				Τ	o 09/30/2016	Date/Time Pre 2/22/2017 4:5	
			Title	XVIII	Hospi tal	Cost	
			Charges	<u> </u>	·		
	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	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	6, 245, 159		6, 245, 159			30. 00
31.00	03100 INTENSIVE CARE UNIT	449, 636		449, 636			31.00
	04300 NURSERY	387, 900		387, 900	)		43.00
	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	1, 499, 346	10, 140, 517	11, 639, 863	0. 360008	0.000000	50. 00
	D5100 RECOVERY ROOM	295, 478	2, 231, 378	2, 526, 856	0. 864633	0.000000	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	405, 522	585, 529	991, 051	0. 769587	0.000000	52. 00
	D5400 RADI OLOGY-DI AGNOSTI C	1, 044, 323	26, 676, 710	27, 721, 033	0. 157016	0.000000	54.00
	06000 LABORATORY	1, 651, 910	12, 103, 765	13, 755, 675	0. 331760	0.000000	60. 00
64.00	06400 INTRAVENOUS THERAPY	0	0	C	0.000000	0.000000	64. 00
	06500 RESPIRATORY THERAPY	919, 486	618, 736	1, 538, 222	0. 706707	0.000000	65. 00
65. 01	D6501 SLEEP LAB	0	1, 008, 473	1, 008, 473	0. 460867	0.000000	65. 01
66.00	D6600 PHYSI CAL THERAPY	670, 126	2, 876, 573	3, 546, 699	0. 614466	0.000000	66. 00
69.00	D6900 ELECTROCARDI OLOGY	99, 901	1, 555, 552	1, 655, 453	0. 280523	0.000000	69. 00
69. 01	D6901 CARDI AC REHAB	15, 254	353, 840	369, 094	0. 699307	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	645, 898	1, 794, 746	2, 440, 644	0. 637713	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	386, 267	571, 834	958, 101	0. 590788	0.000000	72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	1, 111, 983	6, 170, 519	7, 282, 502	0. 451552	0.000000	73. 00
76.00	D3020 CHEMI CAL DEPENDENCY	0	295	295	154. 430508	0.000000	76. 00
76. 01	03480 ONCOLOGY	0	7, 145, 328	7, 145, 328	0. 406009	0.000000	76. 01
	DUTPATIENT SERVICE COST CENTERS						]
88. 00	D8800 RURAL HEALTH CLINIC	0	0	C			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			89. 00
90.00	09000 CLI NI C	0	498, 138	498, 138	0. 815750	0.000000	90. 00
91.00	09100 EMERGENCY	583, 736	13, 957, 232	14, 540, 968	0. 392739	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	247, 476	1, 287, 008	1, 534, 484	1. 349254	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	1, 043, 600	1, 043, 600	)		101. 00
	SPECIAL PURPOSE COST CENTERS						1
113. 00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
116. 00	11600 H0SPI CE	0	503, 806	503, 806			116. 00
200.00	Subtotal (see instructions)	16, 659, 401	91, 123, 579	107, 782, 980	)		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	16, 659, 401	91, 123, 579	107, 782, 980	)		202. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/22/2017 4:50 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	DDS Innationt			

				2/22/2017 4:50 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50. 00
51. 00   05100   RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00   06000   LABORATORY	0. 000000			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 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 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS  76. 00 03020 CHEMI CAL DEPENDENCY	0.000000			73.00
76. 01 03480 ONCOLOGY	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89. 00
90. 00   09000   CLI NI C	0.000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	·			•

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-13	5 Period: Worksheet C From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

			٦	To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
p	(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, 533, 793		8, 533, 793	0	8, 533, 793	30. 00
31.00 03100 INTENSIVE CARE UNIT	514, 422		514, 422	2 0	514, 422	31. 00
43. 00   04300 NURSERY	279, 428		279, 428	3 o	279, 428	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 190, 443		4, 190, 443	0	4, 190, 443	50. 00
51.00   05100   RECOVERY ROOM	2, 184, 802		2, 184, 802	0	2, 184, 802	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	762, 700		762, 700	0	762, 700	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	4, 352, 637		4, 352, 637	7 O	4, 352, 637	54. 00
60. 00   06000   LABORATORY	4, 563, 587		4, 563, 587	7 O	4, 563, 587	60.00
64.00 06400 INTRAVENOUS THERAPY	0		(	ol ol	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	1, 087, 073	0	1, 087, 073	o o	1, 087, 073	65. 00
65. 01  06501   SLEEP LAB	464, 772	0	464, 772	<u>2</u> 0	464, 772	65. 01
66. 00 06600 PHYSI CAL THERAPY	2, 179, 325	0	2, 179, 325	5 o	2, 179, 325	66. 00
69. 00 06900 ELECTROCARDI OLOGY	464, 393		464, 393	o o	464, 393	69. 00
69. 01   06901   CARDI AC   REHAB	258, 110		258, 110	ol ol	258, 110	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 556, 430		1, 556, 430	o	1, 556, 430	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	566, 035		566, 035	ol ol	566, 035	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 288, 430		3, 288, 430	o	3, 288, 430	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	45, 557		45, 557	0	45, 557	76. 00
76. 01 03480 ONCOLOGY	2, 901, 064		2, 901, 064	1 o	2, 901, 064	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0		(	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		(	o	0	89. 00
90. 00  09000   CLI NI C	406, 356		406, 356	0	406, 356	90. 00
91. 00 09100 EMERGENCY	5, 710, 810		5, 710, 810	o	5, 710, 810	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 070, 408		2, 070, 408	3	2, 070, 408	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 219, 462		1, 219, 462	2	1, 219, 462	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
116. 00 11600 HOSPI CE	264, 352		264, 352	2	264, 352	
200.00 Subtotal (see instructions)	47, 864, 389	0	47, 864, 389	0	47, 864, 389	200. 00
201.00 Less Observation Beds	2, 070, 408		2, 070, 408	3	2, 070, 408	
202.00 Total (see instructions)	45, 793, 981	0	45, 793, 98°	0	45, 793, 981	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 d	er CCN: 15-1315	Peri od: From 10/01/2015	Worksheet C Part I
			To 09/30/2016	Date/Time Prepared:

				Τ	o 09/30/2016	Date/Time Pre 2/22/2017 4:5	
			Titl	e XIX	Hospi tal	PPS	
			Charges	<u> </u>	·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	6, 245, 159		6, 245, 159			30. 00
	03100 INTENSIVE CARE UNIT	449, 636		449, 636			31. 00
	04300 NURSERY	387, 900		387, 900	)		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 499, 346	10, 140, 517			0.000000	
	D5100 RECOVERY ROOM	295, 478	2, 231, 378			0.000000	
52.00	D5200 DELIVERY ROOM & LABOR ROOM	405, 522	585, 529	991, 051	0. 769587	0.000000	52. 00
	D5400 RADI OLOGY-DI AGNOSTI C	1, 044, 323	26, 676, 710	27, 721, 033	0. 157016	0.000000	54.00
	06000 LABORATORY	1, 651, 910	12, 103, 765	13, 755, 675	0. 331760	0.000000	60. 00
64.00	06400 INTRAVENOUS THERAPY	0	0	C	0.000000	0.000000	64. 00
	06500 RESPIRATORY THERAPY	919, 486	618, 736	1, 538, 222	0. 706707	0.000000	65. 00
65. 01	06501 SLEEP LAB	o	1, 008, 473	1, 008, 473	0. 460867	0.000000	65. 01
66. 00	06600 PHYSI CAL THERAPY	670, 126	2, 876, 573	3, 546, 699	0. 614466	0.000000	66. 00
69. 00	06900 ELECTROCARDI OLOGY	99, 901	1, 555, 552	1, 655, 453	0. 280523	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	15, 254	353, 840	369, 094	0. 699307	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	645, 898	1, 794, 746	2, 440, 644	0. 637713	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	386, 267	571, 834	958, 101	0. 590788	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 111, 983	6, 170, 519	7, 282, 502	0. 451552	0.000000	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	o	295	295	154. 430508	0.000000	76. 00
76. 01	D3480 ONCOLOGY	o	7, 145, 328	7, 145, 328	0. 406009	0.000000	76. 01
Ī	DUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0.000000	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	(	0. 000000	0.000000	89. 00
90.00	09000 CLI NI C	o	498, 138	498, 138	0. 815750	0.000000	90. 00
91.00	09100 EMERGENCY	583, 736	13, 957, 232	14, 540, 968	0. 392739	0.000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	247, 476	1, 287, 008	1, 534, 484	1. 349254	0.000000	92. 00
Ī	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	1, 043, 600	1, 043, 600	)		101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 H0SPI CE	o	503, 806	503, 806			116. 00
200.00	Subtotal (see instructions)	16, 659, 401	91, 123, 579				200.00
201.00	Less Observation Beds			, ,			201.00
202.00	Total (see instructions)	16, 659, 401	91, 123, 579	107, 782, 980			202. 00
'	, ,			•			•

Health Financial Systems	CAMERON MEMORIA	_ COMMUNITY	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	5   Period:   Worksheet (   From 10/01/2015   Part     To 09/30/2016   Date/Time F   2/22/2017		
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				

				2/22/2017 4:50 pm
		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 OPERATI NG ROOM	0. 360008			50.00
51.00   05100   RECOVERY ROOM	0. 864633			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 769587			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 157016			54.00
60. 00   06000   LABORATORY	0. 331760			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 706707			65. 00
65. 01   06501   SLEEP LAB	0. 460867			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 614466			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 280523			69. 00
69. 01   06901 CARDI AC REHAB	0. 699307			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 637713			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 590788			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 451552			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	154. 430508			76. 00
76. 01 03480 ONCOLOGY	0. 406009			76. 01
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00   09000   CLI NI C	0. 815750			90.00
91. 00 09100 EMERGENCY	0. 392739			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 349254			92.00
OTHER REIMBURSABLE COST CENTERS	·			
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1=02.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-1315	From 10/01/2015	Worksheet C Part II Date/Time Prepared:

Cost Center Description  Total Cost (Wkst. B, Part (Wkst. B, Part Net of Capital I, col. 26) Cost (col. 1 - col. 2)  Z/22/2017 4:50 process	
(Wkst. B, Part   (Wkst. B, Part   Net of Capital   Reduction   Reduction   Amount	
I, col. 26) II col. 26) Cost (col. 1 - Amount	
col. 2)	
1.00 2.00 3.00 4.00 5.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00   05000   0PERATI NG ROOM   4, 190, 443   921, 007   3, 269, 436   0   0   50	0. 00
	. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   762, 700   266, 610   496, 090   0   5.	2. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 4, 352, 637 710, 189 3, 642, 448 0 0 5	1. 00
60. 00   06000   LABORATORY   4, 563, 587   368, 917   4, 194, 670   0   0   60	0. 00
64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   6	1. 00
65. 00   06500   RESPI RATORY THERAPY   1, 087, 073   118, 738   968, 335   0   0   6	5. 00
65. 01   06501   SLEEP LAB   464, 772   96, 214   368, 558   0   0   6	5. 01
66. 00   06600   PHYSI CAL THERAPY 2, 179, 325 488, 166 1, 691, 159 0 0 6	o. 00
	9. 00
69. 01   06901   CARDI AC REHAB   258, 110   66, 132   191, 978   0   0   6	9. 01
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   1,556,430   99,065   1,457,365   0   0   7	. 00
	2. 00
	3. 00
76. 00   03020   CHEMI CAL   DEPENDENCY   45, 557   1, 095   44, 462   0   0   76	5. 00
	5. 01
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 8	3. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 8	9. 00
90. 00   09000   CLI NI C   406, 356   48, 941   357, 415   0   0   90	0. 00
91. 00   09100   EMERGENCY   5, 710, 810   864, 623   4, 846, 187   0   0   9	. 00
92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   2,070,408   407,848   1,662,560   0   0   9.	2. 00
OTHER REI MBURSABLE COST CENTERS	
101. 00 10100 HOME HEALTH AGENCY 1, 219, 462 76, 950 1, 142, 512 0 0 10	. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE 11:	3. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114	1. 00
116. 00 11600 HOSPI CE 264, 352 15, 971 248, 381 0 0 116	. 00
200.00 Subtotal (sum of lines 50 thru 199) 38,536,746 6,168,275 32,368,471 0 0 200	). 00
201.00 Less Observation Beds 2,070,408 407,848 1,662,560 0 0 20	. 00
202.00 Total (Line 200 minus Line 201) 36, 466, 338 5, 760, 427 30, 705, 911 0 0 20	. 00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-1315	From 10/01/2015	Worksheet C Part II Date/Time Prepared:

						2/22/2017 4:50 pm
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
			(Worksheet C,			
		Operating Cost	Part I, column	Ratio (col. o	5	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS				_	
50.00	05000 OPERATI NG ROOM	4, 190, 443				50.00
51. 00	05100 RECOVERY ROOM	2, 184, 802				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	762, 700	991, 051	0. 76958	7	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	4, 352, 637			6	54.00
60.00	06000 LABORATORY	4, 563, 587	13, 755, 675			60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		64.00
65.00	06500 RESPIRATORY THERAPY	1, 087, 073			7	65. 00
65. 01	06501 SLEEP LAB	464, 772	1, 008, 473	0. 46086	7	65. 01
66.00	06600 PHYSI CAL THERAPY	2, 179, 325	3, 546, 699	0. 61446	6	66. 00
69.00	06900 ELECTROCARDI OLOGY	464, 393	1, 655, 453	0. 28052	3	69. 00
69. 01	06901 CARDI AC REHAB	258, 110	369, 094	0. 69930	7	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 556, 430	2, 440, 644	0. 63771	3	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	566, 035	958, 101	0. 59078	8	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 288, 430	7, 282, 502	0. 45155	2	73.00
76.00	03020 CHEMI CAL DEPENDENCY	45, 557	295	154. 43050	8	76. 00
76. 01	03480 ONCOLOGY	2, 901, 064	7, 145, 328	0.40600	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	0.00000	0	89. 00
90.00	09000 CLI NI C	406, 356	498, 138	0. 81575	0	90.00
91.00	09100 EMERGENCY	5, 710, 810	14, 540, 968	0. 39273	9	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 070, 408	1, 534, 484	1. 34925	4	92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	1, 219, 462	1, 043, 600	1. 16851	5	101. 00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 I NTEREST EXPENSE					113. 00
114.00	11400 UTILIZATION REVIEW-SNF					114. 00
116.00	11600 HOSPI CE	264, 352	503, 806	0. 52471	0	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	38, 536, 746	100, 700, 285			200. 00
201.00	Less Observation Beds	2, 070, 408	0			201. 00
202.00	Total (line 200 minus line 201)	36, 466, 338	100, 700, 285			202. 00
		•		•	•	•

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part II	pared:
			XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)		to Charges	Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
50. 00 05000 OPERATING ROOM	921, 007	11, 639, 863	0. 07912	5 464, 865	36, 782	50.00
51. 00 05100 RECOVERY ROOM	568, 046			3 88, 992	20, 006	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	266, 610	991, 051	0. 26901	7 4, 028	1, 084	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	710, 189	27, 721, 033	0. 02561	9 452, 790	11, 600	54.00
60. 00   06000   LABORATORY	368, 917	13, 755, 675	0. 02681	9 637, 422	17, 095	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	118, 738	1, 538, 222	0. 07719	2 395, 250	30, 510	65. 00
65. 01   06501   SLEEP LAB	96, 214	1, 008, 473	0. 09540	0	0	65. 01
66. 00   06600 PHYSI CAL THERAPY	488, 166	3, 546, 699	0. 13764	0 170, 159	23, 421	66. 00
69. 00 06900 ELECTROCARDI OLOGY	20, 509	1, 655, 453				
69. 01   06901   CARDI AC REHAB	66, 132	369, 094	0. 17917	4 2, 360	423	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	99, 065	2, 440, 644			9, 877	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36, 050	958, 101	0. 03762	199, 920	7, 522	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	140, 675	7, 282, 502	0. 01931	7 433, 136	8, 367	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	1, 095	295	3. 71186	0	0	76. 00
76. 01 03480 ONCOLOGY	852, 529	7, 145, 328	0. 11931	3 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89. 00
90. 00   09000   CLI NI C	48, 941	498, 138	0. 09824	.8	0	90.00
91 00 09100 EMERGENCY	864 623	14 540 968	0.05946	14 225	846	91 00

864, 623

407, 848 6, 075, 354

0.059461

0. 265788

498, 138 14, 540, 968 1, 534, 484 99, 152, 879

14, 225

235, 056 3, 384, 378

846 91.00

62, 475 92. 00 230, 539 200. 00

91. 00 09100 EMERGENCY

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

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared:

			'	0 07/30/2010	2/22/2017 4:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician N	ursing School	Allied Health	All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	0	0	0	50.00
51.00  05100   RECOVERY ROOM	0	0	0	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
60. 00  06000  LABORATORY	0	0	0	0	0	60.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00  06500  RESPI RATORY THERAPY	0	0	0	0	0	65. 00
65. 01  06501  SLEEP LAB	0	0	0	0	0	65. 01
66. 00  06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
69. 00  06900  ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01  06901  CARDI AC REHAB	0	0	0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76.00 03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	76. 00
76. 01 03480 ONCOLOGY	0	0	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC	0	0	0	0	0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00  09000  CLI NI C	0	0	0	0	0	90.00
91. 00   09100   EMERGENCY	0	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
200.00   Total (lines 50-199)	0	0	0	0	0	200. 00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		RVICE OTHER PAS	S Provider CO		Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Pre 2/22/2017 4:5	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Cost (sum of		to Charges (col. 5 ÷ col	Ratio of Cost to Charges	Inpatient Program Charges	
		col . 2, 3 and 4)	8)	7)	(col. 6 ÷ col.		
		6.00	7. 00	8. 00	9, 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7.00	101.00	
50.00	05000 OPERATI NG ROOM	0	11, 639, 863	0.00000	0. 000000	464, 865	50.00
51.00	05100 RECOVERY ROOM	0	2, 526, 856	0. 00000	0. 000000	88, 992	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	991, 051	0. 00000	0. 000000	4, 028	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	27, 721, 033	0.00000	0. 000000	452, 790	54. 00
60.00	06000 LABORATORY	0	13, 755, 675	0.00000		637, 422	60.00
	1	0	0	0. 00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 538, 222	0.00000	0. 000000	395, 250	65. 00
65. 01	06501 SLEEP LAB	0	1, 008, 473			0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	3, 546, 699			170, 159	
69. 00	06900 ELECTROCARDI OLOGY	0	1, 655, 453			42, 844	
69. 01	06901 CARDI AC REHAB	0	369, 094			2, 360	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 440, 644			243, 331	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	958, 101	0. 00000	0. 000000	199, 920	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 282, 502	0. 00000	0. 000000	433, 136	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0	295	0.00000	0. 000000	0	76. 00
76. 01	03480 ONCOLOGY	0	7, 145, 328	0. 00000	0. 000000	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	00.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89. 00
00 00	DOUDO CLINIC	1	/02 132	0 00000	0 000000	0	on nn

498, 138

14, 540, 968 1, 534, 484 99, 152, 879

0.000000

0.000000

0.000000

0. 000000 0. 000000

0.000000

0.000000

90.00 0

14, 225 91. 00

235, 056 92. 00 3, 384, 378 200. 00

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

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

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1315	From 10/01/2015	Worksheet D Part IV Date/Time Prepared:

				10	07/ 30/ 2010	2/22/2017 4: 5	
		Titl∈	XVIII		Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Through				
	Costs (col. 8		Costs (col.	9			
	x col. 10)		x col. 12)				
	11.00	12.00	13. 00				
ANCILLARY SERVICE COST CENTERS							
50.00   05000   OPERATING ROOM	0	0	)	0			50. 00
51.00   05100   RECOVERY ROOM	0	0	)	0			51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	)	0			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)	0			54.00
60. 00   06000   LABORATORY	0	0	)	0			60.00
64.00   06400   I NTRAVENOUS THERAPY	0	0		0			64. 00
65. 00   06500   RESPI RATORY THERAPY	0	0		0			65. 00
65. 01  06501   SLEEP LAB	0	0		0			65. 01
66. 00   06600 PHYSI CAL THERAPY	0	0		0			66. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0		0			69. 00
69. 01   06901   CARDI AC   REHAB	0	0		0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0			73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0		0			76. 00
76. 01 03480 ONCOLOGY	0	0		0			76. 01
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC	0	O	)	0			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0			89. 00
90. 00  09000 CLI NI C	o	0		0			90.00
91. 00   09100   EMERGENCY	o	0		0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0		0			92.00
200.00 Total (lines 50-199)	0	0		0			200. 00
			•				

Health Financial Systems		CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prepared:

				1	To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
			Title	xVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 360008	l .	2, 494, 955		0	00.00
	05100 RECOVERY ROOM	0. 864633	0	427, 298		0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 769587	0	4, 189		0	02.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 157016		6, 695, 993		0	
	06000 LABORATORY	0. 331760	l .	3, 332, 074	1 0	0	00.00
	06400 INTRAVENOUS THERAPY	0. 000000	0	(	0	0	64. 00
	06500 RESPI RATORY THERAPY	0. 706707	0	476, 758		0	65. 00
	06501 SLEEP LAB	0. 460867	0	10, 534		0	00.0.
	06600 PHYSI CAL THERAPY	0. 614466		938, 929		0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 280523	0	458, 769	9 0	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 699307	0	117, 849	9 0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 637713		386, 713	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 590788	0	122, 056		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 451552	0	1, 957, 826	6, 228	0	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	154. 430508	0	(	0	0	76. 00
76. 01	03480 ONCOLOGY	0. 406009	0	2, 067, 693	3 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 815750	0	240, 859	9 0	0	90.00
91.00	09100 EMERGENCY	0. 392739	0	2, 915, 011	1, 966	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 349254	0	697, 148	2, 359	0	92.00
200.00	Subtotal (see instructions)		0	23, 344, 654	10, 553	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	23, 344, 654	10, 553	0	202. 00

Health Financial Systems		CAMERON	MEMORI AL	COMMUNITY		In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVI				CN: 15-1315	Peri od: From 10/01/2015	Worksheet D
						10 07/30/2010	2/22/2017 4:50 p

			Т	o 09/30/2016	Date/Time Prepared: 2/22/2017 4:50 pm	:
		Title	XVIII	Hospi tal	Cost	_
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	898, 204	l			50. 0	
51.00   05100   RECOVERY ROOM	369, 456	l .			51. 0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	3, 224	l .			52. 0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 051, 378	l .			54. 0	
60. 00  06000 LABORATORY	1, 105, 449	0			60. 0	
64.00   06400   I NTRAVENOUS THERAPY	0	0			64. 0	Ю
65. 00   06500   RESPI RATORY THERAPY	336, 928	0			65. 0	Ю
65. 01  06501 SLEEP LAB	4, 855	0			65. 0	)1
66. 00   06600 PHYSI CAL THERAPY	576, 940	0			66. 0	Ю
69. 00   06900   ELECTROCARDI OLOGY	128, 695	0			69. 0	Ю
69. 01   06901   CARDI AC REHAB	82, 413	0			69. 0	)1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	246, 612	0			71. 0	)()
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	72, 109	0			72. 0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	884, 060	2, 812			73. 0	0
76. 00 03020 CHEMI CAL DEPENDENCY	0	0			76. 0	00
76. 01 03480 ONCOLOGY	839, 502	0			76. 0	)1
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0			88. 0	Ю
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 0	0
90. 00   09000   CLI NI C	196, 481	0			90.0	0
91. 00   09100   EMERGENCY	1, 144, 839	772			91. 0	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	940, 630	3, 183			92. 0	Ю
200.00 Subtotal (see instructions)	8, 881, 775	6, 767			200. 0	00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 0	00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	8, 881, 775	6, 767			202. 0	Ю

Health Financial Systems	CAMERON MEMORIA	L COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	/ICES AND VACCINE COST	Provider CCN: 15			Worksheet D	
				om 10/01/2015		
		Component CCN: 1	5-Z315   To	09/30/2016	Date/Time Prep	pared:
		·			2/22/2017 4:50	) pm
		Title XVII	I Sw	ing Beds - SNF	Cost	
		C	harges		Costs	
Cost Center Description	Cost to Charge Pi	PS Reimbursed	Cost	Cost	PPS Services	

						2/22/2017 4:5	O pm
			Ti tl e	xVIII S	wing Beds - SNF	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0. 360008	C	) (	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 864633	C	) (	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 769587	C	) (	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 157016	C	) (	0	0	54.00
60.00	06000 LABORATORY	0. 331760	C	) (	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	C	) (	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 706707	C	) (	o	0	65. 00
65. 01	06501 SLEEP LAB	0. 460867	C	) (	o	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 614466	C	) (	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 280523	C	) (	o	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 699307	C	) (	o	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 637713	C	) (	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 590788	C	) (	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 451552	C	) (	o	0	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	154. 430508	C	) (	o	0	76. 00
76. 01	03480 ONCOLOGY	0. 406009	C	) (	o	0	76. 01
	OUTPATIENT SERVICE COST CENTERS				*		
88. 00	08800 RURAL HEALTH CLINIC	0.000000				0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 815750	C	) (	0	0	90.00
91.00	09100 EMERGENCY	0. 392739	C	) (	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 349254	C	) (	0	0	92.00
200.00	Subtotal (see instructions)		C	) (	0	0	200. 00
201.00	1 '			1	o o		201. 00
	Only Charges						
202.00	1 1 3 9		C	) (	0	0	202. 00

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Component	CN: 15-1315 CCN: 15-Z315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Pre	narod:
		Component	CCN. 13-2313	10 077 307 2010	2/22/2017 4:5	
			XVIII	Swing Beds - SNF	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
	,	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0				50.00
51.00   05100   RECOVERY ROOM	0	0				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00   06000   LABORATORY	0	0	)			60.00
64.00   06400   I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
65. 01  06501   SLEEP LAB	0	0				65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	)			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	2			69. 00
69. 01   06901   CARDI AC   REHAB	0	0	2			69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	2			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				72. 00 73. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03020   CHEMI CAL   DEPENDENCY		0				76.00
76. 00   03020  CHEMI CAL DEPENDENCY		0	()			76.00

0 0 0

76. 01

88. 00

89. 00

90.00

91.00 92. 00

200.00

201. 00

202. 00

03480 ONCOLOGY

90. 00 09000 CLI NI C

91.00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

88. 00 08800 RURAL HEALTH CLINIC

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 +/- line 201)

76. 01

200.00

201.00

202.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY In Lieu of Form					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2015		
				To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
		Ti tl	e XIX	Hospi tal	PPS	Орш
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		, i	
	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 & PEDI ATRI CS	1, 681, 064	107, 822	1, 573, 24	2 4, 319	364. 26	30. 00
31.00 INTENSIVE CARE UNIT	115, 677		115, 67	7 214	540. 55	31. 00
43. 00 NURSERY	42, 984		42, 98	4 434	99. 04	43.00
200.00 Total (lines 30-199)	1, 839, 725		1, 731, 90	3 4, 967		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	59	21, 491		·		30. 00
31.00 INTENSIVE CARE UNIT	37	20, 000	)			31.00
43. 00 NURSERY	0	0	)			43.00
200.00 Total (lines 30-199)	96	41, 491				200. 00

	Health Financial Systems CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10							
	Financial Systems						2552-10	
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der CO		Peri od:	Worksheet D		
					From 10/01/2015 Fo 09/30/2016		narod:	
					10 09/30/2010	2/22/2017 4:5		
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs		
	<b>'</b>	Related Cost	(from Wkst. C,		Program	(column 3 x		
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)		
		Part II, col.	8)	2)		,		
		26)	ŕ	,				
		1.00	2.00	3.00	4. 00	5. 00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	921, 007	11, 639, 863	0. 079125	15, 775	1, 248	50.00	
51.00	05100 RECOVERY ROOM	568, 046	2, 526, 856	0. 224803	3, 109	699	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	266, 610	991, 051	0. 269017	4, 301	1, 157	52. 00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	710, 189	27, 721, 033	0. 025619	10, 987	281	54. 00	
60.00	06000 LABORATORY	368, 917	13, 755, 675	0. 026819	17, 380	466	60.00	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0. 000000	0	0	64. 00	
65.00	06500 RESPIRATORY THERAPY	118, 738	1, 538, 222	0. 077192	9, 674	747	65. 00	
65. 01	06501 SLEEP LAB	96, 214	1, 008, 473	0. 095406	6	0	65. 01	
66. 00	06600 PHYSI CAL THERAPY	488, 166	3, 546, 699	0. 137640	7, 050	970	66. 00	
69. 00	06900 ELECTROCARDI OLOGY	20, 509			1, 051	13	69. 00	
69. 01	06901 CARDI AC REHAB	66, 132				29	69. 01	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	99, 065	2, 440, 644	0. 040590	10, 859	441	71. 00	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	36, 050		0. 037627		0	72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	140, 675	7, 282, 502	0. 019317	11, 699	226	73. 00	
76. 00	03020 CHEMI CAL DEPENDENCY	1, 095				0	76. 00	
	03480 ONCOLOGY	852, 529				0	76. 01	
	OUTPATIENT SERVICE COST CENTERS	, 02.	.,,020				1	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0. 000000	0	0	88. 00	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		ا	0. 000000		0	89. 00	
90. 00	09000 CLI NI C	48, 941	498, 138			0	90.00	
	00100 EMEDCENCY	044 422				245		

864, 623

409, 428 6, 076, 934

0. 059461

0. 266818

6, 650 104, 836

14, 540, 968 1, 534, 484 99, 152, 879

365 91.00

1, 774 92. 00 8, 416 200. 00

91. 00 09100 EMERGENCY

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

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	TS Provider Co		Period: From 10/01/2015 To 09/30/2016		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	l o		0	l o	43.00
200.00 Total (lines 30-199)	0	O		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
		ĺ .		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 319	0.00	5	9 0		30.00
31.00 03100 INTENSIVE CARE UNIT	214	0.00	) 3	7 0		31.00
43. 00   04300 NURSERY	434	l .	•	0		43.00
200.00   Total (lines 30-199)	4, 967	l .	I .	6 0		200. 00

Health Financial Systems	CAMERON MEMORIAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared:

				1	0 09/30/2016	2/22/2017 4:50	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0	0	0	50. 00
	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
	06000 LABORATORY	0	0	0	0	0	60.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
	06501 SLEEP LAB	0	0	0	0	0	65. 01
	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	06901 CARDI AC REHAB	0	0	0	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	76. 00
	03480 ONCOLOGY	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	09000 CLI NI C	0	0	0	0	01	90. 00
	09100 EMERGENCY	0	0	0	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Heal th	Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	S Provider C		Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Pre 2/22/2017 4:5	
			Ti tl	e XIX	Hospi tal	PPS	o piii
	Cost Center Description	Total	Total Charges			Inpati ent	
	·	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	11, 639, 863			15, 775	
51. 00	05100 RECOVERY ROOM	0	2, 526, 856	•		•	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	991, 051	•		4, 301	52. 00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	27, 721, 033				54. 00
60.00	06000 LABORATORY	0	13, 755, 675			17, 380	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 538, 222	0.00000		9, 674	65. 00
65. 01	06501 SLEEP LAB	0	1, 008, 473	0.00000	0. 000000	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	3, 546, 699			7, 050	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 655, 453	0.00000	0. 000000	1, 051	69. 00
69. 01	06901 CARDI AC REHAB	0	369, 094	0.00000	0. 000000	160	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 440, 644	0.00000	0. 000000	10, 859	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	958, 101	0.00000	0. 000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 282, 502	0.00000	0. 000000	11, 699	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0	295	0.00000	0. 000000	0	76. 00
76. 01	03480 ONCOLOGY	0	7, 145, 328	0.00000	0. 000000	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89. 00
90 00	09000 CLINIC	1 0	498 138	0 00000	0 000000	0	90 00

498, 138

14, 540, 968 1, 534, 484 99, 152, 879

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

90.00 0

6, 141 91. 00

6, 650 92. 00 104, 836 200. 00

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

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

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared:

					2/22/2017 4: 5	50 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11. 00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	C		0		50.00
51.00   05100   RECOVERY ROOM	0	C		0		51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C		0		52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00   06000   LABORATORY	0	C		0		60.00
64.00   06400   I NTRAVENOUS THERAPY	0	C		0		64. 00
65. 00   06500   RESPI RATORY THERAPY	0	C		0		65. 00
65. 01   06501   SLEEP LAB	0	C		0		65. 01
66. 00   06600   PHYSI CAL THERAPY	0	C		0		66. 00
69. 00   06900   ELECTROCARDI OLOGY	0	C		0		69. 00
69. 01   06901   CARDI AC REHAB	0	C		0		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	C		0		76. 00
76. 01 03480 ONCOLOGY	0	C		0		76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89. 00
90. 00   09000   CLI NI C	0	C		0		90. 00
91. 00   09100   EMERGENCY	0	C		0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92. 00
200.00 Total (lines 50-199)	0	C		0		200.00
	·					

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:	15-1315	Peri od: From 10/01/2015	Worksheet D-1	
				To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
		Title X\	/111	Hospi tal	Cost	
Cost Center Description						

3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)			Title XVIII	Hospi tal	Cost	o piii
INPATITION DAYS   INPATITION		Cost Center Description				
MARTIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Inpattient days (Including private room days and swing-bed days, excluding newborn)						
Private room days (excluding seing-bed and observation bed days)   If you have only private room days   0   3.00	1.00		s, excluding newborn)		4, 855	1. 00
do not complete this line.  4.00 Selli-private room days (excluding swing-bed and observation bod days)  5.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period calendar year, enter 0 on this line)  9.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days)  10.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  11.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  11.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  12.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  13.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  14.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  15.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  16.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  17.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  18.00 Swing-bod SW type inpatient days applicable to title XWIII only (including private room days)  18.00 Swing-bod SW type inpatient days applicable to t					4, 319	2. 00
Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SW type inpartient days (including private room days) after December 31 of the cost reporting period in Call Swing-bed SW type inpartient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to the Program (excluding swing-bed and 1,185 9.00 10.00 Swing-bed SW type inpartient days applicable to title xVIII only (including private room days) through December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SW type inpartient days applicable to title xVIII only (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  10.00 Swing-bed W type inpatient days applicable to title xVIII only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to titles V or XX only (including private room days)  10.00 Swing-bed W type inpatient days applicable to services after December 31 of the cost reporting period (including to the cost reporting period (including to the cost report	3.00		/s). If you have only pri	vate room days,	0	3. 00
Total saring bed SW Type Inpatient days (Including private room days) after December 31 of the cost	4 00		od days)		2 105	4 00
reporting period (if cal endar year, enter 0 on this line)  7. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  8. 00 Total sing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding sping-bed and neaborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  15. 00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  16. 00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  17. 00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  18. 00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  18. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  18. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  18. 00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days)  18. 00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (line SNF type services applicable to services after December 31 of the cost reporting period (line SNF type services after December 31 of the c				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total sing bed Mr type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles y or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles y or XIX only (including private room days) 15.00 Intola nursery days (title V or XIX only) 16.00 Mays private room days applicable to titles y or XIX only (including private room days) 17.00 Total nursery days (title V or XIX only) 18.00 Nedically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nedical rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nedical rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Nedical rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00	0.00		adyer till edgi. December	0. 0. 1 0001	· ·	0.00
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost proporting period (if calendar year, enter 0 on this line)  100 Variety of the cost proporting period (if calendar year, enter 0 on this line)  100 Variety of the cost proporting period (if calendar year, enter 0 on this line)  100 Variety of the cost reporting period (if calendar year, enter 0 on this line)  100 Variety of the cost reporting period (if calendar year, enter 0 on this line)  100 Variety of the cost reporting period (see instructions)  100 Variety of the cost reporting period (see instructions)  101 Variety of the cost reporting period (if calendar year, enter 0 on this line)  102 Variety of the cost reporting period (if calendar year, enter 0 on this line)  103 Variety of the cost reporting period (if calendar year, enter 0 on this line)  104 Variety of the cost reporting period (if calendar year, enter 0 on this line)  105 Variety of the cost reporting period (if calendar year, enter 0 on this line)  106 Variety of the cost reporting period (if calendar year, enter 0 on this line)  107 Variety of the cost reporting period (if calendar year, enter 0 on this line)  108 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar on the period (if calendar year, enter 0 on this line)  109 Variety of the cost reporting period (if calendar year, enter 0 on thi	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	296	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed Switers of 10 of the cost reporting period (see instructions)  11. 00 Swing-bed Switers of 10 of the cost reporting period (see instructions)  12. 00 Swing-bed Switers of 10 of the cost reporting period (see instructions)  13. 00 Swing-bed Switers of 10 of the cost reporting period (see instructions)  14. 00 Medically necessary private room days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (see instructions)  14. 00 Medically necessary private room days applicable to titles Vor XIX only (including private room days) of 13. 00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) of 13. 00 Swing-bed NF type inpatient days applicable to titles Vor XIX only (including private room days) of 14. 00 Medically necessary private room days applicable to titles Vor XIX only (including private room days) of 14. 00 Medically necessary private room days applicable to titles Vor XIX only (including private room days) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain dursery days (title Vor XIX only) of 15. 00 Inclain durser		reporting period (if calendar year, enter 0 on this line)			_	
10   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   1.185   9.00   10tal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   287   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   287   11.00   287	7.00		n days) through December	31 of the cost	0	7.00
reporting period (if calledar year, enter 0 on this line)  10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions)  13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Y or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title Y or XIX only)  16.00 Nursery days (title Y or XIX only)  17.00 Nursery days (title Y or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medical dare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical dare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical dare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical dare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical dare for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical dare for swing-bed NF service	8 00		n days) after December 3	1 of the cost	240	8 00
newborn days	0.00		. aayo, artor boodiiibor o		2.0	0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Next on the XIX only (including private room days) 16.00 Notice and inversely days (title V or XIX only) 17.00 Notice BOD ADUSTNETH 17.00 SNIM BED ADUSTNETH 18.00 Redicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Redicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Redicare rate for swing-bed SNF services applicable to services after December 31 of the cost 134.09 19.00 Redical drate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 Redical drate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost 137.30 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x k line 18) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x k line 18) 24.00 Swing-bed cost applicable to SNF type services after De	9.00		the Program (excluding	swi ng-bed and	1, 185	9. 00
through December 31 of the cost reporting period (see instructions)  11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line)  12.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Norry days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Including private room days)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days)  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days applicable to services after December 31 of the cost (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including private room days applicable to SNF type services after December 31 of the cost reporting period (Including	40.00					40.00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Interference on the private room days applicable to the Program (excluding swing-bed days) 16.00 Medical nursery days (title V or XIX only) 17.00 Medical nursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period including swing-bed some period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x including private	10.00			oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00	11. 00			oom davs) after	287	11. 00
through December 31 of the cost reporting period  13.00 arg bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Navery days (title V or XIX only)  17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  17.00 Navery days (title V or XIX only)  18.00 Navery days (title V or XIX only)  19.00 Navery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost applicable to services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line solve)  20.00 Swing-bed cost applicable to NF						
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) and refree December 31 of the cost reporting period (If calendar year, enter 0 on this line)  14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  18.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Inc. 00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (Inc. 00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Inc. 00 Modicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (Inc. 01 Modicare)  19.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Inc. 01 Modicare)  20.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Inc. 01 Modicare)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Inc. 01 Nova)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (Inc. 01 Nova)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc. 01 Nova)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc. 01 Nova)  26.00 Total swing-bed cost (see instructions)  27.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (Inc. 01 Nova)  28.00 General inpatient routine service cost (see Charges)  29.00 Office of the swing-bed cost (see instructions)  29.00 Office of the swing-bed cost	12.00		only (including private	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, énter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medical race rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting reporting period reporting period reporting reportin	40.00					40.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 32)  24.00 Total swing-bed cost (see instructions)  25.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost	13.00				0	13.00
15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting report	14.00	Medically necessary private room days applicable to the Progra	am (excludina swina-bed a	davs)	0	14. 00
SWI NG BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 134.09 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 Total general inpatient routine service cost (see instructions)  21.00 Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  29.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26)  29.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average peride minus line service cost /charge ratio (line 27 + line 28)  30.00 Average peride minus line service cost /charge ratio (line 27 + line 28)  30.00 Average peride minus line service cost			(		0	15. 00
17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost   134.09   19.00   20.00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   137.30   20.00   reporting period   19.00   20.00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   137.30   20.00   20.00   20.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   5 x line 17)   22.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   5 x line 18)   22.00   2	16.00	Nursery days (title V or XIX only)			0	16. 00
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 134.09 19.00 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Total swing-bed cost (see instructions) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost charges ratio (line 27 + line 28) 32.00 Average per jivate room per diem charge (line 29 + line 3) 33.00 Average per private room per diem charge (line 30 + line 4) 34.00 Average per private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instruct						
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period on the cost reporting period period reporting period period reporting period period reporting period (and arate for swing-bed NF services applicable to services after December 31 of the cost reporting period (and arate for swing-bed NF services applicable to services after December 31 of the cost reporting period (and arate for swing-bed NF service cost (see instructions) (and service) (and arate for swing-bed NF service cost (see instructions) (and service) (and servi	17. 00		es through December 31 o	f the cost		17. 00
reporting period  10.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 + line 3)  30.00 Average perivate room per diem charge (line 30 + line 4)  30.00 Average perivate room cost differential (line 32 minus line 33) (see instructions)  31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 31)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 37 x line 38)  35.00 Application (see instructions)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient	18 00		es after December 31 of	the cost		18 00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 8,533,793 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7, 955, 609 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 0, 29.00 Private room charges (excluding swing-bed charges) 0, 29.00 Private room charges (excluding swing-bed charges) 0, 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.00 32.00 Average per diem private room per diem charge (line 30 + line 4) 0.00 33.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 33.00 33.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room cost differential (line 37 x line 31) 0.00 35.00 Average per diem private room cost differential (line 37 x line 31) 0.00 35.00 Average per diem private room cost differential (line 30 x line 31)	10.00		arter becomber 31 or	the cost		10.00
20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average period (line 27 + line 3)  33. 00 Average period (line 27 + line 3)  34. 00 Average period (line 27 + line 3)  35. 00 Average period (line 27 + line 3)  36. 00 Private room cost differential (line 34 x line 31)  37. 00 General inpatient routine service cost differential (line 32 minus line 33)(see instructions)  38. 00 Average period emprivate room charge differential (line 34 x line 31)  39. 00 Average period (line 27 + line 36)  30. 00 Average period (line 27 + line 36)  30. 00 Average period (line 27 + line 36)  30. 00 Average period (line 28 + line 37)  30. 00 Average period (line 28 + line 36)  30. 00 Average period (line 28 + line 36)  30. 00 Average period (line 28 + line 36)  30. 00 Average period (line 28 + line 36)  30. 00 Average period (line 28 + line 36)  30. 00 Average period (line 28 + line 36)  30. 00 Average p	19. 00		s through December 31 of	the cost	134.09	19. 00
reporting period  Total general inpatient routine service cost (see instructions)  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  25.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00  Total swing-bed cost (see instructions)  Total swing-bed cost (see instructions)  Total swing-bed cost (see instructions)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Definition of the cost reporting period (line 8 x line 20)  Swing-bed cost (see instructions)  Total swing-bed cost (see instructions)  Sometime troutine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service cost/charge ratio (line 27 + line 28)  Sometime troutine service cost/charge ratio (line 27 + line 28)  Sometime troutine service cost/charge ratio (line 27 + line 28)  Sometime troutine service cost/charge ratio (line 28 minus line 33)(see instructions)  Sometime troutine service cost net of swing-bed cost and private room cost differential (line 3 x line 31)  Sometime troutine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  Total swing-bed cost applicable to NF type service safter December 31 of the cost reporting period (line 8 x line 31)  Sometime troutine service cost net of swing-bed cost and private room cost						
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26.00 Total general inpatient routine service cost net of swing-bed cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Fivate ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20.00		s after December 31 of th	ne cost	137. 30	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 X line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  31.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 3 x line 35)  34.00 Private room cost differential adjustment (line 3 x line 35)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  48.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  49.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21 00	, , , , , , , , , , , , , , , , , , , ,	3)		8 533 793	21 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed sarges)  30.00 Average private room per diem charge (line 29 * line 3)  30.00 Average per diem private room cost differential (line 30 * line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost diffe				ng period (line		
x     ine   18    24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   7 x line   19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   8   32,952   25.00   x line   20)   26.00   Total swing-bed cost (see instructions)   578,184   26.00   27.00   Ceneral inpatient routine service cost net of swing-bed cost (line   21 minus   line   26)   7,955,609   27.00   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT			·			
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 12, 952 25. 00 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average per diem private room per diem charge (line 30 + line 4)  33. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 1ine 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  32. 00 Average semi-private room per diem charge (line 30 + line 4)  33. 00 Average per diem private room cost differential (line 32 x line 31)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00		21 of the cost reportion	ag ported (Line	0	24 00
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 1 ine 20)  26. 00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 31 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  30. 00 Adj usted general inpatient routine service cost per diem (see instructions)  30. 00 Adj usted general inpatient routine service cost (line 9 x line 38)  30. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		31 of the cost reportin	ig perrou (Trile	O	24.00
Total swing-bed cost (see instructions)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Average per diem private room cost applicable to the Program (line 14 x line 35)  O do do. 00  Average per diem private room cost applicable to the Program (line 14 x line 35)	25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	32, 952	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7, 955, 609 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00 Average private room per diem charge (line 29 + line 3)  32. 00 Average semi-private room per diem charge (line 30 + line 4)  33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 27. 00 40. 00						
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  O 28.00  29.00 Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  O 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 31)  O 00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Average per diem private room cost differential (line 3 x line 38)  Average per diem private room cost differential (line 3 x line 33) (see instructions)  Avera			(1: 21 -: 1: 2/)			
28. 00 29. 00 29. 00 29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 30	27.00		(Tine 21 minus Tine 26)		7, 955, 609	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 31.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 37.00 37.00	28. 00		d and observation bed cha	arges)	0	28. 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0				a. goo)	-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  7, 955, 609  7, 955, 609  37.00  38.00  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  34.00  35.00  36.00  37.00  27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  2, 182, 770  40.00			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  7, 955, 609  7, 955, 609  7, 955, 609  7, 955, 609  37.00  38.00  37.00  40.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 955, 609 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	nue lino 22)(soo instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 955, 609)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 7, 955, 609 37.00 38.00 38.00 9, 955, 609 37.00 2, 1842.00 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00				11 0113)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 955, 609 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 2, 955, 609  37.00 2, 955, 609  37.00 2, 955, 609  37.00 2, 955, 609  37.00 2, 955, 609  37.00 2, 955, 609		, , ,	3.,			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,842.00 38.00  Program general inpatient routine service cost (line 9 x line 38)  2,182,770 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,842.00 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,842.00 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,842.00 38.00  2,182,770 39.00  40.00			ICTUENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2, 182, 770 39.00 40.00	30 00			T	1 042 00	30 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
		, ,	•			
	41. 00	, , , , , , , , , , , , , , , , , , , ,	•		2, 182, 770	41. 00

Heal th	n Financial Systems CAMERON MEMORIA	L COMMUNITY	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Peri od: From 10/01/2015	Worksheet D-1	
			To 09/30/2016	Date/Time Prep 2/22/2017 4:50	
		Title XVIII	Hospi tal	Cost	5 piii
	Cost Center Description Total	Total Average Per	Program Days	Program Cost (col. 3 x col.	
		col . 2)		4)	
42. 00	NURSERY (title V & XIX only) 0	2.00 3.00	4.00	5. 00 0	42. 00
	Intensive Care Type Inpatient Hospital Units	014		4/5 0/5	40.00
43. 00 44. 00	1	214 2, 403. 8	4 69	165, 865	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT				45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				46. 00 47. 00
	Cost Center Description	·		1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)		1. 00 1, 719, 123	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(s PASS THROUGH COST ADJUSTMENTS	ee instructions)		4, 067, 758	49. 00
50. 00	Pass through costs applicable to Program inpatient routine s	ervices (from Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary	services (from Wkst. D, s	um of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)			0	52. 00
53. 00	Total Program inpatient operating cost excluding capital rel medical education costs (line 49 minus line 52)	ated, non-physician anesth	etist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION			_	
54. 00 55. 00	Program discharges Target amount per discharge			0 0. 00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)			0	56.00
57. 00 58. 00	, , , , ,	get amount (line 56 minus	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period e	nding 1996, updated and co	mpounded by the	0.00	59. 00
60.00				0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 e which operating costs (line 53) are less than expected costs			0	61. 00
	amount (line 56), otherwise enter zero (see instructions)	(1111c3 54 X 00), 01 1% 01	the target		
62. 00 63. 00	,	tions)		0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST		ng period (See	0	64. 00
	instructions)(title XVIII only)	·			
65. 00	instructions) (title XVIII only)			528, 654	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 6 CAH (see instructions)	4 plus line 65)(title XVII	l only). For	528, 654	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through (line 12 x line 19)	December 31 of the cost re	porting period	0	67. 00
68. 00	1 <u></u>	cember 31 of the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (I PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY,			0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID rout	ine service cost (line 37)			70. 00
71. 00 72. 00		ne 70 ÷ line 2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program				73. 00
74. 00 75. 00			art II. column		74. 00 75. 00
76. 00	26, line 45)				76. 00
77. 00	Program capital-related costs (line 9 x line 76)				77. 00
78. 00 79. 00		ovi der records)			78. 00 79. 00
80.00	Total Program routine service costs for comparison to the co	· .	us line 79)		80. 00
81. 00 82. 00	' ·				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions	)			83. 00
84. 00 85. 00		s)			84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 thr				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)			1, 124	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ Observation bed cost (line 87 x line 88) (see instructions)	line 2)		1, 842. 00 2, 070, 408	
U7. UU	Tobact various bed cost (Title of A Title 00) (See Tilstructions)			2,070,408	07.00

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016		
		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, 681, 064	8, 533, 793	0. 19698	9 2, 070, 408	407, 848	90.00
91.00 Nursing School cost	0	8, 533, 793	0.00000	0 2, 070, 408	0	91.00
92.00 Allied health cost	o	8, 533, 793	0.00000	0 2, 070, 408	0	92.00
93.00 All other Medical Education	o	8, 533, 793	0.00000	0 2, 070, 408	0	93. 00

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2	552-10	
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN: 15-1315	Peri od:	Worksheet D-1		
				From 10/01/2015 To 09/30/2016	Date/Time Prep 2/22/2017 4:50		
			Title XIX	Hospi tal	PPS		
	Cost Center Description						
					1.00		
	PART I - ALL PROVIDER COMPONENTS						
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn) 4,855 1.						
2.00	2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 4,319					2.00	
3 00	O Private room days (excluding swing-hed and observation hed days) If you have only private room days						

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 855	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 319	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		1
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 195	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
,	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	296	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	U <sub> </sub>	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	240	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	240	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	59	9. 00
7.00	newborn days)	9,	1
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		1
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		1
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ا	
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	434	
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT		17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period		16.00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	report in g peri od	0.00	17.00
20.00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		1
21.00	Total general inpatient routine service cost (see instructions)	8, 533, 793	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		1
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25 00	7 x line 19)		25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)	547, 345	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 986, 448	•
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7, 900, 440	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	ı
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 986, 448	37.00
	27 minus line 36)		l
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		l
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 849. 14	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	109, 099	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	109, 099	41.00

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	O/ INICION INICINOTOTY	AL COMMUNITY Provider	CCN: 15-1315	Peri od:	wof Form CMS-2 Worksheet D-1	
					From 10/01/2015 To 09/30/2016	Date/Time Pre	
			Ti t	le XIX	Hospi tal	2/22/2017 4: 5 PPS	U pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Pers Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1. 00 279, 428	2. 00	3. 00 4 643.	4. 00 84 0	5. 00	42. 0
2.00	Intensive Care Type Inpatient Hospital Units			71 043.	04  0		72.0
3. 00	INTENSIVE CARE UNIT	514, 422	21	4 2, 403.	84 37	88, 942	43.0
4. 00							44. 0
5. 00	BURN INTENSIVE CARE UNIT						45.0
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 0 47. 0
7.00	Cost Center Description						47.0
	<u>,                                      </u>					1. 00	
8.00	Program inpatient ancillary service cost (Wk					54, 337	•
9. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		252, 378	49.0
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D su	m of Parts I and	41, 491	50 O
0. 00		attent routine	301 11 003 (11 0	iii iii(3t. b, 3di	m or rarts r and	11, 171	00.0
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	8, 416	51.0
2 00	and IV)	FO and F1)				40.007	E2 0
2.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anest	hetist and	49, 907 202, 471	
0.00	medical education costs (line 49 minus line		ratea, non pri	yor or arr arrest	noti st, and	202, 171	00.0
	TARGET AMOUNT AND LIMIT COMPUTATION						
4. 00						-	54.0
5. 00 6. 00						0.00	55. 0 56. 0
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	line 53)	0	1
8. 00	1	g	, g (			0	
9. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.0
0 00	market basket	cost roport up	datad by the	markat backat		0.00	60.0
0.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less that					Ü	" "
	amount (line 56), otherwise enter zero (see	instructions)			Ü		
2.00	,					0	
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.0
	instructions)(title XVIII only)						
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	65)(title XVI	II only) For	0	66.0
0.00	CAH (see instructions)		o. p. 45	00) (11 11 0 7111		Ü	00.0
7. 00	9 1	e costs through	December 31	of the cost r	eporting period	0	67.0
0 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient routin	o costs often D	ocombor 21 of	the cost ron	orting ported	0	68.0
0.00	(line 13 x line 20)	e costs after b	ecember 31 01	the cost rep	orting perrou	0	00.0
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69.0
0.0-	PART III - SKILLED NURSING FACILITY, OTHER N						
0.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70.0
1. 00 2. 00			ine /o = iine	<i>∠)</i>			72.0
3. 00	Medically necessary private room cost applic	,	(line 14 x l	ine 35)			73. 0
4. 00	Total Program general inpatient routine serv	•		•			74.0
5. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 0
6. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7. 00	Program capital related costs (line 9 x line	,					77. C
8. 00	,						78.0
9. 00	Aggregate charges to beneficiaries for exces				==:		79.0
0.00	,		ost limitatio	n (IIne 78 mi	nus line 79)		80.0
1.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				82.0
3. 00	Reasonable inpatient routine service costs (		•				83. 0
4. 00	Program inpatient ancillary services (see in	structions)					84. 0
	Utilization review - physician compensation						85.0
6. 00	Total Program inpatient operating costs (sum		rough 85)				86.0
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					1, 124	87 0
	Adjusted general inpatient routine cost per	•					
8. 00	That asted general impatrent routine cost per	arem (irne 27 ÷	line 2)			1, 849. 14	J 00. C

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 10/01/2015 To 09/30/2016		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 681, 064	8, 533, 793	0. 19698	9 2, 078, 433	409, 428	90.00
91.00 Nursing School cost	0	8, 533, 793	0.00000	2, 078, 433	0	91.00
92.00 Allied health cost	0	8, 533, 793	0.00000	2, 078, 433	0	92.00
93.00 All other Medical Education	0	8, 533, 793	0.00000	2, 078, 433	0	93.00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	CAMERON MEMORIAL COMMUNITY	CCN: 15-1315		eu of Form CMS-1	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider	CN: 15-1315	Peri od: From 10/01/2015	Worksheet D-3	
				To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
		Ti tl	e XVIII	Hospi tal	Cost	о рііі
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				, and the second	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			1, 599, 550		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			138, 000		31. 00
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS				1	
50.00			0. 36000			1
51. 00	05100 RECOVERY ROOM		0. 86463			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 76958			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1570			1
60.00	06000 LABORATORY		0. 33176		1	
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00	06500 RESPI RATORY THERAPY		0. 70670		1	1
65. 01	06501 SLEEP LAB		0. 46086		0	
66. 00	06600 PHYSI CAL THERAPY		0. 61446			1
69. 00	06900 ELECTROCARDI OLOGY		0. 28052			1
69. 01	06901 CARDI AC REHAB		0. 69930			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 6377			1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 59078			1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 4515	· ·		1
76. 00	03020 CHEMI CAL DEPENDENCY		154. 43050			
76. 01	03480 ONCOLOGY		0. 40600	09 0	0	76. 01
00 00	OUTPATIENT SERVICE COST CENTERS		0.0000	20		00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC		0.00000		0	
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90.00	09000 CLI NI C 09100 EMERGENCY		0. 81575 0. 39273			
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 3492!			
200.00	,		1. 34923	3, 384, 378		
200.00	1 1 .	rogram only charges (line 61)	1	3, 384, 378	1	200.00
201.00		rogram only charges (Title 01)		3, 384, 378	l	201.00
202.00	Incr charges (Time 200 millias Time 201)		1	3, 304, 370	I	1202.00

Health Financial Systems		CAMERON MEMORIAL COMMUNITY		In Lieu of Form CM		
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provide		Provi der C		Peri od:	Worksheet D-3	
		Component		From 10/01/2015 To 09/30/2016	Date/Time Pre	narad.
		Component	CCN: 15-Z315	10 09/30/2016	2/22/2017 4:5	
		Title	XVIII :	Swing Beds - SNF		o piii
	Cost Center Description		Ratio of Cost		Inpati ent	
	<b>'</b>		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	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		1	-1		
	05000 OPERATI NG ROOM		0. 36000			50.00
51.00	05100 RECOVERY ROOM		0. 86463		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 76958		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 15701			54.00
60.00	06000 LABORATORY		0. 33176		l	60.00
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0 9, 899	64. 00 65. 00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB		0.70670	· ·	9, 899	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 46086 0. 61446		1	
69. 00	06900 ELECTROCARDI OLOGY		0. 61446		100, 143	69.00
69. 01	06901 CARDI AC REHAB		0. 28032			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 63771			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 59078	· ·	0, 434	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 45155		17, 400	
76. 00	03020 CHEMI CAL DEPENDENCY		154. 43050	· ·	· ·	76.00
	03480 ONCOLOGY		0. 40600			76. 01
	OUTPATIENT SERVICE COST CENTERS			-		
88. 00	08800 RURAL HEALTH CLINIC		0.00000	o	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90.00			0. 81575		0	90.00
91.00	09100 EMERGENCY		0. 39273		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 34925	4, 780	6, 449	92.00
200.00	Total (sum of lines 50-94 and 96-98)			253, 491	146, 071	200. 00
201.00	Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			253, 491		202. 00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Hoal +b	Financial Systems	CAMERON MEMORIAL COMMUNITY		In Lie	u of Form CMS	2552 10
Title XIX				CCN: 15-1315	Peri od:		
NAME   Cost Center Description   Ratio of Cost   Inpatient   Program Costs (col. 1 x col. 2)						Data /Tima Dra	narad.
NPATIENT ROUTINE SERVICE COST CENTERS   NACIONAL SERVICE COS					10 09/30/2016		
NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.			Ti t	le XIX	Hospi tal		
INPATI ENT ROUTI NE SERVI CE COST CENTERS   1.00   2.00   3.00		Cost Center Description					
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00				To Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   3.00					Charges		
NPATIENT ROUTINE SERVICE COST CENTERS   55, 432   30.00   30.00   30.00   ADULTS & PEDIATRICS   55, 432   31.00   31.00   30.00   INTENSI VE CARE UNIT   4, 731   31.00   43				1 00	2 00		
30.00   03000   ADULTS & PEDIATRICS   55, 432   31.00   03100   INTENSI VE CARE UNIT   31.00   04300   NURSERY   0   4.731   31.00   04300   NURSERY   0   0   43.00   AVAILARY SERVICE COST CENTERS   0.00   05000   PERATING ROOM   0.864633   3, 109   2, 688   51.00   05100   RECOVERY ROOM   0.864633   3, 109   2, 688   51.00   05200   DELI VERY ROOM & LABOR ROOM   0.864633   3, 109   2, 688   51.00   05200   DELI VERY ROOM & LABOR ROOM   0.769587   4, 301   3, 310   52.00   05200   DELI VERY ROOM & LABOR ROOM   0.769587   4, 301   3, 310   52.00   05000   DELI VERY ROOM & LABOR ROOM   0.71000   0.71000   0.71000   0.71000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.710000   0.7100000   0.7100000   0.7100000   0.7100000   0.7100000   0.7100000   0.71000000   0.71000000   0.71000000   0.71000000   0.710000000   0.710000000   0.710000000   0.7100000000   0.7100000000   0.7100000000   0.71000000000   0.7100000000000000   0.7100000000000000000000000000000000000		INDATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
31.00   03100   INTENSI VE CARE UNIT   0.04300   NURSERY   0.04300   NURSERY   0.04300   0.04300   NURSERY   0.04300   0.043					55 432		30 00
43. 00   04300   NURSERY   0   0   43.00   NURSERY   N							
50. 00   05000   OPERATI NG ROOM   0.360008   15,775   5,679   50. 00   51. 00   05100   RECOVERY ROOM   0.864633   3, 109   2,688   51. 00   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0.769587   4, 301   3, 310   52. 00   05200   DELI VERY ROOM & LABOR ROOM   0.769587   4, 301   3, 310   52. 00   05400   RADI OLOGY-DI AGNOSTI C   0.157016   10,987   1,725   54. 00   06. 00   06. 00   0.4000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000							
51.00   05100   RECOVERY ROOM   0.864633   3,109   2,688   51.00   52.00   05200   DELI VERY ROOM & LABOR ROOM   0.769587   4,301   3,310   52.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.157016   10,987   1,725   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.331760   17,380   5,766   60.00   64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0   64.00   64.00   65.00   06500   RESPI RATORY THERAPY   0.706707   9,674   6,837   65.00   65.01   06501   SLEEP LAB   0.460867   0   0   65.01   66.00   06600   PHYSI CAL THERAPY   0.68087   0   0   65.01   66.00   06600   PHYSI CAL THERAPY   0.68070   0.50070				1		!	
52.00   05200   DELIVERY ROOM & LABOR ROOM   0.769587   4,301   3,310   52.00     54.00   05400   RADIO LOCY-DI AGNOSTI C   0.157016   10,987   1,725   54.00     60.00   06000   LABORATORY   0.331760   17,380   5,766   60.00     64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0.44.00     65.00   06500   RESPIRATORY THERAPY   0.706707   9,674   6,837   65.00     65.01   06501   SLEEP LAB   0.460867   0   0.650.01     60.00   06600   PHYSI CAL THERAPY   0.630707   9,674   6,837   65.00     69.00   06600   PHYSI CAL THERAPY   0.640867   0   0.650.01     60.00   06600   PHYSI CAL THERAPY   0.640867   0   0.650.01     60.00   06600   PHYSI CAL THERAPY   0.630707   1.051   295   69.00     69.01   06901   CARDIA CREHAB   0.699307   1.051   295   69.00     69.01   06901   CARDIA CREHAB   0.699307   1.060   112   69.01     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.5970788   0   0.72.00     73.00   07300   DRUGS CHARGED TO PATIENTS   0.590788   0   0.72.00     73.00   07300   DRUGS CHARGED TO PATIENTS   0.451552   11,699   5,283     76.01   03480   NOCOLOGY   0.406009   0   0.76.01     03480   NOCOLOGY   0.406009   0   0.76.01     03480   NOCOLOGY   0.406009   0   0.76.01     03480   NOCOLOGY   0.815750   0   0.9000     09.00   09000   CILINI C   0.000000   0   88.00     09.00   09000   CILINI C   0.000000   0   0.815750   0   0.9000     10.00   09000   DEMERGENCY   0.392739   6,141   2,412   91.00     92.00   09200   DESERVATI ON BEDS (NON-DISTINCT PART   1.349254   6,650   8,973   92.00     201.00   201.00   EMERGENCY   0.000000   0   0.00000     201.00   0.00   0.00   0.00   0.00000   0.00000     201.00   0.00   0.00   0.00   0.00000   0.00000     201.00   0.00   0.00   0.00000   0.00000   0.00000   0.00000     201.00   0.00   0.00   0.000000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000	50. 00	05000 OPERATING ROOM		0. 36000	08 15, 775	5, 679	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 157016   10, 987   1, 725   54. 00   60. 00   60000   LABORATORY   0. 000000   0   0   64. 00   06400   INTRAVENOUS THERAPY   0. 000000   0   0   64. 00   06500   RESPI RATORY THERAPY   0. 706707   9, 674   6, 837   65. 00   65. 01   65				0. 86463	3, 109	2, 688	51.00
60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB 60. 00 6600 PHYSI CAL THERAPY 60. 00 06600 PHYSI CAL THERAPY 60. 00 06600 PHYSI CAL THERAPY 60. 00 06600 PHYSI CAL THERAPY 60. 00 06900 ELECTROCARDI OLOGY 60. 01 06901 CARDI AC REHAB 60. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 60. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 60. 00 07300 DRUGS CHARGED TO PATI ENTS 60. 00	52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 76958	4, 301	3, 310	52. 00
64. 00   06400   INTRAVENOUS THERAPY   0.000000   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0.706707   9, 674   6, 837   65. 00   06501   SLEEP LAB   0.460867   0   0   65. 01   06501   SLEEP LAB   0.460867   0   0   65. 01   06501   06900   ELECTROCARDI OLOGY   0.280523   1, 051   295   69. 00   06900   ELECTROCARDI OLOGY   0.280523   1, 051   295   69. 00   06901   CARDI AC REHAB   0.699307   160   112   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.637713   10, 859   6, 925   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0.590788   0   0.280523   11, 699   5, 283   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.590788   0   0.72. 00   07300   DRUGS CHARGED TO PATIENTS   0.451552   11, 699   5, 283   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.451552   11, 699   5, 283   73. 00   076. 00   03480   ONCOLOGY   0.406009   0   0   0   76. 00   076. 00   03480   ONCOLOGY   0.406009   0   0   0   0   0   0   0   0   0							1
65. 00   06500   RESPI RATORY THERAPY   0. 706707   9, 674   6, 837   65. 00		l e e e e e e e e e e e e e e e e e e e					
65. 01   06501   SLEEP LAB   0.460867   0   0.65. 01     66. 00   06600   PHYSI CAL THERAPY   0.6144466   7,050   4,332   66. 00     69. 00   06900   ELECTROCARDI OLOGY   0.280523   1,051   295   69. 00     69. 01   06901   CARDI AC REHAB   0.699307   160   112   69. 01     71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   0.637713   10,859   6,925   71. 00     72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.590788   0   0   72. 00     73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.451552   11,699   5,283   73. 00     76. 00   03020   CHEMI CAL DEPENDENCY   154. 430508   0   0   76. 00     76. 01   00000   0.406009   0   0   0     76. 01   000000   0.000000   0   0     88. 00   08800   RURAL HEALTH CLINI C   0.000000   0   0   89. 00     90. 00   09000   CLINI C   0.815750   0   0   90. 00     91. 00   09200   08SERVATI ON BEDS (NON-DI STINCT PART   1.349254   6,650   8,973   92. 00     200. 00   00000   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   0   00000     00. 000000   0.000000   0.000000   0							
66. 00							
69. 00   06900   CARDI AC REHAB   0. 699307   160   112   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 637713   10, 859   6, 925   71. 00   072.00   MPL. DEV. CHARGED TO PATI ENTS   0. 590788   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 451552   11, 699   5, 283   73. 00   07300   CHEMI CAL DEPENDENCY   154. 430508   0   0   0   76. 00   03480   ONCOLOGY   0. 406009   0   0   0   0   76. 01   000000   0   0   0   0   0   0   0							
69. 01 06901 CARDI AC REHAB							1
71. 00							
72. 00						l	
73. 00							
76. 00				1			
76. 01 03480 ONCOLOGY 0. 406009 0 0 76. 01 OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0. 0.000000 0 0 0 88. 00 89. 00 O9000 CLINIC 0. 815750 0 0 0 90. 00 90. 00 O9100 EMERGENCY 0. 392739 6, 141 2, 412 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 349254 6, 650 8, 973 92. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0. 406009 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
S8. 00   OBSON   RURAL HEALTH CLINIC   O. 000000   O   O   S8. 00							
88. 00				0. 10000	5,1		70.01
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0.000000   0   89. 00   90. 00   90. 00   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   201. 00   0.000000   0.000000000000000000				0,0000	00 0	0	88. 00
91. 00   09100   EMERGENCY   0. 392739   6, 141   2, 412   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   1. 349254   6, 650   8, 973   92. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   2						0	1
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   1.349254   6,650   8,973   92. 00   200. 00   Total (sum of lines 50-94 and 96-98)   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00	90. 00	09000 CLI NI C		0. 8157	50 0	0	90.00
200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)  104,836 54,337 200.00 201.00	91. 00	09100 EMERGENCY		0. 39273	6, 141	2, 412	91.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 3492	6, 650	8, 973	92.00
					104, 836	54, 337	
202.00   Net Charges (line 200 minus line 201)   104,836   202.00			rogram only charges (line 61)		J		
	202. 00	Net Charges (line 200 minus line 201)			104, 836		202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/22/2017 4:50 pm
	Title XVIII	Hospi tal	Cost

PART. B MEDICAL_AND_OTHER_HEALTH SERVICES   1.00				To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
ART B - MEDICAL AND OTHER HEALTH SERVICES			Title XVIII	Hospi tal		- p
Name					1 00	
Medical and other services reimbursed under OPPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
PS payments   0   0   0   0   0   0   0   0   0	1.00	Medical and other services (see instructions)			8, 888, 542	1.00
0.0   Unit in payment (see instructions)   0.0   4.		· · · · · · · · · · · · · · · · · · ·	ti ons)			
Enter the fiospital specific payment to cost ratio (see instructions)   0.000   5.						
Line 2 times line 5			ctions)			
7.00         Sum of Fline 3 plus line 4 divided by line 6         0.00         0.00         8           8.00         Transit fonal corridor payment (see instructions)         0         8           9.00         Ancillary service other pass through costs from Wkst. D, Pt. IV. col. 13, line 200         0         0           11.00         Total cost (sum of lines 1 and 10) (see instructions)         0         10           12.00         Ancillary service charges         0         12           12.00         Ancillary service charges         0         12           14.00         Organ acquisition charges (from Wkst. B-4, Pt. III. col. 4, line 69)         0         12           15.00         Angregate amount actually collected from patients liable for payment for services on a charge basis.         0         14           15.00         Aggregate amount actually collected from patients liable for payment for services on a chargebasis.         0         15           16.00         Total customary charges (see instructions)         0         0         0           17.00         Date sees of customary charges (see instructions)         0         0         0           19.00         Excess of customary charges (see instructions)         0         0         0         0         0           19.00         Total customary cha			211 0113)			1
0.00   0.00					0.00	
10.00   Organ acquisitions   8, 888, 542   1.00   Total cost (sum of lines 1 and 10) (see instructions)   8, 888, 542   1.00   Total cost (sum of lines 1 and 10) (see instructions)   0   12.   1.00   1.0	8.00	Transitional corridor payment (see instructions)			0	8.00
1.0		, ,	IV, col. 13, line 200		_	
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges (Prom Wkst. D-4, Pt. III, col. 4, Iine 69)					_	
Reasonable charges	11.00				8, 888, 542	] 11.00
13.00   Organ acquistion charges (From Wisst. D-4, Pt. III, col. 4, line 69)   0   13.						
14.00   Total reasonable charges (sum of lines 12 and 13)   14.					0	
Customary charges   Customary charges   O   15.			ne 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.	14.00				0	14. 00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   a had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.	15 00		navment for services on	a charge hasis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)		, 66 6	3	•		
18.00   Total customary charges (see instructions)   0   18.		had such payment been made in accordance with 42 CFR §413.13(6	e)	Ü		
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19.						1
instructions    20.00			:£  : 10 -  :	11) (	-	
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.	19.00		y II ITHE 18 exceeds II	ne II) (See	U	19.00
Instructions	20. 00		y if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0   22.		l				
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.			e instructions)			1
Total prospective payment (sum of lines 3, 4, 8 and 9)		·	suctions)		-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance (for CAH, see instructions)   40,039   25.			detrons)			1
26.00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)         4,009,000         26.           27.00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         4,928,298         27.           28.00         Direct graduate medical education costs (from Wkst. E-4, line 50)         0         28.           29.00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29.           30.00         Subtotal (sum of lines 27 through 29)         4,928,298         30.           31.00         Primary payer payments         1,061         31.           32.00         Subtotal (line 30 minus line 31)         4,927,237         32.           34.00         Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         30.	2 00					1 00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,928,298   27.	25. 00	· · · · · · · · · · · · · · · · · · ·				
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.		· ·		1 007 (		
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28.	27.00		olus the sum of lines 22	and 23] (see	4, 928, 298	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29.   30.00   Subtotal (sum of lines 27 through 29)   4, 928, 298   30.   31.00   Frimary payer payments   1,061   31.   32.00   Subtotal (line 30 minus line 31)   4, 927, 237   32.   32.   32.   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.   34.00   Allowable bad debts (see instructions)   733, 045   34.   35.00   Adjusted reimbursable bad debts (see instructions)   476, 479   35.   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   5, 403, 716   37.   38.00   MSP-LCC reconciliation amount from PS&R   0   39.   39.   39.   50   Pioneer ACO demonstration payment adjustment (see instructions)   39. 99   Partial or full credits received from manufacturers for replaced devices (see instructions)   39. 99   AECOVERY OF ACCELERATED DEPRECIATION   0   39.   39. 99   ACCELERATED DEPRECIATION   0   39.   40. 00   Subtotal (see instructions)   5, 403, 716   40.   40	28. 00	l	ne 50)		0	28. 00
31.00   Primary payer payments   1,061   31.   4,927,237   32.		, , , , , , , , , , , , , , , , , , , ,			0	29. 00
32.00   Subtotal (line 30 minus line 31)   A, 927, 237   32.	30.00	Subtotal (sum of lines 27 through 29)			4, 928, 298	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I - 5, I ine 11)						
33. 00 Composite rate ESRD (from Wkst. I-5, line 11)  34. 00 All lowable bad debts (see instructions)  35. 00 Adjusted reimbursable bad debts (see instructions)  36. 00 All lowable bad debts (see instructions)  37. 30. 00 All lowable bad debts for dual eligible beneficiaries (see instructions)  38. 00 Subtotal (see instructions)  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  40. 00 Subtotal (see instructions)  50 Sequestration adjustment (see instructions)  51 Aday (10 All Devices	32. 00	· ,	2567		4, 927, 237	32. 00
34.00       Allowable bad debts (see instructions)       733,045       34.         35.00       Adjusted reimbursable bad debts (see instructions)       476,479       35.         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       608,985       36.         37.00       Subtotal (see instructions)       5,403,716       37.         38.00       MSP-LCC reconciliation amount from PS&R       0       38.         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.         39.50       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.         39.99       Pactial or full credits received from manufacturers for replaced devices (see instructions)       0       39.         40.01       Sequestration adjustment (see instructions)       5,403,716       40.         40.01       Sequestration adjustment (see instructions)       5,403,716       40.         41.00       Interim payments       4,882,296       41.         42.00       Balance due provider/program (see instructions)       413,346       43.         44.       Original outlier amount (see instructions)       90.       90.         90.00       The rate used to calculate the Time Value of Money       90.       90.     <	33 00	Composite rate FSRD (from Wkst 1-5 line 11)	JES)		0	33.00
35. 00 Adj usted reimbursable bad debts (see instructions) 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 01 Sequestration adjustment (see instructions) 40. 02 Subtotal (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 5115. 2  TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 Ten rate used to calculate the Time Value of Money 0 On 91. 00 0 Time Value of Money (see instructions) 0 On 92. 00 Time Value of Money (see instructions) 0 On 93.						
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}\frac{115}{5}\frac{2}{15}\frac{1}{5}\fr		, ,				1
38.00 MSP-LCC reconciliation amount from PS&R 0 38. 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 39.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 40.00 Subtotal (see instructions) 5, 403, 716 40. 40.01 Subtotal (see instructions) 108,074 40. 41.00 Interim payments 1108,074 40. 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 413, 346 43. 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 45.00 Ottlier reconciliation adjustment amount (see instructions) 0 90. 46.00 Ottlier reconciliation adjustment amount (see instructions) 0 90. 47.00 Ottlier reconciliation adjustment amount (see instructions) 0 90. 48.00 The rate used to calculate the Time Value of Money 10 90. 49.00 Time Value of Money (see instructions) 0 93.			ructions)			
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 5, 403, 716 40. 41. 00 Interim payments 42. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Outlier reconciliation adjustment amount (see instructions) 79. 00 Outlier reconciliation adjustment amount (see instructions) 79. 00 The rate used to calculate the Time Value of Money 79. 00 Time Value of Money (see instructions)		1				
39. 50 Pioneer ACO demonstration payment adjustment (see instructions)  39. 88 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  5, 403, 716  40. 01 Sequestration adjustment (see instructions)  10 Interim payments  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2    TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  79. 00 The rate used to calculate the Time Value of Money  92. 00 Time Value of Money (see instructions)  93. 00 Time Value of Money (see instructions)  94. 00 Outlier reconciliation adjustment amount (see instructions)  93. 00 Time Value of Money (see instructions)  94. 00 Outlier of Money (see instructions)  95. 00 Outlier of Money (see instructions)  96. 00 Outlier of Money (see instructions)  97. 00 Outlier of Money (see instructions)  98. 00 Outlier of Money (see instructions)						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  5, 403, 716 40.  40. 01 Sequestration adjustment (see instructions)  108, 074 40.  41. 00 Interim payments  108, 074 40.  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  0 90.  91. 00 Outlier reconciliation adjustment amount (see instructions)  10 90.  91. 00 The rate used to calculate the Time Value of Money  10 93.  93. 00 Time Value of Money (see instructions)  0 93.			-)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  5, 403, 716 40.  40. 01 Sequestration adjustment (see instructions)  108, 074 40.  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, s115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  0 riginal outlier amount (see instructions)  10 90.  91. 00 Outlier reconciliation adjustment amount (see instructions)  10 90.  92. 00 The rate used to calculate the Time Value of Money  10 93.  11 92.  12 93.  13 94.  14 94.  15 94.  16 95.  17 96.  18 96.  18 97.  19 98.  19 99.  19 99.  19 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.  10 99.				tions)	-	
40.00 Subtotal (see instructions)  5, 403, 716 40.  40.01 Sequestration adjustment (see instructions)  108, 074 40.  11 Interim payments  Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{5}{15}.2\$  \$\frac{10}{10} \text{ BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions)  0 outlier reconciliation adjustment amount (see instructions)  10 90.  91.00 Other rate used to calculate the Time Value of Money  11 me Value of Money (see instructions)  12		·	204 401. 000 (000		0	39. 99
41. 00       Interim payments       4, 882, 296       41.         42. 00       Tentative settlement (for contractors use only)       0       42.         43. 00       Balance due provider/program (see instructions)       413, 346       43.         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       44.         For BE COMPLETED BY CONTRACTOR       0       90.       00       90.         90. 00       Original outlier amount (see instructions)       0       91.         92. 00       Outlier reconciliation adjustment amount (see instructions)       0       91.         92. 00       The rate used to calculate the Time Value of Money       0.00       92.         93. 00       Time Value of Money (see instructions)       0       93.					5, 403, 716	1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 413,346 43.  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00	40. 01	Sequestration adjustment (see instructions)			108, 074	40. 01
43.00 Balance due provider/program (see instructions)  413,346 43.  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Attached the Time Value of Money  95.00 Time Value of Money (see instructions)  96.00 Option Time Value of Money (see instructions)  97.00 Option Time Value of Money (see instructions)  98.00 Time Value of Money (see instructions)		1 3				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5115.2}\$ \frac{10 \text{ BE COMPLETED BY CONTRACTOR}}\$  90.00 Original outlier amount (see instructions) \$0 \text{ Outlier reconciliation adjustment amount (see instructions)}\$  91.00 The rate used to calculate the Time Value of Money \$0.00 \text{ Outlier reconciliation adjustment amount}\$  10.00 92.  11.00 Time Value of Money (see instructions) \$0 \text{ Outlier reconciliation}\$  12.00 Time Value of Money (see instructions) \$0 \text{ Outlier reconciliation}\$  13.00 Time Value of Money (see instructions) \$0 \text{ Outlier reconciliation}\$		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.		, , , , , , , , , , , , , , , , , , , ,	aco with CMS Dub. 15.2	chantor 1		1
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 90. 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91. 92.00 The rate used to calculate the Time Value of Money 0.00 92. 93.00 Time Value of Money (see instructions) 0 93.	44.00		ice with own run. 10-2,	σπαρτοί Ι,		44.00
90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 90.  0 91.  0 92.  0 93.  0 93.						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92. 93.00 Time Value of Money (see instructions) 0 93.		Original outlier amount (see instructions)				
93.00 Time Value of Money (see instructions) 0 93.		,				
77. 00   10tai (30iii 01 111ie3 71 ana 70)		· ·				
	74.00	Total (Sum of Filios / Edite 75)				1 /4.00

Provider CCN: 15-1315

					2/22/2017 4:50	) pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 902, 592	2	4, 726, 696	1. 00
2.00	Interim payments payable on individual bills, either				0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	04/14/2016	234, 300		155, 600	3. 01
3. 02		09/30/2016	185, 900		0	3. 02
3.03			(		0	3. 03
3.04			(		0	3. 04
3. 05			(	)	0	3. 05
	Provi der to Program	l	_		_	
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51			(		0	3. 51
3. 52			(		0	3. 52
3.53			(		0	3. 53
3.54			(		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		420, 200	)	155, 600	3. 99
4 00	3. 50-3. 98)		2 222 702		4 000 004	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		3, 322, 792	<u>′</u>	4, 882, 296	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02					l ol	5. 02
5. 03					l ol	5. 03
	Provider to Program	•	•			
5.50	TENTATI VE TO PROGRAM		(	)	0	5. 50
5. 51			(		0	5. 51
5.52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		299, 899	9	413, 346	6. 01
6. 02	SETTLEMENT TO PROGRAM		(		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 622, 691		5, 295, 642	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Turn Caracter State Control of the C	(	)	1. 00	2.00	
8.00	Name of Contractor	I			i l	8. 00

		Component	CCN: 15-Z315   10	0 09/30/2016	2/22/2017 4:5	
		Title	XVIII Sv	ving Beds - SNF		Орш
			it 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		547, 858		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
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					]
3. 01	ADJUSTMENTS TO PROVIDER	04/14/2016	41, 600		0	3. 01
3.02			0		0	3. 02
3.03			0		0	
3.04			0		0	
3.05			0		0	3. 05
	Provi der to Program				1	
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3.51			0		0	
3. 52 3. 53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		41, 600		0	
3. 77	3. 50-3. 98)		41,000			3. //
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		589, 458		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER	T	0		0	5. 01
5. 01	TENTATIVE TO PROVIDER		0		0	
5. 02			0		0	
0.00	Provider to Program		<u> </u>			0.00
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
,	the cost report. (1)					, _
6. 01	SETTLEMENT TO PROVIDER		73, 017		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	0.02
7. 00	Total Medicare program liability (see instructions)		662, 475	Contracts	NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8.00	Name of Contractor			00	2.00	8. 00
	1	1			1	

Heal th	Financial Systems CAMERON MEMORIAL	_ COMMUNITY	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016		pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			1, 344	
1. 00					•
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		1, 254	1
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			586	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		3, 409	•
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			107, 782, 980	•
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I			604, 683	•
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31. 00
22 00	Dalamas due provider (line 0 (or line 10) minus line 20 and l	ing 21) (occ instruction	201	ا م	22 00

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1315	Peri od: From 10/01/2015	Worksheet E-2
		Component CCN: 15-Z315		Date/Time Prepared: 2/22/2017 4:50 pm
		Title XVIII	Swina Beds - SNF	Cost

		, , , , , , , , , , , , , , , , , , ,		2/22/2017 4:50	) pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		533, 941	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	147, 532	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	structions)			
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
	instructions)				
5.00	Program days		287	0	5. 00
6.00	Interns and residents not in approved teaching program (see in			0	6. 00
7.00	Utilization review - physician compensation - SNF optional met	thod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		681, 473	0	8. 00
9.00	Primary payer payments (see instructions)		3, 707	0	9. 00
10.00	Subtotal (line 8 minus line 9)		677, 766	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		677, 766	0	12.00
13.00		(excl ude coi nsurance	1, 771	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	675, 995	0	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)	0	0	16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19. 00	Total (see instructions)		675, 995	0	19. 00
19. 01	Sequestration adjustment (see instructions)		13, 520	0	19. 01
20.00	Interim payments		589, 458	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a		73, 017	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Heal th	Financial Systems	CAMERON MEMORIAL	COMMUNI TY	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1315	Peri od: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prep 2/22/2017 4:50	pared:
			Title XVIII	Hospi tal	Cost	
					1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLE	MENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services				4, 067, 758	1.00
2.00	2.00 Nursing and Allied Health Managed Care payment (see instructions)			0	2.00	
3.00	3.00 Organ acqui si ti on				0	3.00
4.00	Subtotal (sum of lines 1 through 3)				4, 067, 758	4.00

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4, 067, 758	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2. 00
3.00	Organ acqui si ti on	ő	3. 00
4. 00	Subtotal (sum of lines 1 through 3)	4, 067, 758	
5.00	Primary payer payments	0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4, 108, 436	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 payment for services on a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	۷	12.00
12.00		0.000000	12 00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0. 000000	
	Total customary charges (see instructions)	0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15. 00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
	instructions)		
17.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	4, 108, 436	19. 00
	Deductibles (exclude professional component)	441, 140	
	Excess reasonable cost (from line 16)	0	
	Subtotal (line 19 minus line 20 and 21)	3, 667, 296	
	Coi nsurance	3, 007, 270	23. 00
		- 1	
	Subtotal (line 22 minus line 23)	3, 667, 296	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45, 119	
	Adjusted reimbursable bad debts (see instructions)	29, 327	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	26, 541	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	3, 696, 623	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ol	29. 50
29, 99	Recovery of Accelerated Depreciation	0	29. 99
	Subtotal (see instructions)	3, 696, 623	
	Sequestration adjustment (see instructions)	73, 932	
	Interim payments	3, 322, 792	
		3, 322, 192	
	Tentative settlement (for contractor use only)	-	
	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	299, 899	
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34. 00
	§115. 2	ı	l

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 10/01/2015 To 09/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 2/22/2017 4:50 pm
	T: +1 - VIV	11: 4-1	DDC

				2/22/2017 4:50	0 pm
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		60, 162		8. 00
9.00	Ancillary service charges		104, 836	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		164, 998	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13.00
	basi s				
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	R §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		164, 998	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if	fline 16 exceeds	164, 998	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide			
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41.00	Interim payments		129, 820	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		-129, 820	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance v	ith CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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 10/01/2015 To 09/30/2016 Date/Ti me Prepared: 2/22/2017 4:50 pm

		General Fund	Speci fi c	Endowment Fund	2/22/2017 4:5 Plant Fund	O pm
		General Tuna	Purpose Fund	Lildowillett Turid	Frant Tunu	
	Journey Aggreg	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	40, 123	T c	ol ol	0	1.00
2.00	Temporary investments	40, 123		- 1	0	
3.00	Notes recei vabl e	234, 719		=	0	
4.00	Accounts receivable	9, 552, 228		o	0	
5.00	Other recei vabl e	599, 269	C	0	0	1
6.00	Allowances for uncollectible notes and accounts receivable	0	C	0	0	6. 00
7.00	Inventory	921, 867	C	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	978, 840 1, 369, 664			0	8. 00 9. 00
10. 00	Due from other funds	1, 307, 004			0	10.00
11. 00	Total current assets (sum of lines 1-10)	13, 696, 710	d	o	0	11. 00
	FIXED ASSETS					
12. 00	Land	1, 317, 868		- 1	0	1
13. 00	Land improvements	0	C	- 1	0	13.00
14. 00 15. 00	Accumulated depreciation	0	C	0	0	14. 00 15. 00
16. 00	Buildings Accumulated depreciation	56, 625, 524 -9, 524, 903			0	16.00
17. 00	Leasehold improvements	0			0	17. 00
18. 00	Accumulated depreciation	0	d	o o	0	18. 00
19. 00	Fi xed equipment	0	C	o	0	19. 00
20. 00	Accumul ated depreciation	0	C	0	0	20. 00
21. 00	Automobiles and trucks	0	C	0	0	21. 00
22. 00	Accumulated depreciation	0	C	0	0	22. 00
23. 00 24. 00	Major movable equipment Accumulated depreciation	17, 221, 107 -9, 620, 494			0	23. 00 24. 00
25. 00	Mi nor equi pment depreci abl e	- 7, 020, 474 0			0	25. 00
26. 00	Accumulated depreciation	0		o o	0	26.00
27. 00	HIT designated Assets	0	c	o	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C	-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	56, 019, 102	C	0	0	30. 00
31. 00	OTHER ASSETS Investments	20, 271, 773		ا	0	31.00
32. 00	Deposits on Leases	20, 271, 773			0	32.00
33. 00	Due from owners/officers	0		o o	0	33.00
34.00	Other assets	606, 948	c	o	0	34.00
35.00	Total other assets (sum of lines 31-34)	20, 878, 721	C	o	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	90, 594, 533	C	0	0	36. 00
27.00	CURRENT LIABILITIES	2 740 142		ol	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	3, 740, 142 1, 699, 116		=	0	37. 00 38. 00
39. 00	Payroll taxes payable	1,077,110			0	39.00
40. 00	Notes and Loans payable (short term)	1, 037, 239	d	o o	0	40. 00
41.00	Deferred income	0	C	o	0	41. 00
42.00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0	C	0	0	
44. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 208, 919	۱ .		0	
45. 00	LONG TERM LIABILITIES	7, 685, 416		ol ol	0	45. 00
46. 00	Mortgage payable	1 0		ol ol	0	46. 00
47. 00	Notes payable	0	ď	Ó	0	1
48.00	Unsecured Loans	0	C	o	0	48. 00
49. 00	Other long term liabilities	45, 161, 262		0	0	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	45, 161, 262		-1	0	
51. 00	Total liabilities (sum of lines 45 and 50)	52, 846, 678	<u> </u>	0	0	51.00
52. 00	CAPITAL ACCOUNTS  General fund balance	37, 747, 855	Ι			52.00
53. 00	Specific purpose fund	37, 747, 033		)		53.00
54. 00	Donor created - endowment fund balance - restricted		1	o		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	37, 747, 855			0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	90, 594, 533	•		0	
55. 55	[59]	, 5, 5, 1, 555			O	55.55
		•	•			

Provider CCN: 15-1315

					То	09/30/2016	Date/Time Pre 2/22/2017 4:5	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	o piii
				·				
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		37, 583, 321			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		223, 531			_		2. 00
3.00	Total (sum of line 1 and line 2)		37, 806, 852			0		3. 00
4.00	Additions (credit adjustments) (specify)	47.004			0		0	4. 00
5.00	CONTRI BUTI ONS	47, 004			0		0	5. 00
6. 00 7. 00					0		0	6. 00 7. 00
8.00					0			8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		47, 004		U	0	0	10.00
11. 00	Subtotal (line 3 plus line 10)		37, 853, 856			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	37,033,030		0	O	0	12.00
13. 00	NET ASSETS RELEASED	106, 001			0		Ö	13. 00
14. 00	NET NOSETO RELENCES	100,001			0		o o	14. 00
15. 00		o			0		o o	15. 00
16.00		O			0		0	16. 00
17.00		o			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		106, 001			0		18. 00
19.00	Fund balance at end of period per balance		37, 747, 855			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)				Ŭ			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	CONTRI BUTI ONS		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13. 00	NET ASSETS RELEASED		0					13. 00
14. 00			0					14. 00
15.00			0					15. 00
16.00			0					16.00
17.00	Total deductions (sum of lines 12 17)		O					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17)				0			18. 00 19. 00
17.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	9			U			19.00
	pancer (Title II milius IIIIe 10)	ı I	l	I	- 1			I

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

			To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
	Cost Center Description	Inpati ent	Outpati ent	Total	<u> </u>
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	6, 633, 05	59	6, 633, 059	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	6, 633, 05	59	6, 633, 059	10.00
	Intensive Care Type Inpatient Hospital Services	T	T		
11.00	INTENSIVE CARE UNIT	449, 63	36	449, 636	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	140 (		440 (2)	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	449, 63	36	449, 636	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 082, 69	0.5	7, 082, 695	17. 00
18. 00	Ancillary services	8, 745, 49		82, 579, 290	18.00
19. 00	Outpatient services	682, 2			19.00
20. 00	RURAL HEALTH CLINIC	002, 2	0 13, 671, 377	10, 373, 372	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22. 00	HOME HEALTH AGENCY		1, 043, 600		22.00
23. 00	AMBULANCE SERVI CES		1, 043, 000	1, 043, 000	23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE		0 503, 806	503, 806	
27. 00	MOB		0 48, 015	48, 015	
27. 01	URGENT CARE		0 3, 415, 654	3, 415, 654	27. 01
27. 02	PROFESSI ONAL FEES	786, 59		1, 144, 868	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	17, 296, 99	·		•
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		54, 508, 279		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	Total deductions (sum of lines 27 41)		٦		41.00
42. 00	Total deductions (sum of lines 37-41)		E4 500 270		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		54, 508, 279		43. 00
	10 WASE 0-3, TIME 4)	I	I	1	I

Hoal th	Financial Systems CAMERON MEMORIAL	I COMMUNITY	In Lio	u of Form CMS-2	0552 10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1315	Peri od:	Worksheet G-3	2332-10
			From 10/01/2015 To 09/30/2016	Date/Time Prep 2/22/2017 4:50	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	*		112, 391, 520	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	nts		59, 518, 967	2. 00
3.00	Net patient revenues (line 1 minus line 2)			52, 872, 553	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		54, 508, 279	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 635, 726	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters				15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER I NCOME			1, 753, 256	24.00
24. 01	NET ASSETS RELEASED FROM RESTRICTION			106, 001	24. 01
25.00	Total other income (sum of lines 6-24)			1, 859, 257	25.00
26.00	Total (line 5 plus line 25)			223, 531	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line 28)			223, 531	29. 00
			·	·	

	Financial Systems		CAMERON MEMORIA				u of Form CMS-2	
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C		Peri od: From 10/01/2015	Worksheet H-1 Part I	
				HHA CCN:	15-7117	To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
						Home Health Agency I	PPS	
			Capital Rela	ated Costs		Agency I		
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on	Subtotal	-
		for Cost	Fixtures	Equi pment	Operation	&	(col s. 0-4)	
		Allocation (from Wkst. H,			Mai ntenanc	e		
		col . 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1. 00
2. 00	Fixtures Capital Related - Movable	0		0			0	2. 00
	Equi pment			· ·			_	
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3. 00 4. 00
5. 00	Administrative and General	132, 253	ő	0		0 0	132, 253	
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	284, 638	O	0		0 0	284, 638	6.00
7. 00	Physical Therapy	159, 886	0	0	1	0 0	159, 886	•
8.00	Occupational Therapy	30, 408	0	0	•	0 0	30, 408	
9. 00 10. 00	Speech Pathology Medical Social Services	3, 166 5, 514	0	0		0 0	3, 166 5, 514	9. 00 10. 00
11. 00	Home Health Aide	51, 113	0	0		0 0	51, 113	11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	0 0	0	0		0 0	0	
14. 00	DME	o o	Ö	Ö	•	0 0	0	1
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	ol	0	ı	0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	•	0 0	0	
17. 00	Private Duty Nursing	0	0	0	1	0 0	0	
18. 00 19. 00	Clinic Health Promotion Activities		0	0		0 0	0	
20. 00	Day Care Program	0	0	0		0 0	0	
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23. 00	All Others (specify)	Ö	ő	Ö		0 0	0	23. 00
23. 50	Telemedicine Total (sum of lines 1-23)	0 666, 978	0	0	1	0 0	0 666, 978	
24.00	Total (Suil of Titles 1-23)	Admi ni strati ve	Total (cols.			0 0	000, 478	24.00
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	5.00	8.00					
1.00	Capital Related - Bldg. & Fixtures							1. 00
2.00	Capital Related - Movable							2. 00
2 00	Equipment							2 00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	132, 253						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	70, 399	355, 037					6.00
7.00	Physi cal Therapy	39, 544	199, 430					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	7, 521 783	37, 929 3, 949					8. 00 9. 00
10. 00	Medical Social Services	1, 364	6, 878					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	12, 642	63, 755 0					11. 00 12. 00
13. 00	Drugs	0	0					13. 00
14. 00	DME	0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16. 00	Respiratory Therapy	0	0					16. 00
17. 00 18. 00	Private Duty Nursing	0	0					17. 00 18. 00
19. 00	Health Promotion Activities	0	О					19. 00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
21.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23. 00
	Telemedicine Total (sum of lines 1-23)	0	0 666, 978					23. 50 24. 00
	,		• -1					•

	F:		OMEDON MEMORI	AL COMMUNITY			6 F 046 A	0550 40
	Financial Systems LLOCATION - HHA STATISTICAL BAS	21.0	CAMERON MEMORI	Provider C	ON. 1E 101E	Peri od:	eu of Form CMS-2 Worksheet H-1	
COST A	LLUCATION - NNA STATISTICAL BAS	51 3		HHA CCN:	15-7117	From 10/01/2015 To 09/30/2016	Part II Date/Time Pre	pared:
						Home Health Agency I	2/22/2017 4: 5 PPS	O piii
		Capital Re	lated Costs			Agency 1		
		BI dgs &	Movabl e	PI ant		onReconciliation		
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance			(ACCUM. COST)	
		1.00	2.00	(SQUARE FEET) 3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	3.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	1	0		3. 00
4.00	Transportation (see	0	0	0	)	0		4. 00
	instructions)		_	_				
5. 00	Administrative and General	0	0	0	1	0 -132, 253	534, 725	5. 00
	HHA REIMBURSABLE SERVICES	1					004 (00	, ,,,
6.00	Skilled Nursing Care	0	_	0	1	0 0		
7. 00 8. 00	Physical Therapy Occupational Therapy		0	0	1	0 0	159, 886 30, 408	
9. 00	Speech Pathology		0	0		0	30, 406	
10. 00	Medical Social Services		0	0		0 0	5, 100	
11. 00	Home Heal th Aide		0	0		0 0		11. 00
12.00	Supplies (see instructions)		0	0		0 0	0 0	1
13. 00	Drugs	1 0	0	Ö		0	0	
14. 00	DME	l o		Ö		0 0	Ö	
	HHA NONREIMBURSABLE SERVICES	'		-	'			
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0		0 0	0	16. 00
17.00	Private Duty Nursing	0	0	0		0 0	0	17. 00
18. 00	Clinic	0	0	0	1	0 0	0	
19. 00	Health Promotion Activities	0	0	0	)	0 0	0	
20. 00	Day Care Program	0	0	0		0 0	0	
21. 00	Home Delivered Meals Program	0	0	0	1	0 0	0	
22. 00	Homemaker Service	0	0	0	1	0 0	0	
23. 00	All Others (specify)	0	0	0	1	0 0	0	
23. 50	Tel emedi ci ne	0	0	0		0 0	0	
24. 00	Total (sum of lines 1-23)		0	0		0 -132, 253		
25. 00	Cost To Be Allocated (per		0		1	U	132, 253	25.00
26 00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 0000	00	0. 247329	26 00
20.00	1011 C 003C Mai Cipitei	0.000000	0.000000	0.000000	0.0000		0. 24/329	1 20.00

Home Health PPS

						Agency I	PPS	
			CAPITAL REI	ATED COSTS		, geney :		
	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 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 355, 037 199, 430 37, 929 3, 949 6, 878	0 0 0 0 0	0 0	173, 333 0 0 0 0 0 0	212, 113 355, 037 199, 430 37, 929 3, 949 6, 878	83, 836 47, 091 8, 956 932	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 18. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	63, 755 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	63, 755 0 0 0 0 0 0 0 0 0	15, 054 0 0 0 0 0 0 0 0 0	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 19. 50 20. 00 21. 00	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 column 26, line 1, rounded to 6 decimal places.	0 0 666, 978	0 0 0	0 38, 780	0 0 173, 333	0. 000000		19. 00 19. 50 20. 00 21. 00
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
	T	7. 00	8. 00	9. 00	10. 00	11. 00	13. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	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)	60, 025 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	240 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 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 18. 00 19. 00 20. 00 21. 00

<sup>(1)</sup> 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.

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

6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> 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 H BASIS	HA COST CENTERS STATISTICAL	Provi der CCN: 15-1315 HHA CCN: 15-7117		Worksheet H-2 Part II Date/Time Prepared: 2/22/2017 4:50 pm
		+	Home Health	DDS

						Home Health	PPS	
	,					Agency I		
		CAPITAL REL	LATED COSTS					
	0 1 0 1 0 1 1	DI DO A FLVT	MANDLE FOLLID	EMBL OVEE		ADMINI CEDATINE	ODEDATION OF	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	PLANT	
				(GROSS		(ACCOW. COST)	(SQUARE FEET)	
				SALARI ES)				
		1.00	2.00	4. 00	5A	5. 00	7. 00	
1. 00	Administrative and General	0	1, 469				1, 469	1. 00
2.00	Skilled Nursing Care	0	0	0			0	2. 00
3. 00	Physical Therapy	0	0	l o		199, 430	o	3. 00
4.00	Occupational Therapy	0	0	o c			o	4. 00
5.00	Speech Pathology	0	0	l c	) (	3, 949	0	5.00
6.00	Medical Social Services	0	0	O	) (	6, 878	O	6.00
7.00	Home Health Aide	0	0	0	) (	63, 755	o	7.00
8.00	Supplies (see instructions)	0	0	0	) (	0	0	8.00
9.00	Drugs	0	0	0	) (	0	0	9. 00
10.00	DME	0	0	0	) (	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	) (	0	0	11. 00
12. 00	Respiratory Therapy	0	0	0	) (	0	0	12.00
13. 00	Private Duty Nursing	0	0	0	) (	0	0	13. 00
14. 00	Clinic	0	0	0		0	0	14. 00
15. 00	Health Promotion Activities	0	0	0		0	0	15. 00
16.00	Day Care Program	0	0			0	0	16. 00
17. 00	Home Delivered Meals Program	0	0			0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0			0	0	18. 00 19. 00
19. 50	Telemedicine	0					0	19. 50
20. 00	Total (sum of lines 1-19)	0	1, 469	583, 794		879, 091	1, 469	
21. 00	Total cost to be allocated	0	38, 780		•	207, 579		
22. 00	Unit cost multiplier	0. 000000	26. 398911	l .		0. 236129		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	·	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVICES &	
		(POUNDS OF	SERVIC)				SUPPLY	
		LAUNDR)				(DI RECT_NRSI NG		
		0.00	0.00	10.00	11 00	HR)	REQUIS.)	
1 00	Administrative and General	8. 00	9. 00	10.00	11. 00	13.00	14.00	1 00
1. 00 2. 00	Skilled Nursing Care	59	91		928		7, 628 0	1. 00 2. 00
3.00	Physical Therapy	0					0	3. 00
4. 00	Occupational Therapy	0					0	4. 00
5. 00	Speech Pathology	0					0	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	l o		o o	o	8. 00
9.00	Drugs	0	0	o c	) (	0	0	9. 00
10.00	DME	0	0	o	) (	0	o	10.00
11. 00	Home Dialysis Aide Services	0	0	0	) (	0	0	11.00
12.00	Respiratory Therapy	0	0	0	) (	0	0	12.00
13. 00	Private Duty Nursing	0	0	0	) (	0	0	13.00
	Clinic	0	0	0	) (	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	) (	0	0	
16. 00	Day Care Program	0	0	0		J 0	0	
17. 00	Home Delivered Meals Program					0	0	17. 00
18. 00 19. 00	Homemaker Service						0	
	All Others (specify) Telemedicine						0	19. 00 19. 50
20. 00		59	91		928	)   0	· -	20. 00
21. 00	Total cost to be allocated	240	32, 802		37, 910			21. 00
22. 00		4. 067797						
	The state of the s		, , , , , , , , , , , , , , , , , , , ,	,			,	

	Financial Systems		CAMERON MEMORIAL				u of Form CMS-	
	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provider CCN:	15-1315	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	15-7117	From 10/01/2015 To 09/30/2016	Part II Date/Time Pre	narod:
				TITIA CON.	13 /11/	077 307 2010	2/22/2017 4:5	0 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	PHARMACY	MEDI CAL					
		(COSTED	RECORDS &					
		REQUI S. )	LI BRARY					
			(TIME SPENT)					
		15. 00	16. 00					
1.00	Administrative and General	0	0					1. 00
2.00	Skilled Nursing Care	0	0					2. 00
3.00	Physical Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4. 00
5.00	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	0					6. 00
7.00	Home Health Aide	0	0					7. 00
8.00	Supplies (see instructions)	0	0					8. 00
9.00	Drugs	0	0					9. 00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11. 00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15. 00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17. 00
18.00	Homemaker Service	0	o					18. 00
19.00	All Others (specify)	0	o					19. 00
19. 50	Tel emedi ci ne	0	o					19. 50
20.00	Total (sum of lines 1-19)	0	o					20.00
21.00	Total cost to be allocated	0	o					21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000					22. 00
	•	•	. '					•

1. 00 2. 00 3. 00 5. 00 6. 00	Financial Systems ONMENT OF PATIENT SERVICE COST  Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	From, Wkst. H-2, Part I, col. 28, line	1.00	Provider C HHA CCN: Title	CN: 15-1315 15-7117 XVIII Total HHA Costs (cols.	Peri od: From 10/01/2015 To 09/30/2016 Home Health Agency I Total Visits		pared:
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Shared Ancillary Costs (from	Total HHA Costs (cols.	To 09/30/2016  Home Health Agency I  Total Visits	Date/Time Prep 2/22/2017 4:50 PPS  Average Cost	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Shared Ancillary Costs (from	Total HHA Costs (cols.	Agency I Total Visits	PPS Average Cost	о рііі
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols.			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy	col. 28, line	1.00	Costs (from	7	1	Dar Vicit	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy	0	1.00					
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy			Part II)	+ 2)		(col. 3 ÷ col.	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy			2.00	3.00	4. 00	4) 5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy	- Additedate t	ROURANI COST, A		IE PROGRAM I I N		5.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost Per Visit Computation Skilled Nursing Care Physical Therapy			OUNLUATE OF TE	IL I NOOKAW LIN	II TATTON COST, OF	<b>\</b>	l
2. 00 3. 00 4. 00 5. 00 6. 00	Physi cal Therapy							
3. 00 4. 00 5. 00 6. 00		2. 00	649, 131		649, 13	1, 808	359. 03	1.00
4. 00 5. 00 6. 00	Occupational Therapy	3. 00	364, 625	C	364, 62	25 2, 037	179. 00	2. 00
5. 00 6. 00		4. 00	69, 347	C	69, 34	17 364	190. 51	3. 00
6.00	Speech Pathology	5. 00	7, 219	C	7, 2	19 57	126. 65	4. 00
- 1	Medical Social Services	6. 00	12, 575		12, 5		381. 06	
7. 00	Home Heal th Aide	7. 00	116, 565		116, 50		65. 49	ł
	Total (sum of lines 1-6)		1, 219, 462	C	.,, .,			7. 00
					Program Visi			
	C+ C+ D!	0+ 1::+-	CDCA No. (1)	D+ A		art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles			
					Coinsurance			
		0	1.00	2. 00	3. 00	4. 00	5. 00	
-	Limitation Cost Computation	U	1.00	2.00	0.00	1. 00	0.00	
	Skilled Nursing Care		50031	C	)	34		8.00
	Skilled Nursing Care		99915	C	4.	18		8. 01
9.00	Physical Therapy		50031	C	18	30		9. 00
9. 01	Physi cal Therapy		99915	C	6	79		9. 01
	Occupational Therapy		50031	C		37		10.00
10. 01	Occupational Therapy		99915	C	1.	19		10. 01
	Speech Pathology		50031	C	1	5		11. 00
	Speech Pathology		99915	C	)	8		11. 01
	Medical Social Services		50031	C	1	6		12. 00
	Medical Social Services		99915	C		15		12. 01
	Home Heal th Ai de		50031	C		24		13.00
	Home Heal th Ai de		99915	C	13			13. 01
14.00	Total (sum of lines 8-13)	From Wico+ II 2	Facility Costs	Shared	1,73 Total HHA	Total Charges	Datia (asl 2	14. 00
	Cost Center Description	Part I, col.	Facility Costs (from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	+ COI. 4)	
		20, 11110	11 2, Tuit 1)	Part II)	' - '	(Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa	ations						
- 1	Cost of Medical Supplies	8. 00	0	C	)	0		
16. 00	Cost of Drugs	9. 00	0	C		0 0	0. 000000	16. 00
			Program Visits		Cost of			
					Servi ces	D 1 D		
	Coot Conton Decement on	Downt A	Par Not Subject to		Dont A	Part B	Subject to	
	Cost Center Description	Part A	Deductibles &		Part A	Not Subject to Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
	Skilled Nursing Care	0	532			0 191, 004		1.00
- 1	Physi cal Therapy	0	859			0 153, 761		2.00
	Occupati onal Therapy	0	156			0 29, 720		3. 00
	Speech Pathology	0	13			0 1, 646		4. 00
	Medical Social Services	0	21			0 8, 002		5. 00
	Home Health Aide	0	155			0 10, 151		6. 00
	Total (sum of lines 1-6)	0	1, 736		[	0 394, 284		7. 00

Hear tr	Financial Systems		CAMERON MEMORIA	AL COMMUNITY		In Lie	u of Form CMS-	2552-10
APPOR	FIONMENT OF PATIENT SERVICE COST	S		Provi der Co	CN: 15-1315	Peri od: From 10/01/2015	Worksheet H-3 Part I	3
				HHA CCN:	15-7117	To 09/30/2016	Date/Time Pre 2/22/2017 4:5	
				Ti tl e	· XVIII	Home Health Agency I	PPS	ос рііі
	Cost Center Description	6.00	7. 00	0.00	0.00		11. 00	
	Limitation Cost Computation	6.00	7.00	8. 00	9. 00	10. 00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01
14. 00	Total (sum of lines 8-13)	Drag	ram Causered Cha	na.o.	Cost of			14. 00
		Prog	ram Covered Cha		Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Cumpling and Drugg Cost Comput	6.00	7.00	8. 00	9. 00	10.00	11. 00	-
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 0	O	0		0 0	(	15. 00
	Cost of Drugs		400	0		0	(	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	<u> </u>	
1.00	Skilled Nursing Care	191, 004						1.00
2.00	Physical Therapy Occupational Therapy	153, 761 29, 720						2.00
4. 00	Speech Pathology	1, 646						4.00
5.00	Medical Social Services	8, 002						5. 00
6.00	Home Heal th Ai de	10, 151						6.00
7. 00	Total (sum of lines 1-6)  Cost Center Description	394, 284			,			7. 00
	oost center bescriptron	12. 00	-					1
	Limitation Cost Computation							
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Speech Pathology							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00

Heal th	Financial Systems		CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPOR	FIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7117	From 10/01/2015 To 09/30/2016		
	Title XVIII Home Health PPS						PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		l
1.00	Physi cal Therapy	66. 00	0. 614466	O	)	0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 637713	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 451552	0	)	0 col. 2, line 1	6. 00	5. 00

AI CIII	Financial Systems CAMERON MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N· 15_1315	Peri od:	eu of Form CMS-: Worksheet H-4	
ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	HHA CCN:	15-7117	From 10/01/2015 To 09/30/2016	5 Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	
				Pa	rt B	
			Part A	Not Subject to		
				Deductibles & Coinsurance	Deductibles & Coinsurance	
			1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	DMARY CHARGES		2.00	0.00	
	Reasonable Cost of Part A & Part B Services				_	
00	Reasonable cost of services (see instructions)				0	
00	Total charges			0 400	0 0	2
00	Customary Charges			0 (	0	١.
00	Amount actually collected from patients liable for payment for on a charge basis (from your records)				0	3
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			
00	Total customary charges (see instructions)			0 400	•	
00	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	(complete		0 400	0	7
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	8
00	Primary payer amounts			0	0 0	9
				Part A	Part B	
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)				0 0	
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				317, 431	1
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			(	317, 431 1, 855	12
00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			(	317, 431 1, 855 11, 915	12 12 13
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes			(	317, 431 0 1, 855 0 11, 915 0 627	1: 1: 1: 1:
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			(	317, 431 0 1, 855 0 11, 915 0 627 0 1, 114	1: 1: 1: 1: 1:
00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			(	317, 431 0 1, 855 0 11, 915 0 627	1: 1: 1: 1: 1: 1:
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			(	317, 431 1, 855 11, 915 0 627 0 1, 114	1: 1: 1: 1: 1: 1: 1:
00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			(	317, 431 1, 855 11, 915 627 0 1, 114 0 0	1: 1: 1: 1: 1: 1: 1: 1:
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments				317, 431 1, 855 0 11, 915 0 627 0 1, 114 0 0 0 0 0 0	1: 1: 1: 1: 1: 1: 1: 1: 1: 1: 2:
00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions)  Total PPS Reimbursement - Full Episodes without Outliers  Total PPS Reimbursement - Full Episodes with Outliers  Total PPS Reimbursement - LUPA Episodes  Total PPS Reimbursement - PEP Episodes  Total PPS Outlier Reimbursement - Full Episodes with Outliers  Total PPS Outlier Reimbursement - PEP Episodes  Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coinsu	urance)			317, 431 1, 855 0 11, 915 0 627 0 1, 114 0 0 0 0 0 0 0 0 0	1: 1: 1: 1: 1: 1: 1: 1: 1: 2: 2: 2:
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21)	urance)			317, 431 1, 855 11, 915 0 627 0 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1: 1: 1: 1: 1: 1: 1: 1: 1: 2: 2: 2:
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	urance)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21 22 22 23
00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	urance)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 121 131 141 151 161 172 173 174 175 175 175 175 175 175 175 175 175 175
00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	urance)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 18 19 20 21 22 22 22 22 22 22 22 25 25 24 25 25 25 25 25 25 25 25 25 25 25 25 25
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	urance)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 20 21 22 22 24 25 26
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Quilier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)				317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 232 242 252 262 277
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	nstructi ons)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 21 222 232 24 25 26 27 28
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	nstructi ons)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 244 256 267 277 288 299 299 299 299 299 299 299 299 299
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	nstructions) e 27)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 211 222 244 255 266 277 288 299 300
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see intotal costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	nstructions) e 27)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 212 222 232 244 255 267 27 288 299 300 313 301 313 314 315 316 317 317 317 317 317 317 317 317 317 317
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	nstructions) e 27)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 153 164 175 186 197 200 21 22 22 24 25 26 27 28 29 30 31 31 31 31 31 31 31 31 31 31 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	nstructions) e 27)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 21 222 24 25 26 27 28 29 30 30 31 31 31 31 31 31 31 31 31 31 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	nstructions) e 27) s)			317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 21 222 244 255 260 300 31 31 31 33 33
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	nstructions) e 27) s) and 33)	Dub. 45.0		317, 431 1, 855 11, 915 627 1, 114 0 0 0 0 0 0 0 0 0 0 0 0 0	111 122 133 144 155 166 177 188 199 200 212 223 244 255 266 277 288 299 300 313 313 313 323 333 343

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

Provider CCN: 15-1315 TO PROGRAM BENEFICIARIES HHA CCN: 15-7117

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	<u> </u>	1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	326, 283 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 05				0	l ől	3. 05
	Provider to Program					
3.50				0	0	3. 50
3. 51				0	0	3. 51
3. 52 3. 53				0	0	3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	o	3. 99
	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)		1	0	326, 283	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
5. 01	Program to Provider			0	0	5. 01
5. 01				0	0	5. 01
5. 03				0	l ől	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on		'	O		6. 00
,	the cost report. (1)					,
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM   Total Medicare program liability (see instructions)			0	326, 283	6. 02 7. 00
7.00	Total medicale program trabitity (see thatractions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		(	)	1. 00	2. 00	
8. 00	Name of Contractor				Π	8. 00

Peri od: From 10/01/2015 To 09/30/2016 Worksheet 0 Date/Time Prepared: 2/22/2017 4:50 pm Hospi ce CCN: 15-1561

					11! 1	2/22/2017 4.3	о рііі
					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 & FLXT*		C	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	ol ol	0	0	2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0	0	3. 00
4. 00	ADMI NI STRATI VE & GENERAL*		8, 647	8, 647	5, 350	13, 997	4. 00
5. 00	PLANT OPERATION & MAINTENANCE*		0, 047	0,047	3, 330	13, 777	5. 00
			0		0		
6.00	LAUNDRY & LINEN SERVICE*	0	U		U	0	6. 00
7. 00	HOUSEKEEPI NG*	0	O	0	0	0	7. 00
8.00	DI ETARY*	0	38		0	38	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11. 00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION*	l ol	21, 030	21, 030	o	21, 030	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	7, 775	. 0	7, 775	0	7, 775	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	16. 00
		١	U	ή	U U	U	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				_1		
25. 00	INPATIENT CARE-CONTRACTED**	0	0	1	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER**	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE**	65, 928	3, 991	69, 919	0	69, 919	28. 00
29.00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	o	0	ol	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	l	0	ol	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	31, 245	0	31, 245	0	31, 245	33. 00
34. 00	SPIRITUAL COUNSELING**	6, 694	0	6, 694	0	6, 694	34. 00
35. 00	DI ETARY COUNSELI NG**	0,0,1	0	0,0,1	0	0, 0, 1	35. 00
36. 00	COUNSELING - OTHER**	0	0		0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	1	0	2 120	0	2, 120	37. 00
		2, 120	U	2, 120	U	· ·	
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	U	0	U	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	Ü	0	0	0	39. 00
40.00	I MAGI NG SERVI CES**	0	0	0	0	0	40. 00
41. 00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42. 00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY**	l ol	0	ol ol	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	o	0	ol	o	0	46. 00
	NONREI MBURSABLE COST CENTERS	-1		-1	- 1		
60. 00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM *	0	0	1	Ö	0	61. 00
62. 00	FUNDRAI SI NG*	0	0		0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0		0	0	63.00
			0		0		
64.00	PALLIATIVE CARE PROGRAM*	0	U		0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0	<u>[</u>	0	0	65. 00
66. 00	RESI DENTI AL CARE*	0	0	미	0	0	66. 00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	68. 00
69. 00	THRI FT STORE*	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	o	0	0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	o	0	ol	o	0	71. 00
100.00		113, 762	33, 706	147, 468	5, 350	152, 818	100.00
	·			,	2, 200		

<sup>\*</sup> 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.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	13, 997		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6. 00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	38		8. 00
9.00	NURSING ADMINISTRATION*	0	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDI CAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	21, 030		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	7, 775		13.00
14.00	PHARMACY*	0	0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
16.00	OTHER GENERAL SERVICE*	0	0		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	PHYSI CI AN SERVI CES**	0	0		26. 00
27. 00	NURSE PRACTITIONER**	0	0		27. 00
28. 00	REGI STERED NURSE**	0	69, 919		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31. 00	OCCUPATIONAL THERAPY**	0	0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0	31, 245		33. 00
34.00	SPIRITUAL COUNSELING**	0	6, 694		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	2, 120		37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/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	MEDI CAL SUPPLI ES-NON-ROUTI NE**	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
	NONREI MBURSABLE COST CENTERS		_1		
60.00	BEREAVEMENT PROGRAM *	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	0		63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65. 00	OTHER PHYSI CI AN SERVI CES*	0	0		65. 00
66.00	RESI DENTI AL CARE*	0	0		66.00
67. 00	ADVERTI SI NG*	0	0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68. 00
69. 00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	152.040		71.00
100.00	TOTAL	0	152, 818		100. 00

<sup>\*</sup> 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.

CARE

Hospi ce CCN: 15-1561

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 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	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	65, 683	3, 977	69, 660	0	69, 660	28. 00
29.00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	31, 129	0	31, 129	0	31, 129	33. 00
34.00	SPIRITUAL COUNSELING	6, 669	0	6, 669	0	6, 669	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2, 112	0	2, 112	0	2, 112	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	105, 593	3, 977	109, 570	0	109, 570	100.00

<sup>\*</sup> 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	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	69, 660		28. 00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	0		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	31, 129		33.00
34.00	SPIRITUAL COUNSELING	0	6, 669		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	2, 112		37.00
38.00	DURABLE MEDICAL EQUIPMENT/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 & 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	109, 570	10	00.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Date/Time Prepared: 2/22/2017 4:50 pm Hospi ce CCN: 15-1561

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00   I NPATI ENT CARE-CONTRACTED	0	0	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	89	5	94	0	94	28. 00
29. 00   LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	42	0	42	0	42	33. 00
34.00 SPIRITUAL COUNSELING	9	0	9	0	9	34. 00
35. 00 DIETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	3	0	3	0	3	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00   I MAGI NG SERVI CES	0	0	0	0	0	40. 00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43. 00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100. 00 TOTAL *	143	5	148	0	148	100.00
* T	1 1 1! 50					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		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	94	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	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	42	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	9	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	3	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	148	100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

2/22/2017 4:50 pm 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 0 26.00 0 0 0 0 0 0 0 0 0 0 0 0 26.00 NURSE PRACTITIONER 0 0 27.00 27.00 Ω 28.00 REGISTERED NURSE 156 9 165 165 28.00 29.00 LPN/LVN 0 29.00 0 0 0 30.00 PHYSI CAL THERAPY 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 74 74 74 33.00 SPIRITUAL COUNSELING 16 34.00 0 16 16 34.00 35.00 DIETARY COUNSELING 0 0 5 0 0 35.00 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 5 37.00 37.00 5 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 0 0 0 0 39.00 40.00 IMAGING SERVICES 40.00 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 0 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 44.00

0

0

0

260

0

0

0

45.00

0

0 46.00

260 100. 00

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

45.00

100.00 TOTAL

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT 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	165	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	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	74	33. 00
34.00	SPIRITUAL COUNSELING	0	16	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	5	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39. 00	PATIENT 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	260	100.00

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

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

EVDEN	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 15-1315	Peri od: From 10/01/2015	Worksheet 0-5	
EXPEN:	SES FOR ALLOCATION	Hospi ce CCI	N: 15-1561	To 09/30/2016	Date/Time Prep 2/22/2017 4:50	
				Hospi ce I		
	Descriptions			SERVICE SEXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
	T		1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 7, 946	7, 946	2.00
3. 00 4. 00	EMPLOYEE BENEFITS DEPARTMENT		13. 9	0 35, 365	35, 365	3. 00 4. 00
4. 00 5. 00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE		13, 9	97 55, 544 0 12, 299	69, 541 12, 299	5.00
6. 00	LAUNDRY & LINEN SERVICE			0 12, 244	12, 299	6.00
7. 00	HOUSEKEEPI NG			0 0	0	7.00
8. 00	DI ETARY			38 0	38	8.00
9. 00	NURSI NG ADMI NI STRATI ON			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 380	380	
11. 00	MEDI CAL RECORDS			0 0	0	11.00
12.00	STAFF TRANSPORTATION		21, 0	30	21, 030	12.00
13.00	VOLUNTEER SERVICE COORDINATION		7, 7	75	7, 775	13.00
14.00	PHARMACY			0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	
16. 00	OTHER GENERAL SERVICE			0	0	
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
FO 00	LEVEL OF CARE				0	
50.00	HOSPI CE CONTI NUOUS HOME CARE		100 5	0	100 570	
51. 00 52. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE		109, 5	70 48	109, 570 148	51. 00 52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE		•	50	260	
33. 00	NONREI MBURSABLE COST CENTERS			50	200	33.00
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	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
	PALLIATIVE CARE PROGRAM			0	0	64.00
				0	0	65.00
64. 00 65. 00	OTHER PHYSICIAN SERVICES				0	66.00
64. 00 65. 00 66. 00	RESI DENTI AL CARE			0		l
64. 00 65. 00 66. 00 67. 00	RESI DENTI AL CARE ADVERTI SI NG			0	0	
64. 00 65. 00 66. 00 67. 00 68. 00	RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG			O	0	68.00
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE			0 0	0	68. 00 69. 00
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD			0 0 0	0 0	67. 00 68. 00 69. 00 70. 00
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE			0 0	0	68. 00 69. 00

Heal th Financial	Systems		CAMERON MEM	ORIAL COMMUNITY		In Lieu	of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COSTS	Provi der CCN:	15-1315 P	Peri od:	Worksheet 0-6

						2/22/201/ 4:50	) pm
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG 8	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
	F		FLX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS			2.00	0.00	07.	
1.00	CAP REL COSTS-BLDG & FLXT	0	C				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	7, 946		7, 946			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	35, 365	C		35, 365		3. 00
4. 00	ADMINISTRATIVE & GENERAL	69, 541	Ċ		0	69, 541	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	12, 299	Č			12, 299	5. 00
6. 00	LAUNDRY & LINEN SERVICE	12,277				12, 277	6. 00
7. 00	HOUSEKEEPI NG	0	Ċ			0	7. 00
8.00	DI ETARY	38				38	8. 00
		38	C				
9.00	NURSING ADMINISTRATION	0	C			0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	380	C		0	380	
11. 00	MEDI CAL RECORDS	0	C	)	0	0	11. 00
12. 00	STAFF TRANSPORTATION	21, 030	C	)	0	21, 030	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	7, 775	C	)	0	7, 775	13. 00
14.00	PHARMACY	0	C	)	0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C	)	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	C	) (	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		C	) (		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	109, 570			35, 233	144, 803	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	148	C	) (	48	196	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	260	C	7, 946	84	8, 290	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	C	) (	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	C	) (	o	0	61. 00
62.00	FUNDRAI SI NG	0	C	) (	o	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C		o	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	C	) (	ol	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	C		o	0	65. 00
66. 00	RESI DENTI AL CARE	0	C		o	0	66. 00
67. 00	ADVERTI SI NG	0	Ċ		o	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	Ċ			0	68. 00
69. 00	THRI FT STORE	0	Ċ			0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD	0	_			0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	ام	r		ا ا	0	71. 00
99. 00	NEGATIVE COST CENTER		<u></u>			o	99.00
	TOTAL	264, 352	C	7, 946	35, 365	264, 352	
100.00	// TOTAL	204, 332	C	ή , , , , , , , , , , , , , , , , , , ,	, Joseph	204, 332	100.00

Heal th Financial	Systems		CAMERON MEMORIAL	COMMUNI TY	In Lieu	of Form CMS-2552-10
COST ALLOCATION	- HOSPITAL-BASED H	IOSPI CE GENERAL	SERVICE COSTS	Provider CCN: 15-1315	Peri od:	Worksheet 0-6

From 10/01/2015 To 09/30/2016 Part I Date/Time Prepared: Hospi ce CCN: 15-1561 2/22/2017 4:50 pm Hospi ce I Descriptions ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY OPERATION & LINEN SERVICE & GENERAL MAI NTENANCE 4. 00 6.00 7. 00 8. 00 5.00 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 69, 541 4.00 5.00 PLANT OPERATION & MAINTENANCE 4, 390 16, 689 5.00 LAUNDRY & LINEN SERVICE 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 14 0 0 0 0 0 0 0 52 8.00 NURSING ADMINISTRATION 9.00 0 9.00 0 ROUTINE MEDICAL SUPPLIES 10.00 10.00 136 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 7,507 12.00 VOLUNTEER SERVICE COORDINATION 2, 775 13.00 13.00 14.00 PHARMACY 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 0 16.00 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 0 HOSPICE ROUTINE HOME CARE 51.00 51, 690 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 70 0 0 22 52.00 2, 959 0 53.00 HOSPICE GENERAL INPATIENT CARE 16, 689 0 30 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 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 0 63.00 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 Ω 71.00 C 0 0 99.00 NEGATIVE COST CENTER 0 0 99.00

69, 541

16, 689

52 100.00

100.00 TOTAL

Heal th	Financial Systems	AL COMMUNITY	COMMUNITY In			2552-10	
COST A	COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SER		Provi der CC	Provider CCN: 15-1315		Worksheet 0-6 Part I	
			Hospi ce CCN	l: 15-1561		Date/Time Pre 2/22/2017 4:5	pared: O pm
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00

	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10. 00	11. 00	12.00	13. 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	HOUSEKEEPING						7. 00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	O					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	O	516				10.00
11. 00	MEDI CAL RECORDS	0			)		11. 00
12.00	STAFF TRANSPORTATION	0			28, 537		12.00
13.00	VOLUNTEER SERVICE COORDINATION	O			0	10, 550	13. 00
14.00	PHARMACY	o			0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	o			0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	•		•			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	) C	0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE	0	514	· c	28, 430	10, 511	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1		39	14	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	1		68	25	53. 00
	NONREI MBURSABLE COST CENTERS	· ·		•			
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0			0	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	o			0	0	68. 00
69.00	THRI FT STORE	0			0	0	69. 00
70. 00	I .						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o			0	0	71. 00
99. 00		o	0	) c	0	0	99. 00
	OTOTAL	0	516		28, 537	10, 550	
				•	,		•

Heal th Financial	Systems		CAMERON MEM	ORIAL COMMUNITY		In Lieu	of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COSTS	Provi der CCN:	15-1315 P	Peri od:	Worksheet 0-6

From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared: Hospi ce CCN: 15-1561 2/22/2017 4:50 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS 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 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 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 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 0 0 0 HOSPICE ROUTINE HOME CARE 0 235, 948 51.00 0 51.00 0 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 342 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 28, 062 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 0 63.00 0 63.00 0 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 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 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 0 71.00 Ω

0

0

0 99.00

264, 352 100. 00

0

99.00 NEGATIVE COST CENTER

100.00 TOTAL

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:	15-1315 15-1561	Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II Date/Time Prepared: 2/22/2017 4:50 pm

			nospi ce con	1. 13-1301	0 07/30/2010	2/22/2017 4:5	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	•	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (		DEPARTMENT		(ACCUMULATED	
		(	, , , , , , , , , , , , , , , ,	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2. 00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1					
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	119, 113			3. 00
4. 00	ADMI NI STRATI VE & GENERAL		0	117, 115	-69, 541	194, 811	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0		-07, 541	12, 299	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0			12, 244	6.00
	1	0	0			0	
7.00	HOUSEKEEPI NG	0	U	C		-	7. 00
8.00	DI ETARY	0	0	C	0	38	8. 00
9.00	NURSING ADMINISTRATION	0	0	C	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	C	0	380	10. 00
11. 00	MEDI CAL RECORDS	0	0	C	이	0	11. 00
12. 00	STAFF TRANSPORTATION	0	0	C	0	21, 030	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	C	0	7, 775	13. 00
14.00	PHARMACY	0	0	C	0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	C	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	C	0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		o	0	17. 00
	LEVEL OF CARE	<u>.                                      </u>					
50.00	HOSPI CE CONTI NUOUS HOME CARE			C	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			118, 668	ıl ol	144, 803	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	o	0	162		196	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	301	283		8, 290	53. 00
00.00	NONREI MBURSABLE COST CENTERS	<u> </u>		200	9	0,2,0	00.00
60.00	BEREAVEMENT PROGRAM	0	0	C	ol ol	0	60.00
61. 00	VOLUNTEER PROGRAM	j o	o o		1	0	61.00
62. 00	FUNDRAI SI NG		0			0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0			0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0			0	65.00
		0	U	(			•
66. 00	RESI DENTI AL CARE	0	0	C	U	0	66.00
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	(	0	0	68. 00
69. 00	THRI FT STORE	0	0	C	이	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	C	0	0	71. 00
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		7, 946	35, 365		69, 541	1
101.00	UNIT COST MULTIPLIER	0. 000000	26. 398671	0. 296903		0. 356966	101. 00

Heal th	Health Financial Systems CAMERON MEMORIAL COMMUNITY In Lieu of Form CMS-2552-10								
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provi der CCI Hospi ce CCI	F	Period: From 10/01/2015 To 09/30/2016				
					Hospi ce I	2/22/2017 1.00	о ріп		
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (IN-FACI LI TY	NURSI NG ADMI NI STRATI ON			
		(SQUARE FEET)	(IN-FACILITY DAYS)		DAYS)	(DI RECT NURS. HRS.)			
		5. 00	6. 00	7. 00	8. 00	9. 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	301					5. 00		
6.00	LAUNDRY & LINEN SERVICE	0	12				6.00		
7.00	HOUSEKEEPI NG	0		301			7. 00		
8.00	DI ETARY	0		(	12		8. 00		
9.00	NURSING ADMINISTRATION	0		(		0	9. 00		

Health Financial Systems	CAMERON MEMORI	AL COMMUNITY		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der CO	CN: 15-1315 F	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				From 10/01/2015		
		Hospi ce CCN	N: 15-1561   1	Γo 09/30/2016		
					2/22/2017 4:5	O pm
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	(CHARGES)	
	SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		

Cost Center Descriptions							2/22/2017 4:5	O pm
REDICAL SUPPLIES   CPATIENT DAYS   TRANSPORTATION   SERVICE   CHARGES   CPATIENT DAYS   TRANSPORTATION   CORD INATION (HOURS OF SERVICE)						Hospi ce I		
MEDICAL SUPPLIES CHARTON   CAPTIENT DAYS   C		Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
SUPPLIES								
CAPATI ENT DAYS    CMI LEAGE  SERVICE							(0.0.000)	
CENERAL SERVICE COST CENTERS   10.00   11.00   12.00   13.00   14.00   1.00				(I KII LNI DKIS)	(MILEAGE)			
SENERAL SERVICE COST CENTERS			(PATTENT DATS)		(WILLEAGE)	,		
GENERAL SERVICE COST CENTERS			10.00	44.00	10.00		44.00	
1.00			10.00	11.00	12.00	13.00	14.00	
2.00				,	,			_
3. 00	1. 00							
4, 00   ADMINI STRATI VE & GENERAL	2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
5. 00   PLANT OPERATION & MAINTENANCE	3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
5. 00   PLANT OPERATION & MAINTENANCE	4.00	ADMINISTRATIVE & GENERAL						4.00
6. 00   LAUNDRY & LINEN SERVICE								1
7. 00   HOUSEKEEPING		1						
8. 00 DI ETARY 9. 00 NURSING ADMINISTRATION 9. 00 ROUTINE MEDICAL SUPPLIES 3, 245 11. 00 11. 00 MEDICAL RECORDS 13. 00 VOLUNTEER SERVICE COORDINATION 12. 00 STAFF TRANSPORTATION 13. 00 VOLUNTEER SERVICE COORDINATION 14. 00 PHARMACY 0 0 10, 551 13. 00 16. 00 OTHER GENERAL SERVICE 0 0 0 0 0 15. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 10. 00 OTHER GENERAL SERVICE 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
9. 00 NURSI NG ADMI NI STRATI ON								
10. 00   ROUTINE MEDICAL SUPPLIES   3, 245   3, 245   10. 00   11. 00   MEDICAL RECORDS   11. 00   11. 00   MEDICAL RECORDS   3, 245   11. 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   13. 00   14. 00   14. 00   14. 00   15. 00   14. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   16. 00   17. 00   1								1
11. 00   MEDI CAL RECORDS   3, 245   28, 540   12. 00   12. 00   13. 00   VOLUNTEER SERVI CE COORDI NATI ON   0   10, 551   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   15. 00   16. 00   0   0   0   0   0   0   0   0   0								1
12. 00   13. 00   VOLUNTEER SERVI CE COORDINATION   0   10,551   13. 00   14. 00   14. 00   15. 00   14. 00   15. 00   14. 00   10,551   13. 00   15. 00   15. 00   16. 00   0   0   0   0   0   0   0   0   15. 00   15. 00   16. 00   0   0   0   0   0   0   0   0   0			3, 245	l .				
13. 00   VOLUNTEER SERVICE COORDINATION   0   10,551   13. 00   14. 00   14. 00   14. 00   14. 00   15. 00   0   0   0   0   0   0   0   0   0	11. 00	MEDI CAL RECORDS		3, 245				11. 00
14. 00   PHARMACY   0 0 0 0 14. 00   15. 00	12.00	STAFF TRANSPORTATION			28, 540			12.00
15. 00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   0 0 0 16. 00   16. 00   17. 00   16. 00   17. 00	13.00	VOLUNTEER SERVICE COORDINATION			0	10, 551		13.00
15. 00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   0 0 0 16. 00   16. 00   17. 00   16. 00   17. 00	14.00	PHARMACY			0	0	0	14.00
16. 00   OTHER GENERAL SERVICE   O O O O O O O O O O O O O O O O O O					0	0	0	1
17. 00   PATI ENT/RESI DENTI AL CARE SERVI CES					ا آ	0	-	1
LEVEL OF CARE						J	0	1
Description	17.00							17.00
S1. 00	FO 00					٥		F0 00
1			0 000		_	-	-	
NONREI MBURSABLE COST CENTERS   7   7   68   25   0   53.00			3, 233	3, 233				1
NONREI MBURSABLE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	5	5			-	
60. 00       BEREAVEMENT PROGRAM       0       0       60. 00         61. 00       VOLUNTEER PROGRAM       0       0       0       61. 00         62. 00       FUNDRAI SI NG       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS       0       0       0       62. 00         63. 00       PALLI ATI VE CARE PROGRAM       0       0       0       64. 00         65. 00       OTHER PHYSI CI AN SERVI CES       0       0       0       65. 00         66. 00       RESI DENTI AL CARE       0       0       0       65. 00         67. 00       ADVERTI SI NG       0       0       0       67. 00         68. 00       TELEHEALTH/TELEMONI TORI NG       0       0       0       68. 00         69. 00       THRI FT STORE       0       0       0       69. 00         70. 00       NURSI NG FACI LI TY ROOM & BOARD       70. 00       70. 00       71. 00         70. 00       NEGATI VE COST CENTER       99. 00	53. 00		7	7	68	25	0	53. 00
61.00 VOLUNTEER PROGRAM 62.00 FUNDRAI SI NG 0 0 0 0 62.00 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 0 0 63.00 64.00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 0 0 66.00 67.00 ADVERTI SI NG 0 0 0 0 66.00 68.00 TELEHEALTH/TELEMONI TORI NG 69.00 THRI FT STORE 0 0 0 0 69.00 70.00 NURSI NG FACILITY ROOM & BOARD 71.00 OTHER NONREI MBURSABLE (SPECI FY) 99.00 NEGATI VE COST CENTER		NONREI MBURSABLE COST CENTERS						
62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 69. 00 THRI FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER	60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THRIFT STORE 69. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER	61.00	VOLUNTEER PROGRAM			0	0	0	61.00
64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER	62.00	FUNDRAI SI NG			0	o	0	62.00
64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 0 0 0 0 0 0 71. 00 0 77. 00 0 0 0 0 0 71. 00	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER  0 0 0 0 65. 00 0 0 67. 00 0 0 0 68. 00 0 0 0 0 69. 00 0 0 0 0 71. 00 0 0 0 0 71. 00		1			0	0		1
66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 68. 00 0 0 0 67. 00 68. 00 0 0 0 67. 00 68. 00 0 0 0 68. 00 0 0 0 68. 00 0 0 0 68. 00 0 0 0 0 68. 00 0 0 0 0 69. 00 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			ا م	0	0	1
67. 00   ADVERTISING   0 0 0 67. 00 68. 00 68. 00   TELEHEALTH/TELEMONITORING   0 0 0 68. 00 69. 00   THRIFT STORE   0 0 0 69. 00 69. 00 70. 00   NURSING FACILITY ROOM & BOARD   70. 00   THER NONREIMBURSABLE (SPECIFY)   0 0 0 71. 00 99. 00   NEGATIVE COST CENTER   99. 00						0	-	
68. 00   TELEHEALTH/TELEMONI TORI NG   0 0 0 68. 00 69. 00   14RI FT STORE   0 0 0 0 69. 00 70. 00   14RI FT STORE   0 0 0 0 69. 00 70. 00 71. 00   04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1				0	0	1
69.00 THRIFT STORE 0 0 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00					0	U	0	
70.00   NURSING FACILITY ROOM & BOARD   70.00   71.00   OTHER NONREIMBURSABLE (SPECIFY)   0   0   71.00   99.00   NEGATIVE COST CENTER   99.00					0	0		
71.00 OTHER NONREIMBURSABLE (SPECIFY) 99.00 NEGATIVE COST CENTER 0 0 0 71.00 99.00					0	0	0	07.00
99.00 NEGATIVE COST CENTER 99.00								
	71. 00				0	0	0	71.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 516 0 28,537 10,550 0 100.00	99. 00	NEGATIVE COST CENTER						99. 00
	100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	516	0	28, 537	10, 550	0	100.00
101. 00 UNIT COST MULTIPLIER 0. 159014 0. 000000 0. 999895 0. 999905 0. 000000 101. 00			0. 159014	0. 000000	0. 999895	0. 999905	0.000000	101.00

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: Hospice CCN:		Worksheet 0-6 Part II Date/Time Prepared: 2/22/2017 4:50 pm

			Hospi ce cci	N: 15-1561	10 09/30/201	2/22/2017	
					Hospi ce I	2,22,231,	1. 00 p
	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	S		
		(PATIENT DAYS)	BASIS)	(IN-FACILITY	•		
				DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	4					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	NURSING ADMINISTRATION						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	3, 245					15. 00
16.00	OTHER GENERAL SERVICE		0	)			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			1	2		17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0				50. 00
51. 00	HOSPICE ROUTINE HOME CARE	3, 233	0	1			51. 00
	HOSPICE INPATIENT RESPITE CARE	5	0	1	5		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	7	0		7		53. 00
	NONREI MBURSABLE COST CENTERS	T	T	,			
60. 00	BEREAVEMENT PROGRAM		0	1			60. 00
61. 00	VOLUNTEER PROGRAM		0				61. 00
62. 00	FUNDRAI SI NG		0	1			62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	1			63. 00
64. 00	PALLIATIVE CARE PROGRAM		0	1			64. 00
65. 00	OTHER PHYSI CI AN SERVI CES	_	0	1			65. 00
66. 00	RESI DENTI AL CARE	0	-	1	0		66. 00
67. 00	ADVERTI SI NG		0				67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	1			68. 00
	THRIFT STORE		0	1			69. 00
70.00	NURSING FACILITY ROOM & BOARD	_	_				70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	0		71. 00
	NEGATI VE COST CENTER				_		99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0		U		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	U		101. 00

	Financial Systems	CAMERON MEMORIA	L COMMUNITY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE			Provider CO		Peri od:	Worksheet 0-7	
			Hospi ce CCI	N: 15-1561	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/22/2017 4:5	pared: O pm
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C Part I, Col. 9 line	Ratio		HRHC	HI RC	
		0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 614466		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	73. 00 96. 00 60. 00	0. 451552 0. 331760		0 0	0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC	71. 00 93. 00 55. 00	0. 637713		0 0	0	7. 00 8. 00 9. 00
10. 00 10. 01	CHEMICAL DEPENDENCY ONCOLOGY Totals (sum of lines 1-11)	76. 00 76. 01	154. 430508 0. 406009		0 0	0	10. 00 10. 01 11. 00
		Charges by LOC (from Provider Records)			ce Costs by LOC		
	Cost Center Descriptions		col . 2)	col . 3)	xHIRC (col. 1 x col. 4)	col. 5)	
	ANCILLARY SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	4. 00 5. 00
6. 00 7. 00 8. 00	LABORATORY MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	6. 00 7. 00 8. 00
9. 00 10. 00 10. 01	RADIOLOGY-THERAPEUTIC CHEMICAL DEPENDENCY ONCOLOGY Totals (sum of lines 1-11)	0 0	0 0		0 0 0	0	9. 00 10. 00 10. 01 11. 00

Health Financial Systems	CAMERON	MEMORI AL	COMMUNI TY			In Lieu of Form CMS-2552-10			
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Г		Provi der	CCN:	15-1315	Perio	od: 10/01/2015	Worksheet 0-8	
			Hospi ce C	CN:	15-1561			Date/Time Prepared:	

		1.0001.00		077 007 2010	2/22/2017 4: 50	
				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 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,			235, 948	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				3, 233	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				72. 98	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	2, 938			9. 00
10.00	Program cost (line 8 times line 9)		214, 415	11, 312		10. 00
	HOSPICE INPATIENT RESPITE CARE					
11. 00		7, col. 8,			342	11. 00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				5	12. 00
	Total average cost per diem (line 11 divided by line 12)				68. 40	13. 00
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	4	1		14. 00
15. 00	Program cost (line 13 times line 14)		274	68		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, 062	16. 00
47.00	line 11)				_	47.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				/ /	17. 00
	Total average cost per diem (line 16 divided by line 17)		_	_	4, 008. 86	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	7	0		19. 00
20.00	Program cost (line 18 times line 19)		28, 062	0		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				264, 352	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)					22. 00
23. 00	Average cost per diem (line 21 divided by line 22)				81. 46	23. 00