Health Financ		BLUFFTON REGIONAL M	EDICAL CENTER	In Lie	u of Form CMS-2552-10
payments made	s required by law (42 USC 1395g; 42 since the beginning of the cost rep	orting period being	g deemed overpayments (	ult in all interim	FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
AND SETTLEMEN		PORT CERTIFICATION	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/28/2017 1:36 pm
PART I - COST	REPORT STATUS				=/==/=== =: =: = pm
Provider use only	<ol> <li>[ X ] Electronically filed cost rep</li> <li>2. [ ] Manually submitted cost rep</li> <li>3. [ 0 ] If this is an amended repor</li> <li>4. [ F ] Medicare Utilization. Enter</li> </ol>	ort ort enter the number	of times the provider _" for low.	Date: 2/28/20 resubmitted this c	
Contractor use only	(1) As Submitted 7. Con (2) Settled without Audit 8. [ N	e Received: tractor No. ]Initial Report fo ]Final Report for	or this Provider CCN 12.		or Code: 4 Tumn 1 is 4: Enter es reopened = 0-9.

## PART II - CERTIFICATION

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

## CERTIFICATION BY 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 BLUFFTON REGIONAL MEDICAL CENTER ( 15-0075 ) 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.

Encryption Information

ECR: Date: 2/28/2017 Time: 1:36 pm VACRzDL8g6r2eFGvMd1Ddmy5ceYNb0 pw3pR0:wxnf6ux5oLj49uTwyNJoY3n :W6418iBY00vaHz2

PI: Date: 2/28/2017 Time: 1:36 pm tHNNfF8Amr5QpGzLLATg0FI114jCC0 3su4B0Sss2GYRJX6FWGXTaA11BGunE

Z15j0Psbx.Oit0km

Subprovider - IPF

Subprovider - IRF

SKILLED NURSING FACILITY

Swing bed - SNF Swing bed - NF

Hospital

1.00

2.00

3.00

5.00

6.00

7.00

200.00 Total

PART III - SETTLEMENT SUMMARY

(Signed)

or Administrator of Provider(s)

President, Revenue Management

Date

Title XVIII Part A Part B HIT Title XIX 2.00 3.00 4.00 5.00 125,569 37,896 0 1.00 0 0 2.00 0 0 0 3.00 0 0 5.00 0 6.00

0

7.00

125,569 37,896 0 200.00 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.

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Title V

1.00

Health Financial Systems BLUFFTON REGIONAL MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0075 Peri od: Worksheet S-2 From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 303 S. MAIN STREET 1.00 PO Box: 1.00 2.00 City: BLUFFTON State: IN Zip Code: 46714-County: WELLS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal BLUFFTON REGIONAL 150075 23060 07/01/1966 Ν 0 3.00 MEDICAL CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF BLUFFTON SKILLED 155373 23060 03/13/1991 Ρ Ν 9.00 NURSI NG 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2015 09/30/2016 20.00 21.00 Type of Control (see instructions) 4 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22 00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 121 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 25.00 0 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.

HOSPI T	Financial Systems BLUFFTON RE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	N: 15-0075	Peri od:		Workshe	m CMS-2 et S-2	
					From 10/01, To 09/30,		Part I Date/Ti 2/28/20		
			<u> </u>	<u>'</u>	Urban/Rui			Geogr	
26. 00	Enter your standard geographic classification (not wa			inning of the		1	2.0	,,,	26. C
27. 00	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 enter the effective date of the geographic reclassifi	ge) sta "2" fo	atus at the end or rural. If ap			1			27. C
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. C
	· · · · · ·				Begi nni 1. 00		Endi ı 2. C		
6. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number	-				36. 0
7. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the nu	umber of period	ls MDH status		0			37. (
7. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37. (
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 0
					Y/N 1. 00		Y/I 2. C		
39. 00	Does this facility qualify for the inpatient hospital						Y		39. C
10. 00	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 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges program of the state of	ui remer or "N" adjust er 1. [	nts in accordar for no. (see i tment? Enter "Y Enter "Y" for y	nce with 42 nstructions) " for yes or	N -		Y		40. 0
	no in column 2, for discharges on or after October 1.	(366.1	riisti ucti olis)			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2. 00	3.00	
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)					N	N	N	45. (
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46. (
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. ( 48. (
6. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56. (
7. 00	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 h of th	r "N" for no in nis cost report olete Worksheet	column 1. If	column 1 Enter "Y"				57. (
8. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ıns' servi ces	as	N			58. (
	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N			59.0
0. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	for yes	s or "N" for no	. (see instru	uctions)	N			60.0
		Y/N	IME	Direct GME	IME		Di rect	: GME	
1. 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	0.00	5. C		61.0
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care		0.00	0.0	20	0.00		0.00	61. (
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		5.00	J. V					
1. 02	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		0.00	0. (	od				61. (
1. 03	ACA). (see instructions) 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. (
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0. 0	00				61. 0
	current cost reporting period. (see instructions). Enter the difference between the baseline primary		0.00	0.0					61. (

Health Fina	ancial Systems	BLUFFTON RE	EGI ONAL	MEDICAL CENTER	₹	In Lie	u of Form CMS-2	2552-10
HOSPI TAL AI	ND HOSPITAL HEALTH CARE COMPL	LEX IDENTIFICATION DA	·ΤΑ	Provi der CC	:N: 15-0075   Pe Fr To	eriod: rom 10/01/2015 o 09/30/2016		pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
used	er the amount of ACA §5503 aw d for cap relief and/or FTEs e or general surgery. (see in	that are nonprimary	1.00	2.00	3.00	4.00	5.00	61. 06
Care	on general surgery. (see in	Structions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
spec for col u prog unwe	the FTEs in line 61.05, specicialty, if any, and the numbe each new program. (see instrumn 1, the program name, entegram code, enter in column 3, bighted count and enter in columweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE		1.00	2. 00	3.00	4.00	61. 10
61. 20 Of t progresi instente 3, t	the FTEs in line 61.05, speci gram specialty, if any, and t dents for each expanded prog tructions) Enter in column 1, er in column 2, the program c the IME FTE unweighted count direct 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
					(UDOA)		1.00	
	Provisions Affecting the Hea er the number of FTE resident					od for which	0.00	62. 00
62.01 Ente	hospital received HRSA PCRE or the number of FTE resident ng in this cost reporting pe	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	ching Hospitals that Claim Re your facility trained reside for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
					Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Sect	tion 5504 of the ACA Base Yea	r FTF Residents in No	nnrovi (	der Settings	1.00 This base year	2.00	3.00	
64.00 Ente in t resi sett	od that begins on or after Jer in column 1, if line 63 is the base year period, the num dent FTEs attributable to rotings. Enter in column 2 the dent FTEs that trained in yo	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweighted	re June ty trair n-primar all nor d non-pr	30, 2010. ned residents ry care nprovider rimary care	0.00			64. 00
	(column 1 divided by (column	1 + column 2)). (see	instruc	ctions)	Upwoi ahtad	Upwai abtad	Ratio (col. 3/	
		Program Name	PIC	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	(col. 3 + col. 4))	
45 00 Ento	er in column 1, if line 63	1. 00		2. 00	3. 00	4. 00	5. 00 0. 000000	45.00
is y trai year asso FTES prog resi the col u unwe resi rota non- col u unwe resi your 5, t	yes, or your facility ned residents in the base period, the program name ociated with primary care for each primary care gram in which you trained dents. Enter in column 2, program code, enter in umn 3, the number of eighted primary care FTE dents attributable to ations occurring in all provider settings. Enter in umn 4, the number of eighted primary care dent FTEs that trained in hospital. Enter in column the ratio of (column 3 ded by (column 3 + column (see instructions)							

Health Financial Systems  BLUFFTON REGIONAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	MEDICAL CENTER		Ir eri od:	n Lieu	u of Form Workshee	CMS-2552-1	-10
			om 10/01/		Part I	e Prepared	d:
			V		2/28/201 XI X	7 1:33 pm	
			1.00		2. 00		
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column.			0. 00 N		O. OC N	95. C 96. C	
97.00 If line 96 is "Y", enter the reduction percentage in the appropriate Rural Providers	plicable column	ı	0. 00		0. 00	97. C	00
105.00 Does this hospital qualify as a critical access hospital (C. 106.00  f this facility qualifies as a CAH, has it elected the all		nod of payment	N			105. C	
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 instr	ructions) If				107. 0	00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	N			108. C	00
	Physi cal 1.00	Occupati onal 2.00	Speecl 3.00		Respi ra		
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.		2.00	3.00		4. 00 N	109. C	00
					1.00		
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	_	N	110. C	00
				1. 00	2. 00	3. 00	
Miscellaneous Cost Reporting Information 115.00 st this an all-inclusive rate provider? Enter "Y" for yes o	n "N" fon no in	a column 1 lf	aalumn 1	N		0 115 0	
is yes, enter the method used (A, B, or E only) in column 2  3 either "93" percent for short term hospital or "98" percel psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 i nt for long ter	s "E", enter i rm care (includ	n column es	IN		0  115. C	00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu	•		N" for	Y N		116. C	
118.00 s the malpractice insurance a claims-made or occurrence po	licy? Enter 1 i	f the policy i	s	1		118. C	00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	5	Insura	nce	
		1. 00	2.00		3.00	)	
118.01 List amounts of mal practice premiums and paid losses:		17, 014		7, 001		'6, 844 118. C	01
			1. 00		2.00	)	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein.	center other 1 dule listing co	than the ost centers	N			118.0	
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §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 th	' for yes or ne Outpatient	N		N	119. C	
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 devices	s charged to	Y			121. 0	00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes?			N			122. 0	00
for no in column 1. If column 1 is "Y", enter in column 2 to where these taxes are included.  Transplant Center Information	he Worksheet A	line number					
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N			125. C	00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e		fication date				126. C	00
in column 1 and termination date, if applicable, in column 1. 127.00 of this is a Medicare certified heart transplant center, en	ter the certifi	cation date				127. C	00
in column 1 and termination date, if applicable, in column 128.00 of this is a Medicare certified liver transplant center, en	ter the certifi	cation date				128. C	00
in column 1 and termination date, if applicable, in column 1. 129.00 of this is a Medicare certified lung transplant center, ent		cation date in				129. 0	00
column 1 and termination date, if applicable, in column 2. 130.00 olf this is a Medicare certified pancreas transplant center,		ti fi cati on				130. C	00
date in column 1 and termination date, if applicable, in co 131.00 of this is a Medicare certified intestinal transplant cente	r, enter the ce	erti fi cati on				131. C	00
date in column 1 and termination date, if applicable, in co 132.00 f this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date				132. 0	00

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	BLUFFTON REGIONAL IDENTIFICATION DATA	Provi der CC		Peri od:		u of Form CMS Worksheet S	
					0/01/2015 9/30/2016	Part I Date/Time Pi	
						2/28/2017 1:	: 33 pm
					1. 00	2. 00	
33.00 If this is a Medicare certified othe in column 1 and termination date, if	applicable, in column	2.					133. 0
34.00 If this is an organ procurement orga and termination date, if applicable, AII Providers		he OPO number i	n column 1				134. 0
40.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. If	yes, and home	office cost	S	Y	449008	140. 0
1.00	2. (				3. 00		
If this facility is part of a chain home office and enter the home office				name and	address	of the	
41.00 Name: CHS / COMMUNITY HEALTH SYSTEM				tor's Nu	mber: 5228	0	141.0
42.00 Street: 4000 MERIDIAN BLVD	PO Box:				070/	_	142.0
43.00 City: FRANKLIN	State: TN	N	Zi p Cod	9:	3706	) / 	143. 0
						1.00	
44.00 Are provider based physicians' costs	included in Worksheet	A?				Y	144. 0
					1. 00	2.00	-
45.00 f costs for renal services are clai	med on Wkst. A, line 74	, are the costs	s for		N N	2.00	145. 0
inpatient services only? Enter "Y" foo, does the dialysis facility inclu	de Medicare utilization						
period? Enter "Y" for yes or "N" fo 46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in c	changed from the previo			f	N		146. 0
yes, enter the approval date (mm/dd/							
						1 00	_
47.00 Was there a change in the statistica	L basis? Enter "Y" for	ves or "N" for	no.			1.00 N	147. 0
48.00 Was there a change in the order of a						N	148. 0
49.00 Was there a change to the simplified	cost finding method? E				: +1 - \/	N T: +1 - VIV	149. 0
		Part A 1.00	2.00		itle V 3.00	Title XIX 4.00	$\dashv$
Does this facility contain a provide			n the applic		f the lowe	r of costs	
or charges? Enter "Y" for yes or "N" 55.00 Hospi tal	for no for each compor	nent for Part A	and Part B. N	(See 42	2 CFR §413 N	N N	155. 0
56. 00 Subprovi der – TPF		N	N N		N	N	156. 0
57.00 Subprovider - IRF		N	N		N	N	157. C
58. 00 SUBPROVI DER 59. 00 SNF		N	l N		N	N	158. C
60.00HOME HEALTH AGENCY		N N	N N		N	N N	160. 0
61. 00 CMHC			N		N	N	161. 0
						1.00	_
Multicampus						1.00	
65.00 Is this hospital part of a Multicamp	us hospital that has on	e or more campu	uses in diff	erent CB	SSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	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,						0.	00 166. 0
CBSA in column 4, FTE/Campus in			1 1				
CBSA in column 4, FTE/Campus in						1. 00	+
CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT)				nt Act			
CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) 67.00 is this provider a meaningful user u 68.00 if this provider is a CAH (line 105	nder §1886(n)? Enter " is "Y") and is a meanin	Y" for yes or " gful user (line	'N" for no.		the	1. 00 Y	
CBSA in column 4, FTE/Campus in column 5 (see instructions)	nder §1886(n)? Enter " is "Y") and is a meanin assets (see instructio a meaningful user, doe	Y" for yes or " gful user (line ns) s this provider	'N" for no. e 167 is "Y" - qualify fo	), enter r a hard			167. 0 0168. 0 168. 0

Health Financial Systems	BLUFFTON REGIONAL N	MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0075	Peri od: From 10/01/2015	Worksheet S-2	
				Date/Time Pre	
				2/28/2017 1:3	3 PIII
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be- period respectively (mm/dd/yyyy)	ginning date and ending da	ite for the reporting	01/01/2016	03/30/2016	170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. If column 1 is yes, e	enter the number of section	n		
1876 Medicare days in column 2. (se	e instructions)				

Ν

N

18.00

19.00

N

N

18.00

in columns 2 and 4. (see instructions)

cost report? If yes, see instructions.

information? If yes, see instructions.

If line 16 or 17 is yes, were adjustments made to PS&R

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

Heal th	Financial Systems BLUFFTON REGIONAL	MEDICAL CENTE	R	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0075	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 2/28/2017 1:3	epared:
			i pti on	Y/N	Y/N	
20. 00	If line 1/ or 17 is use were adjustments made to DCCD		0	1. 00 N	3. 00 N	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00	
	Capital Related Cost		•			
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere	d into durina	this cost re	porting period?	Υ	24. 00
	If yes, see instructions	- · · · · · · · · · · · · · · · · · · ·		parating parating		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
24 00	instructions.	a cost roporti	na nori od? I	f voc. soo	N	26. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	le cost reporti	ng period? i	ı yes, see	įΝ	26.00
27. 00	Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit	N	27. 00
	сору.					
20.00	Interest Expense	*	464		N.	20.00
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	iterea into aur	ing the cost	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (De	bt Service R	eserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see instr	uctions		,		
30. 00	Has existing debt been replaced prior to its scheduled matu	rity with new	debt? If yes	, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	suance of new	deht2 If ves	202	N	31.00
31.00	instructions.	Suarice of flew	debt: 11 yes	, 366	IN	31.00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	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		na to competi	tive hidding? If	N	33.00
33.00	no, see instructions.	irea pertariir	ig to competi	tive broating: II	IN	33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physi ci ans?	N	34. 00
25 00	If yes, see instructions.	a+: na aanaaman	.+ +	nrovi don boood	N	35. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	pi ovi dei -based	IN	33.00
	<u> </u>			Y/N	Date	
				1. 00	2. 00	
26 00	Home Office Costs Were home office costs claimed on the cost report?			Y		26 00
36. 00 37. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr	epared by the	home office?			36. 00 37. 00
57.00	If yes, see instructions.	ou by 1110	5111661			355
38. 00	If line 36 is yes , was the fiscal year end of the home off			Υ	12/31/2015	38. 00
20 00	the provider? If yes, enter in column 2 the fiscal year end			NI NI		20 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	а спаги сотрог	ients: if yes	, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	i nstructi ons.					
		1	00	2	00	
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00		KUZI WA		TSI GA		41. 00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively.	cus				42.00
42. 00	Enter the employer/company name of the cost report preparer.	CHS				42. 00
43. 00		615-465-3416		KUZI WA_TSI GA@CI	HS. NET	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	BLUFFTON REGIONAL	MEDIC	CAL CENTER	In Lie	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Pr	ovider CCN: 15-0075	riod: om 10/01/2015 09/30/2016		epared:
				3.00			
	Cost Report Preparer Contact Information						
	Enter the first name, last name and the ti held by the cost report preparer in column respectively.		SENI OF	R MANAGER			41.00
	Enter the employer/company name of the cospreparer.	st report					42. 00
43. 00	Enter the telephone number and email addre report preparer in columns 1 and 2, respec						43. 00

					''	0 77 307 2010	2/28/2017 1: 3:	
							I/P Days / 0/P	5 p
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	oomponent.	Line Number	140.	or beas	Avai I abl e	oran nodi s	'''	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		55	20, 130	0.00		1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		00	20, 100	0.00	ا	
	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						o	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF							6. 00
7. 00	Total Adults and Peds. (exclude observation			55	20, 130	0.00		7. 00
7.00	beds) (see instructions)			55	20, 130	0.00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		7	2, 562	0.00	o	8. 00
9. 00	CORONARY CARE UNIT	31.00		,	2, 302	0.00	O O	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00								11. 00
	SURGICAL INTENSIVE CARE UNIT							
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00						12.00
13.00	NURSERY	43. 00			22 (02	0.00	0	13.00
14.00	Total (see instructions)			62	22, 692	0. 00		14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER						_	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		13	4, 758		0	19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			75				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)							
33.00	LTCH non-covered days							33.00
	•	,		'			. '	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 10/01/2015 | Part I | To 09/30/2016 | Date/Time Prepared: | 2/28/2017 1:33 pm Health Financial Systems BLUFFTON REHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA BLUFFTON REGIONAL MEDICAL CENTER Provider CCN: 15-0075

					-	2/28/2017 1:3	3 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 777	159	3, 663			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)	991	953				2. 00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0	ł			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF	4 777	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 777	159	3, 663			7. 00
8. 00	beds) (see instructions)	371	4	950			8. 00
9. 00	INTENSIVE CARE UNIT	3/1	6	950			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		66	644			13.00
14. 00	Total (see instructions)	2, 148	231			212. 98	
15. 00	CAH visits	2, 140	0		0.00	212. 70	15. 00
16. 00	SUBPROVI DER - I PF	o o	0	٦			16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	1, 604	0	3, 003	0.00	12. 56	
20. 00	NURSING FACILITY	.,	· ·	0,000	0.00	12.00	20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	l c	)		24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	225. 54	27. 00
28. 00	Observation Bed Days		0	1, 476	,		28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C	)		30. 00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0				32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared: Health Financial Systems BLUFFTON REHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0075

				10	09/30/2016	2/28/2017 1:33	
		Full Time	<u>'</u>	Di sch	arges		- · · ·
		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		0	587	249	1, 529	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			254	0		2. 00
3.00	HMO IPF Subprovider			234	0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				٩		5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNI						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						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						13. 00
14.00	Total (see instructions)	0. 00	0	587	249	1, 529	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00 29. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						30. 00
31. 00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. 01	outpatient days (see instructions)						02.01
33. 00	LTCH non-covered days					ļ	33. 00
<del>-</del>		1			ı ı	'	

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

					To	09/30/2016	Date/Time Pre 2/28/2017 1:3	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	Worksheet A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6.00	
	PART II - WAGE DATA		2.00	0.00	1. 55	0.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	11, 848, 027	1 0	11, 848, 027	469, 129. 00	25. 26	1.00
2. 00	instructions) Non-physician anesthetist Part	200.00	11, 040, 027		, ,	0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0	_		0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	_		0.00		
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 0
7. 01	approved program) Contracted interns and residents (in an approved		0	0	О	0. 00	0. 00	7.0
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0.00	8. 0
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	606, 605 3, 503	l .	606, 605 74, 385	26, 123. 00 2, 812. 00		
	instructions) OTHER WAGES & RELATED COSTS		-,	.,		,		
11. 00	Contract Labor: Direct Patient Care		95, 629			1, 608. 00		
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0.00	12.0
13. 00	Contract Labor: Physician-Part A - Administrative		105, 214	0	105, 214	805.00	130. 70	13. 0
14. 00	Home office and/or related orgainzation salaries and wage-related costs		980, 596	0	980, 596	28, 094. 00	34. 90	14.0
14. 01	Home office salaries		0	_	0	0.00		14. 0
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	_	0	0. 00 0. 00	•	
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 0
	WAGE-RELATED COSTS							
17. 00 18. 00	Wage-related costs (core) (see instructions)		2, 876, 590		2, 876, 590			17. 0
19. 00	Wage-related costs (other) (see instructions) Excluded areas		232, 633		232, 633			18. 0
20. 00	Non-physician anesthetist Part A		0	0	0			20. 0
21. 00	Non-physician anesthetist Part B		0	_	0			21.0
22. 00	Physician Part A - Administrative		0	_	0			22.0
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 0
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 0 25. 0
25. 50 25. 51	Home office wage-related Related orgainzation		0	_	0			25. 5 25. 5
25. 52	wage-related Home office: Physician Part A - Administrative -		0	0	0			25. 5
25. 53	wage-related Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 5
24 00	wage-related  OVERHEAD COSTS - DIRECT SALARIE		1/2 202		1/2 202	E 2/2 00	20.47	26.00
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	163, 382 1, 567, 292	l .	,	5, 362. 00 56, 919. 00		26. 00 27. 00

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0075

						077 007 2010	2/28/2017 1: 3	
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	309, 081	0	309, 081	13, 595. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32. 00	Housekeepi ng	9. 00	206, 983	0	206, 983	16, 657. 00	12. 43	32.00
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	390, 924	-192, 925	197, 999	15, 424. 13	12. 84	34.00
35. 00	Di etary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	192, 925	192, 925	15, 028. 87		36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	820, 885	153, 171	974, 056	25, 872. 00	37. 65	38. 00
39. 00	Central Services and Supply	14. 00	117, 007	0	117, 007	7, 538. 00	15. 52	39. 00
40.00	Pharmacy	15. 00	512, 763	0	512, 763	13, 289. 00	38. 59	40.00
41.00	Medical Records & Medical	16. 00	293, 264	0	293, 264	16, 567. 00	17. 70	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

4.00

5.00

6.00

7.00

38.73

25. 76

32 35

23.14

4.00

5.00

6.00

7.00

BLUFFTON REGIONAL MEDICAL CENTER HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0075 Peri od: From 10/01/2015 To 09/30/2016 2/28/2017 1:33 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1. 00 4.00 5.00 6.00 2.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 11, 848, 027 11, 848, 027 469, 129. 00 25. 26 1.00 instructions) 2.00 Excluded area salaries (see 610, 108 70, 882 680, 990 28, 935. 00 23. 54 2.00 instructions) 3.00 Subtotal salaries (line 1 11, 237, 919 -70, 882 11, 167, 037 440, 194. 00 25.37 3.00

1, 181, 439

2, 876, 590

15, 225, 066

4, 310, 699

C

-70, 882

-70, 882

30, 507. 00

470, 701. 00

186, 252. 00

0.00

1, 181, 439

2, 876, 590

15, 295, 948

4, 381, 581

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER			u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-007	From 10/01/2015	Worksheet S-3 Part IV Date/Time Prepared:

	To 09/30/2016	Date/Time Prep 2/28/2017 1:33	
		Amount	5 piii
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	258, 165	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	ol	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	ol	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 680, 447	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	ol	8. 03
9.00	Prescription Drug Plan	ol	9. 00
10.00	Dental, Hearing and Vision Plan	16, 975	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	11, 216	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	411	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13, 282	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	l ol	14. 00
15. 00	'Workers' Compensation Insurance	193, 891	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	l ol	16. 00
	Non cumulative portion)		1
	TAXES		l
17.00	FICA-Employers Portion Only	748, 801	17. 00
	Medicare Taxes - Employers Portion Only	175, 123	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	10, 912	20. 00
	OTHER		l
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	3, 109, 223	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS	0	25. 00

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0075	From 10/01/2015	Worksheet S-3 Part V Date/Time Prep 2/28/2017 1:33	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1 00	2 00	

Cost Center Description  Contract Labor Benefit Cost  1.00  2.00  PART V - Contract Labor and Benefit Cost	1.00
	1.00
PART V - Contract Labor and Benefit Cost	1 00
	4 00
Hospital and Hospital-Based Component Identification:	4 00
1.00   Total facility's contract labor and benefit cost 95,629 3,109,223 1.	1.00
2. 00 Hospi tal 95, 629 2, 876, 590 2.	2.00
3.00   Subprovi der - IPF   3.	3.00
4.00   Subprovi der - I RF   4.	4.00
5.00   Subprovi der - (0ther)   0   0   5.	5.00
6.00   Swing Beds - SNF   0   0   6.	6.00
7.00   Swing Beds - NF   0   0   7.	7.00
8.00 Hospi tal -Based SNF 0 213, 770 8.	8.00
9.00 Hospi tal -Based NF 9.	9.00
10. 00 Hospi tal -Based OLTC 10.	10. 00
11. 00 Hospi tal -Based HHA 11.	11. 00
12.00 Separately Certified ASC 12.	12. 00
13. 00 Hospi tal -Based Hospi ce	13. 00
14.00 Hospital-Based Health Clinic RHC 14.	14. 00
15.00 Hospital-Based Health Clinic FQHC 15.	15. 00
16. 00 Hospi tal -Based-CMHC 16.	16. 00
17. 00 Renal Dialysis 17.	17. 00
18.00 Other 0 18,863 18.	18. 00

Health Financial Systems BLUFFTON REGIONAL	MEDICAL CENTE	R	In Li€	eu of Form CMS-:	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der C	CN: 15-0075	Peri od:	Worksheet S-7	
			From 10/01/2015 To 09/30/2016		nared:
				2/28/2017 1: 3	
	Group	SNF Days	Swing Bed SNF		
			Days	col. 2 + 3)	
(0.00	1.00	2.00	3.00	4.00	10.00
69. 00 70. 00	PE2 PE1			_	
71. 00	PD2			0	
72.00	PD1			0	1
73.00	PC2			Ö	
74. 00	PC1		0	ő	
75. 00	PB2		o c	Ō	
76. 00	PB1		5 C	5	76. 00
77. 00	PA2		0 0	0	77. 00
78. 00	PA1		0 0	0	
199. 00	AAA		0 0	0	
200. 00 TOTAL		1, 60		· · · · · · · · · · · · · · · · · · ·	200. 00
			CBSA at	CBSA on/after	
			Beginning of Cost Reporting	October 1 of the Cost	
			Peri od	Reporting	
				Period (if	
				appl i cabl e)	
			1. 00	2. 00	
SNF SERVI CES				T	
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA			23060	23060	201. 00
in effect at the beginning of the cost reporting period. En					
The effect on or after october 1 of the cost reporting period	о (тарритсас	Expenses	Percentage	Associ ated	
		Expenses	rereentage	with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2. 00	3.00	
A notice published in the Federal Register Volume 68, No. 1 payments beginning 10/01/2003. Congress expected this incre					
expenses. For lines 202 through 207: Enter in column 1 the					
column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" for					
with direct patient care and related expenses for each cate					
202.00 Staffing			0.00		202. 00
203.00 Recrui tment			0.00		203. 00
204.00 Retention of employees			0.00		204. 00
205. 00 Trai ni ng			0.00		205. 00
206.00 OTHER (SPECIFY) 207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	<b>\</b>	2 114 00	0.00		206. 00 207. 00
207.00 Total Sir Levellue (worksheet 6-2, Part 1, Title 7, Corumn 3,	,	3, 114, 99	, ol	I	1207.00

Heal th	Financial Systems BLUFFTON REGIONAL ME	DICAL CENTE	R	In Lie	u of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0075	Peri od:	Worksheet S-10	0		
	From 10/01/2015 To 09/30/2016 Da							
					2/28/2017 1: 3:	D DIII		
					1. 00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 column	n 8)	0. 158921	1. 00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				1, 208, 808	2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplementa	1 2	from Medicaio	1?	Υ	4. 00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from the control of th	om Medicaid			0			
6.00	Medi cai d charges				27, 312, 762			
7. 00 8. 00	Medicaid cost (line 1 times line 6)	(line 7 min	ua aum af lin	soo O and E. I.f.	4, 340, 571	1		
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(Tine / min	us sum or iii	ies 2 and 5; 11	3, 131, 763	8.00		
	Children's Health Insurance Program (CHIP) (see instructions f	for each lin	<u>e)</u>					
9. 00	Net revenue from stand-alone CHIP	or cach iiii	c)		0	9. 00		
10. 00	Stand-alone CHIP charges				Ö	1		
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9: i	f < zero then	Ö	12. 00		
	enter zero)	(			_			
	Other state or local government indigent care program (see ins	structions f	or each line)					
13.00	Net revenue from state or local indigent care program (Not ind	cluded on li	nes 2, 5 or 9	9)	3, 343	13. 00		
14.00	Charges for patients covered under state or local indigent can	re program (	Not included	in lines 6 or	71, 102	14. 00		
	10)							
15. 00	State or local indigent care program cost (line 1 times line 1	,			11, 300	•		
16. 00	Difference between net revenue and costs for state or local in	ndigent care	program (lir	ne 15 minus line	7, 957	16. 00		
	13; if < zero then enter zero)							
17. 00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to 1	Funding char	ity caro		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of				0			
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	3, 139, 720			
19.00	8, 12 and 16)	ai indigent	care programs	s (suii oi iiiles	3, 134, 720	19.00		
	107 12 dila 107		Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
20.00	Charity care charges for the entire facility (see instructions	5)	332, 66	59 0	332, 669	20. 00		
21. 00	Cost of patients approved for charity care (line 1 times line	20)	52, 86		52, 868	1		
22. 00	Partial payment by patients approved for charity care		15, 26		15, 269			
23. 00	Cost of charity care (line 21 minus line 22)		37, 59	99 0	37, 599	23. 00		
0.4.00					1. 00	04.00		
24. 00	Does the amount in line 20 column 2 include charges for patier		nd a Length o	of stay limit	N	24. 00		
25 00	imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0					25. 00		
	26. 00 Total bad debt expense for the entire hospital complex (see instructions)  2, 863, 691							
28. 00								
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (		,	28)	446, 657	•		
30.00		.,,,,,,,,		, 23)	484, 256	1		
	Total unreimbursed and uncompensated care cost (line 19 plus I	i ne 30)			3, 623, 976			
	,	/			2, 2-2, 7, 9			

Heal th	Financial Systems BLI	UFFTON REGIONAL	MEDICAL CENTE	R	In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eri od:	Worksheet A	
					rom 10/01/2015	D-+- /T: D	
				1	o 09/30/2016	Date/Time Pre 2/28/2017 1:3	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	J pili
	cost center bescription	Jul al 1 C3	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				+ COI. 2)	0113 (366 A-0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 024, 727	1, 024, 727	262, 235	1, 286, 962	1.00
1. 01	00101 WELLS CRC COSTS-BLDG & FLXT		0,021,727	1		0	1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 687, 531	1	_	2, 975, 440	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	163, 382	108, 390			2, 337, 800	
5. 01	01160 COMMUNI CATI ONS	100,002	100, 070	1 271,772	585, 980		1
5. 02	00540 ADMITTING		0		361, 275	361, 275	1
5. 03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE		0		1, 015, 740		1
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	1, 567, 292	8, 776, 783	10, 344, 075			ı
7. 00	00700 OPERATION OF PLANT	309, 081	1, 572, 577			1	1
8. 00	00800 LAUNDRY & LINEN SERVICE	307,001	121, 470			121, 470	1
9. 00	00900 HOUSEKEEPING	206, 983	144, 115			350, 313	1
10.00	01000 DI ETARY	390, 924	253, 072			325, 566	
11. 00	01100 CAFETERI A	370, 724	253, 072		317, 223	317, 223	
	1 1	920 995	-	1			1
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	820, 885	135, 435 1, 094, 011				1
14.00		117, 007				517, 757	
15.00	01500 PHARMACY	512, 763	1, 321, 829			698, 161	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	293, 264	220, 440	513, 704	-5, 928	507, 776	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 720 255	1 227 050	2 050 112	(00 147	2 240 044	20.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 720, 255	1, 237, 858			2, 349, 966	
31.00		674, 541	109, 423	783, 964			
43.00	04300 NURSERY	(0) (05	07 501	704 106	354, 180		1
44. 00	04400 SKILLED NURSING FACILITY	606, 605	97, 501	704, 106	-1, 814	702, 292	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	925, 539	1, 135, 242	2, 060, 781	-34, 895	2, 025, 886	50. 00
51. 00	05100 RECOVERY ROOM	725, 537	1, 133, 242			1	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		219, 471	219, 471	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	861, 738	235, 484	1, 097, 222		1, 031, 929	1
54. 00	03630 ULTRA SOUND	001,730	233, 464	1,097,222	-03, 243	1,031,429	1
56. 00	05600 RADI OI SOTOPE	74, 574	81, 267	155, 841	0	155, 841	1
57. 00	05700 CT SCAN	74, 374	01, 207	155, 641		155, 641	1
58. 00	05800 MRI		0			Ö	1
60.00	06000 LABORATORY	610, 926	781, 593	1, 392, 519	-70, 226		1
65. 00	06500 RESPI RATORY THERAPY	351, 956	46, 755			1	1
66. 00	06600 PHYSI CAL THERAPY	690, 935	80, 734				1
67. 00	06700 OCCUPATI ONAL THERAPY	070,700	00, 701	1	1, ,,,	0	ı
68. 00	06800 SPEECH PATHOLOGY		0		i o	Ö	1
69. 00	06900 ELECTROCARDI OLOGY	165, 139	12, 510	177, 649	Ö	177, 649	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	.2, 0.0	177,017	149, 817	149, 817	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		555, 630	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 087, 963	1	1
	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			0	1
	03951 SLEEP LAB	79, 746	14, 282	94, 028	-935	93, 093	
	03953 WOUND CARE	25, 310	17, 042				
	OUTPATIENT SERVICE COST CENTERS		,			,	
90.00	09000 CLI NI C	49, 472	15, 111	64, 583	0	64, 583	90.00
	09100 EMERGENCY	626, 207	370, 374				
	09200 OBSERVATION BEDS (NON-DISTINCT PART		,		_,	,	92. 00
,2.00	OTHER REIMBURSABLE COST CENTERS			1			72.00
95. 00	09500 AMBULANCE SERVICES	0	C	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS	-1		_			1
118.00		11, 844, 524	21, 695, 556	33, 540, 080	-107, 611	33, 432, 469	118.00
	NONREI MBURSABLE COST CENTERS	,			,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 883	22, 883	-19	22, 864	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	. 0	0	0		192. 00
	07950 OTHER NONREIMBURSABLE COST CENTER		0	0	o	l e	194. 00
	07955 MARKETI NG		0	) 0	107, 922	l .	
	07952 SENI OR CIRCLE	3, 503	4, 999	8, 502			194. 02
	07953 BUSI NESS HEALTH	0	0	0	0		194. 03
	07954 VACANT SPACE	o	O	0	0		194. 04
200.00	1 1	11, 848, 027	21, 723, 438	33, 571, 465	0	l .	
		·					

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANC	BLUFFTON REGIONAL	MEDICAL CENTER Provider CCN	Peri od:	u of Form CMS- Worksheet A	2552-10
				From 10/01/2015 To 09/30/2016	Date/Time Pre 2/28/2017 1:3	epared:
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		2,20,20.,	, join
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-126, 954	1, 160, 008			1. 00
1. 01	00101 WELLS CRC COSTS-BLDG & FIXT	556	556			1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-661, 422	2, 314, 018			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-804	2, 336, 996			4. 00
5. 01	01160 COMMUNI CATI ONS	-26, 339	559, 641			5. 01 5. 02
5. 02 5. 03	00540 ADMITTING 00550 CASHIERING/ACCOUNTS RECEIVABLE	0	361, 275 1, 015, 740			5. 02
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	-696, 774	5, 069, 362			5. 04
7. 00	00700 OPERATION OF PLANT	0	1, 879, 503			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	121, 470			8. 00
9. 00	00900 HOUSEKEEPI NG	0	350, 313			9. 00
10. 00	01000 DI ETARY	0	325, 566			10. 00
11. 00	01100 CAFETERI A	-42, 364	274, 859			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-30, 401	1, 078, 369			13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	517, 757 698, 161			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-458	507, 318			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	100	33.73.3			1 .0.00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 349, 966			30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	782, 631			31. 00
43.00	04300 NURSERY	0	354, 180			43. 00
44. 00	04400 SKILLED NURSING FACILITY	-250	702, 042			44. 00
E0 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	021 524	1 104 250			E0 00
50. 00 51. 00	05100 RECOVERY ROOM	-831, 536 0	1, 194, 350			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	219, 471			52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	O	1, 031, 929			54. 00
54. 01	03630 ULTRA SOUND	0	0			54. 01
56.00	05600 RADI OI SOTOPE	0	155, 841			56. 00
57. 00	05700 CT SCAN	0	0			57. 00
58. 00	05800 MRI	0	0			58. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	1, 322, 293			60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	397, 541 769, 690			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	o o	707, 070			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	o			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	177, 649			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	149, 817			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	555, 630			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 087, 963			73.00
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB	0	93, 093			76. 00 76. 01
76. 01	03953 WOUND CARE	0	41, 974			76. 03
70.00	OUTPATIENT SERVICE COST CENTERS		11, 7, 1			70.00
90. 00	09000 CLI NI C	0	64, 583			90. 00
91. 00	09100 EMERGENCY	-168, 063	826, 105			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
05.00	OTHER REIMBURSABLE COST CENTERS					05.00
95. 00	09500 AMBULANCE SERVICES	0	0			95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	-2, 584, 809	30, 847, 660			118. 00
110.00	NONREI MBURSABLE COST CENTERS	2,304,007	30, 047, 000			1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 864			190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0			192. 00
	07950 OTHER NONREIMBURSABLE COST CENTER	0	O			194. 00
	07955 MARKETI NG	0	107, 922			194. 01
	207952 SENI OR CI RCLE	0	8, 210			194. 02
	BO7953 BUSINESS HEALTH BO7954 VACANT SPACE	0	0			194. 03 194. 04
200.00	l l	-2, 584, 809	30, 986, 656			200. 00
200.00	I TOTAL (SOM OF LINES TIO-177)	2, 304, 809	30, 700, 030			1200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0075

					2/28/2017 1:33 pm
		Increases			
	Cost Center	Li ne #	Salary	Other	
	2. 00	3. 00	4.00	5. 00	
1. 00	A - RECLASS EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	2, 068, 773	1.00
2. 00	LWI LOTEL BENEFITTS BELAKTIMENT	0.00	o	2,000,773	2. 00
2.00	TOTALS — — — —		<del> </del>	2, 068, 773	2.00
	B - RECLASS OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 782	1. 00
	PATI ENT				
2.00		0.00	•	0	2. 00
	TOTALS		0	7, 782	
	C - RECLASS RENTAL AND LEASE E			000 007	1.00
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	280, 987	1.00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4.00		0.00	0	0	4. 00
5. 00		0.00	0	0	5. 00
6. 00		0.00	Ö	0	6. 00
7. 00		0.00	o	Ö	7. 00
8. 00		0.00	O	0	8. 00
9.00		0.00	O	0	9. 00
10. 00		0.00	0	0	10.00
11. 00		0.00	0	0	11. 00
12.00		0.00	0	0	12. 00
13.00		0.00	0	0	13. 00
14.00		0.00	0	0	14.00
15. 00		0.00	0	0	15.00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
18. 00	1	0.00	0	0	18.00
19. 00		0.00	0	0	19. 00
20. 00		0.00	Ö	0	20.00
21. 00		0.00	o	Ö	21. 00
22. 00		0.00	O	0	22. 00
	TOTALS			280, 987	
	D - RECLASS OTHER CAPITAL COST				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	66, 603	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195, 632	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 922	3.00
4. 00	TOTALS — — — —	0.00		0	4.00
	E - RECLASS MARKETING DEPT		U	269, 157	
1. 00	MARKETI NG	194. 01	70, 882	37, 040	1.00
1.00	TOTALS		70, 882	37, 040	1. 66
	F - RECLASS CNO COSTS		70,002	0.70.0	
1.00	NURSING ADMINISTRATION	13.00	153, 171	0	1. 00
	TOTALS		153, 171		
	G - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	142, 035	1.00
	PATI ENT	70.00		555 (00	
2. 00	I MPL. DEV. CHARGED TO	72. 00	0	555, 630	2. 00
	TOTALS	+			
	H - RECLASS COST OF DRUGS/IV S	OLUTIONS	U	097,000	
1. 00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 087, 963	1.00
1.00	TOTALS		<del> </del>	1, 087, 963	1. 55
	I - RECLASS LABOR AND DELIVERY	COSTS	-1	.,,,	
1.00	NURSERY	43.00	265, 160	89, 020	1. 00
2.00	DELIVERY ROOM & LABOR ROOM	5200	164, 309	5 <u>5, 1</u> 62	2. 00
	TOTALS		429, 469	144, 182	
	L - RECLASS A PORTION OF DIETA				
1. 00	CAFETERI A	1100	192, 925	124, 298	1.00
	TOTALS		192, 925	124, 298	
	M - RECLASS ADMIN AND GENERAL				
1. 00	COMMUNI CATI ONS	5. 01	44, 765	541, 215	1. 00
	ADMI TTI NG	5. 02	317, 449	43, 826 919, 063	2.00
	CACHIEDING (ACCOUNTS			0.10 UP.31	
	CASHI ERI NG/ACCOUNTS	5. 03	96, 677	717,003	3.00
2. 00 3. 00	CASHI ERI NG/ACCOUNTS RECEI VABLE TOTALS		458, 891	1, 504, 104	3. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0075

CAN INDIAL   CAN							2/28/2017 1:33 pm
A - RECLASS EMPLOYEE BENEFITS   10.00							
A - RECLASS LEVELOVE BENEFITS   SOCIETY   SO							
1.00				8. 00	9. 00	10. 00	
200					0.010.700		
DILITARY   10.00   0   771   0   0   2.08,773	1.00		5. 04	O	2, 068, 700	O	1.00
TOTALS	2 00	l .	10.00		72		2.00
R. PECLASS DAYSER	2.00						2. 00
1.00				U U	2,000,773		
CENTRAL SERVICES & SURPLY   14.00	1 00		7 00		100		1.00
TOTALS   C		1					2.00
C - RECLASS RENTAL AND LEASE EXPENSE	2.00			<del> </del>			2.00
DEPLOYEE BERKET ITS DEPRATURITY   4.00   0   2,745   10   1   1   1   1   1   1   1   1			FYDENSE	<u> </u>	7, 702		
0 OTHER ADMINISTRATIVE AND S.04 0 15,994 0 SIRPAR ADMINISTRATIVE AND SENSE OF SENSE	1 00			O	2 745	10	1.00
CREPATION OF PLANT		l e	· •			l .	2. 00
3.00   OPERATION OF PLANT	2.00		3.04	٩	13, 774		2.00
MOUSEKEEPING	3.00		7. 00	0	1. 965	0	3.00
DICTARY   10.00			•			l 1	4.00
0.00   MURSING ADMIN STRATION   12.00   0   721   0   0   0   0   0   0   0   0   0		l .	•	0		0	5. 00
7.00   CENTRAL SERVICES & SUPPLY   14.00   0   21,515   0   7.   8.00   PHARMACY   TO   15.00   0   48,468   0   8.   9.00   MEDICAL RECORDS & LIBRARY   16.00   0   5,928   0   9.   9.00   MEDICAL RECORDS & LIBRARY   16.00   0   5,928   0   9.   11.00   AUILTS & PEDIATRICS   30.00   0   34,496   0   10.   11.00   INTERSIVE CARE UNIT   31.00   0   1,814   0   12.   13.00   DEPRATING ROOM   50.00   0   1,614   0   12.   13.00   DEPRATING ROOM   50.00   0   6,935   0   13.   13.00   DEPRATING ROOM   50.00   0   6,935   0   13.   14.00   RESPIRATORY THERAPY   66.00   0   70,222   0   15.   16.00   RESPIRATORY THERAPY   66.00   0   1,709   0   17.   18.00   SLEEP LAB   76.01   0   935   0   18.   18.00   DEPRATING ROOM   19.00   0   2,413   0   20.   20.00   BEREGENCY   91.00   0   2,413   0   20.   21.00   GIFF, FLOWER, COFFEE SHOP & 190.00   0   2,413   0   20.   22.00   SEIN BOUR COFFEE SHOP & 190.00   0   22.   23.00   CANTEEN   194.02   0   292   0   22.   24.00   SENIOR CIRCLE   194.02   0   292   0   22.   25.00   SENIOR CIRCLE   194.02   0   292   0   22.   26.00   SENIOR CIRCLE   194.02   0   269,157   0   0   17.   27.00   OFFER ADMINISTRATIVE AND   5.04   0   269,157   0   1.   28.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER ADMINISTRATIVE AND   5.04   70,882   37,040   0   1.   29.00   OTHER A			· •	0		0	6.00
B. 00   PHARMACY   15. 00   0   48. 468   0   9. 0		l .	· •	0		0	7. 00
9.00 MEDICAL RECORDS & LIBRARY 16.00 0 5.928 0 19. 10.00 ADULTS & PEDIATRIS S 30.00 0 34.496 0 110. 11.00 MINTERSIVE CARE UNIT 31.00 0 0 1.833 0 111. 13.00 OFFARTING ROOM 50.00 0 1.814 0 112. 13.00 OFFARTING ROOM 50.00 0 0 1.814 0 112. 13.00 OFFARTING ROOM 50.00 0 0 1.834 0 113. 15.00 LABORATORY 60.00 0 0 70.226 0 115. 15.00 LABORATORY 7 60.00 0 0 70.226 0 115. 17.00 PHYSICAL THERAPY 65.00 0 1.1,770 0 16. 18.00 SLEEP LAB 7.6.01 0 935 0 0 117. 18.00 SLEEP LAB 7.6.01 0 935 0 0 118. 19.00 MOUND CARE 7.6.03 0 378 0 118. 19.00 MOUND CARE 7.6.03 0 378 0 119. 22.00 SAME CARE CONFEE SHOP & 190.00 0 19 0 2.413 0 20. 19.00 SAME CARE CONFEE SHOP & 190.00 0 19 0 22. 21.00 SAME CARE CONFEE SHOP & 190.00 0 19 0 12 0 22. 22.00 SAME CARE CARE LAB 7.6.03 0 0 0 12 0 22. 23.00 SAME CARE CARE LAB 7.6.03 0 0 0 12 0 22. 24.00 SAME CARE CARE LAB 7.6.03 0 0 0 12 0 22. 25.00 SAME CARE CARE LAB 7.6.03 0 0 0 12 0 22. 26.00 SAME CARE CARE LAB 7.6.03 0 0 0 12 0 22. 27.00 SAME OF CARE CARE LAB 7.6.03 0 0 0 12 0 22. 28.00 SAME OF CARE CARE LAB 7.6.03 0 0 0 0 12 0 22. 29.00 SAME OF CARE CAPITAL COSTS		1	· · · · · · · · · · · · · · · · · · ·	0		l .	8. 00
10.00   ADULTS & PEDIATRICS   30.00   0   34,496   0   10.10   Intersive CARE UNIT   31.00   0   1.333   0   11.   12.00   SKILLED NURSING FACILITY   44,00   0   1.814   0   12.   31.00   OPERATING ROWI   50.00   0   1.834   0   13.   41.00   RADIOLOGY-JI DARNOSTIC   54.00   0   65,793   0   14.   41.00   RADIOLOGY-JI DARNOSTIC   54.00   0   65,793   0   14.   41.00   RESPIRATORY   FIRERAPY   65.00   0   1,170   0   16.   41.00   RESPIRATORY THERRAPY   65.00   0   1,170   0   16.   41.00   DARNOSTICAL THERRAPY   66.00   0   1,979   0   17.   41.00   DARNOSTICAL THERRAPY   66.00   0   335   0   18.   41.00   DARNOSTICAL THERRAPY   66.00   0   3788   0   19.   41.00   DARNOSTICAL THERRAPY   67.01   0   935   0   18.   41.00   DARNOSTICAL THERRAPY   67.01   0   935   0   18.   41.00   DARNOSTICAL THERRAPY   67.01   0   935   0   19.   41.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   41.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   41.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   42.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   43.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   44.00   DARNOSTICAL THERRAPY   76.01   0   0   22.   45.00   DARNOSTICAL THERRAPY   76.01   0   0   0   22.   47.00   DARNOSTICAL THERRAPY   76.01   0   0   0   0   22.   47.00   DARNOSTICAL THERRAPY   76.01   0   0   0   0   0   22.   47.00   DARNOSTICAL THERRAPY   76.01   0   0   0   0   0   0   0   0   0		1	· · · · · · · · · · · · · · · · · · ·	0			9. 00
11 0.0   INTERSIVE CARE UNIT   31 0.0   0   1,333   0   11.			· · · · · · · · · · · · · · · · · · ·	0		l 1	10.00
12.00   SKILLED NURSING FACILITY				0		l .	11.00
13.00   OPERATING ROOM			· · · · · · · · · · · · · · · · · · ·	0			12. 00
14. 00   RADI OLOGY-DI AGNOSTIC   54. 00   0   65. 293   0   14.				0			13. 00
15.00   LABORATORY   60.00   0   70.226   0   15.				0		0	14. 00
16.00   RESPIRATORY THERAPY   65.00   0   1.170   0   16.   17.00			l	Ö		l 1	15. 00
17. 00		1	· · · · · · · · · · · · · · · · · · ·	Ö		- 1	16. 00
18. 00   SLEEP LAB		1	· · · · · · · · · · · · · · · · · · ·	Ö		- 1	17. 00
19.00   MOUND CARE			· · · · · · · · · · · · · · · · · · ·	Ö			18. 00
20.00   EMERCENCY   91.00   0   2,413   0   20.01		1	· · · · · · · · · · · · · · · · · · ·	o		l .	19. 00
21. 0.0 CAPTERN NOTALS  22. 0.0 SENI OR CI RICLE  194. 02  0 0 292  0 0 293  0 0 280. 987  1. 0.0 0 0 0 0 12  1. 0.0 0 0 0 0 13  2. 0.0 0 0 0 0 13  2. 0.0 0 0 0 0 13  3. 0.0 0 0 0 0 0 12  3. 0.0 0 0 0 0 0 12  3. 0.0 0 0 0 0 0 0 12  3. 0.0 0 0 0 0 0 0 0 12  3. 0.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	•	o		l .	20. 00
CANTEEN   194.02		l .	· · · · · · · · · · · · · · · · · · ·	Ö		l 1	21. 00
SENIOR CIRCLE	21.00		1,0.00		.,	Ĭ	265
TOTALS	22.00		194, 02	o	292	o	22. 00
1. 0.0   0. 0.0   0. 0.0   0   12   1.   2. 0.0   0. 0.0   0. 0.0   0. 0   13   2.   3. 0.0   0. 0.0   0. 0.0   0. 0   12   3.   4. 0.0   OTHER ADMINISTRATIVE AND   5. 0.4   0. 269, 157   0.   GENERAL		TOTALS — — — — —			280, 987		
2.00		D - RECLASS OTHER CAPITAL COS	STS				
3.00   OTHER ADMINISTRATIVE AND   S. 04   O   269, 157   O   44.	1.00		0.00	0	0	12	1. 00
4.00   OTHER ADMINISTRATIVE AND   5.04   0   269,157   0   4.	2.00		0.00	0	0	13	2.00
CENERAL	3.00		0.00	0	0	12	3.00
TOTALS	4.00	OTHER ADMINISTRATIVE AND	5. 04	0	269, 157	0	4.00
E - RECLASS MARKETING DEPT  1. 00 OTHER ADMINI STRATI VE AND		GENERAL					
1.00				0	269, 157		
CENERAL							
TOTALS F - RECLASS CNO COSTS  1. 00 OTHER ADMINISTRATIVE AND GENERAL TOTALS 1. 00 GENERAL TOTALS 1. 00 GENERAL TOTALS 1. 00 CENTRAL SERVICES & SUPPLY 1. 00 CENTRAL SERVICES & SUPPLY 1. 00 TOTALS 0 0 697, 665  H - RECLASS COST OF DRUGS/IV SOLUTIONS 1. 00 PHARMACY 1. 00 PHARMACY 1. 00 TOTALS 0 0 1, 087, 963 0 1. 087, 963 1 - RECLASS LABOR AND DELIVERY COSTS 1. 00 TOTALS 1. 1. 504, 104 TOTALS 1.	1. 00		5. 04	70, 882	37, 040	0	1.00
Totals			+				
1. 00 OTHER ADMI NI STRATI VE AND GENERAL TOTALS 153, 171 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				70, 882	37, 040		
CENERAL   TOTALS   153, 171   0				450 474			1.00
TOTALS     153, 171   0	1.00		5. 04	153, 171	0	0	1.00
C - RECLASS MEDICAL SUPPLIES   14.00			+		<del>-</del>	<del></del>	•
1. 00   CENTRAL SERVI CES & SUPPLY   14. 00   0   664, 154   0   2. 00   OPERATING ROOM   50. 00   0   33, 511   0   2.				153, 171	0		
2. 00 OPERATING ROOM 50. 00 0 33, 511 0 0 697, 665	1 00	G - RECLASS MEDICAL SUPPLIES	14 00	ما	/// 1E/		1 00
TOTALS H - RECLASS COST OF DRUGS/I V SOLUTIONS  1. 00 PHARMACY 15. 00 0 1, 087, 963 0 1. TOTALS I - RECLASS LABOR AND DELIVERY COSTS  1. 00 ADULTS & PEDIATRICS 30. 00 429, 469 144, 182 0 0 0 1. TOTALS L - RECLASS A PORTION OF DIETARY TO CAFE  1. 00 DIETARY TOTALS 1. 00 OTHER ADMINISTRATIVE AND TOTALS 1. 00							1.00
H - RECLASS COST OF DRUGS/I V SOLUTIONS  1.00 PHARMACY	2.00						2. 00
1. 00 PHARMACY 15. 00 0 1, 087, 963 0 1 1. 07ALS 0 1, 087, 963 0 1 1. 087, 963 1 1 1. 00 1, 087, 963 1 1 1. 00 1, 087, 963 1 1 1. 00 ADULTS & PEDI ATRI CS 30. 00 429, 469 144, 182 0 0 0 1 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0			COLUTIONS	U	697, 665		
TOTALS    1 - RECLASS LABOR AND DELIVERY COSTS	1 00			ما	1 007 0/2	0	1.00
1 - RECLASS LABOR AND DELIVERY COSTS   30.00   429, 469   144, 182   0   0   0   1.	1.00						1.00
1. 00 ADULTS & PEDIATRICS 30. 00 429, 469 144, 182 0 0 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			DV COCTC	U]	1, 087, 963		
2. 00   0   0   0   0   0   0   0   0   0	1 00			420, 440	144 100	0	1.00
TOTALS  L - RECLASS A PORTION OF DIETARY TO CAFE  1. 00 DIETARY  TOTALS  M - RECLASS ADMIN AND GENERAL COSTS  1. 00 OTHER ADMINISTRATIVE AND  GENERAL  2. 00  3. 00  TOTALS  0. 00  0 0 0  2. 00  TOTALS  429, 469  144, 182  124, 298  0  1. 1, 504, 298  0  1. 504, 104  0  1. 504, 104  0  2. 00  3. 00  TOTALS  458, 891  1, 504, 104  0  3. 00  3. 00  1. 504, 104  0  3. 00  3. 00  1. 504, 104  0  3. 00  3. 00  1. 504, 104		ADULIS & PEDIATRICS		429, 469	144, 182		1.00
L - RECLASS A PORTION OF DIETARY TO CAFE  1. 00 DIETARY	2.00	TOTAL C — — — — —			0		2. 00
1. 00 DI ETARY 10. 00 192, 925 124, 298 0 1. TOTALS 192, 925 124, 298 1. O 1. O 192, 925 124, 298 1. O 1. O 192, 925 124, 298 1. O 1. O 192, 925 124, 298 1. O 192, 925 124, 928 1. O 192, 925 124, 928 1			TADY TO CAFE	429, 409	144, 182		
TOTALS  M - RECLASS ADMI N AND GENERAL COSTS  1. 00 OTHER ADMI NI STRATI VE AND 5. 04 458, 891 1, 504, 104 0 1. GENERAL  2. 00 3. 00 0.00 0 0 0 0 2. 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00			102 025	124 200		1 00
M - RECLASS ADMI N AND GENERAL COSTS  1. 00 OTHER ADMI NI STRATI VE AND	1.00		10.00				1.00
1. 00 OTHER ADMINISTRATIVE AND			COSTS	192, 925	124, 298		
GENERAL  2. 00 3. 00  TOTALS  GENERAL  0. 00 0 0 0 0 2. 0 0 0 0 3.	1 00			4E0 001	1 504 104	ما	1 00
2. 00 3. 00 0 0 0 0 3. 00 0 0 0 3. TOTALS 458, 891 1, 504, 104	1.00		5. 04	400, 891	1, 304, 104	ا	1. 00
3. 00	2 00	OLIVLIAL	0.00		^		2. 00
TOTALS 458, 891 1, 504, 104			· · · · · · · · · · · · · · · · · · ·	٥	0		3. 00
	3.00	TOTALS — — — —		<sub>450 901</sub>	0		3.00
500. 50 ps. and 15tar. Decircuses   1 1, 500, 500  0, 221, 751    1	500 00						500.00
	550.00	Joi and Total. Decleases	ı	1, 303, 330	0, 441, 701	ı l	300.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0075 Peri od: Worksheet A-7 From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 2/28/2017 1:33 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 3, 844, 900 0 1.00 0 2.00 Land Improvements 748, 002 0 0 2.00 0 3.00 21, 419, 131 1, 765 3.00 Buildings and Fixtures 1, 765 0 4, 917, 682 0 4.00 Building Improvements 37, 647 37, 647 0 4.00 5.00 Fixed Equipment 4, 222, 933 0 242, 700 5.00 14, 979, 871 0 6.00 Movable Equipment 1, 842, 916 1, 842, 916 172, 732 6.00 0 7.00 HIT designated Assets 4, 206, 037 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 54, 338, 556 1, 882, 328 1, 882, 328 415, 432 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 54, 338, 556 1, 882, 328 1, 882, 328 10.00 0 415, 432 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 3,844,900 0 1.00 2.00 Land Improvements 748, 002 0 2.00 3.00 Buildings and Fixtures 21, 420, 896 0 3.00 0 4.00 Building Improvements 4, 955, 329 4.00 5.00 Fi xed Equipment 3, 980, 233 0 5.00 Movable Equipment 16, 650, 055 0 6.00 6.00 7. 00 7.00 HIT designated Assets 4, 206, 037 0

55, 805, 452

55, 805, 452

0

0

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15	-0075

				1	To 09/30/2016	Date/Time Prep 2/28/2017 1:3	
			SL	JMMARY OF CAPIT	ΓAL	2, 20, 2017 110	<u> </u>
					T		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9. 00	10.00	11. 00	12.00	instructions) 13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 024, 727		Tiu Z			1. 00
1. 00	WELLS CRC COSTS-BLDG & FLXT	1,024,727	0				1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2, 687, 531	0				2. 00
3. 00	Total (sum of lines 1-2)	3, 712, 258	0			0	3. 00
SUMMARY OF CAPITAL					3. 00		
	Cost Center Description	Other	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	<u>(SHEET A, COLUM</u>					
1. 00	CAP REL COSTS-BLDG & FLXT	0	1, 024, 727				1. 00
1. 01	WELLS CRC COSTS-BLDG & FLXT	0	0				1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 687, 531	1			2. 00
3.00	Total (sum of lines 1-2)	0	3, 712, 258				3. 00

Heal th	Financial Systems BL	JFFTON REGIONAL	MEDICAL CENTE	R	In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		F		Period: From 10/01/2015 Fo 09/30/2016	2/28/2017 1:33	
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	39, 155, 397	0			0	1. 00
1. 01	WELLS CRC COSTS-BLDG & FLXT	0	ľ	1	0. 000000	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	16, 650, 054	0	16, 650, 05 <sub>0</sub>		0	2.00
3.00	Total (sum of lines 1-2)	55, 805, 451	0	55, 805, 45°		0	3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other Capi tal-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	)	665, 859	0	1.00
1.01	WELLS CRC COSTS-BLDG & FLXT	0	0	)	556	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	2, 004, 425	280, 987	2.00
3.00	Total (sum of lines 1-2)	0	0	(	2, 670, 840	280, 987	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see instructions)		Capi tal -Rel ate d Costs (see	Total (2) (sum of cols. 9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	216, 889		1		1, 160, 008	1. 00
1.01	WELLS CRC COSTS-BLDG & FIXT	0			0	556	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 922	1	21, 684		2.00
3.00	Total (sum of lines 1-2)	216, 889	73, 525	195, 63	2 36, 709	3, 474, 582	3. 00

				T	Date/Time Prep 2/28/2017 1:33	pared:	
				Expense Classification on		2/28/2017 1: 3.	3 PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0.00	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - WELLS CRC		0	WELLS CRC COSTS-BLDG &	1. 01	0	1. 01
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			FIXT CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-26 339	COMMUNI CATI ONS	5. 01	0	7. 00
,, 00	stations excluded) (chapter		20,007		0.0.		7.00
8. 00	21) Television and radio service	A	-786	OTHER ADMINISTRATIVE AND	5. 04	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0	GENERAL	0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-187, 565		2.22	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	205, 148			0	12. 00
	transactions (chapter 10)		200, 110		0.00		
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-42, 364	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others	1	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 patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-458	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	O	RESTINATORY ITTERAFT	03.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-358, 868	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
26. 01	Depreciation - WELLS CRC	А	556	WELLS CRC COSTS-BLDG &	1. 01	9	26. 01
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-683, 106	FIXT CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	A 0 2	0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	Λοο					
31.00	pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)	1					<u> </u>

09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 32.00 CAH HIT Adjustment for 0.00 32. 00 Depreciation and Interest 33.00 INSERVICE EDUCATION В -10, 624 NURSING ADMINISTRATION 13.00 33.00 33.01 FITNESS REVENUE В -239, 004 OTHER ADMINISTRATIVE AND 5.04 33.01 GENERAL OTHER MISC REVENUE -15, 212 OTHER ADMINISTRATIVE AND 33.02 В 5.04 33.02 GENERAL -2, 900 NURSING ADMINISTRATION 33.03 TRAINING REVENUE Α 13.00 0 33.03 33.04 PATIENT PHONES BENEFITS -804 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.04 Α -174, 115 OTHER ADMINISTRATIVE AND 33.05 MARKETI NG 5.04 33.05 Α GENERAL -4, 015 OTHER ADMINISTRATIVE AND 33.06 LOBBYING EXPENSE 33.06 Α 5.04 GENERAL -45, 386 OTHER ADMINISTRATIVE AND 33.07 PHYSICIAN RECRUITING Α 5.04 33.07 GENERAL 33.08 CHARITABLE CONTRIBUTIONS Α -48, 770 OTHER ADMINISTRATIVE AND 5.04 33.08 GENERAL -829, 161 OPERATING ROOM CRNA COSTS 33.09 50.00 33.09 33. 10 PROMOTIONAL ITEMS Α -60 OTHER ADMINISTRATIVE AND 5.04 33. 10 GENERAL 33. 12 COUNTRY CLUB DUES -46, 675 OTHER ADMINISTRATIVE AND 5.04 33.12 GENERAL NON-ALLOWABLE LEGAL (DOJ -74, 301 OTHER ADMINISTRATIVE AND 33.13 5.04 33.13 Α SETTLEMENT) GENERAL 50.00 TOTAL (sum of lines 1 thru 49) -2, 584, 809 50.00 (Transfer to Worksheet A,

column 6, line 200.)
(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0075

Worksheet A-8-1

From 10/01/2015

				Го 09/30/2016	Date/Time Pre 2/28/2017 1:3	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	о р
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			DIRECT ALLOC - CAPITAL-RELAT	216, 889		1. 00
2.00	I		PASI CAPITAL COSTS - BLDG &	9, 472		2. 00
3.00			PASI CAPITAL COSTS - MOVABLE	1, 486		3.00
4.00		OTHER ADMINISTRATIVE AND GEN		140, 869		4. 00
4. 01			NEW CAPITAL - BLDG & FIXTURE	5, 553		4. 01
4. 02	1		NEW CAPITAL - MOVABLE EQUIPM			4. 02
4.03		OTHER ADMINISTRATIVE AND GEN		923, 364		4. 03
4.04		OTHER ADMINISTRATIVE AND GEN		280, 859		4. 04
4.05			CIG LEASED EQUIPMENT	54, 285		4. 05
4.06		OTHER ADMINISTRATIVE AND GEN	I	0	903, 201	4. 06
4.07		OTHER ADMINISTRATIVE AND GEN		0	6, 197	4. 07
4.08		OTHER ADMINISTRATIVE AND GEN		0	24, 011	4. 08
4. 09	I	OTHER ADMINISTRATIVE AND GEN	l .	103, 504	548, 225	4. 09
4. 14	I	OTHER ADMINISTRATIVE AND GEN	l .	0	22, 343	4. 14
4. 17	I	OTHER ADMINISTRATIVE AND GEN	l .	0	168, 047	4. 17
4. 18	•	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT	0	11, 321	4. 18
5.00	TOTALS (sum of lines 1-4).			1, 812, 992	1, 607, 844	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6.00	В	CHS, INC.	100.00	CHS, INC.	100.00	6. 00
7.00			0.00		0.00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10. 00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

					10 09/30/2016	2/28/2017 1:33 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED OF	RGANIZATIONS OR C	:LAI MED
	HOME OFFICE CO					
1. 00	216, 889					1.0
2.00	9, 472					2. 0
3.00	1, 486					3. 0
4.00	140, 869					4.0
4. 01	5, 553					4.0
4. 02	76, 711	14				4.0
4.03	923, 364					4.0
4.04	467, 158					4.0
4. 05	-56, 513	14				4.0
4.06	-903, 201	0				4.0
4.07	-6, 197	0				4.0
4.08	-24, 011	0				4.0
4.09	-444, 721	0				4.0
4.14	-22, 343	0				4. 1
4. 17	-168, 047	0				4. 1
4. 18	-11, 321	0				4. 1
5.00	205, 148					5. 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.

 	cordinate i diagraf 2, the discourt difference of court be friended in cordination for this parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOSPITAL MANAGE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
9. 00 10. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0075

					-	To 09/30/2016	Date/Time Pre 2/28/2017 1:3	
	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		NURSING ADMINISTRATION	42, 230			1		
2.00		SKILLED NURSING FACILITY	250				0	
3.00		OPERATING ROOM	2, 375			0	1	
4.00		EMERGENCY	168, 063			0	0	
5.00	0. 00		0	1	_	0	0	0.00
6.00	0. 00		0	0	0	0	0	0.00
7.00	0. 00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	7.00
10.00	0. 00		0	0	0	0	0	10.00
200.00		0 1 0 1 (5)	212, 918				330	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	Trisurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1.00		NURSI NG ADMI NI STRATI ON	25, 353				14.00	1.00
2. 00		SKILLED NURSING FACILITY	0	1		-		1
3.00		OPERATING ROOM	0	1	-	1	1	1
4. 00		EMERGENCY	0	0	0	0	0	1
5.00	0.00		0	0	0	0	0	i
6.00	0.00		0	0	0	0	0	i
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			25, 353			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	47.00	10.00		
1 00	1.00	2. 00	15. 00	16. 00	17. 00	18.00		1 00
1. 00 2. 00		NURSING ADMINISTRATION SKILLED NURSING FACILITY	0			1		1. 00 2. 00
2. 00 3. 00		OPERATING ROOM	0	1	_			3.00
		EMERGENCY	0	0	0			
4. 00 5. 00	0.00	EWERGENCY				168, 063 0	1	4. 00 5. 00
6. 00	0.00				0			6.00
7. 00	0.00							7.00
7. 00 8. 00	0.00				0			8.00
9. 00	0.00							9.00
10. 00	0.00							10.00
200.00	0.00			25, 353	15, 272	187, 565		200.00
_55.50	1		1	, 20,000	10,212	, 107, 303	I .	

In Lieu of Form CMS-2552-10
Worksheet B
01/2015 Part I
030/2016 Date/Time Prepared:
2/28/2017 1:33 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS BLUFFTON REGIONAL MEDICAL CENTER Provider CCN: 15-0075 Peri od: From 10/01/2015 To 09/30/2016 CAPITAL RELATED COSTS

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		col. 7) 0	1. 00	1. 01	2. 00	4. 00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 160, 008	1, 160, 008				1.00
1.01	00101 WELLS CRC COSTS-BLDG & FIXT	556	0	556		i	1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 314, 018			2, 314, 018	ı	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 336, 996	0	7	15, 569	2, 352, 572	4. 00
5.01	01160 COMMUNI CATI ONS	559, 641	5, 823	0	9, 994	9, 013	5. 01
5.02	00540 ADMI TTI NG	361, 275	7, 719	0	13, 248	63, 915	5. 02
5.03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 015, 740	11, 369	0	19, 512	19, 465	5. 03
5.04	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 069, 362	95, 844	4	172, 269	178, 054	5. 04
7.00	00700 OPERATION OF PLANT	1, 879, 503	67, 235		115, 387	62, 230	
8.00	00800 LAUNDRY & LINEN SERVICE	121, 470	1, 134		29, 718	0	8. 00
9. 00	00900 HOUSEKEEPI NG	350, 313	4, 790		8, 220	41, 674	9. 00
10. 00	01000 DI ETARY	325, 566	47, 054		80, 752	39, 865	1
11. 00	01100 CAFETERI A	274, 859	0	16	35, 759	38, 843	1
13. 00	01300 NURSING ADMINISTRATION	1, 078, 369	2, 362		4, 054	196, 115	
14. 00	01400 CENTRAL SERVICES & SUPPLY	517, 757	58, 340		100, 122	23, 558	
15. 00	1	698, 161	0	0	0	103, 239	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	507, 318	13, 867	0	23, 799	59, 045	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 349, 966	98, 519	0	169, 076	259, 885	30.00
31. 00		782, 631	17, 358		29, 789	135, 811	31.00
43. 00		354, 180	2, 888		4, 956	53, 387	43. 00
44. 00	1 1	702, 042	35, 242		60, 481	122, 133	•
00	ANCI LLARY SERVI CE COST CENTERS	7027012	00, 212		307 101	122, 100	
50.00	05000 OPERATING ROOM	1, 194, 350	92, 720	0	159, 123	186, 347	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	219, 471	3, 402	0	5, 838	33, 082	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 031, 929	64, 548	0	110, 775	173, 501	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	155, 841	4, 205	0	7, 217	15, 015	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60. 00	06000 LABORATORY	1, 322, 293	26, 731		45, 875	123, 003	1
65. 00	06500 RESPI RATORY THERAPY	397, 541	31, 355		53, 811	70, 862	1
66. 00	06600 PHYSI CAL THERAPY	769, 690	29, 099		49, 939	139, 112	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	1	0	0	0	10 10(	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	177, 649	0	6	13, 136		1
71. 00	1	149, 817	0	0	0	0	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	555, 630 1, 087, 963	0 8, 652	7	29, 698	0	72. 00 73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	1,007,903	0, 052	/	29, 090	0	76.00
76. 01	03951 SLEEP LAB	93, 093	2, 049	0	3, 517	16, 056	
76. 03	1	41, 974	2,017		0, 017	5, 096	•
	OUTPATIENT SERVICE COST CENTERS	,	-		-1	3, 212	
90.00	09000 CLI NI C	64, 583	6, 343	0	10, 886	9, 961	90.00
91. 00	09100 EMERGENCY	826, 105	28, 101	0	48, 226	126, 080	91. 00
92.00							92. 00
05.00	OTHER REIMBURSABLE COST CENTERS			1	ام		
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1-117)	30, 847, 660	766, 749	53	1, 430, 746	2, 337, 596	118 00
110.00	NONREI MBURSABLE COST CENTERS	30, 847, 880	700, 749	] 53	1, 430, 740	2, 337, 340	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 864	5, 451	0	9, 355	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	353, 978		772, 984		192. 00
	07950 OTHER NONREIMBURSABLE COST CENTER	0	20, 913		35, 891		194. 00
	1 07955 MARKETI NG	107, 922	12, 917	0	22, 167	14, 271	
	2 07952 SENIOR CIRCLE	8, 210	. 0	0	0		194. 02
	07953 BUSINESS HEALTH	0	0	20	42, 875		194. 03
194.04	4 07954 VACANT SPACE	0	0		o	0	194. 04
200.00						1	200. 00
201.00			0	_	0		201. 00
202.00	TOTAL (sum lines 118-201)	30, 986, 656	1, 160, 008	556	2, 314, 018	2, 352, 572	202. 00

				То	09/30/2016	Date/Time Pre 2/28/2017 1:3	oared: 3 pm
	Cost Center Description	COMMUNI CATIONS	Subtotal	ADMI TTI NG	Subtotal	CASHI ERI NG/ACC	<b>У</b>
	·					OUNTS	
		5. 01	5A. 01	5. 02	EA 02	RECEI VABLE 5. 03	
	GENERAL SERVICE COST CENTERS	5.01	5A. UT	5. 02	5A. 02	5.05	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01	00101 WELLS CRC COSTS-BLDG & FLXT						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS	584, 471					5. 01
5. 02	00540 ADMITTING	9, 539	455, 696	455, 696	4 000 000	4 000 000	5. 02
5. 03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 937	1, 073, 023	16, 016	1, 089, 039	1, 089, 039	5. 03
5. 04 7. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	45, 093	5, 560, 626	82, 988	5, 643, 614	205, 563	5. 04 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	10, 406 867	2, 134, 761 153, 202	31, 863 2, 287	2, 166, 624 155, 489	78, 921 5, 664	8. 00
9. 00	00900 HOUSEKEEPI NG	1, 734	406, 731	6, 071	412, 802	15, 037	9. 00
10. 00	01000 DI ETARY	7, 805	501, 042	7, 479	508, 521	18, 523	10. 00
11. 00	01100 CAFETERI A	0	349, 477	5, 216	354, 693	12, 920	11. 00
13.00	01300 NURSING ADMINISTRATION	2, 602	1, 283, 502	19, 158	1, 302, 660	47, 451	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 336	704, 113	10, 510	714, 623	26, 031	14.00
15.00	01500 PHARMACY	9, 539	810, 939	12, 104	823, 043	29, 980	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	21, 679	625, 708	9, 339	635, 047	23, 132	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17 242	2 004 700	42, 200	2 027 007	107. 019	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 343 4, 336	2, 894, 789 969, 925	43, 208 14, 477	2, 937, 997 984, 402	35, 858	30. 00 31. 00
43. 00	04300 NURSERY	867	416, 278	6, 213	422, 491	15, 390	43. 00
44. 00	04400 SKILLED NURSING FACILITY	8, 672	928, 570	13, 860	942, 430	34, 329	44. 00
	ANCILLARY SERVICE COST CENTERS	272:=	.==,,		= /	2.7, ==:	
50.00	05000 OPERATING ROOM	29, 484	1, 662, 024	24, 807	1, 686, 831	61, 445	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 734	263, 527	3, 933	267, 460	9, 742	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 211	1, 398, 964	20, 881	1, 419, 845	51, 719	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	1, 734	184, 012	2, 747	186, 759	6, 803	56.00
57. 00 58. 00	05700   CT   SCAN   05800   MRI	0	0	0	0	0	57. 00 58. 00
60.00	06000 LABORATORY	16, 476	1, 534, 378	22, 902	1, 557, 280	56, 725	60.00
65. 00	06500 RESPI RATORY THERAPY	2,602	556, 171	8, 301	564, 472	20, 561	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 336	992, 176	14, 809	1, 006, 985	36, 680	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	O	0	o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	5, 203	229, 243	3, 422	232, 665	8, 475	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	149, 817	2, 236	152, 053	5, 539	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	555, 630	8, 293	563, 923	20, 541	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 126, 320	16, 811 0	1, 143, 131	41, 640 0	73.00
76. 00 76. 01	03950 OTHER ANCILLARY SERVICE COST CENTER 03951 SLEEP LAB	0	114, 715	1, 712	116, 427	4, 241	76. 00 76. 01
76. 03	03953 WOUND CARE		47, 070	703	47, 773	1, 740	76. 01
70.00	OUTPATIENT SERVICE COST CENTERS		177 07 0	, 55	177770	.,,	, 0, 00
90.00	09000 CLI NI C	4, 336	96, 109	1, 435	97, 544	3, 553	90.00
91.00	09100 EMERGENCY	14, 742	1, 043, 254	15, 572	1, 058, 826	38, 569	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0	0	0	0	0	95. 00
110 0	SPECIAL PURPOSE COST CENTERS	250 (12	20 221 702	420.252	20 105 440	1 000 701	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	250, 613	29, 221, 792	429, 353	29, 195, 449	1, 023, 791	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 469	41, 139	614	41, 753	1 521	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	330, 389	1, 457, 427	21, 754	1, 479, 181	53, 881	
	07950 OTHER NONREIMBURSABLE COST CENTER	0	56, 804	848	57, 652		194. 00
	07955 MARKETI NG	o	157, 277	2, 348	159, 625		194. 01
	07952 SENI OR CIRCLE		8, 915	133	9, 048		194. 02
	07953 BUSI NESS HEALTH	0	42, 895	640	43, 535		194. 03
	1 07954 VACANT SPACE		407	6	413	15	194. 04
200.00			0	_	O	=	200.00
201.00		O FOA 474	30,004,454	0 455 404	30,004,454		201. 00
202.00	TOTAL (sum lines 118-201)	584, 471	30, 986, 656	455, 696	30, 986, 656	1, 089, 039	2U2. UU

Provider CCN: 15-0075

				1	0 09/30/2016	2/28/2017 1:3	
	Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	Э рііі
		5A. 03	5. 04	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 WELLS CRC COSTS-BLDG & FLXT						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00540 ADMITTING						5. 02
5.03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 849, 177	5, 849, 177				5. 04
7. 00	00700 OPERATION OF PLANT	2, 245, 545					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	161, 153					8. 00
9.00	00900 HOUSEKEEPI NG	427, 839				538, 954	9. 00
10. 00	01000 DI ETARY	527, 044				22, 549	1
11. 00	01100 CAFETERI A	367, 613				9, 985	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 350, 111	314, 153			1, 132	1
14. 00	01400 CENTRAL SERVI CES & SUPPLY	740, 654		140, 822	10, 719		1
15.00	01500 PHARMACY	853, 023		0	0	0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	658, 179	153, 150	33, 473	0	6, 646	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.045.017	700 547	227.00/	04 (27	47.010	1 20 00
30.00	03000 ADULTS & PEDI ATRI CS	3, 045, 016				47, 212	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 020, 260			15, 244 0	8, 318	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	437, 881 976, 759	101, 889		_	1, 384	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	970,759	227, 279	85, 066	30, 516	16, 888	44.00
50. 00	05000 OPERATING ROOM	1, 748, 276	406, 801	223, 807	39, 176	44, 433	50.00
51. 00	05100 RECOVERY ROOM	1, 746, 276	400, 801	223, 607	34, 170	1 44, 433	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	277, 202		1	-	1, 630	ı
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 471, 564				30, 932	
54. 01	03630 ULTRA SOUND	1, 1, 1, 1, 001	0 12, 111	0	21, 701	00,702	54. 01
56. 00	05600 RADI OI SOTOPE	193, 562	_	10, 150	0	2, 015	ı
57. 00	05700 CT SCAN	0		0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	o o	58.00
60. 00	06000 LABORATORY	1, 614, 005	375, 558	64, 523	0	12, 810	
65. 00	06500 RESPIRATORY THERAPY	585, 033					1
66. 00	06600 PHYSI CAL THERAPY	1, 043, 665		70, 240			1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	241, 140	56, 110	18, 476	0	3, 668	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157, 592	36, 670	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	584, 464	135, 997	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 184, 771	275, 681	41, 770	0	8, 293	73. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	120, 668	28, 078	4, 947		982	76. 01
76. 03	03953 WOUND CARE	49, 513	11, 521	0	43	0	76. 03
	OUTPATIENT SERVICE COST CENTERS				I		
	09000 CLI NI C	101, 097					
	09100 EMERGENCY	1, 097, 395		67, 831	35, 343	13, 467	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	OTHER REIMBURSABLE COST CENTERS	_	_	_	_		
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	00 100 001	- 447.000	1 505 700	0.40.450	000 010	
118.00		29, 130, 201	5, 417, 203	1, 525, 733	240, 450	292, 313	1118.00
100.00	NONREI MBURSABLE COST CENTERS	42.074	10.0(0	12.150		2 (12	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	43, 274					190. 00
	07950 OTHER NONREIMBURSABLE COST CENTER	1, 533, 062			0		
	1 1	59, 752			0	10, 022	•
	07955  MARKETI NG  07952  SENI OR CI RCLE	165, 440			0		194. 01
	07952  SENTOR CTRCLE	9, 378 45, 121				11, 972	194. 02
	07954 VACANT SPACE	45, 121					194. 03
200.00		428	l .	١			200. 00
200.00				_	0	n	200.00
201.00		30, 986, 656	_	1	240, 450		
_52. 50	1 1 1 1 2 ( 2 2 2 2 2 2 2 2 2 2 2 2 2 2		-,0.,,.,,	_, _,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2.57.50	, 555, 701	,

Provider CCN: 15-0075

				To	09/30/2016	Date/Time Pre 2/28/2017 1:3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	O PIII
				ADMI NI STRATI ON	SERVICES &		
		10.00	11 00	12.00	SUPPLY	1F 00	
	GENERAL SERVICE COST CENTERS	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 WELLS CRC COSTS-BLDG & FIXT						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00540 ADMI TTI NG						5. 02
5. 03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 04
7. 00 8. 00	00700 OPERATION OF PLANT						7.00
9. 00	OO8OO  LAUNDRY & LINEN SERVICE   OO9OO  HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY	785, 808					10.00
11. 00	01100 CAFETERI A	0	513, 433				11. 00
13. 00	01300 NURSING ADMINISTRATION	o	38, 345	1			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	11, 158		1, 103, 652		14. 00
15.00	01500 PHARMACY	O	19, 696	0	37, 735	1, 108, 941	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	24, 536	0	1, 367	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	437, 654	77, 429		97, 940	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	69, 359	30, 177		19, 458	0	31.00
43. 00	04300 NURSERY	0 278, 795	13, 193		12 102	0	43.00
44. 00	04400 SKILLED NURSING FACILITY   ANCILLARY SERVICE COST CENTERS	278, 795	38, 715	226, 489	13, 193	U	44. 00
50. 00	05000 OPERATING ROOM	O	49, 565	345, 570	133, 028	0	50.00
51. 00	05100 RECOVERY ROOM		0	010,070	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	8, 168	61, 348	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	44, 140	0	47, 677	0	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	3, 267	0	874	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	0	43, 492	0	171, 838	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	18, 248 33, 259	1	11, 050 10, 512	0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY		33, 239 N	0	10, 512	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		16, 306	Ö	o	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0	0	95, 809	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	0	376, 569	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 108, 941	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	0	3, 884	1	3, 269	0	76. 01
76. 03	03953 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	1, 572	9, 450	2, 040	0	76. 03
90. 00	09000 CLINIC	O	1, 449	0	7, 268	0	90.00
	09100 EMERGENCY		32, 673		57, 205	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART		02,070	200,000	07,200	· ·	92.00
	OTHER REIMBURSABLE COST CENTERS			<u> </u>			
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		785, 808	509, 272	1, 709, 467	1, 086, 832	1, 108, 941	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15, 547		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 OTHER NONREIMBURSABLE COST CENTER 07955 MARKETING	0	2 052	0	1 272		194. 00 194. 01
	07952 SENIOR CIRCLE		3, 853 308		1, 273		194. 01
	07953 BUSINESS HEALTH		300		0		194. 02
	07954 VACANT SPACE		0		ol Ol		194. 04
200.00			0		Ĭ	Ü	200. 00
201.00		0	0	0	o		201. 00
202.00	TOTAL (sum lines 118-201)	785, 808	513, 433	1, 709, 467	1, 103, 652	1, 108, 941	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems BLUFFTON REGIONAL MEDICAL CENTER Worksheet B Part I Date/Time Prepared: 2/28/2017 1:33 pm COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0075 Peri od: From 10/01/2015 To 09/30/2016 Cost Center Description Subtotal Total MEDI CAL Intern & RECORDS & Residents Cost

		LI BRARY		Residents Cost & Post		
				Stepdown		
		16, 00	24. 00	Adjustments 25.00	24, 00	
GEN	ERAL SERVICE COST CENTERS	16.00	24.00	25.00	26. 00	
	00 CAP REL COSTS-BLDG & FIXT					1. 00
	01 WELLS CRC COSTS-BLDG & FIXT					1. 01
	00 CAP REL COSTS-MVBLE EQUIP					2.00
	00 EMPLOYEE BENEFITS DEPARTMENT 60 COMMUNICATIONS					4. 00 5. 01
	40 ADMI TTI NG					5. 02
	50 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03
5. 04 005	60 OTHER ADMINISTRATIVE AND GENERAL					5. 04
	OO OPERATION OF PLANT					7. 00
	00 LAUNDRY & LINEN SERVICE					8. 00
	00 HOUSEKEEPI NG 00 DI ETARY					9. 00 10. 00
	OO CAFETERI A					11.00
	OO NURSING ADMINISTRATION					13. 00
	OO CENTRAL SERVICES & SUPPLY					14. 00
	OO PHARMACY					15. 00
	00 MEDI CAL RECORDS & LI BRARY	877, 351				16. 00
	ATIENT ROUTINE SERVICE COST CENTERS	E0.7E0	F 27/ 02F		E 27/ 02F	20.00
	OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT	58, 750 15, 357	5, 276, 935 1, 709, 328		5, 276, 935 1, 709, 328	30. 00 31. 00
	00 NURSERY	4, 880	665, 201	0	665, 201	43. 00
	OO SKILLED NURSING FACILITY	15, 974	1, 909, 674		1, 909, 674	44. 00
	ILLARY SERVICE COST CENTERS					
	OO OPERATING ROOM	174, 014	3, 164, 670	1	3, 164, 670	50.00
	OO RECOVERY ROOM	0	424 005	0	424 005	51.00
	OO DELIVERY ROOM & LABOR ROOM OO RADIOLOGY-DIAGNOSTIC	3, 024 162, 159	424, 085 2, 276, 592		424, 085 2, 276, 592	52. 00 54. 00
	30 ULTRA SOUND	102, 137	2,270,372	o o	2, 270, 372	54. 01
	00 RADI OI SOTOPE	5, 451	260, 358	0	260, 358	56.00
57. 00 057	OO CT SCAN	O	0	0	0	57. 00
	OO MRI	0	0	0	0	58. 00
	OO LABORATORY	155, 264	2, 437, 490		2, 437, 490	60.00
	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY	19, 458 30, 973	861, 887 1, 447, 009		861, 887 1, 447, 009	65. 00 66. 00
	00 OCCUPATIONAL THERAPY	30, 473	1, 447, 009	1	1, 447, 009	67. 00
	00 SPEECH PATHOLOGY		0	Ö	0	68. 00
	00 ELECTROCARDI OLOGY	11, 123	346, 823	0	346, 823	69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 688	325, 759		325, 759	71. 00
	00 I MPL. DEV. CHARGED TO PATIENTS	28, 174	1, 125, 204		1, 125, 204	72.00
	OO DRUGS CHARGED TO PATIENTS	68, 765	2, 688, 221	1	2, 688, 221	73.00
	50 OTHER ANCILLARY SERVICE COST CENTER 51 SLEEP LAB	2, 893	0 164, 744	_	164, 744	76. 00 76. 01
	53 WOUND CARE	1, 778	75, 917		75, 917	76. 03
	PATIENT SERVICE COST CENTERS	.,				
	OO CLI NI C	1, 579	153, 268		153, 268	90.00
	OO EMERGENCY	82, 047	1, 875, 119	1	1, 875, 119	91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART			0		92. 00
	ER REIMBURSABLE COST CENTERS OO AMBULANCE SERVICES	0	0	0	0	95. 00
	CLAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>	75.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	877, 351	27, 188, 284	0	27, 188, 284	118. 00
NON	REIMBURSABLE COST CENTERS					
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84, 660		84, 660	190. 00
	OO PHYSI CLANS' PRI VATE OFFI CES	0	3, 192, 832		3, 192, 832	192.00
	50 OTHER NONREIMBURSABLE COST CENTER 55 MARKETING		134, 159 246, 430		134, 159 246, 430	194. 00 194. 01
	52 SENI OR CI RCLE		11, 868		11, 868	194. 02
	53 BUSI NESS HEALTH		127, 895		127, 895	194. 03
	54 VACANT SPACE	0	528	0	528	194. 04
200.00	Cross Foot Adjustments		0		0	200. 00
201. 00 202. 00	Negative Cost Centers	0 877, 351	20 004 454	0	20 004 454	201. 00 202. 00
202.00	TOTAL (sum lines 118-201)	0//,351	30, 986, 656	ı o	30, 986, 656	J2U2. UU

| Period: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0075

					T	09/30/2016	Date/Time Pre	
				CAP	 ITAL RELATED CO	ISTS	2/28/2017 1:3	3 pm
				O/III	TAL KELATED OC	.515		
		Cost Center Description	Di rectly	BLDG & FIXT	WELLS CRC	MVBLE EQUIP	Subtotal	
			Assigned New		COSTS-BLDG &			
			Capital Related Costs		FLXT			
			0	1. 00	1. 01	2. 00	2A	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FLXT						1.00
1. 01 2. 00	1	WELLS CRC COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	7	15, 569	15, 576	4. 00
5. 01		COMMUNI CATI ONS	0	5, 823		9, 994	15, 817	5. 01
5.02		ADMITTING	0	7, 719	0	13, 248	20, 967	5. 02
5. 03		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	11, 369		19, 512	30, 881	5. 03
5.04	1	OTHER ADMINISTRATIVE AND GENERAL	0	95, 844		172, 269	268, 117	5. 04
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	67, 235 1, 134		115, 387 29, 718	182, 622 30, 865	7. 00 8. 00
9. 00		HOUSEKEEPI NG	l ő	4, 790		8, 220	13, 010	9. 00
10.00		DIETARY	0	47, 054		80, 752	127, 806	
11. 00		CAFETERI A	0	0	16	35, 759	35, 775	11. 00
13.00		NURSI NG ADMI NI STRATI ON	0	2, 362	0	4, 054	6, 416	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	58, 340 0		100, 122	158, 462 0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY		13, 867	0	23, 799	37, 666	16. 00
	INPAT	IENT ROUTINE SERVICE COST CENTERS	-			==,,	3.7.222	
30.00	03000	ADULTS & PEDIATRICS	0	98, 519		169, 076	267, 595	30. 00
31.00		INTENSIVE CARE UNIT	0	17, 358		29, 789	47, 147	31.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	0	2, 888 35, 242		4, 956 60, 481	7, 844 95, 723	
44.00		LARY SERVICE COST CENTERS	<u> </u>	33, 242		00, 401	75, 725	44.00
50.00		OPERATING ROOM	0	92, 720	0	159, 123	251, 843	50. 00
51.00	1	RECOVERY ROOM	0	0		0	0	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	3, 402		5, 838	9, 240	
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	0	64, 548 0		110, 775 0	175, 323 0	54. 00 54. 01
56. 00	1	RADI OI SOTOPE		4, 205	_	7, 217	11, 422	56. 00
57.00		CT SCAN	0	0		. 0	0	57. 00
58. 00	05800		0	0	_	0	0	58. 00
60.00	1	LABORATORY	0	26, 731	0	45, 875	72, 606	60.00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	31, 355 29, 099		53, 811 49, 939	85, 166 79, 038	
67. 00		OCCUPATIONAL THERAPY		27,077		47, 737	7 7, 030	67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	0	6	13, 136	13, 142	
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0 8, 652	_	29, 698	0 38, 357	72. 00 73. 00
76. 00	1	OTHER ANCILLARY SERVICE COST CENTER	O	0, 032	Ó	27, 070	0	76.00
76. 01	1	SLEEP LAB	0	2, 049	0	3, 517	5, 566	76. 01
76. 03		WOUND CARE	0	0	0	0	0	76. 03
90. 00		TIENT SERVICE COST CENTERS CLINIC	O	6, 343	0	10, 886	17, 229	90. 00
91.00		EMERGENCY		28, 101		48, 226	76, 327	
92.00		OBSERVATION BEDS (NON-DISTINCT PART		•			0	
		REIMBURSABLE COST CENTERS		_	_	-1		
95. 00		AL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	0	766, 749	53	1, 430, 746	2, 197, 548	118. 00
	NONRE	IMBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 451		9, 355	14, 806	
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE COST CENTER	0	353, 978		772, 984	1, 127, 038	
		MARKETING		20, 913 12, 917		35, 891 22, 167	56, 804 35, 084	
		SENI OR CI RCLE	O	0		0		194. 02
194. 03	07953	BUSINESS HEALTH	0	0	20	42, 875	42, 895	
		VACANT SPACE	0	0	407	0		194. 04
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		0	_			200. 00 201. 00
201.00	1	TOTAL (sum lines 118-201)	0	1, 160, 008	556	2, 314, 018	3, 474, 582	
_02.00	-1	1.1 (54 1.1.55 1.15 201)	١	., 100, 000	1 330	2, 311, 310	5, 1, 1, 502	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2015 Part II
To 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm

				'	0 09/30/2010	2/28/2017 1: 3	
	Cost Center Description	EMPLOYEE	COMMUNI CATI ONS	ADMITTI NG	CASHI ERI NG/ACC		
		BENEFITS				ADMI NI STRATI VE	
		DEPARTMENT	5.04		RECEI VABLE	AND GENERAL	
	CENEDAL CEDVICE COCT CENTEDO	4.00	5. 01	5. 02	5. 03	5. 04	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 00	00101 WELLS CRC COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 576					4.00
5. 01	01160 COMMUNI CATI ONS	60	15, 877				5. 01
5. 02	00540 ADMI TTI NG	423	259	21, 649			5. 02
5. 03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	129	188	761			5. 03
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	1, 179	1, 225	3, 947		280, 498	5. 04
7.00	00700 OPERATION OF PLANT	412	283	1, 514	· ·		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	24	109		1, 798	8. 00
9.00	00900 HOUSEKEEPI NG	276	47	288	441	4, 774	9. 00
10.00	01000 DI ETARY	264	212	355	544	5, 881	10.00
11. 00	01100 CAFETERI A	257	0	248	379	4, 102	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 298	71	910	1, 393	15, 066	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	156	118	499	764	8, 265	14. 00
15. 00		684	259	575	880	9, 519	15. 00
16. 00		391	589	444	679	7, 345	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		1, 721	471	2, 052		33, 967	30. 00
31. 00		899	118	688		'	31. 00
43. 00		353	24	295		4, 886	43. 00
44. 00		809	236	658	1, 007	10, 900	44. 00
	ANCILLARY SERVICE COST CENTERS	1 004	004			10.500	
50.00		1, 234	801	1, 178		19, 509	50.00
51.00		0	0	(		0	51.00
52. 00		219	47	187		3, 093	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	1, 149 0	495 0	992	· ·	16, 421 0	
54. 01	1 1	99	-		-		54. 01
56. 00 57. 00		99	47 0	130		2, 160	56. 00 57. 00
58. 00		0	0	(	1	0	58.00
60. 00		814	448	1, 088	-	18, 011	60.00
65. 00		469	71	394		6, 528	65. 00
66. 00		921	118	703		11, 646	66. 00
67. 00	1	0	0	700		0	67. 00
68. 00		0	o	(	1	0	68. 00
69. 00		220	141	163	1	2, 691	69. 00
71. 00	1	0	0	106		1, 759	71. 00
72. 00		0	o	394		6, 522	72. 00
73. 00		0	o	799		13, 221	73. 00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	O	(	· ·	0	76. 00
76. 01	03951 SLEEP LAB	106	o	81	124	1, 347	76. 01
76. 03		34	o	33	51	553	76. 03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	66	118	68	104	1, 128	90. 00
91. 00	09100 EMERGENCY	835	400	740	1, 132	12, 246	91. 00
92.00							92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0	0	(	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 0	,	15, 477	6, 810	20, 399	30, 043	259, 781	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	94	29			190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	8, 973	1, 033		17, 107	1
	0 07950 OTHER NONREIMBURSABLE COST CENTER	0	0	40			194. 00
	1 07955 MARKETI NG	94	0	112			194. 01
	2 07952 SENI OR CI RCLE	5	0	6			194. 02
	3 07953 BUSI NESS HEALTH	0	0	30			194. 03
	4 07954 VACANT SPACE	0	U	(	ر ا	5	194. 04
200. 00 201. 00		0		,		_	200. 00 201. 00
201.0		15, 576	15, 877	21, 649	31, 959		
202.0	O 1101AL (Suil 111103 110-201)	13,370	15, 677	21,045	J1, 707	200, 470	1202.00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0075

					То	09/30/2016	Date/Time Pre 2/28/2017 1:3	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	3 pili
		·	PLANT	LINEN SERVICE				
	CENED	AL CEDULAE CAST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT						1.00
1. 01		WELLS CRC COSTS-BLDG & FIXT						1. 01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		COMMUNI CATI ONS						5. 01
5. 02 5. 03		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 02 5. 03
5. 03		OTHER ADMINISTRATIVE AND GENERAL						5. 03
7. 00		OPERATION OF PLANT	212, 205					7. 00
8.00		LAUNDRY & LINEN SERVICE	3, 204	36, 166				8. 00
9.00		HOUSEKEEPI NG	886	0	19, 722			9. 00
10.00		DIETARY	8, 707	0		144, 594		10.00
11.00		CAFETERIA	3, 856	0		0	44, 982	1
13. 00 14. 00		NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY	437 10, 796	1, 612	41 1, 023	0	3, 359 978	
15. 00		PHARMACY	10, 7 70	1,012		0	1, 726	1
16. 00		MEDICAL RECORDS & LIBRARY	2, 566	Ö		Ö	2, 150	
	I NPATI	ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	18, 231	12, 730		80, 531	6, 781	30. 00
31. 00		INTENSIVE CARE UNIT	3, 212	2, 293		12, 763	2, 644	
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	534 6, 521	0 4, 590		0 51, 300	1, 156 3, 392	
44.00		LARY SERVICE COST CENTERS	0, 521	4, 590	010	51, 500	3, 392	44.00
50. 00		OPERATING ROOM	17, 158	5, 893	1, 626	0	4, 342	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	630	0		0	716	1
54. 00		RADI OLOGY-DI AGNOSTI C	11, 944	3, 294		0	3, 867	
54. 01 56. 00		ULTRA SOUND RADI OI SOTOPE	0 778	0		0	0 286	
57. 00		CT SCAN	0	0		0	0	1
58. 00	05800		Ö	Ö		o	0	1
60.00	06000	LABORATORY	4, 946	0	469	0	3, 810	60.00
65. 00		RESPI RATORY THERAPY	5, 802			0	1, 599	
66. 00		PHYSI CAL THERAPY	5, 385	236		0	2, 914	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0	0	1
69.00		ELECTROCARDI OLOGY	1, 416	0		0	1, 429	
71. 00	1 .	MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		ő	0	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	О	0	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	3, 202	0		0	0	1
76. 00		OTHER ANCILLARY SERVICE COST CENTER	0	0	-	0	0	
76. 01 76. 03		SLEEP LAB WOUND CARE	379 0	3		0	340 138	
70.03		TIENT SERVICE COST CENTERS	0	0	<u> </u>	<u> </u>	130	70.03
90.00		CLINIC	1, 174	0	111	0	127	90.00
91.00		EMERGENCY	5, 200	5, 316	493	0	2, 863	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00		REIMBURSABLE COST CENTERS			1	ما		05.00
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	116, 964	36, 166	10, 696	144, 594	44 617	118. 00
	NONREI	MBURSABLE COST CENTERS	110,701	00,100	10,070	111,071	11,017	1.10.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 009	0		0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	83, 349			0		192. 00
		OTHER NONREIMBURSABLE COST CENTER	3, 870			0		194. 00
		MARKETI NG SENI OR CI RCLE	2, 390 0	0	227	0		194. 01 194. 02
		BUSI NESS HEALTH	4, 623	o o	438	0		194. 02
		VACANT SPACE	0	0	0	o		194. 04
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0	0	. 0	0		201. 00
202.00	ן וי	TOTAL (sum lines 118-201)	212, 205	36, 166	19, 722	144, 594	44, 982	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

			10	) 09/30/2016	2/28/2017 1:3	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	<u>β</u>
	13. 00	14. 00	15. 00	16.00	24.00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FIXT 1. 01   00101   WELLS CRC   COSTS-BLDG & FIXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP						1. 00 1. 01 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02   00540   ADMI TTI NG 5. 03   00550   CASHI ERI NG/ACCOUNTS   RECEI VABLE						5. 02 5. 03
5. 04 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 03
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						10. 00 11. 00
13. 00 01300 NURSING ADMINISTRATION	28, 995					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	182, 673				14. 00
15. 00   01500   PHARMACY	0	6, 246	19, 889	F0 000		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	226	0	52, 299		16. 00
30. 00 03000 ADULTS & PEDIATRICS	8, 174	16, 211	0	3, 506	456, 839	30.00
31.00 03100 INTENSIVE CARE UNIT	4, 272	3, 221	0	916	90, 914	31. 00
43. 00   04300   NURSERY	1, 679	0	0	291	17, 565	43. 00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	3, 842	2, 184	0	953	182, 733	44. 00
50. 00 05000 OPERATING ROOM	5, 861	22, 018	0	10, 331	343, 597	50.00
51. 00   05100   RECOVERY   ROOM	0	0	Ö	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 041	0	0	180	15, 699	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	7, 891	0	9, 676	233, 702	54.00
54. 01   03630   ULTRA SOUND 56. 00   05600   RADI OI SOTOPE	0	145	0	325	0 15, 666	54. 01 56. 00
57. 00 05700 CT SCAN	0	0	0	0	15, 000	57. 00
58. 00   05800   MRI	0	O	0	0	0	58. 00
60. 00   06000   LABORATORY	0	28, 442	0	9, 265	141, 564	60.00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY	0	1, 829	0	1, 161	104, 361	•
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	1, 740 0	0	1, 848 0	106, 135 0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	o	Ö	Ö	o	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	o	0	664	20, 249	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15, 858	0	2, 130	20, 016	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	62, 328 0	0 19, 889	1, 681 4, 103	71, 528 81, 096	72. 00 73. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	o	17,007	4, 103	01,070	76.00
76. 01   03951   SLEEP LAB	0	541	0	173	8, 696	76. 01
76. 03 03953 WOUND CARE	160	338	0	106	1, 419	76. 03
90. 00 OPPATIENT SERVICE COST CENTERS 90. 00 OPPOS CLINIC	0	1, 203	0	94	21, 422	90.00
91. 00   09100   EMERGENCY	3, 966	9, 468		4, 896	123, 882	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		·		·		92. 00
OTHER REIMBURSABLE COST CENTERS				-1		
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28, 995	179, 889	19, 889	52, 299	2, 057, 083	118 00
NONREI MBURSABLE COST CENTERS	20,770	1,7,7007	. , , 00 ,	02,277	2,00,,000	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 573	0	0	19, 135	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	1, 246, 979	
194. 00 07950 0THER NONREIMBURSABLE COST CENTER 194. 01 07955 MARKETING	0	211	0	0	61, 810 40, 473	194.00
194. 02 07952 SENI OR CIRCLE		0	0	ol		194. 01
194. 03 07953 BUSI NESS HEALTH	0	o	Ō	O	48, 537	194. 03
194. 04 07954 VACANT SPACE	0	o	0	0		194. 04
200.00 Cross Foot Adjustments						200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	28, 995	182, 673	19, 889	52, 299	3, 474, 582	
(34 1.1.35 1.70 201)	20,770	.52, 5, 5	. ,, 557	52,277	5, 1, 002	,

| Period: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0075

					/Time Prepared: /2017 1:33 pm
	Cost Center Description	Intern &	Total	2/20.	72017 1.33 pill
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	CENEDAL CEDIU CE COCT CENTEDO	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.00
1. 01	00101 WELLS CRC COSTS-BLDG & FIXT				1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUI P				2. 00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS				4. 00 5. 01
5. 02	00540 ADMITTING				5. 02
5.03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 03
5. 04 7. 00	00560 OTHER ADMINISTRATIVE AND GENERAL				5. 04
8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE				7. 00 8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON				11. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	456, 839		30.00
31. 00	03100   NTENSI VE CARE UNI T	o	90, 914		31. 00
43.00	04300 NURSERY	0	17, 565		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	182, 733		44. 00
50.00	05000 OPERATING ROOM	0	343, 597		50.00
51. 00	05100 RECOVERY ROOM	0	0		51.00
52. 00 54. 00	05200   DELIVERY ROOM & LABOR ROOM   05400   RADIOLOGY-DIAGNOSTIC	0	15, 699 233, 702		52. 00 54. 00
54. 00	03630 ULTRA SOUND		233, 702		54. 00
56.00	05600 RADI OI SOTOPE	O	15, 666		56.00
57. 00	05700 CT SCAN	0	0		57. 00
58. 00 60. 00	05800   MRI		0 141, 564		58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	o	104, 361		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	106, 135		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		20, 249		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20, 016		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	71, 528		72. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTER		81, 096		73. 00 76. 00
76. 01	03951 SLEEP LAB	Ö	8, 696		76. 01
76. 03	03953 WOUND CARE	0	1, 419		76. 03
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	O	21, 422		90.00
91. 00	09100 EMERGENCY	o	123, 882		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	O			92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES	O	0		95. 00
95.00	SPECIAL PURPOSE COST CENTERS	ı	U <sub>1</sub>		95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2, 057, 083		118. 00
100.00	NONREI MBURSABLE COST CENTERS		10 105		100.00
	1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN   1920  PHYSICIANS' PRIVATE OFFICES	0	19, 135 1, 246, 979		190. 00 192. 00
	07950 OTHER NONREI MBURSABLE COST CENTER		61, 810		194. 00
	07955 MARKETI NG	0	40, 473		194. 01
	07952 SENI OR CIRCLE 07953 BUSI NESS HEALTH	0	153 48, 537		194. 02 194. 03
	107954 VACANT SPACE		46, 537		194. 03
200.00	Cross Foot Adjustments	Ó	0		200. 00
201.00		0	0 2 474 E93		201. 00
202.00	TOTAL (sum lines 118-201)	١	3, 474, 582		202. 00

| Period: | Worksheet B-1 | From 10/01/2015 | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0075

					o 09/30/2016	Date/Time Pre 2/28/2017 1:3	
		CAP	TAL RELATED CO	OSTS		2/20/2017 1.3	J pili
	Cost Center Description	BLDG & FIXT	WELLS CRC	MVBLE EQUIP	EMPLOYEE	COMMUNICATIONS	
	cost conto. Doson per on	(SQUARE FEET)	COSTS-BLDG &	(SQUARE FEET)	BENEFI TS		
			FIXT (SQUARE FEET)		DEPARTMENT (GROSS	(NONPATIENT PHONES)	
			, ,		SALARI ES)	ŕ	
	GENERAL SERVICE COST CENTERS	1. 00	1. 01	2.00	4. 00	5. 01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	196, 409					1. 00
1.01	00101 WELLS CRC COSTS-BLDG & FIXT	0	119, 997				1. 01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 536	228, 300 1, 536			2. 00 4. 00
5.01	01160 COMMUNI CATI ONS	986	O	986	44, 765	674	5. 01
5. 02 5. 03	00540 ADMITTING 00550 CASHIERING/ACCOUNTS RECEIVABLE	1, 307 1, 925	0	1, 307 1, 925		1	5. 02 5. 03
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	16, 228	ł	1			5. 04
7. 00 8. 00	00700 OPERATION OF PLANT	11, 384	2 740	1,		l	7. 00 8. 00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	192 811	2, 740 0	1			9. 00
10.00	01000 DI ETARY	7, 967	0	7, 967		l .	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	400	3, 528	3, 528		l .	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	9, 878	O	1	117, 007	5	14. 00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	2, 348	0				15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 340		2, 540	273, 204		10.00
30.00	03000 ADULTS & PEDIATRICS	16, 681	0			l .	1
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	2, 939 489	l e		· ·		31. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	5, 967	0	5, 967			44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	15, 699		15, 699	925, 539	34	50. 00
51.00	05100 RECOVERY ROOM	0	0	1		0	51. 00
52. 00 54. 00	O5200   DELIVERY ROOM & LABOR ROOM   O5400   RADIOLOGY-DIAGNOSTIC	576 10, 929	0	57 <i>6</i> 10, 929			52. 00 54. 00
54. 00	03630 ULTRA SOUND	10, 929		10, 925			54. 00
56.00	05600 RADI OI SOTOPE	712	0	712			56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0				0	57. 00 58. 00
60.00	06000 LABORATORY	4, 526	ł	4, 526		19	60. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5, 309 4, 927	0	5, 309 4, 927		l .	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	4, 727	Ö	) 4, 72,			67. 00
68.00	06800 SPEECH PATHOLOGY	0	1 200	1 204		_	68.00
69. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT		1, 296	1, 296		l	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		_	0	72. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03950 OTHER ANCILLARY SERVICE COST CENTER	1, 465	1, 465 0	1		0	73. 00 76. 00
76. 01	03951 SLEEP LAB	347	1	1	-	l .	76. 01
76. 03	03953  WOUND CARE   OUTPATIENT SERVICE COST CENTERS	0	0	) (	25, 310	0	76. 03
90. 00	09000 CLINIC	1, 074	О	1, 074	49, 472	5	90. 00
	09100 EMERGENCY	4, 758	O	4, 758	626, 207	17	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVI CES	0	0	) (	0	0	95. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	129, 824	11, 333	141, 157	11, 610, 260	280	118. 00
	NONREI MBURSABLE COST CENTERS	127, 024	11, 333	141, 137	11, 010, 200	207	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	l e	923			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE COST CENTER	59, 934 3, 541	16, 328 0	76, 262 3, 541			192. 00 194. 00
194. 01	07955 MARKETI NG	2, 187	0	2, 187	70, 882	0	194. 01
	07952 SENIOR CIRCLE 07953 BUSINESS HEALTH	0	0 4, 230	4, 230	-,		194. 02 194. 03
194. 04	07954 VACANT SPACE	0	88, 106			l .	194. 04
200.00	1 1						200. 00
201. 00 202. 00	1 1 3	1, 160, 008	556	2, 314, 018	2, 352, 572	584, 471	201. 00 202. 00
	Part I)						
203. 00 204. 00		5. 906084	0. 004633	10. 135865	0. 201339 15, 576		203. 00 204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part				0. 001333	23. 556380	205. 00
	1/	<u> </u>	ļ	1	1	1	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Peri od: Worksheet B-1 From 10/01/2015 To 09/30/2016 Date/Ti me Prepared:

2/28/2017 1:33 pm Cost Center Description Reconciliation ADMI TTI NG Reconciliation CASHIERING/ACC Reconciliation (ACCUM. COST) OUNTS RECEI VABLE (ACCUM. COST) 5A. 03 5A. 02 5.02 5A. 04 5.03 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 WELLS CRC COSTS-BLDG & FIXT 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00540 ADMITTING 5.02 -455, 696 30, 530, 960 5.02 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 1,073,023 -1, 089, 039 29, 897, 617 5.03 5.04 00560 OTHER ADMINISTRATIVE AND GENERAL 0 5, 560, 626 5, 643, 614 -5, 849, 177 5.04 7.00 00700 OPERATION OF PLANT 2, 134, 761 2, 166, 624 7.00 0 0 8.00 00800 LAUNDRY & LINEN SERVICE 153, 202 0 155, 489 8.00 Λ 0 9.00 00900 HOUSEKEEPI NG 406, 731 0 412, 802 0 9.00 10.00 01000 DI ETARY 0 0 0 501, 042 508, 521 0 10.00 01100 CAFETERI A 349, 477 0 354, 693 11.00 11.00 0 01300 NURSING ADMINISTRATION 0 13.00 1, 283, 502 1, 302, 660 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 704, 113 0 714, 623 0 14.00 0 0 15.00 01500 PHARMACY 810, 939 823, 043 0 15.00 01600 MEDICAL RECORDS & LIBRARY 625, 708 0 16 00 635, 047 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 894, 789 0 2, 937, 997 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 969, 925 0 984, 402 0 31.00 0 0 04300 NURSERY 416, 278 422, 491 43 00 43 00 0 04400 SKILLED NURSING FACILITY 44.00 0 928, 570 0 942, 430 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM O n 50.00 00000000000000000000 1,662,024 1, 686, 831 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 263, 527 267, 460 0 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1, 398, 964 1, 419, 845 0 54.00 54 01 03630 ULTRA SOUND 0 54 01 0 05600 RADI OI SOTOPE 0 56.00 184, 012 186, 759 0 56.00 05700 CT SCAN 0 57.00 57.00 0 05800 MRI 58.00 0 0 0 58.00 0 06000 LABORATORY 1, 534, 378 1, 557, 280 60 00 60.00 0 06500 RESPIRATORY THERAPY 65.00 556, 171 0 564, 472 0 65.00 06600 PHYSI CAL THERAPY 66.00 992, 176 1,006,985 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 C 0 0 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 229, 243 232, 665 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 149, 817 0 152, 053 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 563, 923 72.00 555, 630 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 126, 320 1, 143, 131 Ω 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 0 76.00 76. 01 03951 SLEEP LAB 114, 715 0 116, 427 0 76.01 03953 WOUND CARE 76.03 0 47, 773 47,070 0 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 96, 109 97. 544 0 90.00 91.00 09100 EMERGENCY 0 1, 043, 254 0 1, 058, 826 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -455, 696 28, 766, 096 -1, 089, 039 28, 106, 410 -5, 849, 177 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 41, 753 0 190. 00 41, 139 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 1, 457, 427 1, 479, 181 0 192, 00 0 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTER 56, 804 57, 652 0 194.00 194. 01 07955 MARKETI NG 0 194. 01 0 0 157, 277 159, 625 194. 02 07952 SENI OR CIRCLE 0 0 194, 02 8, 915 9.048 194. 03 07953 BUSINESS HEALTH 0 194. 03 42, 895 0 43, 535 194. 04 07954 VACANT SPACE 407 413 0 194. 04 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 455, 696 1, 089, 039 202.00 Part I) Unit cost multiplier (Wkst. B, Part I) 0.014926 203.00 0.036426 203.00 Cost to be allocated (per Wkst. B, 31, 959 204.00 204.00 21, 649 Part II) 0.000709 205.00 Unit cost multiplier (Wkst. B, Part 0.001069 205.00

Provider CCN: 15-0075

				11	0 09/30/2016	Date/lime Pre 2/28/2017 1:3	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		AND GENERAL (ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)			
		5. 04	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 WELLS CRC COSTS-BLDG & FIXT						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	OO4OO						4. 00 5. 01
5. 02	00540 ADMI TTI NG						5. 02
5. 03	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00560 OTHER ADMINISTRATIVE AND GENERAL	25, 137, 479					5. 04
7.00	00700 OPERATION OF PLANT	2, 245, 545	194, 166				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	161, 153		270, 767			8. 00
9.00	00900 HOUSEKEEPI NG	427, 839		0	190, 423		9.00
10.00	01000 DI ETARY	527, 044		0	7, 967	30, 669 0	10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	367, 613 1, 350, 111	3, 528 400	27	3, 528 400	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	740, 654	9, 878	12, 071	9, 878	0	14. 00
15. 00	01500 PHARMACY	853, 023		0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	658, 179		0	2, 348	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 045, 016		95, 308		17, 081	30.00
31.00	03100   NTENSI VE CARE UNI T	1, 020, 260		17, 166		2, 707	31.00
43. 00	04300 NURSERY	437, 881	489	0	489	10.001	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	976, 759	5, 967	34, 364	5, 967	10, 881	44. 00
50. 00	05000 OPERATING ROOM	1, 748, 276	15, 699	44, 116	15, 699	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	277, 202	576	0	576	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 471, 564	10, 929	24, 662	10, 929	0	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	193, 562	1	0	712	0	56. 00
57. 00 58. 00	05700   CT   SCAN     05800   MRI	0	0	0	0	0	57. 00 58. 00
60. 00	06000 LABORATORY	1, 614, 005	4, 526	)   	4, 526	0	60.00
65. 00	06500 RESPIRATORY THERAPY	585, 033		1, 414		0	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 043, 665		1, 766	4, 927	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	241, 140		0	1, 296	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	157, 592	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	584, 464 1, 184, 771	2, 930	0	2, 930	0	73.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTER	1, 104, 771	2, 730	0	2, 730	0	76.00
76. 01	03951 SLEEP LAB	120, 668	347	26	347	0	76. 01
76. 03	03953 WOUND CARE	49, 513	0	48	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	101, 097			, ,		
	09100 EMERGENCY	1, 097, 395	4, 758	39, 799	4, 758	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95 00	09500 AMBULANCE SERVICES	0	0	0	ol	0	95. 00
73. 00	SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>	0	75.00
118.00		23, 281, 024	107, 023	270, 767	103, 280	30, 669	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 274	1	0	923		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 533, 062		0			192. 00
	07950 OTHER NONREIMBURSABLE COST CENTER	59, 752		0			194. 00
	07955   MARKETI NG   07952   SENI OR CI RCLE	165, 440 9, 378		0	2, 187		194. 01 194. 02
	07953 BUSI NESS HEALTH	45, 121		0	4, 230		194. 02
	07954 VACANT SPACE	428			7, 230		194. 04
200.00							200. 00
201.00	Negative Cost Centers						201. 00
202.00		5, 849, 177	2, 768, 054	240, 450	538, 954	785, 808	202. 00
202.00	Part I)	0.000/07	14 05/404	0.000000	2 02022	25 (22224	202 00
203. 00 204. 00		0. 232687 280, 498		0. 888033 36, 166	2. 830299 19. 723	25. 622224 144, 594	
204. UU	Part II)	200, 498	212, 205	36, 166	19, 722	144, 594	204.00
205.00		0. 011159	1. 092905	0. 133569	0. 103569	4. 714663	205. 00

Health Financial Systems BLUFFTON REGIONAL MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0075 Peri od: Worksheet B-1 From 10/01/2015 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL SERVICES & (% COSTED R (FTES) ADMI NI STRATI ON RECORDS & **SUPPLY** EQUI) LI BRARY (FTES IN NU (COSTED (GROSS CHAR RSING ARE) REQUIS.) GES) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 WELLS CRC COSTS-BLDG & FIXT 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00540 ADMITTING 5.02 5.02 5.03 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.04 00560 OTHER ADMINISTRATIVE AND GENERAL 5.04 00700 OPERATION OF PLANT 7.00 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 CAFETERIA 11 00 16, 657 11 00 01300 NURSING ADMINISTRATION 13.00 1, 244 4, 578, 457 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 362 1, 628, 450 14.00 01500 PHARMACY 15 00 639 55 679 1, 087, 963 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 796 2, 017 171, 080, 443 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 512 1, 290, 786 144, 512 11, 456, 768 30.00 03100 INTENSIVE CARE UNIT 0 2, 994, 642 31.00 979 674, 541 28, 710 31 00 43.00 04300 NURSERY 428 265, 160 C 0 951, 666 43.00 04400 SKILLED NURSING FACILITY 44.00 1, 256 606, 605 19, 467 3, 114, 990 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 608 925, 539 33, 924, 140 50 00 196, 284 51.00 05100 RECOVERY ROOM 0 51.00 589, 711 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 265 164, 309 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 432 70, 348 31, 622, 305 54.00 03630 ULTRA SOUND 54.01 C C 0 54.01 56.00 05600 RADI OI SOTOPE 106 1, 289 1, 063, 051 0 0 0 0 0 56.00 05700 CT SCAN 57.00 0 Ω 57 00 58.00 05800 MRI 0 0 58.00 0 0 06000 LABORATORY 1, 411 30, 277, 604 60.00 253, 549 60 00 16, 305 06500 RESPIRATORY THERAPY 592 3, 794, 535 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 1,079 15, 511 0 6, 039, 948 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 0 0 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 529 0 2, 169, 162 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 141, 367 6, 959, 491 71.00 0 71.00 5, 494, 240 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 72.00 555, 630 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 1, 087, 963 13, 409, 682 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 76.00 C 76.01 03951 SLEEP LAB 126 4.823 0 564,077 76.01 03953 WOUND CARE 76.03 51 25, 310 3,010 0 346, 740 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 47 10, 724 0 307, 905 90.00 09100 EMERGENCY 626, 207 15, 999, 786 91 00 1,060 84, 406 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 16, 522 4, 578, 457 1, 603, 631 1, 087, 963 171, 080, 443 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 22 940 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 0 C C 194.00 07950 OTHER NONREIMBURSABLE COST CENTER 0 0 0 194.00 0 194. 01 07955 MARKETI NG 125 0 1,879 0 194. 01 194. 02 07952 SENI OR CIRCLE 0 194. 02 10 Ω C 0 194. 03 194. 03 07953 BUSINESS HEALTH 0 C 0 0 194.04 07954 VACANT SPACE 0 0 194. 04 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 513, 433 1, 709, 467 1, 103, 652 1, 108, 941 877, 351 202. 00 Part I)

30. 823858

44, 982

2.700486

0.373372

0.006333

28, 995

0.677732

0.112176

182, 673

1.019282

0.018281

19,889

0.005128 203.00 52, 299 204. 00

0.000306 205.00

Part II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

203.00

204.00

205.00

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0075		Worksheet C	
		From 10/01/2015	Part	

					09/30/2016	Date/Time Pre 2/28/2017 1:3	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00	03000 ADULTS & PEDI ATRI CS	5, 276, 935		5, 276, 935		5, 276, 935	
	03100 INTENSIVE CARE UNIT	1, 709, 328		1, 709, 328		1, 709, 328	
43. 00	04300 NURSERY	665, 201		665, 201		665, 201	
44. 00	04400 SKILLED NURSING FACILITY	1, 909, 674		1, 909, 674	0	1, 909, 674	44. 00
	ANCILLARY SERVICE COST CENTERS	T	Г	T .	T		
50. 00	05000 OPERATING ROOM	3, 164, 670	l	3, 164, 670	0	3, 164, 670	
	05100 RECOVERY ROOM	0	l	C	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	424, 085		424, 085		424, 085	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 276, 592		2, 276, 592	0	2, 276, 592	
54. 01	03630 ULTRA SOUND	0		0	0	0	54. 01
56. 00	05600 RADI OI SOTOPE	260, 358		260, 358	0	260, 358	
57. 00	05700 CT SCAN	0		0	0	0	57. 00
58.00	05800 MRI	0		0	0	0	58. 00
60.00	06000 LABORATORY	2, 437, 490	l	2, 437, 490		2, 437, 490	60.00
65. 00	06500 RESPI RATORY THERAPY	861, 887	0			861, 887	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 447, 009	0	1, 447, 009	0	1, 447, 009	
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	346, 823	l .	346, 823		346, 823	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	325, 759	l	325, 759		325, 759	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 125, 204		1, 125, 204	0	1, 125, 204	72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 688, 221		2, 688, 221	0	2, 688, 221	73.00
	03950 OTHER ANCILLARY SERVICE COST CENTER	0		4/4 7/4	0	0	76. 00
76. 01	03951 SLEEP LAB	164, 744		164, 744		164, 744	76. 01
76. 03	03953 WOUND CARE	75, 917		75, 917	0	75, 917	76. 03
00 00	OUTPATIENT SERVICE COST CENTERS	152.270		152.270	1	152.270	00.00
90.00	09000   CLI NI C   09100   EMERGENCY	153, 268		153, 268		,	
		1, 875, 119		1, 875, 119		.,,	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	1, 515, 616		1, 515, 616		1, 515, 616	92. 00
05 00			Γ			0	05 00
	09500 AMBULANCE SERVICES	0 702 000	l	20 702 000	0	0 28, 703, 900	95. 00
200. 00 201. 00	,	28, 703, 900 1, 515, 616	l e	28, 703, 900 1, 515, 616			
201.00	1	27, 188, 284	l e			1, 515, 616 27, 188, 284	
202. UU	Total (See Histinctions)	21, 100, 284	0	21, 100, 284	1	21, 100, 284	ZUZ. UU

From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 234, 275 9, 234, 275 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 994, 642 2, 994, 642 31.00 951, 666 04300 NURSERY 951, 666 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 3, 114, 990 3, 114, 990 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 901, 922 25, 022, 218 33, 924, 140 0.093287 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.719140 52.00 424.806 164.905 589.711 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.071993 0.000000 54.00 5, 207, 001 26, 415, 304 31, 622, 305 54 00 54.01 03630 ULTRA SOUND 0.000000 0.000000 54.01 56.00 05600 RADI OI SOTOPE 154, 987 908, 064 1, 063, 051 0. 244916 0.000000 56.00 05700 CT SCAN 0.000000 57.00 0.000000 57.00 58.00 05800 MRI 0 0 0.000000 0.000000 58.00 60.00 06000 LABORATORY 8, 415, 626 21, 861, 978 30, 277, 604 0.080505 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 3, 544, 002 250, 533 3, 794, 535 0. 227139 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 039, 948 0.239573 66.00 3, 201, 426 2, 838, 522 0.000000 66,00 67.00 06700 OCCUPATIONAL THERAPY C 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 823, 163 1, 345, 999 2, 169, 162 0. 159888 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 6, 959, 491 71.00 3, 758, 791 3, 200, 700 0.046808 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 444, 776 2, 049, 464 5, 494, 240 0.204797 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 564, 745 7, 844, 937 13, 409, 682 0.200469 0.000000 73.00 76 00 03950 OTHER ANCILLARY SERVICE COST CENTER C 0.000000 0.000000 76 00 0 03951 SLEEP LAB 76.01 0 564, 077 564,077 0.292059 0.000000 76.01 03953 WOUND CARE 346, 740 346, 740 0. 218945 0.000000 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 0.497777 0.000000 90.00 09000 CLI NI C 40, 471 267, 434 307, 905 91.00 09100 EMERGENCY 3, 086, 926 12, 912, 860 15, 999, 786 0.117197 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 358, 917 1,863,576 2, 222, 493 0.681944 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 95.00 09500 AMBULANCE SERVICES 0.000000 200.00 Subtotal (see instructions) 63, 223, 132 107, 857, 311 171, 080, 443 200.00 201.00 Less Observation Beds 201.00

63, 223, 132

107, 857, 311

171, 080, 443

202.00

202.00

Total (see instructions)

Health Financial Systems	BLUFFTON REGIONAL MED	OLCAL CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0075	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

NPATIENT ROUTINE SERVICE COST CENTERS   11.00   11.00   13.0					77 007 2010	2/28/2017 1:3	
Ratio   11.00				Title XVIII	Hospi tal	PPS	
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   03000   ADULTS & PEDI ATRICS   31.00   43.00   04300   NURSERY   43.00   44.00   04400   SKI LLED NURSING FACI LI TY   44.00   ANGU LLARY SERVICE COST CENTERS   50.00   50.00   05000   OPERATING ROOM   51.00   51.00   05100   RECOVERY ROOM   0.000000   51.00   52.00   05200   DELI VERY ROOM   51.00   54.00   05400   RADI OLOGY -DI AGNOSTIC   0.071993   54.00   54.01   05400   RADI OLOGY -DI AGNOSTIC   0.071993   54.00   55.00   05500   ADULTS A SOUND   0.000000   54.01   56.00   05600   RADI OLOGY -DI AGNOSTIC   0.071993   55.00   57.00   05700   CT SCAN   0.000000   57.00   58.00   05800   MRI   0.000000   57.00   60.00   06600   LaBORATORY   0.000000   57.00   60.00   06600   RESPI RATORY THERAPY   0.227139   65.00   60.00   06600   RESPI RATORY THERAPY   0		Cost Center Description	PPS Inpatient				
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   30.00   ADULTS & PEDI ATRI CS   31.00   31.00   31.00   INTENSI VE CARE UNIT   31.00   43.00   44.00   44.00   SKI LLED NURSING FACI LLITY   44.00   AVIOLED REVISION   44.00   AVIOLED REVISION   45.00   ADULTS & PEDI ATRI CS   44.00   AVIOLED REVISION   45.00   ADULTS & PEDI ATRI CS   45.00   ADULTS &			Ratio				
30. 00   03000   ADULTS & PEDIATRICS   31. 00   31. 00   03100   INTENSI VE CARE UNIT   31. 00   31. 00   04300   NURSERY   43. 00   44. 00   04400   SKI LLED NURSING FACILITY   44. 00   ARCILLARY SERVICE COST CENTERS   50. 00   05000   OPERATING ROOM   0. 093287   50. 00   05000   OPERATING ROOM   0. 0000000   51. 00   05100   RECOVERY ROOM   0. 0000000   51. 00   052. 00   052.00   DELIVERY ROOM & LABOR ROOM   0. 719140   52. 00   054. 00   054. 00   036. 00			11. 00				
31.00 03100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS					
43. 00   04300   NURSERY							30.00
44. 00    0.00   0.00   0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00   0.00   0.00     0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00   0.00   0.00     0.00	31.00	03100 INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS	43.00	04300 NURSERY					43.00
50. 00       05000   OPERATI NG ROOM       0.093287         51. 00       05100   RECOVERY ROOM       0.000000         52. 00       05200   DELI VERY ROOM & LABOR ROOM       0.719140         52. 00       05400   RADI OLOGY-DI AGNOSTI C       0.071993         54. 01       03630   ULTRA SOUND       0.000000         56. 00       05600   RADI OLOGY-DI AGNOSTI C       0.244916         57. 00       05700   CT SCAN       0.000000         57. 00       05700   CT SCAN       0.000000         58. 00       05800   MRI       0.000000         60. 00       06000   LABORATORY       0.808505         60. 00       06500   RESPI RATORY THERAPY       0.227139         66. 00       06500   RESPI RATORY THERAPY       0.239573         67. 00       06700   OCCUPATI ONAL THERAPY       0.239573         68. 00       69600   SPECH PATHOLOGY       0.000000         69. 00       06900   ELECTROCARDI OLOGY       0.000000         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.204797         72. 00       07200   IMPL DEV. CHARGED TO PATI ENTS       0.204797         73. 00       03950   OTHER ANCI LLARY SERVICE COST CENTER       0.000000         76. 01       03951   SLEEP LAB       0.292059 <td>44.00</td> <td>04400 SKILLED NURSING FACILITY</td> <td></td> <td></td> <td></td> <td></td> <td>44.00</td>	44.00	04400 SKILLED NURSING FACILITY					44.00
51. 00       05100       RECOVERY ROOM       0.000000       51. 00         52. 00       05200       DELI VERY ROOM & LABOR ROOM       0.719140       52. 00         54. 00       05400       RADIOLOGY-DI AGNOSTI C       0.071993       54. 01         56. 00       03630       ULTRA SOUND       0.000000       54. 01         56. 00       05600       RADI OI SOTOPE       0.244916       56. 00         57. 00       05700       CT SCAN       0.000000       57. 00         58. 00       05800       MRI       0.000000       58. 00         60. 00       06000       LABORATORY       0.080505       60. 00         65. 00       06500       RESPI RATORY THERAPY       0.239573       65. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       O6800       SPEECH PATHOLOGY       0.000000       67. 00         69. 00       O6900       ELECTROCARDI OLOGY       0.159888       69. 00         71. 00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.204797       72. 00         72. 00       O7200       IMPL. DEV. CHARGED TO PATI ENTS       0.20469       73. 00         76. 01       O3951 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52. 00       05200 DELIVERY ROOM & LABOR ROOM       0.719140       52. 00         54. 00       05400 RADI OLOGY-DI AGNOSTI C       0.071993       54. 00         54. 01       03630 ULTRA SOUND       0.000000       54. 01         56. 00       05600 RADI OLOGY-DI AGNOSTI C       0.000000       56. 00         57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         60. 00       06000 LABORATORY       0.080505       60. 00         66. 00       06500 RESPI RATORY THERAPY       0. 239573       65. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 239573       66. 00         68. 00       06800 SPEECH PATHOLOGY       0.000000       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0. 159888       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0. 204797       72. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0. 204797       72. 00         76. 01       03951 SLEEP LAB       0. 292059       76. 01         76. 03       03953 WOUND CARE       0. 218945       76. 03         90. 00       09000 CLI NI C       0. 497777       90. 00			0. 093287				50.00
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0.071993       54. 00         54. 01       03630       ULTRA SOUND       0.000000       54. 01         56. 00       05600       RADI OI SOTOPE       0.244916       56. 00         57. 00       05700       CT SCAN       0.000000       57. 00         58. 00       05800       MRI       0.000000       58. 00         60. 00       06000       LABORATORY       0.080505       60. 00         65. 00       06500       RESPI RATORY THERAPY       0.227139       65. 00         66. 00       06700       OCUPATI ONAL THERAPY       0.239573       66. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0.000000       68. 00         68. 00       06800       SPECH PATHOLOGY       0.000000       68. 00         69. 00       06900       ELECTROCARDI OLOGY       0.159888       69. 00         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.046808       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.204797       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.204797       72. 00         76. 01	51.00	05100 RECOVERY ROOM	0. 000000				51.00
54. 01 03630 ULTRA SOUND 0.000000 54. 01 56. 00 05600 RADI OI SOTOPE 0.244916 56. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 58. 00 60. 00 06000 LABORATORY 0.080505 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.227139 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.227139 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.159888 69. 00 71. 00 07700 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.046808 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.204797 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.20469 73. 00 76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0.000000 76. 01 03951 SLEEP LAB 0.292059 76. 01 76. 01 03951 SLEEP LAB 0.292059 76. 01 76. 01 03951 SLEEP LAB 0.292059 76. 01 77. 00 09000 CLI NI C 0.49777 91. 00 90. 00 09000 CLI NI C 0.497777 91. 00 91. 00 09000 CLI NI C 0.497777 91. 00 91. 00 09000 CLI NI C 0.497777 91. 00 91. 00 09000 CLI NI C 0.497777 91. 00 91. 00 09000 CLI NI C 0.497777 91. 00 91. 00 09000 EMERGENCY 0.117197 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.681944 92. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 719140				52. 00
56. 00       05600 RADIOI SOTOPE       0. 244916       56. 00         57. 00       05700 CT SCAN       0. 000000       57. 00         58. 00       05800 MRI       0. 000000       58. 00         60. 00       06000 LABORATORY       0. 080505       60. 00         65. 00       06500 RESPI RATORY THERAPY       0. 227139       65. 00         66. 00       06600 PHYSI CAL THERAPY       0. 239573       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0. 000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0. 159888       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0. 046808       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0. 204797       72. 00         76. 00       03950 OTHER ANCI LLARY SERVICE COST CENTER       0. 000000       76. 01         76. 01       03951 SLEEP LAB       0. 292059       76. 01         76. 03       03953 WOUND CARE       0. 218945       76. 03         0UTPATI ENT SERVICE COST CENTERS       0. 117197       90. 00         90. 00       09000 CLI NI C       0. 497777       91. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 071993				54.00
57. 00	54. 01	03630 ULTRA SOUND	0. 000000				54. 01
58. 00       05800 MRI       0.000000       58. 00         60. 00       06000 LABORATORY       0.080505       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.227139       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.239573       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.159888       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.046808       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.204797       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.200469       73. 00         76. 00       03950 OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       76. 00         76. 01       03951 SLEEP LAB       0.292059       76. 01         76. 03       03953 WOUND CARE       0.218945       76. 03         0UTPATI ENT SERVI CE COST CENTERS       0.218945       76. 03         00 09000 CLI NI C       0.497777       91. 00         91. 00       09100 EMERGENCY       0.117197       91. 00         92. 00	56.00	05600 RADI OI SOTOPE	0. 244916				56. 00
60. 00	57.00	05700 CT SCAN	0. 000000				57. 00
65. 00   06500   RESPI RATORY THERAPY   0. 227139   65. 00   06600   PHYSI CAL THERAPY   0. 239573   66. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 000000   68. 00   06900   ELECTROCARDI OLOGY   0. 159888   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 046808   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 204797   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 204797   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 200469   73. 00   76. 00   03950   OTHER ANCI LLARY SERVI CE COST CENTER   0. 000000   76. 01   03951   SLEEP LAB   0. 292059   76. 01   03953   WOUND CARE   0. 218945   76. 03   00000   CLI NI C   0. 218945   76. 03   000000   000000	58.00	05800 MRI	0. 000000				58. 00
66. 00   06600   PHYSI CAL THERAPY   0. 239573   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 000000   68. 00   06900   ELECTROCARDI OLOGY   0. 159888   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 046808   71. 00   7200   IMPL. DEV. CHARGED TO PATI ENTS   0. 204797   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 204797   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 200469   73. 00   76. 01   03951   SLEEP LAB   0. 292059   76. 01   03953   WOUND CARE   0. 292059   76. 01   03953   WOUND CARE   0. 218945   76. 03   000000   00000   000000   000000   000000	60.00	06000 LABORATORY	0. 080505				60.00
67. 00	65.00	06500 RESPI RATORY THERAPY	0. 227139				65. 00
68. 00   06800   SPEECH PATHOLOGY   0.000000   68. 00   69. 00   69. 00   69. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   75. 00   7	66.00	06600 PHYSI CAL THERAPY	0. 239573				66. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 159888   69. 00   71. 00   771. 00   771. 00   771. 00   772. 00	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
71. 00	68.00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 204797   73. 00   7300   DRUGS CHARGED TO PATIENTS   0. 200469   73. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER   0. 000000   76. 01   03951   SLEEP LAB   0. 292059   76. 01   03953   WOUND CARE   0. 218945   76. 03   0100000   01000000   0100000000000	69.00	06900 ELECTROCARDI OLOGY	0. 159888				69. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 200469   73. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER   0. 000000   76. 01   03951   SLEEP LAB   0. 292059   76. 01   03953   WOUND CARE   0. 218945   76. 03   00179ATIENT SERVICE COST CENTERS   0. 218945   76. 03   00179ATIENT SERVICE COST CENTERS   0. 497777   90. 00   09100   EMERGENCY   0. 117197   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 681944   92. 00   09200   08568   0. 2000   0. 20	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 046808				71. 00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTER 0. 000000 76. 01 03951 SLEEP LAB 0. 292059 76. 01 03953 WOUND CARE 0. 218945 76. 03 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 00 09100 EMERGENCY 0. 117197 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 681944 92. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 204797				72. 00
76. 01   03951   SLEEP LAB   0. 292059   76. 01   76. 03   76. 01   76. 03   76. 01   76. 03	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 200469				73. 00
76. 03   03953   WOUND CARE   0. 218945   76. 03	76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76. 00
OUTPATI ENT SERVI CE COST CENTERS           90. 00         09000 CLI NI C         0. 497777         90. 00           91. 00         09100 EMERGENCY         0. 117197         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0. 681944         92. 00	76. 01	03951 SLEEP LAB	0. 292059				76. 01
90. 00   09000   CLI NI C   0. 497777   90. 00 91. 00   09100   EMERGENCY   0. 117197   91. 00 92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0. 681944   92. 00	76. 03	03953 WOUND CARE	0. 218945				76. 03
91. 00   09100   EMERGENCY   0. 117197   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0. 681944   92. 00		OUTPATIENT SERVICE COST CENTERS					
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0. 681944   92. 00	90.00	09000 CLI NI C	0. 497777				90.00
	91.00	09100 EMERGENCY	0. 117197				91.00
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 681944				92. 00
OTHER REIMBURSABLE COST CENTERS		OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00	95.00		0. 000000				95. 00
200.00 Subtotal (see instructions) 200.00	200.00	Subtotal (see instructions)					200.00
201. 00 Less Observation Beds 201. 00		,					
202.00 Total (see instructions) 202.00		l l					

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0075	Peri od: From 10/01/2015	Worksheet C Part I

Total Cost   Tot						From 10/01/2015 To 09/30/2016	Part I Date/Time Pre 2/28/2017 1:3	
NPATIENT ROUTINE SERVICE COST CENTERS				Titl	e XIX	Hospi tal		
CFrom Wisst. B, Part I, col. 260   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   3.00				·		Costs		
CFrom Wisst. B, Part I, col. 260   2.00   3.00   4.00   5.00   2.00   3.00   4.00   5.00   3.00		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00			(from Wkst. B,			Di sal I owance		
INPATI ENT ROUTI NE SERVICE COST CENTERS   1,00   2,00   3,00   4,00   5,00								
NPATI ENT ROUTI NE SERVICE COST CENTERS								
30. 00 03000   ADULTS & PEDI ATRICS   5, 276, 935   5, 276, 935   0 5, 276, 935   0 0. 00   31. 00 03100   INTENSI YE CARE UNIT   1, 709, 328   1, 709, 328   0 1, 709, 328   31, 300   43. 00 04300   NURSERY   665, 201   665, 201   0 665, 201   43. 00   44. 00   04400   SKI LLED NURSING FACILLITY   1, 909, 674   1, 909, 674   0 1, 909, 674   44. 00   04400   SKI LLED NURSING FACILLITY   1, 909, 674   1, 909, 674   0 1, 909, 674   44. 00   04400   SKI LLED NURSING FACILLITY   1, 909, 674   1, 909, 674   0 0 1, 909, 674   44. 00   04400   SKI LLED NURSING FACILLITY   1, 909, 674   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	
31. 00   03100   INTENSI VE CARE UNIT								
43.00   04300   NURSERY   665, 201   1,909, 674   0   1,909, 674   44.00								
A4400   A400   SKILLED NURSI NG FACILITY   1,909,674   1,909,674   ANOI LLARY SERVICE COST CENTERS								
ANCI LLARY SERVI CE COST CENTERS								
50.00     05000     DERATTING ROOM   3, 164, 670   0   0   3, 164, 670   0   0   0   51.00	44. 00		1, 909, 674		1, 909, 67	4 0	1, 909, 674	44. 00
51.00     05100   RECOVERY ROOM     0   0   0   0   0   51.00   52.00   05200   DELI VERY ROOM & LABOR ROOM     424,085     424,085     424,085     0   424,085     0   424,085     0   51.00     0   0   0   0   0   0   0   0			1					
52. 00         05200   DELI VERY ROOM & LABOR ROOM         424, 085   22, 276, 592   0         424, 085   52, 00           54. 01         03630   ULTRA SOUND         0         0         0         0         54, 01           56. 00         05600   RADI OLSOTOPE         260, 358   260, 358   260, 358   0         260, 358   56, 00         0         0         0         0         57, 00         0         0         0         0         0         57, 00         0         0         0         0         0         0         57, 00         0         0         0         0         0         0         57, 00         0         0         0         0         0         0         0         0         57, 00         0         0         0         0         0         57, 00         0         0         0         0         0         57, 00         0         0         0         0         0         0         57, 00         0			1		3, 164, 67	0		
54.00   05400   RADI OLOGY-DI AGNOSTI C   2, 276, 592   0   2, 276, 592   0   0   0   0   0   0   0   0   0						0		
54. 01   03630   ULTRA SOUND   0   0   0   54. 01								
S6. 00			2, 276, 592		2, 276, 59	2 0		1
57. 00         05700 CT SCAN         0         0         0         0         57. 00           58. 00         05800 MRI         0         0         0         0         0         58. 00           60. 00         06000 LABORATORY         2, 437, 490         2, 437, 490         0         2, 437, 490         0         2, 437, 490         0 <td></td> <td></td> <td>0</td> <td></td> <td>2/0.25</td> <td>0</td> <td>_</td> <td></td>			0		2/0.25	0	_	
S8.00   OS800   MRI			260, 358		260, 35	8 0		•
60. 00			0			0	0	
65. 00 06500 RESPIRATORY THERAPY			2 427 400		2 427 40	0	2 427 400	
66. 00   06600   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06800   SPEECH PATHOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
67. 00								
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   346, 823   346, 823   346, 823   0   346, 823   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   325, 759   325, 759   0   325, 759   71. 00   72. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1, 125, 204   1, 125, 204   0   1, 125, 204   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 688, 221   2, 688, 221   0   2, 688, 221   73. 00   76. 00   3950   OTHER ANCI LLARY SERVI CE COST CENTER   0   0   0   76. 00   76. 00   76. 00   76. 01   75, 917   75, 917   75, 917   75, 917   75, 917   76. 03   75, 917   75. 03   75, 917   75. 03   75, 917   75, 917   75, 917   75, 917   75, 917   76. 03   75, 917   75, 917   76. 03   75, 917   75, 917   76. 03   75, 917   76. 03   75, 917   76. 03   75, 917   76. 03   75, 917   76. 03   75, 917   76. 03   75, 917   76.			1, 447, 009	0	1, 447, 00	0		
69. 00   06900   ELECTROCARDI OLOGY   346, 823   346, 823   346, 823   0   346, 823   69. 00   71. 00   7100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   325, 759   325, 759   0   325, 759   71. 00   72. 00   72. 00   72. 00   72. 00   73. 00   74.				0		0	_	
71. 00		l l	246 922	0	246 02	2 0	· ·	l
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   1, 125, 204   1, 125, 204   0   1, 125, 204   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 688, 221   2, 688, 221   0   2, 688, 221   73. 00   76. 00   0   0   0   76. 00   0   0   76. 00   0   0   76. 00   0   0   76. 00   0   0   76. 00   0   0   0   76. 00   0   0   0   0   0   0   0   0   0		l						•
73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 688, 221   2, 688, 221   0   2, 688, 221   73. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER   0   0   0   0   0   76. 00   076. 00   0   0   0   0   0   0   0   0   0								
76. 00 03950 OTHER ANCI LLARY SERVI CE COST CENTER 0 0 0 0 0 76. 00 76. 00 76. 01 03951 SLEEP LAB 164, 744 164, 744 0 164, 744 0 164, 744 0 76. 01 76. 03 03953 WOUND CARE 75, 917 75, 917 0 75, 917 76. 03 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0								
76. 01 03951 SLEEP LAB 164, 744 176. 01 76. 03 03953 WOUND CARE 75, 917 75, 917 0 75, 917 76. 03 03953 WOUND CARE 75, 917 76. 03 0000 CLI NI C 153, 268 153, 268 0 153, 268 90. 00 9100 EMERGENCY 1, 875, 119 1, 875, 119 1, 875, 119 0 1, 875, 119 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 515, 616 201. 00 201. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 200. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 200. 00 201. 00 20			2,000,221		2,000,22			
76. 03 03953 WOUND CARE 75, 917 75, 917 0 75, 917 76. 03 0UTPATI ENT SERVICE COST CENTERS  90. 00 09000 CLINIC 153, 268 153, 268 0 153, 268 90. 00 9100 EMERGENCY 1, 875, 119 1, 875, 119 0 1, 875, 119 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 515, 616 1, 515, 616 1, 515, 616 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 515, 616 0 0 0 0 0 0 95. 00 0			164 744		164 74	4	J	•
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         153, 268         153, 268         0         153, 268         90. 00           91. 00         09100 EMERGENCY         1, 875, 119         1, 875, 119         0         1, 875, 119         91. 00           92. 00         09200 OBSEVATION BEDS (NON-DISTINCT PART Non-DISTINCT PART NO								
90. 00   09000   CLI NI C   153, 268   153, 268   0   153, 268   90. 00   91. 00   91. 00   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   1, 515, 616   1, 515, 616   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   1, 515, 616   1, 515, 616   92. 00   095.	70.00		70,717		70,71	, , , , , , , , , , , , , , , , , , , ,	70, 717	70.00
91. 00   09100   EMERGENCY   1, 875, 119   1, 875, 119   0   1, 875, 119   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   1, 515, 616   1, 515, 616   1, 515, 616   92. 00   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   95. 00   09	90 00		153 268		153 26	8 0	153 268	90 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   1,515,616   1,515,616   1,515,616   92. 00   0THER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   95. 00   200. 00   Subtotal (see instructions)   28,703,900   0   28,703,900   0   28,703,900   0   28,703,900   201. 00   Less Observation Beds   1,515,616   201. 00   0   0   0   0   0   0   0   0   0								
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         0         0         0         95. 00           200. 00         Subtotal (see instructions)         28, 703, 900         0         28, 703, 900         0         28, 703, 900         0         28, 703, 900         200. 00           201. 00         Less Observation Beds         1, 515, 616         1, 515, 616         1, 515, 616         201. 00								1
95. 00   O9500   AMBULANCE SERVICES   O   O   O   O   95. 00   O   O   O   O   O   O   O   O   O			.,		., .,	-	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
200.00     Subtotal (see instructions)     28, 703, 900     0     28, 703, 900     0     28, 703, 900     0     28, 703, 900     0     28, 703, 900     200. 00       201.00     Less Observation Beds     1, 515, 616     1, 515, 616     1, 515, 616     201. 00			0			0 0	0	95. 00
201.00 Less Observation Beds 1,515,616 1,515,616 1,515,616 201.00			28, 703, 900	0	28, 703, 90	ol ol	28, 703, 900	
	202.00	Total (see instructions)	27, 188, 284				27, 188, 284	202. 00

From 10/01/2015 Part I 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 9, 234, 275 9, 234, 275 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 994, 642 2, 994, 642 31.00 951, 666 04300 NURSERY 951, 666 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 3, 114, 990 3, 114, 990 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 901, 922 25, 022, 218 33, 924, 140 0.093287 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.719140 52.00 424.806 164.905 589.711 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.071993 0.000000 54.00 5, 207, 001 26, 415, 304 31, 622, 305 54 00 54.01 03630 ULTRA SOUND 0.000000 0.000000 54.01 56.00 05600 RADI OI SOTOPE 154, 987 908, 064 1, 063, 051 0. 244916 0.000000 56.00 05700 CT SCAN 0.000000 57.00 0.000000 57.00 58.00 05800 MRI 0 0 0.000000 0.000000 58.00 60.00 06000 LABORATORY 8, 415, 626 21, 861, 978 30, 277, 604 0.080505 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 3, 544, 002 250, 533 3, 794, 535 0. 227139 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 039, 948 0.239573 66.00 3, 201, 426 2, 838, 522 0.000000 66,00 67.00 06700 OCCUPATIONAL THERAPY C 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 823, 163 1, 345, 999 2, 169, 162 0. 159888 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 6, 959, 491 71.00 3, 758, 791 3, 200, 700 0.046808 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 444, 776 2, 049, 464 5, 494, 240 0.204797 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 564, 745 7, 844, 937 13, 409, 682 0.200469 0.000000 73.00 76 00 03950 OTHER ANCILLARY SERVICE COST CENTER C 0.000000 0.000000 76 00 0 03951 SLEEP LAB 76.01 0 564, 077 564,077 0.292059 0.000000 76.01 03953 WOUND CARE 346, 740 346, 740 0. 218945 0.000000 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 90.00 0.497777 0.000000 90.00 09000 CLI NI C 40, 471 267, 434 307, 905 91.00 09100 EMERGENCY 3, 086, 926 12, 912, 860 15, 999, 786 0.117197 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 358, 917 1,863,576 2, 222, 493 0.681944 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 95.00 09500 AMBULANCE SERVICES 0.000000

63, 223, 132

63, 223, 132

107, 857, 311

107, 857, 311

171, 080, 443

171, 080, 443

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0075	Peri od: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm
	T1.11 V1.V		0 1

Cost Center Description					2/28/2017 1: 33	B pm
INPATI ENT ROUTINE SERVICE COST CENTERS   11.00			Title XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   33.00   3300   ADULTS & PEDIATRICS   30.00   33.00   3300   ADULTS & PEDIATRICS   31.00   33.00   3	Cost Center Description	PPS Inpatient				
INPATIENT ROUTH RESERVICE COST CENTERS   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   31.						
30.00		11. 00				
31.00   03100   INTENSIVE CARE UNIT						
43. 00   04300   NURSERY	· · · · · · · · · · · · · · · · · · ·					
44. 00						
ANCI LLARY SERVI CE COST CENTERS						
50. 00   05000   OPERATI ING ROOM   0. 000000   51. 00   051.00   051.00   051.00   051.00   051.00   051.00   052.00   DELI VERY ROOM   0. 000000   0. 000000   52. 00   052.00   DELI VERY ROOM   8. LABOR ROOM   0. 000000   052.00   054.00   RADI OLGGY-DI AGNOSTI C   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000						44.00
51.00   05100   RECOVERY ROOM   0.000000   52.00   05200   0						
52.00   05200   DELI VERY ROM & LABOR ROOM   0.000000   54.01     54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   54.01     56.00   05600   RADI OLOGY-DI AGNOSTI C   0.000000   54.01     56.00   05600   RADI OLOGY-DI AGNOSTI C   0.000000   55.00     57.00   05700   05700   05700   05700   05700   05700   05700     58.00   05800   MRI   0.000000   55.00     60.00   06500   RADI OLOGY-DI HERAPY   0.000000   06.00     65.00   06500   RSPI RATORY THERAPY   0.000000   06.00     65.00   06500   RSPI RATORY THERAPY   0.000000   06.00     66.00   06600   DHYSI CAL THERAPY   0.000000   06.00     67.00   06700   0CCUPATI ONAL THERAPY   0.000000   06.00     68.00   06600   PEECH PATHOLOGY   0.000000   06.00     69.00   06900   ELECTROCARDI OLOGY   0.000000   06.00     69.00   06900   ELECTROCARDI OLOGY   0.000000   06.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.000000   07.20     72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.000000   07.00     73.00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   07.00     76.01   03951   SLEEP LAB   0.000000   07.00     76.01   03951   SLEEP LAB   0.000000   0.00000   0.00000     76.01   03951   SLEEP LAB   0.000000   0.00000   0.00000     76.01   03951   SLEEP LAB   0.000000   0.000000   0.00000   0.000000     76.01   03951   SLEEP LAB   0.0000000   0.000000   0.000000   0.000000     76.01   03951   SLEEP LAB   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000						
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   54. 01   03630   ULTRA SOUND   0.000000   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0.000000   55. 00   05600   RADI OLOGY-DI SOCOPE   0.000000   55. 00   05700   CT SCAN   0.000000   57. 00   05800   MRI   0.000000   60. 00   06000   LABORATORY   0.000000   65. 00   06500   RESPI RATORY THERAPY   0.000000   65. 00   06500   RESPI RATORY THERAPY   0.000000   65. 00   06600   PHYSI CAL THERAPY   0.000000   67. 00   06600   PHYSI CAL THERAPY   0.000000   67. 00   06700   0CUPATI ONAL THERAPY   0.000000   67. 00   06700   0CUPATI ONAL THERAPY   0.000000   67. 00   06900   ELECTROCARDI OLOGY   0.000000   68. 00   06900   ELECTROCARDI OLOGY   0.000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   76. 00   03951   SLEEP LAB   0.000000   76. 01   03951   SLEEP LAB   0.000000   0.000000   76. 01   03951   SLEEP LAB   0.000000   0.000000   76. 01   07000   MEDICAL SUPPLIES CHARGED TO PATI ENTS   0.0000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		I I				
54. 01   03630   ULTRA SOUND   0.000000   54. 01     56. 00   05600   RADI OI SOTOPE   0.000000   55. 00     57. 00   05700   CT SCAN   0.000000   57. 00     58. 00   05800   MRI   0.000000   58. 00     60. 00   06000   LABORATORY   0.000000   65. 00     65. 00   06500   RESPI RATORY THERAPY   0.000000   66. 00     66. 00   06500   RESPI RATORY THERAPY   0.000000   66. 00     67. 00   06700   OCCUPATI ONAL THERAPY   0.000000   67. 00     68. 00   06800   SPECH PATHOLOGY   0.000000   68. 00     69. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   71. 00     72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.000000   72. 00     73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   73. 00     76. 01   03951   SLEEP LAB   0.000000   76. 01     76. 01   03951   SLEEP LAB   0.000000   91. 00     91. 00   09000   EMERGENCY   0.000000   91. 00     92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   0.000000   91. 00     92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.00000000		I I				
56. 00   05600   RADI OI SOTOPE   0.000000   55. 00   57. 00   5700   CT SCAN   0.000000   57. 00   58. 00   05800   MRI   0.000000   58. 00   06800   MRI   0.000000   60. 00   60.	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000				
57. 00       05700 CT SCAN       0.000000       57. 00         58. 00       05800 MRI       0.000000       58. 00         60. 00       06500 LABORATORY       0.000000       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPEECH PATHOLOGY       0.00000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATIENT       0.000000       71. 00         72. 00       07200 I IMPL. DEV. CHARGED TO PATIENTS       0.000000       72. 00         73. 00       07300 DRUGS CHARGED TO PATIENTS       0.000000       73. 00         76. 01       03950 OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       76. 01         76. 03       03953 WOUND CARE       0.000000       76. 01         90. 00       P9000 EMERGENCY       0.000000       91. 00         90. 00       P9000 EMERGENCY       0.000000       91. 00         95. 00       OPSOO AMBULANCE SERVI CES       0.000000       92. 00	54. 01   03630   ULTRA SOUND	0. 000000				54. 01
58. 00       05800 MRI       0.000000       58. 00         60. 00       06000 LABORATORY       0.000000       60. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPECH PATHOLOGY       0.000000       68. 00         69. 00       06900 ELECTROCARDI OLOGY       0.000000       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300 D RUGGS CHARGED TO PATI ENTS       0.000000       73. 00         76. 01       03950 OTHER ANCI LLARY SERVI CE COST CENTER       0.000000       76. 00         76. 01       03951 SLEEP LAB       0.000000       76. 01         70. 03       03953 WOUND CARE       0.000000       76. 03         90. 00       09000 CLI NI C       0.000000       90. 00         91. 00       09000 EMERGENCY       0.000000       91. 00         92. 00       09200 DESERVATI ON BEDS (NON-DI STI NCT PART O.000000)       92. 00	56. 00   05600   RADI 0I SOTOPE	0. 000000				
60. 00   06000   LABORATORY   0. 000000   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 00   67. 00   06700   0cCUPATI ONAL THERAPY   0. 000000   67. 00   06. 00	57. 00   05700   CT   SCAN	0. 000000				57.00
65. 00	58. 00   05800   MRI	0. 000000				58.00
66. 00	60. 00   06000   LABORATORY	0. 000000				60.00
67. 00	65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00   71. 00   771. 00   771. 00   771. 00   772. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 075. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73. 00   76. 00   03950   OTHER ANCILLARY SERVICE COST CENTER   0.000000   76. 01   03951   SLEEP LAB   0.000000   76. 01   03953   WOUND CARE   0.000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   0000000   76. 03   00000000   76. 03   00000000   76. 03   000000000000   76. 03   000000000000000000000000000000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
76. 01 03951 SLEEP LAB 0. 000000 76. 03 03953 WOUND CARE 0. 0000000 76. 03 0000000 76. 03 000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000 76. 03 0000000000000000000000000000000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 03   03953   WOUND CARE   0.000000   76. 03	76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS   O. 0000000   90. 00   90. 00   90. 00   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00	76. 01   03951   SLEEP LAB	0. 000000				76. 01
90. 00   09000   CLI NI C   0.000000   91. 00   09100   EMERGENCY   0.000000   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   92. 00   OTHER REI MBURSABLE COST CENTERS   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   0.000000   95. 00   OSSERVATI ON BEDS (NON-DI STI NCT PART   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.0000000   0.000000   0.0000000   0.0000000   0.00000000	76. 03   03953   WOUND CARE	0. 000000				76.03
91. 00   09100   EMERGENCY   0.000000   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	OUTPATIENT SERVICE COST CENTERS					
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0THER REIMBURSABLE COST CENTERS   95. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   92. 00   201. 00   0.000000   0.000000   0.0000000   0.00000000	90. 00 09000 CLI NI C	0. 000000				90.00
OTHER REI MBURSABLE COST CENTERS   95.00   995.00   AMBULANCE SERVI CES   0.000000   95.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	91. 00   09100   EMERGENCY	0. 000000				91.00
95. 00   09500   AMBULANCE SERVICES   0.000000   95. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00	OTHER REIMBURSABLE COST CENTERS	·				
201. 00 Less Observation Beds 201. 00	95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
	200.00 Subtotal (see instructions)				2	200. 00
202. 00   Total (see instructions)   202. 00	201.00 Less Observation Beds				2	201. 00
	202.00 Total (see instructions)				2	202. 00

Health Financial Systems	BLUFFTON REGIONAL	MEDICAL CENTE	R	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2015 To 09/30/2016		nared.
					2/28/2017 1: 3	3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col	•		
	26)	0.00	2)	4.00	F 00	
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	457,000	I	457.00	0 5 120	00.00	20.00
30. 00 ADULTS & PEDIATRICS	456, 839		100,00	· ·		
31. 00 INTENSIVE CARE UNIT	90, 914	l .	90, 91			
43. 00 NURSERY	17, 565	l .	17, 56		•	
44.00 SKILLED NURSING FACILITY	182, 733	l .	182, 73	· ·	•	
200. 00 Total (lines 30-199)	748, 051		748, 05	1 9, 736		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		6)				
	6, 00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	1, 777	157, 975				30.00
31. 00 INTENSIVE CARE UNIT	371	35, 505				31.00
43. 00 NURSERY	]	35,500				43. 00
44.00 SKILLED NURSING FACILITY	1, 604	97, 603				44. 00
200. 00 Total (lines 30-199)	3, 752					200. 00
200.00 .000. (00.00 177)	1 0,702	271,000	11			1200.00

	UFFTON REGIONAL				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2015 To 09/30/2016		
				To 09/30/2016	Date/Time Pre 2/28/2017 1:3	
		Title	: XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
'	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	343, 597	33, 924, 140	0. 01012	8 2, 569, 263	26, 021	50.00
51.00   05100   RECOVERY ROOM	0	0	0.00000		0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	15, 699	589, 711	0. 02662	2, 799	75	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	233, 702	31, 622, 305	0. 00739	0 2, 057, 951	15, 208	54.00
54.01   03630   ULTRA SOUND	0	0	0.00000		0	54. 01
56. 00   05600   RADI 0I SOTOPE	15, 666	1, 063, 051	0. 01473	78, 136	1, 151	56. 00
57.00  05700 CT SCAN	0	0	0.00000		0	57. 00
58. 00   05800   MRI	0	0	0.00000	0	0	58. 00
60. 00   06000   LABORATORY	141, 564	30, 277, 604	0. 00467			60.00
65. 00 06500 RESPIRATORY THERAPY	104, 361	3, 794, 535	0. 02750	3 1, 412, 456	38, 847	65. 00
66. 00   06600 PHYSI CAL THERAPY	106, 135	6, 039, 948	0. 01757	2 275, 769	4, 846	66. 00
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0 0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	20, 249	2, 169, 162	0.00933	5 754, 032	7, 039	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 016	6, 959, 491	0. 00287	6 1, 351, 347	3, 886	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	71, 528	5, 494, 240	0. 01301	9 1, 929, 918	25, 126	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 096	13, 409, 682	0. 00604	8 1, 856, 422	11, 228	73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.00000	0 0	0	76. 00
76. 01   03951   SLEEP LAB	8, 696	564, 077	0. 01541	6 0	0	76. 01
76.03 03953 WOUND CARE	1, 419	346, 740	0. 00409	2 0	0	76. 03
OUTDATIENT SERVICE COST CENTERS	·	·	·	·	·	

21, 422 123, 882 131, 211

1, 440, 243

307, 905 15, 999, 786 2, 222, 493

154, 784, 870

0. 069573 0. 007743 0. 059038

10, 186 1, 351, 190

17, 106, 433

193, 465

90.00 91. 00 92. 00

95.00

709

171, 280 200. 00

10, 462

11, 422

OUTPATIENT SERVICE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

90. 00 | 09000 | CLINI C | 91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DISTINCT PART | OTHER REIMBURSABLE COST CENTERS | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 09200 | 0920

Health Financial Systems BLU	JFFTON REGIONAL	MEDICAL CENTE	R	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period: From 10/01/2015 To 09/30/2016		
		Title	XVIII	Hospi tal	PPS	<u> 5 piii                                </u>
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
43. 00   04300   NURSERY	0	0		0	0	43.00
44.00   04400   SKILLED NURSING FACILITY	0	0	)		0	44. 00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.		I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1		1	_		
30. 00   03000   ADULTS & PEDI ATRI CS	5, 139					30.00
31. 00   03100   INTENSIVE CARE UNIT	950			1 0		31. 00
43. 00   04300   NURSERY	644		1	0		43. 00
44.00 04400 SKILLED NURSING FACILITY	3, 003					44. 00
200.00   Total (lines 30-199)	9, 736		3, 75	2 0	l	200. 00

Health Financial Systems	BLUFFTON REGIONAL ME	EDICAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0075	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2015	Part IV

09/30/2016 Date/Time Prepared: To 2/28/2017 1:33 pm Title XVIII 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 50.00 05000 OPERATING ROOM 0 50.00 0 0 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 03630 ULTRA SOUND 0 54.01 0 54.01 0 05600 RADI OI SOTOPE 0 56.00 0 56.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MRI 0 58.00 06000 LABORATORY 0 60.00 0 0 60.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 76.00 03950 OTHER ANCILLARY SERVICE COST CENTER 0 0 0 76.00 03951 SLEEP LAB 0 76.01 0 0 76.01 03953 WOUND CARE 0 ol 76. 03 76.03 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 90.00 0 0 91.00 91.00 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 200.00 Total (lines 50-199) 0 0 200.00

	<i></i>	UFFTON REGIONAL				u of Form CMS-2	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od: From 10/01/2015	Worksheet D Part IV	
THROUG	GH COSTS				To 09/30/2016		pared:
						2/28/2017 1:3	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			Inpati ent	
			(from Wkst. C,		Ratio of Cost		
		Cost (sum of				Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)	7.00		7)	40.00	
	ANOLLI ADV. CEDVI CE COCT. CENTERO	6. 00	7. 00	8. 00	9. 00	10.00	
F0 00	ANCILLARY SERVICE COST CENTERS		00 004 440	0.0000	0.00000	0.5/0.0/0	F0 00
50.00	05000 OPERATING ROOM	0	33, 924, 140	l .		2, 569, 263	
51.00	05100 RECOVERY ROOM	0	500 744	0.00000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	589, 711	l .		2, 799	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	31, 622, 305			2, 057, 951	54.00
54. 01	03630 ULTRA SOUND	0	4 0/0 054	0.00000		0	54. 01
56.00	05600 RADI OI SOTOPE	0	1, 063, 051	l .		78, 136	56.00
57.00	05700 CT SCAN	0	0	0.00000		0	57. 00
58.00	05800 MRI	0	0 077 (04	0.00000		0	58.00
60.00	06000 LABORATORY	0	30, 277, 604			3, 263, 499	60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 794, 535			1, 412, 456	
66.00	06600 PHYSI CAL THERAPY	0	6, 039, 948			275, 769	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.00000		0	67. 00 68. 00
68.00	06800 SPEECH PATHOLOGY	0	0 4/0 4/0	0.00000		0	
	06900 ELECTROCARDI OLOGY	0	2, 169, 162				69.00
71.00			6, 959, 491			1, 351, 347	
72.00			5, 494, 240	l .		1, 929, 918	
73.00	07300 DRUGS CHARGED TO PATIENTS		13, 409, 682	l .		1, 856, 422	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER		[	0.00000		0	76.00
76. 01	03951 SLEEP LAB		564, 077	l .		0	76. 01
76. 03	03953 WOUND CARE OUTPATIENT SERVICE COST CENTERS	1 0	346, 740	0.00000	0. 000000	0	76. 03
	DUTPATIENT SERVICE COST CENTERS						I

0

307, 905 15, 999, 786

154, 784, 870

2, 222, 493

0.000000

0. 000000 0. 000000 0.000000

0. 000000 0. 000000 10, 186

1, 351, 190

193, 465

95. 00 17, 106, 433 200. 00

90.00

91. 00

92.00

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

95. 00 | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	BLUFFTON REGIONAL ME	DICAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provider CCN: 15-0075	Peri od: From 10/01/2015	Worksheet D
THROUGH COSTS				Date/Time Prepared

				0 09/30/2016	2/28/2017 1:3	
		Title	XVIII	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	5, 395, 264		)		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	6, 049, 972				54.00
54. 01   03630   ULTRA SOUND	0	0	(			54. 01
56. 00   05600   RADI 0I SOTOPE	0	356, 692	· C			56. 00
57. 00   05700   CT   SCAN	0	0	(			57. 00
58. 00   05800   MRI	0	0	(			58. 00
60. 00   06000   LABORATORY	0	2, 288, 588	c c			60.00
65. 00 06500 RESPIRATORY THERAPY	0	86, 176	(			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	26, 959	(			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(			68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	527, 696				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	622, 794				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	604, 137	1 0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 388, 679	·l c			73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	o	0	·			76. 00
76. 01 03951 SLEEP LAB	o	164, 016				76. 01
76. 03 03953 WOUND CARE	0	108, 376				76. 03
OUTPATIENT SERVICE COST CENTERS	<u>'</u>			"		
90. 00 09000 CLI NI C	0	48, 522		)		90.00
91. 00 09100 EMERGENCY	o	2, 554, 513	d			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	351, 532				92.00
OTHER REIMBURSABLE COST CENTERS	'		•	•		
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	0	21, 573, 916	d			200. 00

Health Financial Systems	BLUFFTON REGIONAL ME	BLUFFTON REGIONAL MEDICAL CENTER In		u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0075	Peri od:	Worksheet D

From 10/01/2015 | Part V 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed Cost Center Description 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 093287 5, 395, 264 503, 308 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.719140 0 52 00 52 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.071993 6,049,972 435, 556 54.00 54.01 03630 ULTRA SOUND 0.000000 54.01 0 56.00 05600 RADI OI SOTOPE 0. 244916 0 356, 692 87, 360 56 00 0 57.00 05700 CT SCAN 0.000000 0 57.00 58.00 05800 MRI 0.000000 0 0 58.00 06000 LABORATORY 60.00 0.080505 2, 288, 588 707 0 184, 243 60.00 06500 RESPIRATORY THERAPY 19, 574 86, 176 65 00 0 227139 0 65 00 66.00 06600 PHYSI CAL THERAPY 0. 239573 26, 959 0 6, 459 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 0 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68.00 527, 696 0 06900 ELECTROCARDI OLOGY 69.00 0.159888 84.372 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.046808 622, 794 0 0 29, 152 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 204797 604, 137 0 123, 725 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 200469 2, 388, 679 0 3, 537 478, 856 73.00 0 03950 OTHER ANCILLARY SERVICE COST CENTER 76.00 0.000000 0 0 76.00 76. 01 03951 SLEEP LAB 0. 292059 164, 016 0 0 47, 902 76.01 03953 WOUND CARE 0 76.03 76.03 0.218945 108, 376 0 23, 728 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.497777 48, 522 0 0 24, 153 91.00 09100 EMERGENCY 0.117197 2, 554, 513 0 0 299, 381 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.681944 351, 532 0 239, 725 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 O 95.00 200.00 Subtotal (see instructions) 21, 573, 916 707 3, 537 2, 587, 494 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges Net Charges (line 200 +/- line 201) 707 2, 587, 494 202. 00 202.00 21, 573, 916 3, 537

					From 10/01/2015 To 09/30/2016	Part V Date/Time Pre	
						2/28/2017 1:3	33 pm
				XVIII	Hospi tal	PPS	
C+ C+ D		Cos					
Cost Center Description	Do.	Cost imbursed	Cost Reimbursed				
		ervi ces	Services Not				
		bi ect To	Subject To				
		, ,	Ded. & Coins.				
		ee inst.)	(see inst.)				
	(30	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	<u> </u>						
50. 00 05000 OPERATING ROOM		0	0				50.00
51.00   05100   RECOVERY ROOM		О	0				51.00
52.00 05200 DELIVERY ROOM & LABOR RO	OM	О	0				52. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C		O	0				54. 00
54.01 03630 ULTRA SOUND		O	0				54. 01
56. 00   05600 RADI OI SOTOPE		o	0				56. 00
57.00 05700 CT SCAN		o	0				57. 00
58. 00 05800 MRI		o	0				58. 00
60. 00   06000   LABORATORY		57	0				60.00
65. 00 06500 RESPIRATORY THERAPY		O	0				65. 00
66. 00 06600 PHYSI CAL THERAPY		O	0				66. 00
67. 00 06700 OCCUPATIONAL THERAPY		O	0				67. 00
68.00 06800 SPEECH PATHOLOGY		o	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY		0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PA	TI ENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENT	S	0	709				73.00
76.00 03950 OTHER ANCILLARY SERVICE	COST CENTER	0	0				76. 00
76. 01   03951   SLEEP LAB		0	0				76. 01
76. 03 03953 WOUND CARE		0	0				76. 03
OUTPATIENT SERVICE COST CENTER	?S						
90. 00 09000 CLI NI C		0	0				90.00
91. 00   09100   EMERGENCY		0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI		0	0				92. 00
OTHER REIMBURSABLE COST CENTER	RS .						
95. 00 09500 AMBULANCE SERVICES		0					95. 00
200.00 Subtotal (see instruction		57	709				200. 00
201.00 Less PBP Clinic Lab. Ser	vi ces-Program	0					201. 00
Only Charges							
202.00   Net Charges (line 200 +/	- line 201)	57	709	l			202. 00

		UFFTON REGIONAL N	_			u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C	CN: 15-0075	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-5373	From 10/01/2015 To 09/30/2016		parod:
			Component	UCIN. 13-33/3	10 09/30/2010	2/28/2017 1: 3	pareu. 3 nm
			Ti tl e	: XVIII	Skilled Nursing		о ріп
					Facility		
	Cost Center Description	Non Physician No	ursing School	Allied Heal		Total Cost	
	·	Anesthetist	ŭ		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	O		0 0	0	50.00
51.00	05100 RECOVERY ROOM	o	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
54. 01	03630 ULTRA SOUND	0	0		0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58. 00	05800 MRI	o	0		0 0	0	58. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	o	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
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	O		0 0	0	73. 00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	O		0 0	0	76. 00
76. 01	03951 SLEEP LAB	0	0		0 0	0	76. 01
76. 03	03953 WOUND CARE	0	0		0 0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS	·					1
90.00	09000 CLI NI C	0	O		0 0	0	90.00
	09100 EMERGENCY	0	O		0 0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	O		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50-199)	0	0	1	0 0	1 .	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PAS			Peri od: From 10/01/2015	Worksheet D Part IV	
		Component	CCN: 15-5373	To 09/30/2016	Date/Time Pre 2/28/2017 1:3	pared:
		Title	xVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
500 C 5011 C 5000 F C 501	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	1
	col. 2, 3 and	8)	7)	(col . 6 ÷ col .	onal goo	1
	4)	-,	',	7)		1
	6.00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						4
0.00   05000   OPERATI NG ROOM	0	33, 924, 140			0	1 00.0
1.00 05100 RECOVERY ROOM	0	0	0.0000		0	
2.00   05200   DELIVERY ROOM & LABOR ROOM	0	589, 711			0	1
4. 00   05400   RADI OLOGY-DI AGNOSTI C	0	31, 622, 305			35, 901	
4. 01   03630   ULTRA SOUND	0	0	0. 00000		0	1
6. 00   05600   RADI 0I SOTOPE	0	1, 063, 051	0. 00000		0	1
7.00   05700   CT SCAN	0	0	0.00000		0	1
3. 00   05800   MRI	0	0	0. 00000		0	
0. 00  06000   LABORATORY	0	30, 277, 604	•		230, 204	
5. 00  06500 RESPI RATORY THERAPY	0	3, 794, 535			301, 504	
6. 00   06600 PHYSI CAL THERAPY	0	6, 039, 948			1, 424, 160	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0			0	
B. 00   06800   SPEECH PATHOLOGY	0	0	0. 00000		0	
9. 00  06900   ELECTROCARDI OLOGY	0	2, 169, 162			1, 676	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 959, 491	0. 00000		177, 457	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 494, 240			0	
3.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 409, 682			594, 341	
6.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0. 00000		0	1
6. 01   03951   SLEEP LAB	0	564, 077			0	
6. 03 03953 WOUND CARE	0	346, 740	0. 00000	0. 000000	0	76. (
OUTPATIENT SERVICE COST CENTERS						4
0. 00 09000 CLINIC	0	307, 905			0	1
1. 00   09100   EMERGENCY	0				0	1
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 222, 493	0. 00000	0. 000000	0	92. (
OTHER REIMBURSABLE COST CENTERS			1			4
5. 00 09500 AMBULANCE SERVICES						95.
00.00   Total (lines 50-199)	0	154, 784, 870			2, 765, 243	200.

Health Financial Systems		BLUFFTON REGIONAL	MEDICAL CENTE	:R	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENTA	OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS					From 10/01/2015		
			Component	CCN: 15-5373	To 09/30/2016		
						2/28/2017 1: 3	3 pm
			Title	XVIII	Skilled Nursing	PPS	
					Facility		
Cost Center Des	scription	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9	)		

Cost Center Description	Inpati 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	
ANCI LLARY SERVI CE COST CENTERS				4
50. 00   05000   OPERATI NG 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
54. 01  03630 ULTRA SOUND	0	C	0	54. 01
56. 00   05600   RADI OI SOTOPE	0	C	0	56. 00
57.00  05700   CT SCAN	0	C	0	57. 00
58. 00   05800   MRI	0	C	0	58. 00
60. 00   06000   LABORATORY	0	C	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	C	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	C	0	69. 00
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 03950 OTHER ANCILLARY SERVICE COST CENTER	0	C	0	76. 00
76. 01   03951   SLEEP LAB	0	C	0	76. 01
76. 03 03953 WOUND CARE	0	C	0	76. 03
OUTPATIENT SERVICE COST CENTERS				
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
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES				95.00
200.00   Total (lines 50-199)	0	C	0	200. 00

Health Financial Systems	BLUFFTON REGIONAL ME	DICAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0075	Peri od:	Worksheet D

From 10/01/2015 Part V 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 093287 144, 488 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.719140 12, 865 52 00 0 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.071993 0 367, 031 0 54.00 54.01 03630 ULTRA SOUND 0.000000 54.01 56.00 05600 RADI OI SOTOPE 0. 244916 0 0 56.00 0 05700 CT SCAN 0 57.00 0.000000 0 0 57.00 58.00 05800 MRI 0.000000 0 58.00 06000 LABORATORY 419, 527 60.00 0.080505 0 60.00 06500 RESPIRATORY THERAPY 0. 227139 65 00 4.374 65 00 66.00 06600 PHYSI CAL THERAPY 0. 239573 92,860 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 69 00 0.159888 9.420 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.046808 6, 787 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 204797 6, 587 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 200469 0 64, 394 73.00 0 03950 OTHER ANCILLARY SERVICE COST CENTER 76.00 0.000000 0 C 0 76.00 76.01 03951 SLEEP LAB 0. 292059 8, 182 0 76.01 03953 WOUND CARE 0. 218945 0 76.03 76.03 0 OUTPATIENT SERVICE COST CENTERS 90.00 0. 497777 90 00 09000 CLI NI C 0 5, 559 0 0 91.00 09100 EMERGENCY 0.117197 0 338, 704 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART o 92.00 92.00 0.681944 25, 019 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 200.00 Subtotal (see instructions) 1, 505, 797 0 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges Net Charges (line 200 +/- line 201) 0 0 202. 00 202.00 1, 505, 797 0

ALTONITONWENT OF WEDTCAL, OTHER HEALTH SERVICES AND	VACCINE COST		GN. 13-0073	From 10/01/2015 To 09/30/2016	Part V Date/Time Pro 2/28/2017 1:3	
			e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	13, 479	C	)			50. 00
51.00   05100   RECOVERY ROOM	0	C	)			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 252	C	)			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	26, 424	C	)			54.00
54. 01   03630   ULTRA SOUND	0	C	)			54. 01
56. 00   05600   RADI 0I SOTOPE	0	C	)			56. 00
57. 00   05700 CT SCAN	0	C				57. 00
58. 00   05800 MRI	0	C				58. 00
60. 00   06000   LABORATORY	33, 774	C				60.00
65. 00 06500 RESPIRATORY THERAPY	994	C				65. 00
66. 00   06600 PHYSI CAL THERAPY	22, 247	C				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C				67. 00
68.00 06800 SPEECH PATHOLOGY	0	C				68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 506	C				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	318	l c				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 349	l c				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 909	l c	o			73. 00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	l c	o			76. 00
76. 01   03951   SLEEP LAB	2, 390	l c	o			76. 01
76. 03 03953 WOUND CARE	0	l	o			76. 03
OUTPATIENT SERVICE COST CENTERS	•					
90. 00 09000 CLI NI C	2, 767	C				90.00
91. 00 09100 EMERGENCY	39, 695		o			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 062					92. 00
OTHER REIMBURSABLE COST CENTERS	•	•				
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	184, 166	l c	o			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	1					
202.00   Net Charges (line 200 +/- line 201)	184, 166	c				202. 00

Heal th	Financial Systems BLUFFTON REGIONAL ME	EDI CAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075	Peri od:	Worksheet D-1	
			From 10/01/2015 To 09/30/2016	Date/Time Pre 2/28/2017 1:3	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DDOVIDED COMPONIENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s eveluding newborn)		5, 139	1.00
2.00	Inpatient days (including private room days and swing-bed days.			5, 139	
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days	1, 329	
3.00	do not complete this line.	ys). If you have only pr	rvate room days,	1, 327	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 334	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period	3 ,			
6.00	Total swing-bed SNF type inpatient days (including private roof	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period	m daya) aftar Dagambar 3	1 of the cost	0	8.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) arter becember 3	i or the cost	U	8.00
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing_hed and	1, 777	9.00
7. 00	newborn days)	o the rrogram (exeruaring	Sin ng bea ana	.,,,,,	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc	tions)	• .		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	V only (including privat	o room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
	Total nursery days (title V or XIX only)			0	15. 00
	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				ĺ
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
20.00	reporting period	3 ditter becember 31 di t	110 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		5, 276, 935	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
	5 x line 17)		•		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	r 3। of the cost reporti	ng period (line	0	24. 00

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 139	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)  Private room days (excluding swing-bed and observation bed days). If you have only private room days,	5, 139 1, 329	2. 00 3. 00
3.00	do not complete this line.	1, 327	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 334	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 777	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13. 00
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)	0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	5, 276, 935	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $7 \times 1$ ine 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 276, 935	27. 00
00.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	40 405 044	00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)	10, 185, 941 2, 887, 438	
30. 00	Semi -private room charges (excluding swing-bed charges)	7, 298, 503	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 518061	
32.00	Average private room per diem charge (line 29 ÷ line 3)	2, 172. 64	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	3, 127. 04	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5, 276, 935	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 007 04	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	1, 026. 84 1, 824, 695	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 624, 695	40. 00
41. 00		1, 824, 695	

	Financial Systems B ATION OF INPATIENT OPERATING COST	LUFFTON REGIONAL		CCN: 15-0075	Peri od:	u of Form CMS-2 Worksheet D-1	2552-10
					From 10/01/2015 To 09/30/2016		
			Ti t	le XVIII	Hospi tal	2/28/2017 1: 3: PPS	o piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per ys Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.	00 00	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	1, 709, 328	QI	50 1, 799.	29 371	667, 537	43.00
44. 00	· ·	1,707,320	,	1,777.	371	007, 337	44.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
	oost conter bosci ptron					1. 00	
48. 00	Program inpatient ancillary service cost (W					2, 305, 174	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instruct	i ons)		4, 797, 406	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	natient routine	services (fr	om Wkst D sui	m of Parts L and	193, 480	50. 00
00.00	III)	patront routino	33. 1. 333 (1.1	oot. b, ou.	0	1707 100	00.00
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (	from Wkst. D,	sum of Parts II	171, 280	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	: 50 and 51)				364, 760	52.00
53. 00	Total Program inpatient operating cost excl	,	lated, non-p	hysician anestl	netist, and	4, 432, 646	
	medical education costs (line 49 minus line		<u> </u>		·		
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	   <sub>E4 00</sub>
55. 00						0. 00	
56. 00	Target amount (line 54 x line 55)					0	56.00
57. 00	Difference between adjusted inpatient opera	ting cost and ta	rget amount	(line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions)	onanting paried	andina 100/	undated and a	ampaumdad by the	0 0. 00	58. 00 59. 00
39.00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting perrou	ending 1990,	upuateu anu ci	dilipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	60.00
61. 00	If line 53/54 is less than the lower of lin					0	61.00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (lines 54 )	x 60), or 1% o	r the target		
62. 00							
63. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine co	sts through Dece	mher 31 of t	he cost renort	na period (See	0	64. 00
01.00	instructions)(title XVIII only)	oto tili odgir bece		no cost roport	ng perrod (see		01.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reporting	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout</pre>	ine costs (line	64 nlus line	65)(title XVI	Lonly) For	0	66. 00
00.00	CAH (see instructions)	The costs (The	o+ prus rrne	05)(11110 XVI	1 only). 101	O O	00.00
67. 00	1	ne costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 o	f the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	ne costs arter b	ecember 31 0	i the cost rep	of tring period	O	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER				<b>\</b>		   70. 00
70. 00 71. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	,			,		71.00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72.00
73.00	Medically necessary private room cost appli						73.00
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
73.00	26, line 45)	Toutine service	C0313 (110m	WOLKSHEEL B,	art II, coraiiii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ l						76. 00
77. 00 78. 00	Program capital -related costs (line 9 x lin						77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		rovi der reco	rds)			79.00
80.00	Total Program routine service costs for com	parison to the c			nus line 79)		80.00
81.00	Inpatient routine service cost per diem lim		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs		•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see i		<u>-,</u>				84. 00
85. 00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (SU		rough 85)				86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					1, 476	87. 00
8/.(10)	1 222 222 223	*					
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 026. 84	88. 00

Health Financial Systems BI	UFFTON REGIONAL	MEDICAL CENTER	₹	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2015 Fo 09/30/2016		
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	456, 839	5, 276, 935	0. 086573	1, 515, 616	131, 211	90.00
91.00 Nursing School cost	0	5, 276, 935	0.000000	1, 515, 616	0	91.00
92.00 Allied health cost	0	5, 276, 935	0.000000	1, 515, 616	0	92.00
93 00 All other Medical Education	0	5 276 935	0.000000	1 515 616	0	93 00

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0075	Peri od: From 10/01/2015	Worksheet D-1
	Component CCN: 15-537	To 09/30/2016	Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Skilled Nursing	PPS
		Facility	

Dest Center Description    1.00			litle XVIII	Facility	PPS	
Next   F - ALL REVISER CORPONENTS   Next		Cost Center Description		raciiity		
INPATIENT DAYS		DADT I ALL DROW DED COMPONENTS			1. 00	
1.00   Inpatient days (including private room days, and swing-bed days, excluding newborn)   3,003   2.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.  Annual complete this line.  Annual complete this line.  Bell private room days (excluding swing-bed and observation bed days).  Complete this line.  Complete	1.00		s, excluding newborn)		3, 003	1. 00
do not complete this line.  30 not complete this line.  40 05 misprivate room days (excluding swing-hed and observation bed days) through December 31 of the cost  70 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  70 not reporting period (if callendary year, enter 0 on this line)  70 Total saing-bed NF type inpatient days (including private room days) through December 31 of the cost  70 Total sing-bed NF type inpatient days (including private room days) through December 31 of the cost  80 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost  80 Total sing-bed NF type inpatient days applicable to the Program (excluding swing-bed and  80 newborn days)  80 Total inpatient days including private room days applicable to the Program (excluding swing-bed and  80 newborn days)  81 newborn days)  81 newborn days  81 newborn days  82 newborn days  83 newborn days  84 newborn days  85 newborn days  86 newborn days  86 newborn days  87 newborn days  87 newborn days  87 newborn days  87 newborn days  88 newborn days  89 newborn days  80 newborn						
Semi-private room days (excluding swing-bed ARF type Inpatient days (Including private room days) through December 31 of the cost 0 5.00 foot swing-bed SRF type Inpatient days (Including private room days) after December 31 of the cost 0 5.00 foot swing-bed SRF type Inpatient days (Including private room days) after December 31 of the cost 0 5.00 foot swing-bed NF type Inpatient days (Including private room days) through December 31 of the cost 0 7.00 reporting period (Including private room days) after December 31 of the cost 0 8.00 reporting period (Including private room days) after December 31 of the cost 0 8.00 reporting period (Including private room days) after December 31 of the cost 1 9.00 foot 1 1.60 foot 1	3.00		ys). If you have only p	rivate room days,	2, 025	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-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)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days wing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total inpatient days including private room days)   Total inpatient days including private room days)   Total patient days applicable to title SVIII only (including private room days)   Total patient days applicable to title SVIII only (including private room days)   Total patient days applicable to titles V or XIX only (including private room days)   Total patient days applicable to titles V or XIX only (including private room days)   Total patient days applicable to titles V or XIX only (including private room days)   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V   Total nursery days (title V or XIX only V	4.00		ed davs)		978	4. 00
Total swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (I're calendar year, enter 0 on this Ilne)		Total swing-bed SNF type inpatient days (including private roo		er 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) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost newborn days) including private room days papil cable to the Program (excluding swing-bed and newborn days) including private room days papil cable to the Program (excluding swing-bed and newborn days) including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery, days (title V or XIX only) 17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Medical craft for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 reporting period (including private room days) 18.00 Medical craft for swing-bed SNF services applicable to services after December 31 of the cost 0.00 17.00 reporting period (including private room days) 18.00 Medical craft for swing-bed SNF services applicable to services after December 31 of the cost 1.00 17.00 reporting period (including private room days) 18.00 Medical craft for swing-bed SNF services applicable to services after December 31 of the cost 1.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00		1 1 3 1 1 1		21 -6 +6	0	/ 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   7.00	6.00		on days) arter becember	31 Of the Cost	U	6.00
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)   1.604   9.00   1.604	7.00	Total swing-bed NF type inpatient days (including private roor	m days) through Decembe	r 31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 0.0 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 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV 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 Nursery days (title V or XIX only) 17.00 SNIMS EDD ADUSTRUSH SNIM (title V or XIX only) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period 19.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services afte	0.00	1 9 1		04 6 11		0.00
1.600   Potential inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   1.600   9.00	8.00		m days) arter becember	31 of the cost	Ü	8.00
10.00   Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days)   0   10.00	9.00		o the Program (excludin	g swing-bed and	1, 604	9. 00
through December 31 of the cost reporting period (see instructions)  1. 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)  1. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1. 01 1. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1. 02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1. 03 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1. 04 ON Bedical Iy necessary private room days applicable to the Program (excluding swing-bed days)  1. 05 Total nursery days (title V or XIX only)  1. 06 Total nursery days (title V or XIX only)  1. 07 ON Bedicare rate for swing-bed SNF services applicable to services through December 31 of the cost preporting period  1. 08 Weld-care rate for swing-bed SNF services applicable to services after December 31 of the cost preporting period  1. 09 Weld-care rate for swing-bed NF services applicable to services after December 31 of the cost preporting period  2. 00 Weld-cald drate for swing-bed NF services applicable to services after December 31 of the cost preporting period (including private room days)  2. 00 Weld-cald drate for swing-bed NF services applicable to services after December 31 of the cost preporting period (including private room days applicable to SNF type services after December 31 of the cost preporting period (including private room days applicable to SNF type services through December 31 of the cost reporting period (line violate applicable to SNF type services after December 31 of the cost reporting period (line violate applicable to SNF type services through December 31 of the cost reporting period (line violate applicable to SNF type services after December 31 of the cost reporting period (line violate applicable to SNF	40.00				0	40.00
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12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period 3.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 4.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 6.00 Total nursery days (title V or XIX only) 7.00 Swin NB EBD ADJUSTNENT 7.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 8.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 9.00 Medicaid rate for swing-bed NNF services applicable to services after December 31 of the cost reporting period 9.00 Medicaid rate for swing-bed NNF services applicable to services after December 31 of the cost reporting period 9.00 Medicaid rate for swing-bed NNF services applicable to services after December 31 of the cost reporting period 9.00 Medicaid rate for swing-bed NNF services applicable to services after December 31 of the cost 10.00 Total general inpatient routine service cost (see instructions) 11.909,674 12.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after D	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private	room days) after	0	11. 00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  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 (line dare rate for swing-bed SNF services applicable to services after December 31 of the cost  17. 00 Medicare rate for swing-bed SNF services applicable to services after 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 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 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 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 services after December 31 of the cost reporting period (line S X line 17)  20. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S X line 18)  21. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S X line 19)  22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S X line 29)  23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S X line 29)  24. 00 General inpatient routine service cost period charges)  25. 00 Swing-bed cost	40.00					40.00
13.00   Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including privater room days)   13.00   13.00   14.00   16.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   15.00	12.00		X only (including priva	te room days)	0	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   16.00	13.00		X only (including priva	te room days)	0	13. 00
15.00   Total nursery days (title V or XIX only)   0   15.00   16.00						
16. 00   Nursery days (title V or XIX only)			am (excluding swing-bed	days)	-	
SWING BED ADJUSTMENT  18.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period period reporting period Redical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Redical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Redical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period Redical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 10.00 Total general inpatient routine service cost (see instructions) 1,909,674 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 10.20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 10.20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 10.00 Swing-bed cost applicable to NF type service cost (line 21 minus line 26) 1.00 Swing-bed cost (see instructions) 1.00 Swing-bed cost (s						
reporting period  18.00 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 after December 31 of the cost 0.00 19.00 reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 20.00 reporting period (20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (11 ne 0 1.00 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne 0 2.00 Swing-bed cost (see instructions)		SWI NG BED ADJUSTMENT				
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 0	17. 00	1	es through December 31	of the cost	0. 00	17. 00
19. 00   Medical d Tate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20. 00   20.	18. 00		es after December 31 of	the cost	0.00	18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1. 00 Total general inpatient routine service cost (see instructions)  2. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  5. x line 18)  4. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  5. wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6. wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6. wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  7. x line 19)  6. wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  7. x line 20)  8. wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  9. control swing-bed cost (see instructions)  9. control swing-bed cost (see instructions)  9. control swing-bed cost reporting period (line 8 x line 20)  9. control swing-bed cost reporting period (line 8 x line 20)  9. control swing-bed cost reporting period (line 8 x line 20)  9. control swing-bed cost reporting period (line 8 x line 20)  9. control swing-bed cost reporting period (line 8 x line 20)  9. control swing-bed cost reporting period (line 20 line 20 services after December 31 of the cost reporting period (line 3 line 30)  9. control swing-bed cost reporting period (line 3 line 30)  9. control swing-bed cost applicable to line 3 line 30 service line 3 line 30)  9. control swing-bed cost applicable to line 3 line 31)  9. cont	40.00					40.00
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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 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)  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 Semi-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 private room per diem charge (line 29 + line 3)  30.00 Average private room per diem charge (line 29 + line 4)  40.00 Average per diem private room cost differential (line 3 x line 31)  30.00 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 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 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 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	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	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   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)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   1,909,674   28.00   PRIVATE ROMD DIFFERENTIAL ADJUSTMENT   28.00   29.00   Private room charges (excluding swing-bed charges)   3,114,900   29.00   Private room charges (excluding swing-bed charges)   971,896   30.00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0,613059   31.00   32.00   Average private room per diem charge (line 29 + line 3)   1,058   32.00   33.00   Average semi-private room cost differential (line 32 minus line 33) (see instructions)   993.76   33.00   34.00   Average per diem private room cost differential (line 32 minus line 33) (see instructions)   1,829,524   37.00   Private room cost differential adjustment (line 3 x line 31)   39.58   35.00   37.00   Private room cost differential adjustment (line 3 x line 35)   1,829,524   38.00   Adjusted general inpatient routine service cost (cline 9 x line 38)   70.00   38.00   Adjusted general inpatient routine service cost (line 9 x line 38)   70.00   38.00   Program general inpatient routine service cost (line 9 x line 38)   70.00   38.00   Program general inpatient routine service cost (line 9 x line 38)   70.00   38.00   Program general inpatient routine service cost (line 9 x line 38)   70.00   38.00   Program general inpatient routine service cost (line 9 x line 38)   70.00   38.00   Program general inpatient routine service cost (line 9 x line 38)   70.00   38.00	21 00		s)		1 909 674	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 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 1 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 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 Semi-private room per diem charges (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 3)  30.00 Average per diem private room charge (line 30 + line 4)  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 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524)  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 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				ting period (line		
x line 18) 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 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1,909,674 27.00 PRIVATE 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 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  37.114,990  38.00 Semi-private room charges (excluding swing-bed charges)  38.00 Average per diem private room per diem charge (line 29 + line 3)  38.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  38.00 Average per diem private room cost differential (line 3 x line 31)  39.00 Private room cost differential dijustment (line 3 x line 35)  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 instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  24.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reporti	ng period (line 6	0	23.00
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) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 29.00 Average private room per diem charge (line 29 ÷ line 3) 29.00 Average semi-private room per diem charge (line 30 ÷ line 4) 29.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 29.00 Average per diem private room cost differential (line 34 x line 31) 29.00 Average per diem private room cost differential (line 34 x line 31) 29.00 Private room cost differential adjustment (line 3 x line 35) 29.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524) 27 minus line 36) 28.00 General inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 39.00 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	1	r 31 of the cost report	ing period (line	0	24. 00
x line 20) Total swing-bed cost (see instructions) Ceneral 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) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges) Ceneral inpatient routine service charges) Ceneral inpatient routine service cost/charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 32 minus line 33) (see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 × line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line	25 00	,	21 of the east reportin	a nominal (line 0	0	25 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)  28.00 Private room charges (excluding swing-bed charges)  39.00 Private room charges (excluding swing-bed charges)  39.00 Semi-private room charges (excluding swing-bed charges)  39.00 Average private room pr diem charge (line 29 + line 3)  39.00 Average per diem private room charge differential (line 30 + line 4)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.50 Average per diem private room cost differential (line 3 x line 35)  39.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 a)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.50 Average per diem private room cost differential (line 3 x line 35)  39.50 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 in nus 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)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	25. 00		31 of the cost reportin	g period (iine 8	Ü	25.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average pri vate room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-pri vate room per diem charge (line 29 ÷ line 3)  31. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  32. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  33. 00 Average per diem pri vate room cost differential (line 34 x line 31)  34. 00 Pri vate room cost differential adjustment (line 3 x line 35)  35. 00 Average per diem pri vate room cost differential (line 3 x line 35)  36. 00 Pri vate 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 1, 829, 524)  37. 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 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00					-	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 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) 36.00 Average per diem private room cost differential (line 34 x line 31) 39.58 35.00 Average per diem private room cost differential (line 34 x line 31) 39.58 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 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	27. 00		(line 21 minus line 26)		1, 909, 674	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 Semi-private room charges (excluding swing-bed charges) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 3) 34.00 Average per diem private room per diem charge (line 30 ÷ line 4) 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 829, 524) 37.00 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28. 00		d and observation bed c	harges)	3, 114, 990	28. 00
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 1, 829, 524)  37.00 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)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 0.613059  1, 058.32  32.00  39.00 64.56  39.00 Average per diem charge (line 29 ÷ line 3)  40.00 Medically necessary private room cost differential (line 1, 058.32  31.00  32.00 0.613059  1, 058.32  32.00  39.00 80, 150  39.58 0  80, 150						
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  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Wedically necessary private room cost applicable to the Program (line 14 x line 35)  1, 058. 32 32.00 49.00 Average per diem charge (line 29 ÷ line 3) 49.00 Service instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00						1
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 1, 829, 524)  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)  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)  40.00		,	÷ line 28)			1
Average per diem private room charge differential (line 32 minus line 33) (see instructions)  4. 4 verage per diem private room cost differential (line 34 x line 31)  5. 00  Average per diem private room cost differential (line 34 x line 31)  7. 00  Private room cost differential adjustment (line 3 x line 35)  80, 150  80, 15					•	
35.00 Average per diem private room cost differential (line 34 x line 31)  39.58 35.00 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 1, 829, 524)  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)  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)  39.00 Average per diem private room cost differential (line 3 x line 31)  39.58 80, 150 80, 150 36.00  19.00 Average per diem private room cost differential (line 1, 829, 524)  37.00 Average per diem private room cost differential (line 1, 829, 524)  38.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 1, 829, 524)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average per diem private room cost			aus lina 22)(saa instru	ctions)		1
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 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 1,829,524 37.00		, , ,	, ,	Ctrons)		
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 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 And Defending the service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		,	16 31)			1
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) 40.00			and private room cost d	ifferential (line		•
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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)  40.00		27 minus line 36)		( , , , , ,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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) 38.00 40.00			ICTMENTS			
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) 39.00 40.00	38 00					38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)			41.00

	Financial Systems BL TION OF INPATIENT OPERATING COST	LUFFTON REGIONAL		CN: 15-0075	Peri od: From 10/01/2015	wof Form CMS- Worksheet D-1	
			Component	CCN: 15-5373	To 09/30/2016	Date/Time Pre 2/28/2017 1:3	
			Ti tl e	xVIII	Skilled Nursing Facility	PPS	, u
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
1 00	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units						4
	INTENSIVE CARE UNIT						4
	CORONARY CARE UNIT						4
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						4
- 1	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description				•		
00	Program inpatient ancillary service cost (W	est D_3 col 3	line 200)			1. 00	4
	Total Program inpatient costs (sum of lines			ns)			4
	PASS THROUGH COST ADJUSTMENTS						_ ا
	Pass through costs applicable to Program inp III)	oatient routine s	services (from	ı Wkst. D, su	m of Parts I and		5
00	Pass through costs applicable to Program in	patient ancillary	services (fr	om Wkst. D,	sum of Parts II		5
	and IV) Total Program excludable cost (sum of lines	50 and 51)					5
	Total Program excludable cost (sum of fines Total Program inpatient operating cost exclu	,	ated, non-phy	sician anest	netist, and		5
r	medical education costs (line 49 minus line						] [
	FARGET AMOUNT AND LIMIT COMPUTATION  Program discharges						5
	Target amount per discharge						5
	Target amount (line 54 x line 55)						5
- 1	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)		5
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	eporting period e	endina 1996. i	ipdated and c	ompounded by the		5
r	market basket		C .	•			
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by		6
	which operating costs (line 53) are less tha						0
	amount (line 56), otherwise enter zero (see	instructions)					١,
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payn	ment (see instrud	ctions)				6
P	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Decem	nber 31 of the	cost report	ng period (See		6
	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the d	ost reporting	g period (See		6
ji	instructions)(title XVIII only)						
	Total Medicare swing-bed SNF İnpatient routi CAH (see instructions)	ne costs (line 6	o4 plus line 6	5)(title XVI	II only). For		6
	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 d	of the cost r	eporting period		6
1	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	no costs often Da	combor 21 of	the cost res	arting period		,
	litte vor xix swing-bed ne inpatient routif (line 13 x line 20)	ie costs ai tei De	Cemper 31 OF	the cost rep	orting period		6
00	Total title V or XIX swing-bed NF inpatient						6
	PART III – SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)	1, 829, 524	7
	Adjusted general inpatient routine service (				,	609. 23	
00	Program routine service cost (line 9 x line	71)				977, 205	
- 1	Medically necessary private room cost applio Total Program general inpatient routine serv	•	•			0 977, 205	
- 1	Capital-related cost allocated to inpatient	•			Part II, column	977, 203	1
1	26, line 45)	no 2)				0.00	, ,
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,				0. 00 0	
00  I	Inpatient routine service cost (line 74 minu	us line 77)				0	7
	Aggregate charges to beneficiaries for exces				aug Line 70)	0	
- 1	Total Program routine service costs for comp Inpatient routine service cost per diem limi		osi iimitatior	i (iine /8 mii	ius i i ne 79)	0. 00 0. 00	1 -
00	Inpatient routine service cost limitation (I					0	8 (0
1	Reasonable inpatient routine service costs	•	5)			977, 205	
	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)			558, 512 0	
	Total Program inpatient operating costs (sur					1, 535, 717	
	PART IV - COMPUTATION OF OBSERVATION BED PAS						1 ~
00	Total observation bed days (see instruction: Adjusted general inpatient routine cost per		line 2)			0.00	8
00	Adrusted dellerar fillbatreni ronnine cosi nei						

Health Financial Systems	BLUFFTON REGIONAL	MEDICAL CENTE	R	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 10/01/2015		
		Component	CCN: 15-5373	To 09/30/2016	Date/Time Prep 2/28/2017 1:33	
		Title	XVIII	Skilled Nursing		о ріп
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	1 COST					
90.00 Capital-related cost	0	0	0.00000	0	0	90.00
91.00 Nursing School cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0075	Peri od: From 10/01/2015 To 09/30/2016		pared
		Ti tl e	e XVIII	Hospi tal	2/28/2017 1: 3 PPS	3 piii
	Cost Center Description		Ratio of Cos		Inpatient	
	•		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDI ATRI CS			3, 488, 440		30.
31. 00				1, 614, 752		31.
3. 00						43.
	ANCILLARY SERVICE COST CENTERS			2 5 6 2 6 2 6		
0.00			0. 09328		239, 679	
1.00	05100 RECOVERY ROOM		0.00000		0	51.
2.00	O5200   DELI VERY ROOM & LABOR ROOM   O5400   RADI OLOGY-DI AGNOSTI C		0. 7191 0. 0719			
4. 00	03630   ULTRA SOUND		0.0719		148, 158	
4. 01 6. 00			1		0 19, 137	
7. 00	05700 CT SCAN		0. 2449		19, 137	1
8. 00			0.0000			
0.00	06000 LABORATORY		0. 08050			
5. 00	06500 RESPIRATORY THERAPY		0. 0803		320, 824	1
6. 00	06600 PHYSI CAL THERAPY		0. 2395		66, 067	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 00000		00,007	1
8. 00			0. 00000		Ö	1
9. 00	06900 ELECTROCARDI OLOGY		0. 1598			
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 04680		63, 254	
2. 00			0. 2047	· · ·		
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2004		372, 155	1
6. 00	03950 OTHER ANCILLARY SERVICE COST CENTER		0.0000		0	1
6. 01	03951 SLEEP LAB		0. 2920!		0	76.
6. 03	03953 WOUND CARE		0. 2189	45 0	0	76.
	OUTPATIENT SERVICE COST CENTERS					
0. 00			0. 4977	77 10, 186	5, 070	90.
1. 00	09100 EMERGENCY		0. 11719	97 1, 351, 190	158, 355	91.
2. 00			0. 6819	193, 465	131, 932	92.
	OTHER REIMBURSABLE COST CENTERS					
5. 00						95.
00.00				17, 106, 433	2, 305, 174	1
01.00		es (line 61)		0		201.
02.00	Net Charges (line 200 minus line 201)			17, 106, 433		202.

			_			
	ncial Systems BLUFFTON REGIONAL N NCILLARY SERVICE COST APPORTIONMENT	_	.R CN: 15-0075	Peri od:	u of Form CMS- Worksheet D-3	
		Component	CCN: 15-5373	From 10/01/2015 To 09/30/2016	Date/Time Pre 2/28/2017 1:3	epared:
		Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			0		30.00
	INTENSIVE CARE UNIT			0		31.00
43.00 04300						43. 00
	LARY SERVICE COST CENTERS					
	OPERATI NG ROOM		0. 0932			1
	RECOVERY ROOM		0.0000		0	
	DELIVERY ROOM & LABOR ROOM		0. 7191		0	
	RADI OLOGY-DI AGNOSTI C ULTRA SOUND		0. 0719 0. 0000		2, 585 0	1
	RADI OI SOTOPE		0. 0000			
	CT SCAN		0.0000		0	
58. 00 05800			0. 0000		0	
	LABORATORY		0. 0805		18, 533	
1	RESPI RATORY THERAPY		0. 2271		68, 483	
66.00 06600	PHYSI CAL THERAPY		0. 2395	73 1, 424, 160	341, 190	66.00
67.00 06700	OCCUPATIONAL THERAPY		0.0000		0	67. 00
68.00 06800	SPEECH PATHOLOGY		0.0000	00	0	68. 00
	ELECTROCARDI OLOGY		0. 1598		268	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0468		8, 306	
	IMPL. DEV. CHARGED TO PATIENTS		0. 2047		0	
	DRUGS CHARGED TO PATIENTS		0. 2004		119, 147	
	OTHER ANCILLARY SERVICE COST CENTER SLEEP LAB		0. 0000 0. 2920		0 0	
76. 03 03953			0. 2920			1
	TIENT SERVICE COST CENTERS		0.2107	+5  0	0	70.03
90.00 09000			0. 4977	77 0	0	90.00
	EMERGENCY		0. 1171		Ō	
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART		0. 6819	14 0	0	92. 00
	REIMBURSABLE COST CENTERS					
	AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)			2, 765, 243	558, 512	
201. 00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201. 00
202. 00	Net Charges (line 200 minus line 201)		I	2, 765, 243		202. 00

Heal th Finar	ncial Systems	BLUFFTON REGIONAL MEDICA	AL CENTE	R	In Li∈	eu of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Pro	ovider C	CN: 15-0075	Peri od:	Worksheet D-3	
					From 10/01/2015 To 09/30/2016		narod:
					10 09/30/2010	2/28/2017 1: 3	
-			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
	Cost Center Description			Ratio of Cos		Inpatient	
	<b>'</b>			To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2. 00	3. 00	
	TENT ROUTINE SERVICE COST CENTERS						1
	ADULTS & PEDIATRICS				137, 664		30.00
	INTENSIVE CARE UNIT				30, 342		31. 00
	NURSERY				58, 673		43. 00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM			0. 09328			1
	RECOVERY ROOM			0.0000		0	51.00
	DELIVERY ROOM & LABOR ROOM			0. 7191			
	RADI OLOGY-DI AGNOSTI C			0. 0719			1
	ULTRA SOUND			0. 00000		0	
	RADI OI SOTOPE CT SCAN			0. 2449 0. 0000		0	56. 00 57. 00
58. 00 05800				0.0000		0	
	MRI   LABORATORY			0. 08050		-	
	RESPI RATORY THERAPY			0. 08030			
	PHYSICAL THERAPY			0. 2271.			
	OCCUPATIONAL THERAPY			0. 00000			1
	SPEECH PATHOLOGY			0.0000		0	
	ELECTROCARDI OLOGY			0. 1598		_	
	MEDICAL SUPPLIES CHARGED TO PATIENT	г		0. 04680			1
	IMPL. DEV. CHARGED TO PATIENTS	•		0. 2047			
	DRUGS CHARGED TO PATIENTS			0. 2004			
	OTHER ANCILLARY SERVICE COST CENTER	?		0.0000		0	1
	SLEEP LAB			0. 2920!		0	76. 01
76. 03 03953				0. 2189		0	1
	TIENT SERVICE COST CENTERS						
	CLINIC			0. 4977	77 1, 414	704	90.00
91.00 09100	EMERGENCY			0. 1171	97 24, 974	2, 927	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	Γ		0. 6819	9, 939	6, 778	92. 00
	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES						95. 00
200.00	Total (sum of lines 50-94 and 96-98				385, 853		200. 00
201. 00	Less PBP Clinic Laboratory Services	s-Program only charges (Li	ne 61)		0		201. 00

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

201. 00 202. 00

385, 853

201. 00 202. 00

Health Financial Systems	BLUFFTON REGIONAL MEDIC	CAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr		From 10/01/2015	Worksheet E Part A Date/Time Prepared: 2/28/2017 1:33 pm

				2/28/2017 1:3	3 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior to October 1 (s	see	0	1. 01
	instructions)				
1.02	DRG amounts other than outlier payments for discharges occurrin	3, 300, 211	1. 02		
	instructions)			_	
1. 03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges eccurring	on or after	0	1. 04
1.04	October 1 (see instructions)	discharges occurring to	on or arter	U	1.04
2.00	Outlier payments for discharges. (see instructions)			3, 235	2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0	2. 02
3.00	Managed Care Simulated Payments	•		1, 451, 837	3. 00
4.00	Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	57. 97	4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting p	period ending on	0. 00	5. 00
	or before 12/31/1996. (see instructions)				,
6. 00	FTE count for allopathic and osteopathic programs which meet the	e criteria for an add-d	on to the cap	0. 00	6. 00
7. 00	for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	dor 42 CED 8412 105(f)	(1) (i v) (P) (1)	0.00	7. 00
7. 00	ACA Section 5503 reduction amount to the IME cap as specified un			0.00	7. 00
7.01	If the cost report straddles July 1, 2011 then see instructions	- , ,	(1)(1 V)(b)(2)	0.00	7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allopath		grams for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79				
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under section 5503 of	the ACA. If	0.00	8. 01
	the cost report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachir	ng hospital	0. 00	8. 02
0.00	under section 5506 of ACA. (see instructions)	(0 0 01 0 00) (-		0.00	0.00
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (9	see	0. 00	9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curren	t year from your record	ls	0.00	10. 00
	FTE count for residents in dental and podiatric programs.	t year from your record	,5		11. 00
12. 00	Current year allowable FTE (see instructions)				12. 00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year	ended on or after Sept	ember 30, 1997,	0.00	14. 00
	otherwise enter zero.				
15. 00	Sum of lines 12 through 14 divided by 3.				15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closu	re			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
20. 00	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for Section	n 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE residen		ec. 412.105	0.00	23. 00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo	wer of line 23 or line	24 (see	0.00	25. 00
04.00	instructions)			0.00000	07.00
	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000	
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00 28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	1
27.0.	Disproportionate Share Adjustment				27.0.
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruct	i ons)	2. 80	30. 00
	Percentage of Medicaid patient days (see instructions)	<u> </u>	•		31.00
	Sum of lines 30 and 31			25. 32	
	Allowable disproportionate share percentage (see instructions)			10. 10	33. 00
34. 00	Disproportionate share adjustment (see instructions)			83, 330	34.00

	Financial Systems BLUFFTON REGIONAL M ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0075	Peri od:	Worksheet E	
			From 10/01/2015 To 09/30/2016	Date/Time Pre	
		Title XVIII	Hospi tal	2/28/2017 1: 33 PPS	3 PIII
			Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Adjustment		1		
5. 00 5. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000	6, 406, 145, 534 0. 000040647	35. ( 35. (
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line)	0.00000000	260, 391	35. (
0. 02	(see instructions)	ter zero on tili 3 i i lie)		200, 371	55. (
5. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	0	260, 391	35. 0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		260, 391		36. (
0 00	Additional payment for high percentage of ESRD beneficiary di		gh 46) 0		40. (
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40. (
	032, 002, 003, 004 and 003 (3cc 1113th deth 013)		Before 1/1	On/After 1/1	
			1. 00	1. 01	
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0	0	41. (
1 01	instructions)	DDC= /E2 /02 /02 /04	0		11 (
1. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-טוטט טטע, סטע, סטא, 684	0	0	41. (
2. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42. (
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.
	instructions)				
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
5. 00	days) Average weekly cost for dialysis treatments (see instructions	5)	0.00	0.00	45
6. 00	Total additional payment (line 45 times line 44 times line 41		0	0.00	46.
7. 00	Subtotal (see instructions)		3, 647, 167		47.
8. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.
	only. (see instructions)			Amount	
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructions	s)		3, 647, 167	49. (
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I ar	nd Pt. II, as applicable)		263, 037	50. (
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.
2. 00 3. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52. 53.
4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies				54.
4. 01	Islet isolation add-on payment				54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55.
6. 00	Cost of physicians' services in a teaching hospital (see intr			0	56.
	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57.
7. 00				l 01	58.
7. 00 3. 00	Ancillary service other pass through costs from Wkst. D, Pt.	TV, COL. IT TITLE 200)		3 010 204	50
7. 00 8. 00 9. 00	Total (sum of amounts on lines 49 through 58)	1V, Col. 11 111le 200)		3, 910, 204 0	
7. 00 8. 00 9. 00 0. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			1	60.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries			0 3, 910, 204 550, 872	60. 61. 62.
7.00 8.00 9.00 0.00 1.00 2.00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			0 3, 910, 204 550, 872 3, 780	60. 61. 62. 63.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			0 3, 910, 204 550, 872 3, 780 23, 082	60. 61. 62. 63. 64.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	s line 60)		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003	60. 61. 62. 63. 64. 65.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	s line 60)		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556	60. 61. 62. 63. 64. 65.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	s line 60) tructions)	ee instructions)	0 3, 910, 204 550, 872 3, 780 23, 082 15, 003	60. 61. 62. 63. 64. 65. 66.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	s line 60)  tructions)  applicable to MS-DRGs (s		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0	60. 61. 62. 63. 64. 65. 66. 67. 68.
7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	s line 60)  tructions)  applicable to MS-DRGs (s		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0	60. 61. 62. 63. 64. 65. 66. 67. 68. 69.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	s line 60)  tructions)  applicable to MS-DRGs (s		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0	60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 88	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0	60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 88 0. 89	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0	60. 61. 62. 63. 64. 65. 66. 67. 68. 70. 70.
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 0. 50 0. 88 0. 89 0. 90	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see inst	s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0	60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70.
57. 00 58. 00 59. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 70. 00 70. 00 70. 88 70. 88 70. 89 70. 90 70. 90 70. 90	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0 0 0	60. 61. 62. 63. 64. 65. 66. 67. 70. 70. 70. 70. 70.
57. 00 58. 00 59. 00 50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 70. 50 70. 88 70. 89 70. 91 70. 91 70. 92 70. 93	Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction		0 3, 910, 204 550, 872 3, 780 23, 082 15, 003 17, 556 3, 370, 555 0 0 0	60. 61. 62. 63. 64. 65. 66. 67. 70. 70. 70. 70. 70. 70.

	Financial Systems BLUFFTON REGIONAL MI	_			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CO	CN: 15-0075	Peri od: From 10/01/2015	Worksheet E Part A	
				To 09/30/2016		nared:
				10 07/30/2010	2/28/2017 1: 3:	
		Title	XVIII	Hospi tal	PPS	
		•	FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			2016	387, 529	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				42, 567	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3, 674, 512	
71. 01	Sequestration adjustment (see instructions)				73, 490	
	Interim payments				3, 475, 453	
73.00	Tentative settlement (for contractor use only)				0	
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72				125, 569	
75. 00	Protested amounts (nonallowable cost report items) in accorda	nce with			510, 189	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	,
92.00	Operating outlier reconciliation adjustment amount (see instr				0	
93. 00	Capital outlier reconciliation adjustment amount (see instruc				0	93. 00
	The rate used to calculate the time value of money (see instr				0. 00	
	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1		
	LION D			1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)				0	100. 00
	HVBP Adjustment for HSP Bonus Payment				4 0050754500	
	HVBP adjustment factor (see instructions)	`			1. 0058751509	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	is)			0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment				0.0047	100 00
	HRR adjustment factor (see instructions)	`			0. 9817	
104.00	HRR adjustment amount for HSP bonus payment (see instructions	<i>(</i> )		[ ]	0	104. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet E | From 10/01/2015 Part A Exhibit 4 | To 09/30/2016 Date/Time Prepared: 2/28/2017 1:33 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0075

						07/30/2010	2/28/2017 1:3	3 pm
		W/C F B . A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0		0	0	1. 00
1 01	payments	1 01						1 01
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	(	)	0	1. 01
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	3, 300, 211	0		3, 300, 211	3, 300, 211	1. 02
	payments for discharges							
	occurring on or after October							
1.03	DRG for Federal specific	1. 03	o	0	(	o l	0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1.04	DRG for Federal specific	1. 04	o	0		0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00	3, 235	0	(	3, 235	3, 235	2.00
2.00	discharges (see instructions)	2.00	0,200			0,200	0,200	2.00
2. 01	Outlier payments for	2. 02	0	0	(	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01		0	,		_	3.00
3.00	reconciliation	2.01	l o	U	,	0	0	3.00
4.00	Managed care simulated	3. 00	1, 451, 837	0	(	1, 451, 837	1, 451, 837	4. 00
	payments							
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 00000	0.00000		5. 00
3.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.00000	0.00000		3.00
6.00	IME payment adjustment (see	22. 00	0	0	(	0	0	6. 00
<i>(</i> 01	instructions)	22 01		0	,			/ 01
6. 01	IME payment adjustment for managed care (see	22. 01	٥	U	(	J 0	0	6. 01
	instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	o	0	(	o	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	(	0	0	8. 01
	for managed care (see instructions)							
9.00	Total IME payment (sum of	29. 00	o	0	(	0	0	9. 00
	lines 6 and 8)							
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	O	(	0	0	9. 01
	8. 01)							
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1010	0. 1010	0. 1010	0. 1010		10.00
	instructions)							
11. 00	Di sproporti onate share	34. 00	83, 330	0	(	83, 330	83, 330	11. 00
11 01	adjustment (see instructions)	27.00	2/0 201			2/0 201	225 100	11 01
11. 01	Uncompensated care payments  Additional payment for high per	36.00 centage of FSF	260, 391 RD beneficiary (	0] di scharges		260, 391	325, 109	11.01
12. 00	Total ESRD additional payment	46. 00	0	0	(	0	0	12. 00
40.05	(see instructions)	47.00	0	_!		0 447 417		40.0-
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	3, 647, 167	0	(	3, 647, 167	3, 647, 167 0	1
14.00	(completed by SCH and MDH,	40.00		U	,			14.00
	small rural hospitals only.)							
45.00	(see instructions)	40.00	0 (47 4/7					45.00
15. 00	Total payment for inpatient operating costs (see	49. 00	3, 647, 167	U	(	3, 647, 167	3, 647, 167	15.00
	instructions)							
16.00	Payment for inpatient program	50. 00	263, 037	0	(	263, 037	263, 037	16. 00
17 00	capital	E4 00					_	17 00
17. 00	Special add-on payments for new technologies	54. 00	0	O	(	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	0	0	(	0	0	17. 01
17. 02	Credits received from	68. 00	0	O	(	0	0	17. 02
	manufacturers for replaced devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	o	0	(	o	0	18. 00
	adjustment amount (see							
_	instructions)	<u> </u>	<u>                                      </u>			<u> </u>	<u> </u>	<u> </u>

Health Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 15-0075	Peri od: Worksheet E

						rom 10/01/2015 o 09/30/2016	Date/Time Pre	pared:
							2/28/2017 1:3	3 pm
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
	I	0	1. 00	2. 00	3. 00	4. 00	5. 00	
19. 00	SUBTOTAL			0	C	3, 910, 204	3, 910, 204	19. 00
		W/S L, line	(Amounts from					
			L)	0.00	2.00	4.00	F 00	
	In	0	1.00	2.00	3.00	4. 00	5. 00	20.00
20.00	Capital DRG other than outlier	1. 00	262, 217	0		262, 217	262, 217	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	O	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	820	0	C	820	820	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	С	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	263, 037	0	С	263, 037	263, 037	26. 00
	payments (see That de trons)	W/S E, Part A	(Amounts to F					
		line	Part A)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	-	1.00		0.000000		0.00	27. 00
28. 00	Low volume adjustment	70. 96			0.00000	0.077107	0	
20.00	(transfer amount to Wkst. E, Pt. A, line)	70.70						20.00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				387, 529	387, 529	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0075

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 10/01/2015 Part A Exhibit 5 Date/Time Prepared: 2/28/2017 1:33 pm 09/30/2016 Title XVIII Hospi tal PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 4.00 2.00 3. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 0 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 3, 300, 211 1.02 3, 300, 211 3, 300, 211 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 3, 235 3, 235 3, 235 2.00 0 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 0 O 2.01 Operating outlier reconciliation 3 00 2 01 O 3 00 0 0 4.00 Managed care simulated payments 3.00 1, 451, 837 1, 451, 837 1, 451, 837 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0. 1010 0.1010 0.1010 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 83, 330 0 83.330 83. 330 11.00 instructions) 260, 391 11.01 Uncompensated care payments 36.00 0 260, 391 260, 391 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see n 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 3, 647, 167 0 3, 647, 167 3, 647, 167 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 0 15.00 49.00 3, 647, 167 3, 647, 167 3, 647, 167 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 263, 037 263, 037 263, 037 16.00 Special add-on payments for new technologies 17.00 54.00 0 0 17.00 55.00 Net organ acquisition cost 0 17.01 17.01 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 0 18.00 amount (see instructions) SUBTOTAL 19 00 O 3, 910, 204 3, 910, 204 19. 00

th Financial Systems	BLUFFTON REGIONAL MEDICAL CENTER	In Lieu of Form CMS-

Health Financial Systems B	LUFFTON REGIONAL	MEDICAL CENTE	R	In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5		F	Period: From 10/01/2015 To 09/30/2016	Date/Time Pre 2/28/2017 1:3	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	262, 217	C	262, 217	262, 217	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21.00 Capital DRG outlier payments	2.00	820	C	820	820	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.0000	0.0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	C	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	263, 037	(	263, 037	263, 037	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0			0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	387, 529		387, 529	387, 529	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	19, 389		19, 389	19, 389	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	C	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-60, 394	1 (	-60, 394	-60, 394	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	C	0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		(			32. 00
100.00 Transfer HAC Reduction Program adjustment t Wkst. E, Pt. A.	0	Y				100. 00

Health Financial Systems	BLUFFTON REGIONAL MEDICA	AL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro		From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/28/2017 1:33 pm
		T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	DDC

			10 09/30/2016	2/28/2017 1:33		
		Title XVIII	Hospi tal	PPS	э рііі	
				1. 00		
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			766	1 00	
1. 00 2. 00	Medical and other services (see Instructions)  Medical and other services reimbursed under OPPS (see instruct	tions)		2, 587, 494		
3. 00	PPS payments	ti ons)		2, 336, 039	3.00	
4. 00	Outlier payment (see instructions)			41, 013		
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000		
6. 00	Line 2 times line 5	o t. oo,		0		
7.00	Sum of line 3 plus line 4 divided by line 6			0.00		
8. 00	Transitional corridor payment (see instructions)			0		
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	9.00	
10.00	Organ acqui si ti ons			0	10.00	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			766	11. 00	
	COMPUTATION OF LESSER OF COST OR CHARGES					
	Reasonabl e charges					
	Ancillary service charges				12. 00	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0		
14. 00	Total reasonable charges (sum of lines 12 and 13)			4, 244	14. 00	
15 00	Customary charges			0	15 00	
	Aggregate amount actually collected from patients liable for p			0		
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(		n a chargebasis	0	16. 00	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	=)		0. 000000	17. 00	
	Total customary charges (see instructions)			4, 244		
	Excess of customary charges over reasonable cost (complete onl	lvifline 18 exceeds li	ne 11) (see	3, 478		
. ,	instructions)	. y	, (555	0, 1, 0		
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20.00	
	instructions)					
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		766	21.00	
	Interns and residents (see instructions)			0		
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 377, 052	24. 00	
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			4.50/	05 00	
	Deductibles and coinsurance (for CAH, see instructions)	r CALL coo i notructions)		1, 526	1	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for		and 221 (coo	511, 113		
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	prus the sum of filles 22	and 23] (See	1, 865, 179	27.00	
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		0	28. 00	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			Ö		
	Subtotal (sum of lines 27 through 29)			1, 865, 179		
	Primary payer payments			17	1	
32. 00	Subtotal (line 30 minus line 31)			1, 865, 162	32.00	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			0		
	Allowable bad debts (see instructions)			58, 661		
	Adjusted reimbursable bad debts (see instructions)			38, 130		
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		56, 610		
	Subtotal (see instructions)			1, 903, 292		
	MSP-LCC reconciliation amount from PS&R			0		
	OTHER ADJUSTMENTS PS&R	-)		57, 273	1	
39. 50 39. 98	Pioneer ACO demonstration payment adjustment (see instructions Partial or full credits received from manufacturers for replace	•	tions)	0		
	RECOVERY OF ACCELERATED DEPRECIATION	Led devices (see ilistiuc	tions)	0	1	
	Subtotal (see instructions)			1, 960, 565		
	· · · · · · · · · · · · · · · · · · ·			39, 211	1	
	Interim payments Tentative settlement (for contractors use only)			1, 883, 458 0	1	
	,			37, 896		
			0	1		
44. ()()				50		
44. 00	§115. 2		TO BE COMPLETED BY CONTRACTOR			
44.00						
				0	90.00	
90. 00	TO BE COMPLETED BY CONTRACTOR			0		
90. 00 91. 00 92. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00	
90. 00 91. 00 92. 00 93. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)			0 0. 00 0	91. 00 92. 00	

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 10/01/2015 | Part |
| To 09/30/2016 | Date/Time Prepared: | 2/28/2017 1:33 pm Health Financial Systems BLUFFTOI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0075

InterIm payments payable on Individual bilis, 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						2/28/2017 1:33	3 pm
mm/dd/yyyyy							
1.00			Inpatien	t Part A	Par	⁻t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.    3.00				2.00		4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero   1.00   1	1. 00	Total interim payments paid to provider		3, 475, 45	3	1, 883, 458	1. 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   1.00   1	2.00				0	0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		services rendered in the cost reporting period. If none,					
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 3.02 3.03 3.04 3.05 Provider to Program  3.50 3.51 3.52 3.53 3.54 3.54 3.59 3.50 3.59 3.50 4.00 3.15 3.59 4.00 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3		write "NONE" or enter a zero					
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	List separately each retroactive lump sum adjustment					3.00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02							
3.03   0		ADJUSTMENTS TO PROVIDER					
3.04					-		
3.05	3.03				0		
Provider to Program							
ADJUSTMENTS TO PROGRAM	3.05				0	0	3. 05
3.51   3.52   0							
3.52   3.53   3.54   3.99   3.50		ADJUSTMENTS TO PROGRAM					
3.53   3.54   0   0   0   3.53   3.54   0   0   0   3.53   3.54   3.59   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   3.50-3.98)   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 appropriate)   To BE COMPLETED BY CONTRACTOR   5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   TENTATIVE TO PROVIDER   0   0   5.01   5.02   5.03   Provider to Program   TENTATIVE TO PROGRAM   0   0   5.51   5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines   5.50   5.99   5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   1.50   2.00   1.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.					-	1 - 1	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   0   0   3.54   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.475, 453   1,883,458   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09)   3.99   3.475,453   1.883,458   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.475,453   1.883,458   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.475,453   1.883,458   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   3.475,453   1.883,458   4.00							
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR							
A.00   Total inferim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR	3. 99				0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR  5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  TENTATIVE TO PROVIDER  5.01 5.02 5.03 Provider to Program  5.50 TENTATIVE TO PROGRAM  0 0 0 5.02 5.03 Provider to Program  5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 0 5.59 5.50-5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 0 5.59 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM  0 125,569 37,896 6.01 Total Medicare program liability (see instructions) 3,601,022 1,921,354 7.00 Number Number Number Number Number Number Number Number				0 475 45		4 000 450	
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			3, 475, 45	3	1, 883, 458	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
5.00		appropriate)					
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	F 00			Ι			E 00
## Write "NONE" or enter a zero. (1)   Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
5. 02   0	5 01				0	0	5 01
Solid		TERMINAL TO TROVIDER					
Provider to Program						1 - 1	
TENTATI VE TO PROGRAM   0	0.00	Provider to Program			<u> </u>		0.00
5.51   0	5. 50				0	0	5. 50
5.52   0 0 5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   125,569   37,896   6.01   6.02   SETTLEMENT TO PROGRAM   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	o	
5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 125,569 37,896 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 3,601,022 1,921,354 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					0	o	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	o	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
7.00 Total Medicare program liability (see instructions)  3,601,022  1,921,354  7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01	SETTLEMENT TO PROVIDER		125, 56	9	37, 896	6. 01
Contractor   NPR Date   (Mo/Day/Yr)     0   1.00   2.00	6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program liability (see instructions)		3, 601, 02	2	1, 921, 354	7. 00
0 1.00 2.00						NPR Date	
8.00   Name of Contractor   8.00			(	)	1. 00	2.00	
	8.00	Name of Contractor					8. 00

Un Lieu of Form CMS-2552-10
Worksheet E-1
Part I
B0/2016 Date/Time Prepared:
2/28/2017 1:33 pm Peri od: From 10/01/2015 To 09/30/2016 Component CCN: 15-5373

		Title	XVIII	Skilled Nursing Facility	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		547, 780		0	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero 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		C		0	3. 01
3. 02			C	1	0	3. 02
3.03			C	1	0	3. 03
3.04			C		0	3. 04
3. 05	Provider to Program		C	1	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM			1	0	3. 50
3. 51	ADSOSTMENTS TO TROOKAW		ď		0	3. 51
3. 52			d	)	0	3. 52
3.53			c	)	0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		С		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		547, 780		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					F 00
5.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider			'		
5.01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5.03			C		0	5. 03
F F0	Provi der to Program				0	F F0
5. 50 5. 51	TENTATI VE TO PROGRAM			1	0	5. 50 5. 51
5. 51				1	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ď		o o	5. 99
	5. 50-5. 98)		_		_	
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		c	)	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		d		0	6. 02
7.00	Total Medicare program liability (see instructions)		547, 780		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	

8. 00

8.00 Name of Contractor

Heal th	Financial Systems BLUFFTON REGIONAL	MEDICAL CENTER	In Lie	u of Form CMS-2	<u> 2552-10</u>	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0075 Period: Worksho						
			From 10/01/2015			
			To 09/30/2016	Date/Time Prep 2/28/2017 1:33		
		Title XVIII	Hospi tal	PPS	3 piii	
	Title Will Hospital					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N				
1.00						
2. 00						
3. 00						
4. 00						
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			171, 080, 443	1	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		332, 669	•	
7. 00	CAH only - The reasonable cost incurred for the purchase of		Wkst. S-2. Pt. I	0	7. 00	
	line 168	33	, ,		1	
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)			o	31. 00	
22 00	Polance due provider (line 0 (er line 10) minus line 20 and	line 21) (coo inctruction	20)		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

Heal th	Financial Systems BLUFFTON REGION	NAL MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Peri od:	Worksheet E-3		
		Component CCN: 15-5373	From 10/01/2015 To 09/30/2016	Part VI Date/Time Pre	narod:	
		Component CCN. 13-3373	10 09/30/2010	2/28/2017 1:3		
		Title XVIII	Skilled Nursing	PPS		
			Facility Facility			
				1 00		
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALI	I OTHER HEALTH SERVICES FOR T	TIE VIIII DADT A	1. 00		
	SERVICES	L OTHER HEALTH SERVICES FOR T	IILE AVIII PARI A	PPS SINF		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)					
1.00	Resource Utilization Group Payment (RUGS)			609, 852	1.00	
2.00	Routine service other pass through costs			0	2. 00	
3.00	Ancillary service other pass through costs			0	3. 00	
4.00	4.00   Subtotal (sum of lines 1 through 3)					
	COMPUTATION OF NET COST OF COVERED SERVICES					
5.00						
	Part B. This line is now shaded.)					
6.00	Deducti bl e			0	6. 00	
7.00	Coinsurance			50, 894	7. 00	
8. 00	Allowable bad debts (see instructions)			0	8. 00	
9.00	Reimbursable bad debts for dual eligible beneficiaries (	see instructions)		0	9. 00	
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00	
11. 00	Utilization review	10 11)/ !	>	0	11. 00	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 4, 5 minus lines 6 and 7, plus lines 1, particular polyments	nes 10 and 11)(see Instruction	ns)	558, 958	12. 00 13. 00	
	Inpatient primary payer payments ROUNDING			0	14. 00	
	Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	14. 50	
	Recovery of Accelerated Depreciation	Cti ons)		0	14. 50	
	Subtotal (see instructions			558, 959		
	Sequestration adjustment (see instructions)			11, 179		
	Interim payments			547, 780		
	UNITED THE PAYMENTS SATISFACTOR OF THE PAYMENT OF T					

0 17. 00 0 18. 00

0 19.00

17.00 Tentative settlement (for contractor use only)
18.00 Balance due provider/program (line 15 minus lines 15.01, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, 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: 15-0075

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

onl y)			'	0 09/30/2010	2/28/2017 1: 3	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS			1		
1.00	Cash on hand in banks	-417, 067		_	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		_	0	2. 00 3. 00
4. 00	Accounts receivable	6, 113, 032	1	0	0	4.00
5. 00	Other recei vable	0	Ö	o o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-1, 358, 897	ď	0	0	6. 00
7. 00	Inventory	1, 203, 178		0	0	7. 00
8.00	Prepai d expenses	181, 261	•	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	334, 038		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	6, 055, 545				11.00
	FIXED ASSETS					
12.00	Land	3, 844, 900	C	0	0	12. 00
13. 00	Land improvements	748, 002	1	_		13. 00
14. 00	Accumulated depreciation	-422, 474	•	_	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	21, 420, 896 -9, 415, 339	1	١	0	15. 00 16. 00
17. 00	Leasehold improvements	4, 975, 804	1	_	0	17. 00
18. 00	Accumulated depreciation	-3, 321, 694	•	0	0	18. 00
19. 00	Fi xed equipment	4, 027, 892	. C	0	0	19. 00
20.00	Accumulated depreciation	-2, 911, 786	•	_	0	20.00
21. 00	Automobiles and trucks	27, 200			0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	-27, 200 10, 477, 460			0	22. 00 23. 00
24. 00	Accumulated depreciation	-8, 386, 265		0	0	24.00
25. 00	Mi nor equipment depreciable	2, 855, 990	1	Ö	Ö	25. 00
26.00	Accumulated depreciation	-2, 062, 452	. C	0	0	26. 00
27. 00	HIT designated Assets	0	0	_	0	27. 00
28. 00	Accumulated depreciation	0		_	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	21, 830, 934	0	_	0	29. 00 30. 00
30.00	OTHER ASSETS	21,030,934		<u> </u>	0	30.00
31.00	Investments	0	) C	0	0	31.00
32.00	Deposits on Leases	0	) C	0	0	32. 00
33. 00	Due from owners/officers	0	0	_	0	33. 00
34. 00	Other assets	4, 842, 953		_	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	4, 842, 953 32, 729, 432		_	0	35. 00 36. 00
30. 00	CURRENT LIABILITIES	32, 727, 432	-1	<u> </u>		30.00
37.00	Accounts payable	1, 276, 759	O	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 201, 123	C	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00 41. 00	Notes and loans payable (short term)  Deferred income	0		0	0	40. 00 41. 00
42. 00	Accel erated payments	0		, o	0	42.00
43. 00	Due to other funds	25, 895, 783	C	0	0	43. 00
44.00	Other current liabilities	242, 055		_	ľ	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	28, 615, 720	) C	0	0	45. 00
47,00	LONG TERM LIABILITIES					1/ 00
46. 00 47. 00	Mortgage payable Notes payable	0		_	0	46. 00 47. 00
48. 00	Unsecured Loans	0			0	48. 00
49. 00	Other long term liabilities	0	Ö	Ö	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	) C	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	28, 615, 720	) <u> </u>	0	0	51.00
F2 00	CAPITAL ACCOUNTS	4 112 712	,			F2 00
52. 00 53. 00	General fund balance Specific purpose fund	4, 113, 712				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	4, 113, 712		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	32, 729, 432		o o	Ö	60.00
	59)		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0075

					То	09/30/2016	Date/Time Prep 2/28/2017 1:33	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	•
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		4, 994, 543	1		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-880, 825	1				2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		4, 113, 718		0	0	o	3. 00 4. 00
5. 00	Additions (credit adjustments) (specify)				0		0	5. 00
6. 00					0		0	6. 00
7. 00		O			0		0	7. 00
8.00		0			0		0	8.00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		4, 113, 718			O	0	11.00
12. 00 13. 00	ROUNDI NG	6			0		0	12. 00 13. 00
14. 00					0		0	14. 00
15. 00					0		Ö	15. 00
16. 00		0			0		0	16.00
17. 00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		6			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4, 113, 712			0		19. 00
	Sheet (Title II iii lius II lie 10)	Endowment Fund	PI ant	Fund				
	I <del>-</del>	6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)		0		O			4. 00
5. 00	(, (, (, (, (		0					5. 00
6.00			0					6.00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 4-9)		0		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	ROUNDI NG		0					12. 00
13.00			0					13.00
14.00			0					14.00
15. 00			0					15. 00
16. 00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0			17. 00 18. 00
19. 00	Fund balance at end of period per balance				0			19. 00
50	sheet (line 11 minus line 18)				Ĭ			
	•	,					·	

Health Financial Systems BLUF STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0075

			То	09/30/2016	Date/Time Pre 2/28/2017 1:3	
	Cost Center Description	Inpatient	1	Outpati ent	Total	o piii
		1.00		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	10, 185, 9	41		10, 185, 941	1. 00
2.00	SUBPROVIDER - IPF					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	3, 114, 9	90		3, 114, 990	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)	13, 300, 9	31		13, 300, 931	10. 00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	2, 994, 6	42		2, 994, 642	•
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL I NTENSI VE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 994, 6	42		2, 994, 642	16. 00
47.00	11-15)	4/ 005 5			44 005 570	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	16, 295, 5			16, 295, 573	
18.00	Ancillary services	46, 927, 5	- 1	0	46, 927, 559	18.00
19. 00 20. 00	Outpatient services		0	107, 857, 311	107, 857, 311	19. 00
	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00 22. 00	FEDERALLY QUALIFIED HEALTH CENTER   HOME HEALTH AGENCY		U	٩	Ü	21. 00 22. 00
23. 00	AMBULANCE SERVICES			0	0	23. 00
24. 00	CMHC		U	٩	Ü	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26. 00	HOSPICE					26. 00
27. 00	OTHER (SPECIFY)		0	o	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	63, 223, 1	32	107, 857, 311	171, 080, 443	28. 00
20.00	G-3, line 1)	00,220,	-	.07,007,011	1717 0007 110	20.00
	PART II - OPERATING EXPENSES	<u>'</u>		'		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			33, 571, 465		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	T		0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf to Wkst. G-3, line 4)	er		33, 571, 465		43. 00

Heal th	Financial Systems BLUFFTON REGIONAL N	MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0075	Peri od:	Worksheet G-3	
			From 10/01/2015 To 09/30/2016	Date/Time Pre 2/28/2017 1:3	
				1 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	20. 20)		1. 00 171, 080, 443	1. 00
2.00	Less contractual allowances and discounts on patients' accour			138, 716, 705	2.00
3.00	Net patient revenues (line 1 minus line 2)	11.5		32, 363, 738	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		33, 571, 465	
5. 00	Net income from service to patients (line 3 minus line 4)	43)		-1, 207, 727	
0.00	OTHER I NCOME			1,207,727	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	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	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	
24. 00	OTHER (SPECIFY)			0	
25. 00	Total other income (sum of lines 6-24)			0	25. 00
26. 00	Total (line 5 plus line 25)			-1, 207, 727	26. 00
27. 00	OTHER			-326, 902	
20 00	Total other expenses (sum of Line 27 and subscripts)			224 002	20 00

-326, 902 27. 00 -326, 902 28. 00 -880, 825 29. 00

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

Heal th	Financial Systems BLUFFTON REGIONAL M	MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0075	Peri od: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Pre 2/28/2017 1:3	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCEETING METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			262, 217	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier			202, 217	1
2. 00	Capital DRG outlier payments			820	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	12. 60	
4.00	Number of interns & residents (see instructions)		,	0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	., part A line	0. 00	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	ictions)		0.00	8. 00
9. 00	Sum of lines 7 and 8	icti ons)		0.00	
10.00	Allowable disproportionate share percentage (see instructions	5)			10.00
11. 00	Disproportionate share adjustment (see instructions)	-,		0	
12. 00	, , , , , , , , , , , , , , , , , , , ,			263, 037	12. 00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			11.00	
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6. 00 7. 00	Percentage adjustment for extraordinary circumstances (see in		(lino 4)	0. 00 0	
7. 00 8. 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	/ CITCUMStances (ITHE 2 X	( Time 6)	0	
9. 00	Current year capital payments (from Part I, line 12, as appli	cable)		0	
10. 00	Current year comparison of capital minimum payment level to c		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over o			0	
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	numents (line 10 plus lis	no. 11)	0	12. 00
12.00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over of			0	
14.00	(if line 12 is negative, enter the amount on this line)	capital payment for the f	orrowing period		14.00
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. 00
16. 00		,		0	1
17. 00	Current year exception offset amount (see instructions)			0	17. 00
			·		