Health Financia	al Syst	ems	COLUMBUS REGIONAL I	HOSPI TAL			In Lie	u of Form	CMS-	2552-10
This report is	requi i	red by Law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can	resul	t in all	interim	FORM APP	ROVED)
payments made	since '	the beginning of the co	st reporting period being o	leemed overpaymen	its (42	USC 1395	g).	OMB NO.	0938-	-0050
HOSPITAL AND H AND SETTLEMENT			OST REPORT CERTIFICATION	Provi der CCN: 15	50112	Period:	01/2015	Workshee Parts I-		
AND SETTLEMENT	JUIVIIVIAI	VI						Date/Tim 5/24/201	e Pre	
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	5/24/20	16 Tir	ne: '	9:01 pm
use only	2. [] Manually submitted co	st report							
	3. [0 4. [F] If this is an amended] Medicare Utilization.	report enter the number of Enter "F" for full or "L"	f times the provi for low.	der re	esubmitted	d this co	ost repor	t	
Contractor use only	(1) (2) (3)]Cost Report Status As Submitted Settled without Audit Settled with Audit Reopened		this Provider CC his Provider CCN	11. C CN 12. [ne 5, co			

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (150112) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	` '
Title	
11 (1)	-
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	197, 437	141, 244	-13, 140	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	35, 826	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	233, 263	141, 244	-13, 140	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-MEDI CARE.

Heal th	Financial Systems	COLUMBUS REC	GI ONAL	HOSPI TAL			I	n Li eu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Provi de	r CCN:	150112	Period: From 01/01	/2015	Workshe Part I Date/Ti	et S-2	
	1.00	2.00		3. (nn				5/24/20		
	Hospital and Hospital Health Care Co			J. (<u> </u>			4.00			
1.00	Street: 2400 EAST 17TH STREET	PO Box:									1. 00
2.00	Ci ty: COLUMBUS	State: IN		p Code: 4			ty: BARTHOLO		-+ 6+	(D	2. 00
		Component Name			CBSA umber	Provi der Type	Date Certified		nt Syst 0, or		
			l Nu	illibei W	ullibei	Type	Certified	V ,	XVIII		
		1.00	2	. 00	3. 00	4.00	5. 00	6. 00			
	Hospital and Hospital-Based Componen										
3.00	Hospi tal	COLUMBUS REGIONAL	15	0112 1	8020	1	07/01/1966	b N	P	0	3. 00
4. 00	Subprovider - IPF	HOSPI TAL									4. 00
5.00	Subprovider - IRF	COLUMBUS REGIONAL RE	HAB 15	T112 1	8020	5	01/01/1984	ı N	P	N	5. 00
		UNI T									
6.00	Subprovider - (Other)										6. 00
7.00	Swing Beds - SNF										7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 9. 00
10.00	Hospi tal -Based NF										10.00
11. 00	Hospi tal -Based OLTC										11. 00
12.00	Hospi tal -Based HHA										12. 00
13. 00	Separately Certified ASC										13. 00
	Hospi tal -Based Hospi ce										14.00
15.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15. 00 16. 00
17. 00	Hospital-Based (CMHC) I										17. 00
	Hospi tal -Based (CORF) I										17. 10
18.00	Renal Dialysis										18. 00
19. 00	0ther							<u> </u>			19. 00
							From 1.00		To 2. 0		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20. 00
	Type of Control (see instructions)						0.70.72	8		20.0	21. 00
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it								N		22. 00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				/U(C)(2	2) (11 CK1 C					
22. 01	Did this hospital receive interim un				cost re	eporting	N		Υ		22. 01
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period occur	rring o	n or arte	er octo	ober I.					
22. 02	Is this a newly merged hospital that	requires final uncom	mpensate	ed care p	ayment	ts to be	N		N		22. 02
	determined at cost report settlement	? (see instructions)	Enter i	in column	າ 1້, "ነ	Y" for ye	s				
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for	no, for the portion of	of the o	cost repo	orting	period o	n				
22 03	or after October 1. Did this hospital receive a geograph	ic reclassification (from url	ban to ru	ıral as	s a resul	t N		N		22. 03
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,			antou in	uccor (adrice wit	"				
23. 00	Which method is used to determine Me	dicaid days on lines	24 and					3	N		23. 00
	1, enter 1 if date of admission, 2 i										
	method of identifying the days in th used in the prior cost reporting per	1 3 1									
	jassa iii tiis piisi sest isperting per		-State	In-Stat		ut-of		Medi cai	d 0	ther	
			di cai d	Medi cai		State		HMO day	/s Med	li cai d	
		pai	d days	eligibl			Medicaid		d	lays	
				unpai d days	pai	d days	el i gi bl e unpai d				
		1	1.00	2. 00	-	3. 00	4. 00	5. 00	- +	. 00	
24. 00	If this provider is an IPPS hospital		1, 499			7	0		738		24. 00
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in cout-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
25. 00	If this provider is an IRF, enter th		50	1	55	O	0		O		25. 00
	Medicaid paid days in column 1, the										
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										
-											

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150112 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/24/2016 3:03 pm Program Code Unweighted IME Program Name Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

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

	Financial Systems		REGIONAL HOSPITAL	0011 450440 5			orm CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENIIFICATION DA	IA Provi der	F	eriod: rom 01/01/20 o 12/31/20	015 Part 015 Date	/Time Pre	pared:
				Unwei ghted	Unwei ghte		/2016 3:0 (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col.	1 + col. 2))	
				1. 00	2.00		3. 00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		Nonprovider Setting	gsEffective f	or cost repo	orting pe	ri ods	
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	0.00	0	0. 00	0. 000000	66. 00
	(cordinar - drvided by (cordinar -	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighte FTEs in Hospital	(col.	(col. 3/ 3 + col. 4))	
		1.00	2.00	Si te 3. 00	4.00		5. 00	
67. 00	Enter in column 1, the program	1.00	2.00	0.00		. 00	0. 000000	67. 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
					-	1.00 2.0	00 3.00	_
	Inpatient Psychiatric Facility P	PS				1.00 2.0	0 3.00	
70. 00	Is this facility an Inpatient Ps		PF), or does it cont	ain an IPF subp	orovi der?	N		70. 00
71.00	Enter "Y" for yes or "N" for no. 10 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS							
75. 00	Is this facility an Inpatient Re	habilitation Facility	(IRF), or does it o	contain an IRF		Υ		75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes on in accordance column 2 is Y,	"N" for with 42	N	0	76. 00
							1. 00	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Ent	er	N N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne	w Other subprovider (0.	N	85. 00 86. 00
87. 00	§413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I for yes or "N" for no.		nder section 1886(d)	(1) (B) (i v) (II)			N	87. 00
					1. 00		XI X 2. 00	
90. 00	Title V and XIX Services Does this facility have title V yes or "N" for no in the applica		hospital services? E	Inter "Y" for	N		Y	90. 00
	Is this hospital reimbursed for full or in part? Enter "Y" for y	title V and/or XIX th es or "N" for no in t	he applicable column	١.	N		N	91.00
	Are title XIX NF patients occupy instructions) Enter "Y" for yes	or "N" for no in the	applicable column.				N	92. 00
	Does this facility operate an IC "Y" for yes or "N" for no in the Does title V or XIX reduce capit	applicable column.			N N		N N	93.00
, ,, 50	applicable column.		. 300, and it for it		14			100

Health Financial Systems COLUMBUS REGIO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period: From 01/01/201 To 12/31/201	5 Date/Time Pr 5/24/2016 3:	epared:
			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 ye applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the ap	s or "N" for n	o in the	0. (N	0. C N	95. 00 96. 00 97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (C 106.00 olf this facility qualifies as a CAH, has it elected the all		nod of pavment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	t reimbursemen n 1. (see inst	t for I&R ructions) If	N		107. 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.			N		108. 00
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respiratory 4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109. 00
110.00 Did this hospital participate in the Rural Community Hospit	al Demonstration	on project (41	IOA Demolfor	1. 00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N"		on project (4)	TOA Dellio) Tol	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	110.00
Miscellaneous Cost Reporting Information			1.	00 2.00 3.00)
115.00 s this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide	. If column 2 int for long te	is "E", enter rm care (inclu	in column udes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu				(116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po	licy? Enter 1	f the policy	is	1	118. 00
jord made. Enter E the pointey to code. I dilect		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00	2.00	3.00	0118.01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y ualifies for t	' for yes or ne Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.	antable device	s charged to	Y		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	ter the certif	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	ter the certif	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.		cation date in	ו		129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co	lumn 2.				130. 00
131.00 If this is a Medicare certified intestinal transplant cente date in column 1 and termination date, if applicable, in co	lumn 2.				131. 00
132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column		cation date			132. 00
133.00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column	2.				133. 00
134.00 If this is an organ procurement organization (0P0), enter t and termination date, if applicable, in column 2.	he OPO number	n column 1			134. 00

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPLE		EGIONAL HOSPITAL Provider	CCN: 150112	Peri od:		u of Form CMS- Worksheet S-2	
				From O	1/01/2015 2/31/2015	Part I Date/Time Pre 5/24/2016 3:0	epared
					1. 00	2.00	-
All Providers					1.00	2.00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1.	If yes, and home	office cos		Y		140. (
1.00		2. 00			3. 00		
If this facility is part of a cha home office and enter the home of				name and	d address	of the	
11. 00 Name:	Contractor's Name			ctor's Nu	mber:		141.
2.00 Street:	PO Box:						142.
3. 00 Ci ty:	State:		Zi p Co	de:		I	143.
						1.00	+
14.00 Are provider based physicians' cos	sts included in Workshe	eet A?				Y	144.
rs coluc					1. 00	2. 00	
15.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N" 16.00 Has the cost allocation methodology.	' for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pre	o in column 1. If c tion for this cost eviously filed cost	column 1 is reporting report?		Y	12/31/2015	145.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		ub. 15-2, chapter 4 	·0, §4020)	lf			
						1.00	
7.00 Was there a change in the statisti						Y	147. 148.
8.00Was there a change in the order of 9.00Was there a change to the simplifi				or no		N N	148.
7. oomas there a change to the simpirin	rea cost irriaring method	Part A	Part B		itle V	Title XIX	177.
		1.00	2. 00		3. 00	4.00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or 5.00 Hospi tal	N TOT NO TOT Each Cor	N	and Part B	3. (See 4 ₂	<u>2 CFR 9413</u> N	N N	155.
6.00 Subprovi der - IPF		N	N		N	N	156.
7.00 Subprovi der - IRF		N	N		N	N	157.
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 159.
60. OOHOME HEALTH AGENCY		N N	N N		N	N	160.
51. 00 CMHC			N		N	N	161.
61. 10 CORF			N		N	N	161.
Multicampus						1.00	
65.00 s this hospital part of a Multica	ampus hospital that has	s one or more campu	ses in dif	ferent CE	SSAs?	N	165.
Enter "Y" for yes or "N" for no.		·					
	Name 0	County 1.00		Zip Code	4. 00	FTE/Campus 5.00	4
66.00 If line 165 is yes, for each	0	1.00	2. 00	3. 00	4.00		0166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	
Health Information Technology (HI	T) incentive in the Ame	eri can Recovery and	d Reinvestm	nent Act		1.00	
o7.00 s this provider a meaningful use o8.00 f this provider is a CAH (line 10 reasonable cost incurred for the l	r under §1886(n)? Ente O5 is "Y") and is a mea	er "Y" for yes or " aningful user (line	N" for no.		the	Y	167. 0168.
18.01 If this provider is a CAH and is a exception under §413.70(a)(6)(ii)	not a meaningful user,	does this provider			lshi p		168.
59.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")			s "N"), e			0169.
				Ве	gi nni ng	Endi ng	
70.00 Enter in columns 1 and 2 the EHR I	neginning data and and	ng date for the re	norting	04	1. 00 /20/2015	2.00 07/18/2015	170.
period respectively (mm/dd/yyyy)	beginning date and endi	ing date for the fe	por crity	047	20/2013	077 107 2015	1/0.

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu o					
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provi der CCN: 150112	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/24/2016 3:0	
				1. 00	
171.00 If line 167 is "Y", does this pro	on 1876	N	171. 00		
Medicare cost plans reported on W	nd "N" for no.				
(see instructions)					

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		_		Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pro	2 epared:
					Y/N	5/24/2016 3:0 Date	03 pm
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	oonses. Enter N for	all NO re	esponses. Enter	all dates in	the	
1. 00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of				N		1.00
				Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Progr	am2 If	1.00 N	2. 00	3.00	2. 00
3. 00	yes, enter in column 2 the date of termination voluntary or "I" for involuntary. Is the provider involved in business transact	on and in column 3, tions, including ma	"V" for nagement	Y			3. 00
	contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or inclationships? (see instructions)	d to the provider o l, or members of th	rits e board				
				1.00	7ype 2. 00	3. 00	+
	Financial Data and Reports			1.00	2.00	3.00	
4. 00	Column 1: Were the financial statements prey Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instructions	Audited, "C" for C enter date availab	ompiled,	Y	А		4. 00
5.00	Are the cost report total expenses and total		from	Y			5. 00
	those on the filed financial statements? If y	yes, submit reconci	liation.)/ /NI		
					Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6.00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N		6.00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs?	Olf "V" coolingtru	cti onc		Υ		7. 00
8. 00	Were nursing school and/or allied health produced			d during the	Y		8.00
	cost reporting period? If yes, see instruction	ons.		Ü			
9. 00	Are costs claimed for Interns and Residents i		uate medio	cal education	N		9. 00
10. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		newed in 1	the current	N		10.00
	cost reporting period? If yes, see instruction						
11. 00	Are GME cost directly assigned to cost center		in an App	oroved	N		11.00
	Teaching Program on Worksheet A? If yes, see	I NSTructi ons.				Y/N	
						1.00	
	Bad Debts						
12. 00 13. 00	Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy.				st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? If	f yes, see inst	ructi ons.	N	14.00
15. 00	Did total beds available change from the price	or cost reporting p	eriod? If			N	15. 00
		Descriptio	nn.	Y/N	rt A Date	Part B Y/N	
		0	л I	1.00	2. 00	3. 00	
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	04/20/2016	Y	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			Y	04/20/2016	Y	17. 00
18. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not			N		N	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19. 00
20. 00	instructions.	MGD CARE PART A DIS DAYS	SCH & PT	Y		N	20. 00

					From 01/01/2015 To 12/31/2015		
				Р	art A	Part B	
		Descr	iption	Y/N	Date	Y/N	
			0	1. 00	2. 00	3. 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 HOSPIT	TALS ONLY (EVC	EDT CUIINDENS U	OSDI TALS)		1.00	
	Capital Related Cost	IALS ONL! (LAC	ELL CHIEDKENS II	OSIT TALS)			
	Have assets been relifed for Medicare purpose	es? If yes, se	e instructions			N	22. 00
23.00	Have changes occurred in the Medicare depreci			als made duri	ng the cost	N	23. 00
	reporting period? If yes, see instructions.	·	• • • • • • • • • • • • • • • • • • • •		Ü		
24.00	Were new leases and/or amendments to existing	g Leases enter	ed into during	this cost rep	porting period?	N	24. 00
	If yes, see instructions						
25. 00	Have there been new capitalized leases entere	ed into during	, the cost repor	ting period?	If yes, see	N	25. 00
27 00	instructions.	uinad dunina +	ha aaat manamti	na noniod0 la	F v.o.o	N	24 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	urred durring t	ne cost reporti	ng perrou? I	yes, see	N	26. 00
27. 00	Has the provider's capitalization policy char	naed durina th	ne cost reportin	a period? If	ves submit	N	27. 00
27.00	copy.	ingou au ing in	.o	g po ou	J001 000 t		27.00
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letter	rs of credit e	entered into dur	ing the cost	reporti ng	N	28. 00
	period? If yes, see instructions.						l
29. 00	Did the provider have a funded depreciation a			bt Service Re	eserve Fund)	Y	29. 00
20.00	treated as a funded depreciation account? If			-1-1-40 1.6		N.	20.00
30. 00	Has existing debt been replaced prior to its instructions.	scheduled mat	urity with new	debt? IT yes,	see	N	30.00
31. 00	Has debt been recalled before scheduled matur	rity without i	ssuance of new	deht? If ves	500	N	31. 00
01.00	instructions.	irty wrthout i	SSudifice of fiew	dobt. IT yes,	300		01.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni she	d through co	ntractual	N	32. 00
	arrangements with suppliers of services? If						l
33. 00	If line 32 is yes, were the requirements of S	Sec. 2135.2 ap	plied pertainin	g to competi	tive bidding? If		33. 00
	no, see instructions.						
	Provider-Based Physicians Are services furnished at the provider facili	ity under an a	rrangement with	nrovi der-has	end physicians?	Y	34.00
34.00	If yes, see instructions.	ity under an a	ii i arigeillerit wi tri	provider-bas	seu physicians:	'	34.00
35. 00	If line 34 is yes, were there new agreements	or amended ex	isting agreemen	ts with the i	provi der-based	Υ	35. 00
	physicians during the cost reporting period?						
					Y/N	Date	
					1. 00	2. 00	
	Home Office Costs						
36.00	Were home office costs claimed on the cost re				N		36.00
37. 00	If line 36 is yes, has a home office cost stallf yes, see instructions.	atement been p	repared by the	nome office?			37. 00
38. 00		of the home of	fice different	from that of			38. 00
30. 00	the provider? If yes, enter in column 2 the						30.00
39. 00	If line 36 is yes, did the provider render so	,			,		39. 00
	see instructions.		•				
40.00	If line 36 is yes, did the provider render so	ervices to the	home office?	If yes, see			40. 00
	instructions.						
			1	00	2	00	_
	Cost Report Preparer Contact Information		1.	00	2.	00	
41 00	Enter the first name, last name and the title	e/nosition	CATHERI NE		SIMMONS		41.00
00	held by the cost report preparer in columns				3		50
	respectively.	., _, aa o,					
42.00	Enter the employer/company name of the cost i	report	COLUMBUS REGIO	NAL HOSPITAL			42. 00
	preparer.						
43. 00	Enter the telephone number and email address		812-376-5248		CSI MMONS@CRH. O	RG	43. 00
	report preparer in columns 1 and 2, respective	vei y.	1		1		II

				From 01/01/2015 To 12/31/2015	Part II Date/Time Prep 5/24/2016 3:03	
		Part B		· .		
		Date				
		4. 00				
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	04/20/2016				16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/20/2016				17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21. 00
			3.00			
	Cost Report Preparer Contact Information		2.22			
	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		MANAGER ACCOUNTING			41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report				42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective					43. 00

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	Non-Cl	MS HFS Wor	ksheet
VOLUNT	CARY CONTACT INFORMATION		Provi der CCN: 150112	From 01/01/2015 Part To 12/31/2015 Date	sheet S-2 V /Time Prep /2016 3:0	pared:
				1.00		
	Cost Report Preparer Contact Information					
1.00	First Name			CATHERI NE		1.00
2.00	Last Name			SI MMONS		2. 00
3.00	Ti tl e			MANAGER ACCT/REPORT/	/REIMB	3. 00
4.00	Empl oyer			COLUMBUS REGIONAL HO	OSPI TAL	4. 00
5.00	Phone Number			(812)376-5248		5. 00
6.00	E-mail Address			CSI MMONS@CRH. ORG		6. 00
7.00	Department					7. 00
8.00	3.00 Mailing Address 1 2400 EAST 17TH STREE					
9.00	0.00 Mailing Address 2					
10.00	Ci ty			COLUMBUS		10. 00
11. 00	State				I N	11. 00
12.00				47201		12. 00
	Officer or Administrator of Provider Contact	Information				
13.00	First Name			MARLENE		13. 00
14.00				WEATHERWAX		14. 00
15.00	Ti tl e			VP FINANCE & CFO		15. 00
16.00	Empl oyer			COLUMBUS REGIONAL HO	OSPI TAL	16. 00
17.00	Phone Number			(812)376-5205		17. 00
18. 00	E-mail Address			MWEATHERWAX@CRH. ORG		18. 00
19.00	Department					19. 00
20. 00	Mailing Address 1			2400 EAST 17TH STREE	ET	20. 00
21. 00	Mailing Address 2					21. 00
22. 00				COLUMBUS		22. 00
	State				I N	
24. 00	Zi p			47201		24. 00

Heal th	Health Financial Systems COLUMBUS REGIONAL HOSPITAL Non-CMS HFS Workshe								
HFS Su	pplemental Information	Provi der CCN: 150112	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part IX Date/Time Pre 5/24/2016 3:0	pared:				
			Title V	Title XIX					
			1. 00	2. 00					
	TITLES V AND/OR XIX FOLLOWING MEDICARE								
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Intern stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in and Y/N in column 2 for Title XIX.		Y	Υ	1. 00				
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report Part I (e.g. net of Physician's component)? Enter Y/N in colum			Υ	2. 00				
3.00	<pre>in column 2 for Title XIX. Do Title V or XIX follow Medicare (Title XVIII) for the calcul Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for T 2 for Title XIX.</pre>			Υ	3. 00				
	Inpatient Outpatient								
			1. 00	2. 00					
	CRITICAL ACCESS HOSPITALS								
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Access reimbursed 101% of cost? Enter Y or N in column 1 for inpatien		N 2	N	4. 00				
5. 00	for outpatient. Does Title XIX follow Medicare (Title XVIII) for Critical Accereimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient.	ss Hospitals (CAH) being	g N	N	5. 00				
			Title V	Title XIX					
			1. 00	2. 00					
	RCE DI SALLOWANCE								
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disallo column 4? Enter Y/N in column 1 for Title V and Y/N in column	· · · · · · · · · · · · · · · · · · ·	Y	Υ	6. 00				
	PASS THROUGH COST								
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (paymen worksheets D, parts I through IV? Enter Y/N in column 1 for Ti 2 for Title XIX.		Y	Υ	7. 00				
	RHC		•		1				
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Ente Title V and Y/N in column 2 for Title XIX.	r Y/N in column 1 for	N	N	8. 00				

					To	12/31/2015	Date/Time Prep 5/24/2016 3:03	
							I/P Days / 0/P	5 PIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	INO.	or beds	Avai I abl e	CAIT HOULS	11110	
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		132		0.00		1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		.02	10, 100	0.00		
	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						O	6. 00
7. 00	Total Adults and Peds. (exclude observation			132	48, 180	0.00	o	7. 00
	beds) (see instructions)				,			
8.00	INTENSÎVE CARE UNIT	31. 00		18	6, 570	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0	o	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	o	0.00	0	11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00		43. 00					0	13. 00
14. 00	Total (see instructions)			150	54, 750	0.00	0	14.00
15. 00	1						0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		18	6, 570		0	17. 00
18. 00	SUBPROVI DER	42. 00		0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	o		0	19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	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
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			168				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00								31. 00
32. 00				0	o			32.00
32. 01								32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00

				1	0 12/31/2015	5/24/2016 3:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component		Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
	columns 5, 6, 7 and	12, 268	5, 102	26, 317			1. 00
8 exclude Swing Bed, C							
Hospi ce days) (see inst							
for the portion of LDF	* 1	2, 652					2 00
2.00 HMO and other (see ins 3.00 HMO IPF Subprovider	structions)	2, 002	U				2. 00 3. 00
4.00 HMO IRF Subprovider		407	0				4. 00
5.00 Hospital Adults & Peds	Swing Rod SNE	407	0	0			5. 00
6.00 Hospital Adults & Peds		U .	0	0			6.00
7.00 Total Adults and Peds.		12, 268	5, 102	26, 317			7.00
beds) (see instruction	`	12, 200	3, 102	20, 317			7.00
8. 00 INTENSIVE CARE UNIT	13)	1, 367	361	2, 875			8. 00
9. 00 CORONARY CARE UNIT		1,307	0	2,075			9.00
10.00 BURN INTENSIVE CARE UN	ПТ	0	0	0			10.00
11. 00 SURGICAL INTENSIVE CAR	1	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SF	1	ı —	Ĭ	· ·			12. 00
13. 00 NURSERY	20111)		1, 670	3, 324			13. 00
14.00 Total (see instruction	ns)	13, 635	7, 133	32, 516		1, 223. 00	
15.00 CAH visits	,	0	0	02,010		1,220.00	15. 00
16. 00 SUBPROVI DER - I PF		ol	o	0		0.00	
17. 00 SUBPROVI DER - I RF		2, 825	205	4, 220			
18. 00 SUBPROVI DER		0	0	0	0.00	0.00	
19.00 SKILLED NURSING FACILI	TY	o	o	0			1
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21. 00
22.00 HOME HEALTH AGENCY		o	o	0	0.00	0.00	22. 00
23.00 AMBULATORY SURGICAL CE	NTER (D. P.)						23. 00
24. 00 HOSPI CE							24. 00
24.10 HOSPICE (non-distinct	part)	o	o	0			24. 10
25.00 CMHC - CMHC							25. 00
25. 10 CMHC - CORF		O	o	0	0.00	0.00	25. 10
26.00 RURAL HEALTH CLINIC		0	0	0	0.00	0.00	26. 00
26. 25 FEDERALLY QUALIFIED HE	ALTH CENTER	0	0	0	0.00	0.00	
27.00 Total (sum of lines 14	-26)				0.00	1, 247. 00	27. 00
28.00 Observation Bed Days			709	3, 579			28. 00
29.00 Ambulance Trips		4, 254					29. 00
30.00 Employee discount days	s (see instruction)			0			30. 00
31.00 Employee discount days				0			31. 00
32.00 Labor & delivery days		0	0	0			32. 00
32.01 Total ancillary labor				0			32. 01
outpatient days (see i	nstructi ons)						
33.00 LTCH non-covered days		0	l		1		33.00

				To	12/31/2015	Date/Time Pre 5/24/2016 3:0	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		1, 506	8, 612	1. 00
1.00	8 exclude Swing Bed, Observation Bed and			3, 770	1, 300	0, 012	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			714	0		2. 00
3.00	HMO IPF Subprovider			, , ,	0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						,, 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	C	3, 796	1, 506	8, 612	14. 00
15. 00	CAH visits				·	·	15. 00
16.00	SUBPROVIDER - IPF	0. 00	C	ol o	o	0	16. 00
17. 00	SUBPROVIDER - IRF	0. 00	C	208	15	323	17. 00
18.00	SUBPROVI DER	0. 00	C	ol o	0	0	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	0. 00					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
25. 10	CMHC - CORF	0. 00					25. 10
26.00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150112

Page						Т	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
MRET IT - WARE DATA								Average Hourly	
March 1 - Sac BATA 1 - Sac BAT			Line Number	Reported					
Mart 11 Mart PATA					Worksheet A-6)	3)	col. 4	ŕ	
AAAHIES SAAMES		DADT II WACE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
1.									1
Mon-physic clam anesthetist Part	1.00	Total salaries (see	200. 00	70, 323, 267	-221, 668	70, 101, 599	2, 563, 353. 00	27. 35	1.00
3. 0	2 00			0	0	0	0.00	0.00	2 00
4. 00 Physician Part A — 160	2.00			· ·			0.00	0.00	
4.00 Physician-Part A	3.00			0	0	0	0.00	0.00	3. 00
Hypsicians = Part & - Toaching 0	4.00	15		0	О	0	0.00	0.00	4. 00
Physician-Part 8	4 01			0			0.00	0.00	4 01
Mon-physician-Part B 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.				180, 416		180, 416			
approved program		Non-physician-Part B		0	0	0		l .	
Contracted interns and residents (in an approved programs)	7. 00		21. 00	0	0	0	0.00	0.00	7.00
8. 00	7. 01			0	0	0	0.00	0. 00	7. 01
Home office personnel 4.00 0 0 0 0 0.00 0.00 8.00									
10.00 Excluded area salaries (see 1.497.798 772.015 5.269.813 230.602.00 22.85 10.00	8. 00			0	О	О	0.00	0. 00	8. 00
Instructions OTHER WAGES & RELATED COSTS			44. 00	0	0	0			
OHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 10,861,188 0 10,861,188 233,261.00 46.56 11.00 Contract labor: Top Level 1,410,808 0 1,410,808 32,777.00 43.04 12.00 13.00	10.00			4, 497, 798	//2,015	5, 269, 813	230, 602. 00	22. 85	10.00
Care		OTHER WAGES & RELATED COSTS						I	
12.00 Contract labor: Top level management and other management and other management and administrative services 3.428,569 0 3.428,569 29,264.00 117.16 13.00 4.40 14.00 1.40 14.00 1.41 15.00 14.00 1.41 15.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 1.41 15.00 14.00 14.00 14.00 1.41 15.00 14.00 14.00 14.00 1.41 15.00 14.00 14.00 14.00 1.41 15.00 14.00 14.00 14.00 1.41 15.00 14.00	11. 00			10, 861, 188	0	10, 861, 188	233, 261. 00	46. 56	11.00
management and admin istrative	12. 00	Contract Labor: Top Level		1, 410, 808	О	1, 410, 808	32, 777. 00	43. 04	12. 00
Services									
A - Admin istrative									
14. 00 Home office salaries & 3,799,620 0 3,799,620 16,394.00 231.77 14,00 wage-related costs 0 0 0 0 0 0 0 0 0	13. 00			3, 428, 569	0	3, 428, 569	29, 264. 00	117. 16	13. 00
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0	14. 00			3, 799, 620	О	3, 799, 620	16, 394. 00	231. 77	14. 00
- Administrative physicians Part A - Teaching Physicians Part B - Teaching Physicians Physicians Physicians Part B - Teaching Physicians Part B - Teaching Physicians P	15 00			0			0.00	0.00	15 00
Physic al an Part A - Teaching	13.00			U			0.00	0.00	15.00
WAGE-RELATED COSTS	16. 00			0	0	0	0.00	0. 00	16. 00
Instructions Name									-
18.00 Wage-related costs (other) (see instructions) 18.00 18.0	17. 00			22, 744, 984	0	22, 744, 984			17. 00
19.00 Excluded areas 1,847,596 0 1,847,596 0 20.00 0 0 0 0 0 0 0 0 0	18. 00			0	О	О			18. 00
20.00 Non-physician anesthetist Part A Non-physician anesthetist Part B D D D D D D D D D	10.00	1 ` /		1 047 504		1 047 504			10.00
21.00 Non-physician anesthetist Part B		1		1,847,596		1,847,596			20.00
22.00 Physician Part A -	04.00	A							04 00
Administrative	21.00	B and anesthetist Part		Ü	0	0			21.00
22.01 Physician Part A - Teaching 63,254 0 63,254 23.00	22. 00			0	0	0			22. 00
23. 00 Physician Part B	22. 01			0	0	0			22. 01
25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0		Physician Part B		63, 254	0	63, 254			23. 00
Approved program OVERHEAD COSTS - DIRECT SALARIES		, ,		0	0	0			
26. 00 Empl oyee Benefits Department 4. 00 1, 115, 036 -159, 524 955, 512 4, 634. 00 206. 20 26. 00 27. 00 Administrative & General 5. 00 10, 639, 665 397, 407 11, 037, 072 404, 443. 00 27. 29 27. 00 28. 00 Administrative & General under contract (see inst.) 0 3, 337, 777 0 3, 337, 777 34, 447. 00 96. 90 28. 00 29. 00 Maintenance & Repairs 6. 00 0 0 0 0.00 0.00 0.00 29. 00 30. 00 Operation of Pl ant Department (see instruction of Pl ant Plant Pl	20.00	approved program)] 20.00
27. 00 Administrative & General 5. 00 10, 639, 665 397, 407 11, 037, 072 404, 443.00 27. 29 27. 00 28. 00 Administrative & General under contract (see inst.) 3, 337, 777 0 3, 337, 777 34, 447. 00 96. 90 28. 00 28. 00 29. 00 Maintenance & Repairs 0 0 0 0.00 0.00 0.00 0.00 29. 00 0 0.00 0.	26 00			1 115 036	-150 524	955 512	4 634 00	206.20	26.00
Contract (see inst.) Contract (see instructions) Contract (see instructions							· ·		
29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 1,969,916 0 1,969,916 71,030.00 27.73 30.00 31.00 Laundry & Linen Service 8.00 56,170 0 56,170 3,821.00 14.70 31.00 32.00 Housekeeping 9.00 1,649,833 -1,736 1,648,097 119,253.00 13.82 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0.00 0.00 33.00 34.00 Di etary 10.00 1,814,947 -1,254,349 560,598 35,482.00 15.80 34.00 35.00 Di etary under contract (see instructions) 0 0 0 0.00 0.00 0.00 0.00 0.00 35.00 36.00 Cafeteria 11.00 0 1,241,379 1,241,379 81,595.00 15.21 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 0.00 0	28. 00			3, 337, 777	0	3, 337, 777	34, 447. 00	96. 90	28. 00
30.00 Operation of Plant 7.00 1,969,916 0 1,969,916 71,030.00 27.73 30.00 31.00 Laundry & Linen Service 8.00 56,170 0 56,170 3,821.00 14.70 31.00 31.00 32.00 Housekeeping under contract (see instructions) Dietary 10.00 1,814,947 -1,254,349 560,598 35,482.00 15.80 34.00 35.00 instructions) Dietary under contract (see instructions) 0 0 0 0 0 0 0 0 0	29. 00		6. 00	0	0	0	0.00	0. 00	29. 00
32. 00 Housekeeping Housekeeping under contract (see instructions) 34. 00 Di etary Under contract (see instructions) 36. 00 Cafeteria 11.00 0 1, 241, 379 1, 241	30.00	Operation of Plant	7. 00				71, 030. 00	27. 73	30.00
33.00 Housekeeping under contract (see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 10.00 1,814,947 -1,254,349 0 0 0 0 0 0 0 0 0 0 0 0 0									
34.00 Di etary Under contract (see instructions) 36.00 Cafeteria 38.00 Nursi ng Administration 39.00 Central Services and Supply 10.00 1,814,947 -1,254,349 560,598 35,482.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			7. 00	0 1,047,033	0			l .	1
35.00 Di etary under contract (see i nstructions) 36.00 Cafeteria 11.00 0 1, 241, 379 1, 241, 379 81, 595.00 15. 21 36.00 37.00 Mai ntenance of Personnel 12.00 0 0 0 0 0 0.00 37.00 38.00 Nursi ng Admi ni strati on 13.00 3, 145, 348 -12, 041 3, 133, 307 77, 218.00 40.58 38.00 39.00 Central Servi ces and Supply 14.00 10, 877 0 10, 877 931.00 11.68 39.00	24 00	1 '	10.00	1 01/ 0/7	1 254 240	E40 F00	25 492 00	15 00	24 00
instructions) 36.00 Cafeteria 11.00 0 1,241,379 1,241,379 81,595.00 15.21 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 3,145,348 -12,041 3,133,307 77,218.00 40.58 38.00 39.00 Central Services and Supply 14.00 10,877 0 10,877 931.00 11.68 39.00			10.00	1, 814, 947	-1, 254, 349 0	0 500, 598		l .	
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 3, 145, 348 -12, 041 3, 133, 307 77, 218. 00 40. 58 38. 00 39. 00 Central Services and Supply 14. 00 10, 877 0 10, 877 931. 00 11. 68 39. 00		instructions)	44.00	-	4 044 070	4 044 070			
38.00 Nursing Administration 13.00 3,145,348 -12,041 3,133,307 77,218.00 40.58 38.00 39.00 Central Services and Supply 14.00 10,877 0 10,877 931.00 11.68 39.00		1		0	1, 241, 379 0	1, 241, 379 0			
	38. 00	Nursing Administration	13. 00				77, 218. 00	40. 58	38. 00
				·					1
		i nar macy	13.00	3, 100, 010	177,043	2,700,773	75,041.00	1 40.09	

Health Financial Systems		COLUMBUS REGIO			In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	1	Period: From 01/01/2015		
					Го 12/31/2015	5/24/2016 3:0	3 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 ÷	
		·	(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical Records Library	16. 00	1, 327, 881	-674, 763	653, 118	32, 277. 00	20. 23	41. 00
42.00 Social Service	17. 00	502, 132	3, 814	505, 946	14, 640. 00	34. 56	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150112

							07 E 17 E 0 1 0 0 1 0 0	<u> </u>
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	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)	3)	col. 4		
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		73, 480, 628	-221, 668	73, 258, 960	2, 593, 640. 00	28. 25	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 497, 798	772, 015	5, 269, 813	230, 602. 00	22. 85	2.00
	instructions)							
3.00	Subtotal salaries (line 1		68, 982, 830	-993, 683	67, 989, 147	2, 363, 038. 00	28. 77	3.00
	minus line 2)							
4.00	Subtotal other wages & related		19, 500, 185	0	19, 500, 185	311, 696. 00	62. 56	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		22, 744, 984	0	22, 744, 984	0.00	33. 45	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		111, 227, 999	-993, 683	110, 234, 316	2, 674, 734. 00	41. 21	6.00
7.00	Total overhead cost (see		28, 756, 198	-659, 656	28, 096, 542	952, 812. 00	29. 49	7.00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150112	Peri od: Worksheet S-3 From 01/01/2015 Part IV To 12/31/2015 Date/Time Prepared:

PART IV - WAGE RELATED COSTS		To 12/31/2015	Date/Time Prep 5/24/2016 3:03	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST Septiment			Amount	
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00				
2.00				
3.00 Nonqual if ied Defined Benefit Plan Cost (see instructions) 2,844,148 3.00 0 0 0 0 0 0 0 0 0			3, 303, 183	
4.00	2.00			2. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration Fees 0 0 0 0 0 0 0 0 0	3.00		2, 844, 148	3. 00
5.00	4.00		0	4.00
Legal / Accounting / Management Fees - Pension Plan				
The color of the			-	
HEALTH AND INSURANCE COST			-	
Heal th Insurance (Purchased or Self Funded) 11, 477, 492 8. 00 9. 00 00 00 00 00 00	7.00		0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 597,799 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 68,471 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 897,958 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 237,306 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES 5,166,508 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 59,480 22.00 23.00 Tuit for Rel indurement 25,139,				
10.00 Dental, Hearing and Vision Plan 597,799 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 68,471 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 897,958 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 237,306 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 16.00 17.00 FI CA-Employers Portion Only 5,166,508 18.00 Medicare Taxes - Employers Portion Only 19.00 19.00 Unemployment Insurance 49,618 19.00 20.00 OTHER 21.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00			11, 477, 492	
11.00			_	
12.00				
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) Vorkers' Compensation Insurance 237, 306 15.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 237, 306 15.00 16.00 Non cumulative portion) TOUS HER 20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			68, 471	
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Redicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuit ion Reimbursement Taxes 17. 00 Tuit ion Reimbursement Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuit ion Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost in Cost Reported by FASB 106. Retirement Health Care Cost 106. States FICA-Employers Portion Only Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 49,618 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			897, 958	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES				
Non cumulative portion TAXES Ti CA-Employers Portion Only 5, 166, 508 17. 00 18. 00 19.	15. 00		237, 306	15. 00
TAXES 17.00 FI CA-Employers Portion Only	16.00		0	16. 00
17. 00				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 49,618 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 59,480 22.00 23.00 Tuit ion Reimbursement 437,483 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 25,139,446 24.00 Part B - Other than Core Related Cost 30.00 25,139,446 24.00				
19.00 Unemployment Insurance 49,618 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 59,480 22.00 23.00 Tuit ion Reimbursement 437,483 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 25,139,446 24.00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 59, 480 22.00 Tuit ion Reimbursement 437, 483 23.00 Total Wage Related cost (Sum of Lines 1 -23) 25, 139, 446 24.00 Part B - Other than Core Related Cost				
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 23.00 24.00 25, 139, 446 24.00	20. 00		0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Part B - Other than Core Related Cost instructions)) 29.00				
22. 00 Day Care Cost and Allowances 59, 480 22. 00 23. 00 Tuition Reimbursement 437, 483 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 25, 139, 446 24. 00 Part B - Other than Core Related Cost 24. 00 25, 139, 446 24. 00	21. 00		0	21. 00
23. 00				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 25, 139, 446 24.00				
Part B - Other than Core Related Cost				
	24. 00		25, 139, 446	24.00
25. UU UI HER WAGE RELATED COSTS (SPECTLY) 0 25. 00	05.60			05.00
	25. 00	UIHEK WAGE KELATED COSIS (SPECIFY)	[0	25.00

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TAL CONTRACT LABOR AND BENEFIT COST		Provi der CCN	N: 150112	Peri od: From 01/01/2015	Worksheet S-3 Part V	
					To 12/31/2015	Date/Time Pre 5/24/2016 3:0	
	Cost Center Description				Contract Labor		
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident	i fi cati on:					
1.00	Total facility's contract labor and benefit	cost			10, 215, 695		1. 00
2.00	Hospi tal				10, 215, 695	3, 298, 474	2. 00
3.00	Subprovi der - I PF				0	0	3. 00
4.00	Subprovi der - I RF				0	0	4. 00
5.00	Subprovider - (Other)				0	0	5. 00
6.00	Swing Beds - SNF				0	0	6. 00
7.00	Swing Beds - NF				0	0	
8.00	Hospi tal -Based SNF				0	0	8. 00
9.00	Hospi tal -Based NF						9. 00
10.00	Hospi tal -Based OLTC						10. 00
11. 00	Hospi tal -Based HHA				0	0	
12. 00	Separately Certified ASC						12.00
13. 00	Hospi tal -Based Hospi ce						13. 00
14. 00	Hospital-Based Health Clinic RHC				0	0	
15. 00	Hospital-Based Health Clinic FQHC				0	0	
16. 00	Hospi tal -Based-CMHC						16. 00
16. 10	Hospi tal -Based-CMHC 10				0	0	
17. 00	Renal Dialysis				0	0	
18. 00	Other				0	0	18. 00

Medicaid (see instructions for each line) 2.00 2.00 3.00	Heal th	Financial Systems COLUMBUS REGIONAL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10	
Discription	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150112		Worksheet S-10	0	
Uncompensated and Indigent care cost computation								
1.00								
Medicaid (see instructions for each line) 2.00		Uncompensated and indigent care cost computation						
3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 5.01 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 6.02 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 6.03 Medicaid charges 7.00 Medicaid charges 7.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 7.00 No.00 DI fference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 8, 389, 568 8.0 or state Office of the neter zero) 9.00 No.00 State Office o	1.00		ded by li	ne 202 column	n 8)	0. 363134	1. 00	
4.00 If fine 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? N 4.0 5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid d? Nedicaid charges 7.00 Medicaid cost (line 1 times line 6) Nedicaid cost (line 1 times line 6) Nedicaid cost (line 1 times line 6) Netate Chil dren's Heal th Insurance Program (SCHIP) (see Instructions for each line) Net revenue from stand-alone SCHIP (see Instructions for each line) Net revenue from stand-alone SCHIP (line 1 times line 10) 10.00 Stand-alone SCHIP charges 0 10.00 10.00 Stand-alone SCHIP charges 0 10.00 Net revenue from stand-as one stand-alone SCHIP (line 11 minus line 9: if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from stata or local indigent care program (see instructions for each line) 14.00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9) Net revenue from stata or local indigent care program (Not included on lines 2, 5 or 9) Net revenue from state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (Instructions for each line) Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care Notation in the standard of the state of local indigent care program (sum of lines 8, 889, 568 19, 0 18, 0 18, 0 19, 0	2.00					11, 523, 219	2. 00	
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13: if < zero then enter zero) Uncompensated care (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 389, 568 19. 0 8, 12 and 16) Uninsured Insured patients + col. 2) 1. 00 2. 00 3. 00 20. 00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21. 00 Cost of initial obligation of patients approved for charity care (line 1 4, 544, 133 1, 193, 173 5, 737, 306 21. 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	15.00	State or local indigent care program cost (line 1 times line 14)				0	15. 00	
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19.00 Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 389, 568 19.0 Variable Va								
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24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit N 24.0 imposed on patients covered by Medicaid or other indigent care program?						· ·		
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imposed on patients covered by Medicaid or other indigent care program?	24 00	Does the amount in line 20 column 2 include charges for natient of	lavs hevo	nd a Length o	of stav limit		24. 00	
	24.00			na a rengtii t	or Stay Trimit	.,,	24.00	
25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.0	25. 00		9	ogram's Lengt	h of stay limit	0	25. 00	
						13, 104, 290	26. 00	
	27. 00							
28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 12,625,950 28.0	28. 00							
			nse (line	1 times line	28)			
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 18,630,699 31.0	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line	9 30)			18, 630, 699	31.00	

Cost Center Description		Financial Systems	COLUMBUS REGIONAL				u of Form CMS-2	2552-10
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der			Worksheet A	
Cost Center Description Sel arise						o 12/31/2015		
PRIFICAL SERVICE COST CRIVITES 1.00 2.00 3.00 4.00 5.		0 10 1 0 1			T 1 1 (1 4	B 1 161 11		3 pm
Cell-BML SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 5.00 1.0		Cost Center Description	Sararres	other				
DESCRIPTION CONTRICTORS 1.00 2.00 3.00 4.00 5.00					+ (01. 2)	ons (see A-o)		
CHERNEL SENVICE DOSI CENT HEIST 10 001000 CAP REL COSTS-LOGIC & FIXT 10 0 527, 441 16, 527, 441 -6, 928, 409 9, 599, 022 1 0 0 0000 CAP REL COSTS-LOGIC & FIXT 10 0 0 0000 CAP REL COSTS-LOGIC & FIXT 10 0 0 0000 CAP REL COSTS-LOGIC & FIXT 10 0 0 0000 CAP REL COSTS-LOGIC & FIXT 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
1.00 001000 CAP REL COSTS -BLUCK & FIXX 1.6, 527, 441 1.6, 527, 44			1.00	2. 00	3. 00	4. 00	5. 00	
2.00 00000 LOUR PIEL COSTS - WINEL EDUP 0 0 1, 156, 248 2.00 00000 LOUR CATE PRICE POST 1, 116, 500 22, 979 0 26, 974 1, 100 00000 LOUR CATE PRICE POST 1, 100, 910 00000 1, 100, 910 00000 1, 100, 910 000000	4 00			4/ 507 444	1 4/ 507 444		0.500.000	1 4 00
3.00 000000 FINEN CAP REL COSTS 5.00 00000 ADMINISTRATIVE & CEMERAL 10.039 665 6.00 00000 ADMINISTRATIVE & CEMERAL 10.039 665 6.00 00000 ADMINISTRATIVE & CEMERAL 10.039 665 6.00 00000 ADMINISTRATIVE & CEMERAL 11.049 833 15.00 00000 ADMINISTRATIVE & CEMERAL 15.00 00 1500 ADMINISTRATIVE & CEMERAL 15.00 00 00 00 00 00 00 00 00 00 00 00 00				16, 527, 441	16, 527, 441			
0.00 OD-100 PREDVETE BENEFITS DEPARTWENT				0		9, 130, 243		1
2.00 0.0000 AURITHON OF PIANT 1,949,916 6,055,706 7,975,124 2,131,570 3,843,644 7,00 0.0000 AURITHON 1,641,833 511,768 2,164,601 -1,754 2,162,865 0.00 0.0000 AURITHON 1,641,843 511,768 2,164,601 -1,754 2,164,601 -1,754 2,164,601 -1,754 2,164,601 -1,754 2,164,601 -1,754 2,164,601 -1,754			1, 115, 036	25, 879, 127	26, 994, 163	-3, 064, 720		4. 00
0.00 00000 DURNSHEPHING	5.00	00500 ADMINISTRATIVE & GENERAL	10, 639, 665	42, 996, 980	53, 636, 645	-3, 866, 812	49, 769, 833	5. 00
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90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0 0 0 292, 189 292, 189 90. 04 91. 00 09100 EMERGENCY 4, 615, 227 612, 663 5, 227, 890 1, 872, 015 7, 099, 905 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 2, 749, 263 346, 957 3, 096, 220 28, 376 3, 124, 596 95. 00 99. 10 09910 CORF 0 0 0 0 0 99. 10 0 0 0 0 0 0 0 99. 10 0 0 0 0 0 0 0 0 0								90. 02
91. 00 09100 EMERGENCY 4,615,227 612,663 5,227,890 1,872,015 7,099,905 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 2,749,263 346,957 3,096,220 28,376 3,124,596 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 0 99. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1, 124, 166				90. 03
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 2,749,263 346,957 3,096,220 28,376 3,124,596 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 0 99. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-1	612 663	1			1
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 2, 749, 263 346, 957 3, 096, 220 28, 376 3, 124, 596 95. 00 99. 10 09910 CORF 0 0 0 0 0 99. 10			7,010,227	512,003	3, 227, 090	1, 0, 2, 015	1,077,703	92.00
95. 00 09500 AMBULANCE SERVI CES 2, 749, 263 346, 957 3, 096, 220 28, 376 3, 124, 596 95. 00 99. 10 0 0 0 0 0 99. 10	55							
		09500 AMBULANCE SERVI CES	2, 749, 263	346, 957	3, 096, 220	28, 376		
TOT. DUITOTOUTHOME HEALTH AGENCY UI UI UI OI OI OI OI 101.00			1			0		99. 10
	101.00	DITOTOO HOME HEALTH AGENCY	0	0	1 (이	0	1101.00

Health Financial Systems	COLUMBUS REGION	IAI HOSPITAI		In lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O			CCN: 150112	Peri od:	Worksheet A	1002 10
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 3:0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	l e	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0	111. 00
113.00 11300 INTEREST EXPENSE		1, 327, 695			0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	70, 157, 385	148, 774, 158	218, 931, 54	3 -2, 091, 539	216, 840, 004	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	l e	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	(0 264, 657	264, 657	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	75, 404	·		75, 404	
194. 02 07952 HOSPI CE	0	54, 239	54, 23	9 0	54, 239	
194. 03 07953 OUTREACH CLINICS	0	0	(0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(0 233, 619	233, 619	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0 1, 634, 274	1, 634, 274	194. 05
194.06 07956 CRH FOUNDATION	0	-1, 156	-1, 15	6 0	-1, 156	194. 06
194.07 07957 HEALTHY COMMUNITIES	165, 882	8, 709	174, 59	-41, 011	133, 580	194. 07
200.00 TOTAL (SUM OF LINES 118-199)	70, 323, 267	148, 911, 354	219, 234, 62	1 0	219, 234, 621	200. 00

Provi der CCN: 150112

Period: Worksheet A From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm

				5/24/2016 3:0	3 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS			T.	
1.00	00100 CAP REL COSTS-BLDG & FIXT	229, 723			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-259, 537			2. 00
3.00	00300 OTHER CAP REL COSTS	C		l .	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	997, 830	24, 927, 273		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-18, 665, 080	31, 104, 753		5. 00
7.00	00700 OPERATION OF PLANT	-24, 686	5, 818, 918		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		1		8. 00
9.00	00900 HOUSEKEEPI NG	-408			9. 00
10.00		-2, 234			10.00
11. 00		-1, 176, 242			11.00
13. 00		-77, 133	l .		13. 00
					1
14. 00		54.446			14.00
15. 00		-54, 662			15.00
16. 00		-26, 460			16. 00
17. 00		C			17. 00
23. 00	, ,	C	1		23. 00
23. 01	02301 XRAY EDUCATION	-20, 432	449, 201		23. 01
23. 02	02302 PHARMACY RESIDENCY PROG		352, 302		23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-99, 215	14, 309, 224		30.00
31.00	03100 INTENSIVE CARE UNIT		2, 450, 954		31.00
32. 00		d	1	1	32. 00
33. 00			l control of the cont	•	33. 00
34. 00			1		34. 00
40. 00			-		40. 00
41. 00			l control of the cont		41.00
42. 00			1,,		42.00
43. 00					1
		C			43. 00
44. 00		C) 0		44. 00
	ANCI LLARY SERVI CE COST CENTERS				
50. 00		-96, 718			50. 00
51.00	05100 RECOVERY ROOM	C	1, 352, 160		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		52. 00
53.00	05300 ANESTHESI OLOGY	-9, 090	233, 225		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-39, 851	1, 803, 939		54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1 0	l .		54. 01
54. 02					54. 02
54. 03		-1, 219			54. 03
55. 00		-113, 529			55. 00
57. 00		1			57.00
58. 00		C	1,		58. 00
59. 00		-50, 376			59. 00
60. 00		-15, 596			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	-31, 092			60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	(C	761, 596		62. 00
65.00	06500 RESPI RATORY THERAPY		1, 908, 656		65.00
66.00	06600 PHYSI CAL THERAPY	-25, 610	3, 678, 683		66. 00
67.00					67. 00
68. 00		-719			68. 00
69. 00		-25, 835	1		69. 00
70. 00		25,055		l control of the cont	70.00
71. 00					71.00
71.00					72.00
		-	1,		
73.00					73.00
74.00			1 .,.,		74.00
76. 00		0	1		76. 00
76. 97		-1, 604	102, 286		76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00		C	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0		89. 00
90.00	09000 CLI NI C	C	704, 122		90.00
90. 01					90. 01
90. 02		-180, 416	1	·	90. 02
90. 03		100, 110	1		90. 03
90. 03					90.03
91.00				·	91.00
91.00			1,077,705	'	1
92. UU					92.00
05.00	OTHER REIMBURSABLE COST CENTERS	140 500	0 (00 010		05 00
95. 00		-442, 583			95. 00
	09910 CORF	C	l l	•	99. 10
101. 0	0 10100 HOME HEALTH AGENCY	C	0)	101. 00
	SPECIAL PURPOSE COST CENTERS				
109.0	0 10900 PANCREAS ACQUISITION	C) 0	<u>) </u>	109. 00

Health FinancialSystemsCOLUMBUS REPORTEDRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150112

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			5/24/2016 3:03 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-20, 212, 774	196, 627, 230	118.00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	264, 657	194. 00
194. 01 07951 BUILDING RENTALS	0	75, 404	194. 01
194. 02 07952 HOSPI CE	0	54, 239	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	233, 619	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	1, 634, 274	194. 05
194.06 07956 CRH FOUNDATION	0	-1, 156	194. 06
194.07 07957 HEALTHY COMMUNITIES	0	133, 580	194. 07
200.00 TOTAL (SUM OF LINES 118-199)	-20, 212, 774	199, 021, 847	200. 00

COST CENTERS USED IN COST REPORT

Provi der CCN: 150112

Worksheet Non-CMS W From 01/01/2015 12/31/2015 Date/Time Prepared:

5/24/2016 3:03 pm Cost Center Description CMS Code Standard Label For Non-Standard Codes 2.00 1.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FLXT 00100 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 00200 3.00 OTHER CAP REL COSTS 00300 3 00 4.00 EMPLOYEE BENEFITS DEPARTMENT 00400 4.00 5.00 ADMINISTRATIVE & GENERAL 00500 5.00 7.00 OPERATION OF PLANT 00700 7.00 8.00 LAUNDRY & LINEN SERVICE 00800 8.00 9.00 HOUSEKEEPI NG 00900 9.00 DI ETARY 01000 10.00 10.00 CAFFTERLA 01100 11.00 11.00 NURSING ADMINISTRATION 13.00 01300 13.00 14.00 CENTRAL SERVICES & SUPPLY 01400 14.00 PHARMACY 15.00 01500 15.00 MEDICAL RECORDS & LIBRARY 16.00 01600 16.00 17.00 SOCIAL SERVICE 01700 17.00 PARAMED ED PRGM-(SPECIFY) 23.00 02300 23.00 23 01 XRAY FDUCATION 02301 23 01 23.02 PHARMACY RESIDENCY PROG 02302 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 03000 30.00 INTENSIVE CARE UNIT 31 00 03100 31.00 32.00 CORONARY CARE UNIT 03200 32.00 33.00 BURN INTENSIVE CARE UNIT 03300 33.00 34 00 SURGICAL INTENSIVE CARE UNIT 03400 34 00 40.00 SUBPROVIDER - IPF 04000 40.00 41.00 SUBPROVIDER - IRF 04100 41.00 42.00 SUBPROVI DER 04200 42.00 43 00 NURSERY 04300 43 00 44.00 SKILLED NURSING FACILITY 04400 44.00 ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM 05000 50.00 RECOVERY ROOM 51.00 05100 51.00 52.00 DELIVERY ROOM & LABOR ROOM 05200 52.00 53.00 ANESTHESI OLOGY 05300 53.00 54.00 RADI OLOGY-DI AGNOSTI C 05400 54.00 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 05402 54.01 54.02 ULTRA SOUND 05404 54.02 54.03 MAMMOGRAPHY 05405 54.03 RADI OLOGY-THERAPEUTI C 05500 55.00 55.00 57.00 CT SCAN 05700 57.00 58.00 MRI 05800 58.00 59.00 CARDI AC CATHETERI ZATI ON 05900 59.00 LABORATORY 60.00 06000 60.00 LABORATORY-PATHOLOGI CAL 60.01 06001 60.01 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 06200 62.00 RESPIRATORY THERAPY 65.00 06500 65.00 66.00 PHYSICAL THERAPY 06600 66.00 67.00 OCCUPATIONAL THERAPY 06700 67.00 68.00 SPEECH PATHOLOGY 06800 68.00 69.00 FLFCTROCARDI OLOGY 06900 69.00 70.00 ELECTROENCEPHALOGRAPHY 07000 70.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENT 07100 71.00 IMPL. DEV. CHARGED TO PATIENTS 07200 72.00 72.00 DRUGS CHARGED TO PATIENTS 73.00 07300 73.00 74.00 RENAL DIALYSIS 07400 74.00 ACUPUNCTURE 76.00 **ACUPUNCTURE** 03020 76.00 CARDIAC REHABILITATION 07697 CARDIAC REHABILITATION 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 RURAL HEALTH CLINIC 08800 88.00 89.00 FEDERALLY QUALIFIED HEALTH CENTER 08900 89.00 90 00 CLINIC 09000 90 00 90.01 DI ABETES CENTER 09001 90.01 90.02 NEUROPSYCH 09002 90.02 90.03 WOUND CENTER 09003 90.03 HYPERBARI C OXYGEN THERAPY 90 04 09004 90 04 91.00 **EMERGENCY** 09100 91.00 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09200 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 AMBULANCE SERVICES 09500 95.00 99. 10 CORF 09910 99.10 101. 00 101.00 HOME HEALTH AGENCY 10100

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In Lie	u of Form CMS	-2552-10
COST CENTERS USED IN COST REPORT	Provi der	CCN: 150112	Peri od: From 01/01/2015 To 12/31/2015	Worksheet No Date/Time Pr 5/24/2016 3:	epared:
Cost Center Description		CMS Code	Standard I Non-Standa		
		1.00	2.0	00	
SPECIAL PURPOSE COST CENTERS		1			
109. 00 PANCREAS ACQUISITION		10900			109. 00
110.00 INTESTINAL ACQUISITION		11000			110. 00
111. 00 SLET ACQUISITION		11100			111. 00
113. 00 I NTEREST EXPENSE		11300			113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)					118. 00
NONREI MBURSABLE COST CENTERS		T	T.		_
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN		19000			190. 00
194. 00 WELLNESS COMMUNITY		07950			194. 00
194. 01 BUILDING RENTALS		07951			194. 01
194. 02 HOSPI CE		07952			194. 02
194. 03 OUTREACH CLINICS		07953			194. 03
194.04 SPEECH - HEARING AIDS		07954			194. 04
194. 05 NONALLOWABLE MARKETING		07955			194. 05
194.06 CRH FOUNDATION		07956			194. 06
194.07 HEALTHY COMMUNITIES		07957			194. 07
200.00 TOTAL (SUM OF LINES 118-199)					200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm Provi der CCN: 150112

					/24/2016 3:03 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3.00	4. 00	5. 00	
1 00	B - RECLASS DEPREC BLDG/EQUIF			0.40, 500	4.00
1.00	CAP REL COSTS MARIE FOLLO	1.00	0	842, 590	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		0	48 <u>5, 1</u> 05 1, 327, 695	2. 00
	C - RECLASS INSURANCE		U	1, 327, 093	
1. 00	OCCUPATIONAL THERAPY	67.00	0	1, 241	1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1.00	ő	900, 141	2.00
3.00	AMBULANCE SERVICES	95. 00	o	32, 497	3. 00
4. 00	LABORATORY	60.00	ol	3, 103	4. 00
	0			936, 982	
	D - RECLASS BILLING COST	,			
1.00	ADMINISTRATIVE & GENERAL	5. 00	674, 370	327, 509	1. 00
	0		674, 370	327, 509	
	E - RECLASS HYPERBARIC THERAF	PY EXPENSE			
1.00	HYPERBARI C OXYGEN THERAPY	90.04	•	25 <u>3, 2</u> 42	1. 00
	0		0	253, 242	
	F - RECLASS CAFETERIA EXPENSE				
1. 00	CAFETERI A		1, 250, 314	74 <u>6, 1</u> 59	1.00
	O DECLACE WELLNESS		1, 250, 314	746, 159	
1 00	G - RECLASS WELLNESS	104 00	159, 524	100 107	1, 00
1. 00	WELLNESS COMMUNITY	194.00	15 <u>9, 524</u> 159, 524	12 <u>3, 1</u> 37 123, 137	1.00
	H - RECLASS PHYSICIAN FEES		137, 324	123, 137	
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 185, 169	1.00
2. 00	ADULTS & PEDIATRICS	30.00	0	315, 245	2.00
3. 00	INTENSIVE CARE UNIT	31.00	0	31, 300	3. 00
4. 00	SUBPROVI DER - I RF	41.00	ol	80, 000	4. 00
5. 00	OPERATING ROOM	50.00	ō	189, 400	5. 00
6.00	ANESTHESI OLOGY	53.00	o	45, 000	6. 00
7.00	RADI OLOGY-THERAPEUTI C	55.00	О	150, 000	7. 00
8.00	CARDIAC CATHETERIZATION	59. 00	o	94, 874	8. 00
9.00	LABORATORY-PATHOLOGI CAL	60. 01	O	225, 000	9. 00
10.00	RESPIRATORY THERAPY	65.00	0	50, 700	10. 00
11. 00	PHYSI CAL THERAPY	66.00	0	50, 000	11. 00
12.00	ELECTROCARDI OLOGY	69. 00	0	48, 125	12. 00
13. 00	ELECTROENCEPHALOGRAPHY	70.00	0	11, 150	13. 00
14. 00	CARDI AC REHABI LI TATI ON	76. 97	0	3, 333	14. 00
15. 00	EMERGENCY	91.00	0	1, 839, 917	15. 00
16.00	AMBULANCE SERVICES	95.00	0	17, 500	16.00
17. 00	WOUND CENTER	90. 03	0	8, 852	17. 00
18. 00	HYPERBARI C OXYGEN THERAPY	90.04	•	1, 323	18. 00
	I - RECLASS REHAB SERVICES		0	4, 346, 888	
1.00	OCCUPATI ONAL THERAPY	67.00	10, 413	23, 956	1.00
2. 00	PHYSI CAL THERAPY	66.00	60, 889	41, 498	2.00
3.00	SPEECH PATHOLOGY	68.00	13, 616	74, 469	3. 00
4. 00	SUBPROVI DER - I RF	41.00	148, 902	7, 735	4. 00
5. 00	ELECTROENCEPHALOGRAPHY	70. 00	4, 805	2, 578	5. 00
6. 00	SOCI AL SERVI CE	17. 00	8, 008	4, 297	6. 00
7. 00	ADULTS & PEDIATRICS	30.00	19, 218	10, 314	7. 00
8.00	NEUROPSYCH	90. 02	1, 602	859	8. 00
9.00	WOUND CENTER	90. 03	17, 940	83, 464	9. 00
10.00	HYPERBARI C OXYGEN THERAPY	90.04	<u>2, 0</u> 82	3 <u>5, 5</u> 42	10.00
	0		287, 475	284, 712	
	J - RECLASS PHARMACY RES PROC				
1. 00	PHARMACY RESIDENCY PROG	2302	19 <u>8, 6</u> 07	4, 967	1.00
	U DEGLACO MARKETI NO EVERY		198, 607	4, 967	
1 00	L - RECLASS MARKETING EXPENSE		al	105 000	4
1. 00	NONALLOWABLE MARKETING	194.05	0	125, 000	1.00
	M DECLASS DEDDECLATION EVE	L	0	125, 000	
1. 00	M - RECLASS DEPRECIATION EXPE	2.00	0	8, 671, 140	1.00
1.00	O VEL COSTS-WINDLE ECOTE			8, 671, 140 8, 671, 140	1.00
	N - RECLASS MAINTENANCE EXPEN	I	UU	0, 071, 140	
1. 00	RESPIRATORY THERAPY	65.00	0	19, 842	1.00
2. 00	ELECTROCARDI OLOGY	69.00	o	3, 168	2.00
3. 00	CARDI AC CATHETERI ZATI ON	59.00	ő	287, 899	3. 00
4. 00	ADULTS & PEDIATRICS	30.00	ő	5, 760	4. 00
5. 00	OPERATING ROOM	50.00	ol	437, 189	5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55.00	Ö	149, 832	6. 00
7. 00	LABORATORY	60.00	O	156, 536	7. 00
8.00	LABORATORY-PATHOLOGI CAL	60. 01	О	10, 677	8. 00
9.00	WHOLE BLOOD & PACKED RED	62.00	О	16, 143	9. 00
	BLOOD CELL	<u> </u>			

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2015 To 12/31/2015 Worksheet A-6 Date/Time Prepared: 5/24/2016 3:03 pm Provi der CCN: 150112

COAL CORT CIN						5/24/2016 3:03 pm
1.00 1			Increases			
10.00 MINICH CORY DIAGNESTIC 54.00 0 18.0 355 10.00 17.0						
11.00 MANDROGRAPHY 54.03 0 178, 514 11.00 12.00	10.00			4. 00		10.00
12-00				0	·	
13.00 CT SCAM 13.00 13				0	·	
14.00				0		
10.00 PARAMACY 10.00 0 39, 142 17.00 17.00 18.00 17.00 18.				o		
	15.00	MRI	58.00	0	138, 527	15. 00
ADMINISTRATIVE & CERERAL 5.00 0	16.00	PHARMACY		0	39, 142	
Color Colo				0		
0 - RECLASS PARY EDUCATION EXPENSES 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18. 00	ADMINISTRATIVE & GENERAL		0		18.00
1.00 MAY EDUCATION 23.01 48 0 2.00 3.00 2.304 2.00 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 2.304 3.00 3.00 2.304 3.00		O DECLASS YDAY EDUCATION FY	DENCEC	U	2, 131, 520	
2.00 MAY EDUCATION 23.01 315,303 1,372 2,204 2,006 2,3	1 00			48	0	1 00
SPAY EDUCATION 23 01 0 2,304 310,305 311,305 311,305 311,305 311,305 311,305 311,305 311,305 311,305 31,305 31						
R - RECLASS SAIN N HEALTHY COMMUNITIES 1.00 A	3.00	XRAY_EDUCATION	23. 01	o		3.00
ADMINISTRATIVE & CENERAL		0		315, 351	3, 736	
TOTALES S RECLASS NON ALLOW ADVERTISING COSTS S RECLASS NON ALLOW ADVERTISING COSTS O						1.00
S - RECLASS NON ALLOW ADVERTISING COSTS 1.00 On COMMENDEL MARKETISING COSTS 0 1,500,274	1.00					1.00
1.00			SING COSTS	41,011	U	
T - RFCL EQUIP RENTAL TO CHARGEABLE SUPP T - RFCL EQUIP RENTAL TO CHARGEABLE SUPPL T - RFCL EQUIP RENTAL TO CHARGEABLE TO THE CHARGEABLE SUPPL T - RFCL EQUIP RENTAL TO CHARGEABLE TO THE CHARGEABLE SUPPL T - RFCL EQUIP RENTAL TO CHARGEABLE TO THE CHARGEABLE SUPPL T - RFCL EQUIP RENTAL TO CHARGEABLE TO THE CHARGEABLE TO THE CHARGEABLE TO THE CHARGEABLE TO THE CHARGEABLE SUPPL ES CHARGED TO THE CHARGEABLE TO	1. 00			0	1, 509, 274	1.00
1.00 MEDICAL SUPPLIES CHARGED TO		0				"
PATTENT PATT		T - RECL EQUIP RENTAL TO CHAR	GEABLE SUPP			
MEDICAL SUPPLIES CHARGED TO	1.00		71. 00	0	952	1.00
PATTERNT	0.00		74 00		454 407	0.00
3.00 MEDICAL SUPPLIES CHARGED TO	2.00		/1.00	U	154, 137	2.00
PATTENT A	3 00		71 00	0	61 137	3.00
PATIENT No. PATIENT No.	0.00		71.00	Š	01, 107	0.00
MEDICAL SUPPLIES CHARGED TO	4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	57, 734	4.00
PATE INT						
0	5.00		71.00	0	33, 901	5. 00
U - RECLASS CHARGEABLE SUPPLY COST		0 — — — — — — — — — — — — — — — — — — —	+	— — — d		
PATI ENT		U - RECLASS CHARGEABLE SUPPLY	' COST	<u> </u>	0077001	
Description of the properties of the propertie	1.00		71. 00	0	197, 929	1.00
PATI ENT	0.00		74 00		7/ 0/5	0.00
S. 00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 6, 129	2.00		/1.00	U	76, 245	2.00
PATIENT	3.00		71. 00	0	6, 129	3.00
PATIENT						
5.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 6.179,002 6.00 PATI ENT 6.00 IMPL. DEV. CHARGED TO 72.00 0 2,978,371 6.00 PATI ENT 6	4.00		71. 00	0	2, 431	4.00
PATI ENT	5 00		71 00	0	6 170 002	5.00
6.00 IMPL. DEV. CHARGED TO 72.00 0 2,978,371 6.00 PATI ENTS 7.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 2,956 7.00 PATI ENT 8.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 395,640 9.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 395,640 9.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 6,268 11.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 6,268 11.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 2,520 12.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 115,541 13.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 115,541 13.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 44,274 14.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 44,274 15.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 1,115,702 15.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 1,846,169 16.00 MEDI CAL SUPPLIES CHARGED TO 72.00 0 1,846,169 16.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 17.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 18.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 18.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 19.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 19.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,808 19.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 161.283 20.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 161.283 20.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 15,214 21.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 22.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 27,303 22.00 22.	3.00		71.00	J	0, 177, 002	3.00
7. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT REDICAL SUPPLIES CHARGED TO PATI ENT PAT	6.00	IMPL. DEV. CHARGED TO	72.00	0	2, 978, 371	6. 00
PATI ENT MEDI CAL SUPPLIES CHARGED TO 71.00 0 79, 143 9.00				_		
8.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 79,143 9.00 9.00 PATIENT 11.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 395,640 9.00 11.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 6,268 11.00 PATIENT 12.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 2,520 12.00 PATIENT 13.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 115,541 13.00 PATIENT 14.00 PATIENT 15.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 44,274 14.00 PATIENT 15.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 1,115,702 15.00 MEDICAL SUPPLIES CHARGED TO 72.00 0 1,846,169 16.00 MPLIENT 15.00 PATIENT 15.00 15.00 15.00 PATIENT 15.00 15.00 PATIENT 15.00	7. 00		71.00	0	2, 956	7.00
PATIENT	8 00		71 00	0	79 143	8 00
PATI ENT	0.00		, 00	J	777.10	0.00
11. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 13. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 13. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 13. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 14. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 16. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 16. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 17. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 SPEECH - HEARI NG AIDS 194. 04 0 233, 619 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 SPEECH - HEARI NG AIDS 194. 04 0 233, 619 20. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 MEDI CAL SUPPLI ES CHARGED TO	9.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	395, 640	9.00
PATIENT			74 00			
12. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 13. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 14. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 16. 00 IMPL. DEV. CHARGED TO PATI ENT 17. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 10. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	11.00		/1.00	U	6, 268	11.00
PATI ENT 13. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 115, 541 13. 00	12 00		71 00	0	2 520	12 00
PATI ENT					_, -,	
14. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 16. 00 IMPL. DEV. CHARGED TO 72. 00 0 1,846,169 16. 00 PATI ENT 17. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 31,330 17. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15,808 18. 00 PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15,808 18. 00 PATI ENT 19. 00 SPEECH - HEARI NG AI DS 194. 04 0 233,619 19. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 161,283 20. 00 PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15,214 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27,303 22. 00	13.00		71. 00	0	115, 541	13. 00
PATI ENT 15. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 1, 115, 702 15. 00 1 1 1 1 1 1 1 1 1	14.00		71 00		44 274	14.00
15. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT PA	14.00		71.00	٩	44, 2/4	14.00
PATI ENT 16. 00	15. 00		71. 00	0	1, 115, 702	15. 00
PATI ENTS		PATI ENT				
17. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 SPEECH - HEARI NG AI DS 194. 04 0 233, 619 19. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 20. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	16.00		72. 00	0	1, 846, 169	16. 00
PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 SPEECH - HEARI NG AI DS 194. 04 0 233, 619 20. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	17 00		71 00		24 220	17.00
18. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 808 18. 00 PATI ENT 19. 00 SPEECH - HEARI NG AI DS 194. 04 0 233, 619 19. 00 20. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 21. 00 PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	17.00		/1.00	٩	31, 330	17.00
PATI ENT 19. 00 SPEECH - HEARI NG AI DS 194. 04 0 233, 619 20. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 161, 283 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	18. 00		71.00	n	15. 808	18. 00
20. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 161, 283 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00						
PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 15, 214 21. 00 PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00				О		
21. 00 PATI ENT MEDI CAL SUPPLI ES CHARGED TO PATI ENT 71. 00 0 15, 214 21. 00 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	20. 00		71. 00	0	161, 283	20.00
PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 27, 303 22. 00	21 00		71 00	0	15 214	21 00
22. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 27, 303 22. 00	21.00		, 1. 50	٩	15, 214	21.00
PATI ENT	22. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	27, 303	22.00
		IPATI ENT	I			

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150112

						Fime Prepared: 2016 3:03 pm
		Increases			, , , , , , , , , , , , , , , , , , , ,	20.10 0.100
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
23. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20, 238		23. 00
24. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 068		24. 00
25. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 750		25. 00
	0	+	$$ \dagger	13, 555, 933		
	V - RECL PTO COST FOR STD ELI	MINATION PD				
1.00		0.00	0	0		1. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 194		5. 00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	30, 499		6. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 736		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 035		10. 00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 935		11. 00
12. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	12, 041		12. 00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 236		13. 00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393		14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	64, 323		15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 380		16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 975		17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 045		18. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 964		21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	950		22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	88		23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	988		24. 00
25. 00 26. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	1, 336 2, 992		25. 00 26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 992 17, 973		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 042		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17, 669		29. 00
30.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 879		30.00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9, 071		31.00
32. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	132		32.00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 409		33. 00
34. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 383		34.00
01.00	0		$$ $\overset{\circ}{\circ}$	221, 668		01.00
	W - RECLASS SYSV BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	191, 543		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	o	198, 021		2, 00
3.00	OPERATING ROOM	50.00	0	2, 250, 696		3. 00
4.00	RECOVERY ROOM	51.00	0	333, 169		4. 00
5.00	ANESTHESI OLOGY	53.00	O	27, 934		5. 00
	TOTALS			3, 001, 363		
	X - RECLASS OT SALARIES AND O	THER EXP				
1.00	OCCUPATI ONAL THERAPY	<u>67.</u> 00	612, 056	15 <u>9, 6</u> 08		1. 00
	0		612, 056	159, 608		
	Y - RECL MILLRACE FOR WELLNES					
1. 00	OCCUPATI ONAL THERAPY	67.00	0	2, 350		1.00
2.00	PHYSI CAL THERAPY	66.00	0	11, 472		2. 00
3.00	OCCUPATI ONAL THERAPY	67.00	0	711		3. 00
4.00	PHYSICAL THERAPY	<u>66.</u> 00	•	3, 471		4. 00
	0		0	18, 004		
	Z - RECLASS LAB BLOOD SUPERVI			т.		
1. 00	WHOLE BLOOD & PACKED RED	62.00	69, 127	0		1. 00
	BLOOD CELL	+				
E00 00	Grand Total: Increases		69, 127	20 054 200		F00_00
500.00	por and rotar: increases	ļ	3, 607, 835	38, 056, 398		500.00

RECLASSI FI CATIONS

Provider CCN: 150112

Peri od: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Ti me Prepared:

5/24/2016 3:03 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - RECLASS DEPREC BLDG/EQUIP 1.00 INTEREST EXPENSE 113.00 842, 590 11 1.00 INTEREST EXPENSE 485, 105 2.00 113.00 0 11 2.00 ō 1, 327, 695 - RECLASS INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 1, 241 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 ol 900.141 12 2.00 ADMINISTRATIVE & GENERAL 0 0 3.00 5.00 32, 497 3.00 4.00 ADMINISTRATIVE & GENERAL 5.00 3, 103 0 4.00 0 936, 982 D - RECLASS BILLING COST 1.00 MEDICAL RECORDS & LIBRARY 16.00 67<u>4, 3</u>70 327, 509 0 1.00 674, 370 327, 509 - RECLASS HYPERBARIC THERAPY EXPENSE 1 00 WOUND CENTER 253, 242 90.03 0 1 00 0 253, 242 - RECLASS CAFETERIA EXPENS DI ETARY 1.00 10.00 1, 250, 314 746, 159 0 1.00 1, 250, 314 746, 159 RECLASS WELLNESS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 159, 524 123, 137 0 1.00 159, 524 123, 137 RECLASS PHYSICIAN FEES 1, 185, 169 1.00 OPERATING ROOM 50.00 0 1.00 ADMINISTRATIVE & GENERAL 5.00 0 315, 245 0 2.00 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 0 31, 300 0 3 00 4.00 ADMINISTRATIVE & GENERAL 5.00 0 80,000 0 4.00 ADMINISTRATIVE & GENERAL o 189, 400 0 5.00 5.00 5.00 0 6.00 OPERATING ROOM 50.00 0 45,000 6.00 7 00 ADMINISTRATIVE & GENERAL 5 00 0 150,000 7 00 8.00 ADMINISTRATIVE & GENERAL 5.00 0 94, 874 0 8.00 9.00 ADMINISTRATIVE & GENERAL 5.00 o 225, 000 0 9.00 0 ADMINISTRATIVE & GENERAL 0 50, 700 10.00 5.00 10.00 0 11.00 ADMINISTRATIVE & GENERAL 5.00 0 50,000 11.00 5.00 ADMINISTRATIVE & GENERAL 0 48, 125 0 12.00 12.00 0 13.00 ADMINISTRATIVE & GENERAL 5.00 o 13.00 11, 150 0 14.00 ADMINISTRATIVE & GENERAL 5.00 0 3.333 14.00 0 15.00 ADMINISTRATIVE & GENERAL 5.00 0 1, 839, 917 15.00 ADMINISTRATIVE & GENERAL 16.00 5.00 0 17,500 0 16.00 17.00 ADMINISTRATIVE & GENERAL 5.00 0 8.852 0 17.00 ADMINISTRATIVE & GENERAL 0 18.00 5.00 1, 323 18.00 4, 346, 888 - RECLASS REHAB SERVICES 1.00 ADMINISTRATIVE & GENERAL 10. 413 23, 956 0 5.00 1.00 0 2.00 ADMINISTRATIVE & GENERAL 5.00 60,889 41, 498 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 13, 616 74, 469 0 3.00 4.00 ADMINISTRATIVE & GENERAL 5.00 148, 902 7,735 0 4.00 ADMINISTRATIVE & GENERAL 5.00 0 5.00 4.805 2,578 5.00 6.00 ADMINISTRATIVE & GENERAL 5.00 8,008 4, 297 0 6.00 7.00 ADMINISTRATIVE & GENERAL 5.00 19, 218 10, 314 0 7.00 0 8 00 ADMINISTRATIVE & GENERAL 5 00 1 602 859 8 00 0 9.00 ADMINISTRATIVE & GENERAL 5.00 17, 940 83, 464 9.00 10.00 ADMINISTRATIVE & GENERAL 5. 00 2, 082 35, 542 0 10.00 287, 475 284, 712 J - RECLASS PHARMACY RES PROGRAM 1.00 PHARMACY 15.00 198, 607 4, 967 0 1.00 198, 607 4, 967 RECLASS MARKETING EXPENSE 5. 00 1.00 ADMI NI STRATI VE & GENERAL 125, 000 0 1.00 0 125, 000 - RECLASS DEPRECIATION EXPENSE CAP REL COSTS-BLDG & FIXT 8, 671, 140 1.00 1.00 0 1.00 8, 671, 140 RECLASS MAINTENANCE EXPENSE 1.00 OPERATION OF PLANT 7.00 19,842 1.00 OPERATION OF PLANT 0 0 2.00 7.00 3, 168 2.00 OPERATION OF PLANT 3.00 7.00 0 287.899 0 3 00 4.00 OPERATION OF PLANT 7.00 0 5,760 0 4.00 0 5.00 OPERATION OF PLANT 7.00 0 437, 189 5.00 OPERATION OF PLANT 0 6.00 7.00 0 149.832 6.00 0 7.00 OPERATION OF PLANT 7.00 0 156, 536 7.00 OPERATION OF PLANT 0 0 8.00 7.00 10, 677 8.00 OPERATION OF PLANT 7.00 0 16, 143 9.00 0 9.00 OPERATION OF PLANT 10.00 7.00 186, 355 10.00

Provi der CCN: 150112

Period: Worksheet A-U From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm

						5/24/2016 3:0	03 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
11 00	6.00	7.00	8. 00	9. 00	10. 00		11 00
11. 00	OPERATION OF PLANT	7. 00	0	128, 514			11.00
12.00	OPERATION OF PLANT	7.00	0	89, 539			12.00
13.00	OPERATION OF PLANT	7.00	0	192, 566	0		13.00
14.00	OPERATION OF PLANT	7.00	0	198, 774	0 0		14.00
15. 00 16. 00	OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	138, 527	0		15. 00 16. 00
	OPERATION OF PLANT	7.00	ol	39, 142	-		17. 00
17. 00 18. 00	OPERATION OF PLANT	7.00	0	66, 810	0		18.00
16.00	DERATION OF PLANT	7.00	— — — 0	<u>4, 2</u> 47 2, 131, 520			16.00
	Q - RECLASS XRAY EDUCATION EX	VDENCEC	υ	2, 131, 320			1
1.00	RESPIRATORY THERAPY	65.00	48	0	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	315, 303	1, 372			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	313, 303	2, 364			3.00
3.00	O DENETTIS DELAKTMENT	4.00	315, 351	$\frac{2,304}{3,736}$			3.00
	R - RECLASS ADMIN HEALTHY COM	MMINITIES	313, 331	3, 730			1
1.00	HEALTHY COMMUNITIES	194. 07	41, 011	0	0		1.00
1.00	TOTALS		$\frac{11,011}{41,011}$				1.00
	S - RECLASS NON ALLOW ADVERTI	ISLNG COSTS	11,011	J			1
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 509, 274	0		1.00
	0		— — š	1, 509, 274	— — —		
	T - RECL EQUIP RENTAL TO CHAP	RGEABLE SUPP	9	1,007,271			1
1.00	NURSERY	43.00	0	952	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	o	154, 137	0		2. 00
3. 00	INTENSIVE CARE UNIT	31.00	o	61, 137	0		3. 00
4. 00	SUBPROVI DER - I RF	41.00	o	57, 734	- 1		4. 00
5. 00	RESPIRATORY THERAPY	65.00	o	33, 901	O		5. 00
0.00	0		— — "	307, 861			0.00
	U - RECLASS CHARGEABLE SUPPLY	Y COST	-1	221,7221			1
1.00	ADULTS & PEDIATRICS	30.00	0	197, 929	0		1.00
2. 00	INTENSIVE CARE UNIT	31.00	o	76, 245	o		2.00
3. 00	SUBPROVI DER - I RF	41.00	o	6, 129	o		3. 00
4.00	NURSERY	43.00	o	2, 431	o		4. 00
5. 00	OPERATING ROOM	50.00	o	6, 179, 002	o		5. 00
6. 00	OPERATING ROOM	50.00	o	2, 978, 371	o		6.00
7. 00	RECOVERY ROOM	51.00	o	2, 956	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	79, 143	0		8.00
9. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	o	395, 640	0		9.00
11. 00	MAMMOGRAPHY	54. 03	o	6, 268	0		11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	o	2, 520	0		12.00
13.00	CT SCAN	57.00	o	115, 541	O		13. 00
14.00	MRI	58.00	o	44, 274	O		14.00
15. 00	CARDIAC CATHETERIZATION	59. 00	o	1, 115, 702	0		15. 00
16.00	CARDIAC CATHETERIZATION	59. 00	o	1, 846, 169	0		16.00
17.00	RESPI RATORY THERAPY	65.00	0	31, 330	O		17. 00
18.00	PHYSI CAL THERAPY	66.00	0	15, 808	0		18. 00
19.00	SPEECH PATHOLOGY	68. 00	0	233, 619	0		19.00
20.00	ELECTROCARDI OLOGY	69.00	0	161, 283	0		20.00
21. 00	WOUND CENTER	90. 03	0	15, 214	o		21.00
22. 00	EMERGENCY	91.00	o	27, 303			22. 00
23.00	AMBULANCE SERVICES	95.00	0	20, 238			23. 00
24.00	ANESTHESI OLOGY	53.00	0	1, 068			24. 00
25.00	RENAL DIALYSIS	74.00	o	1, 750	0		25. 00
	0 — — — — — —		0	13, 555, 933			1
	V - RECL PTO COST FOR STD ELI	IMINATION PD					
1.00		0.00	0	0	0		1.00
5.00	SOCIAL SERVICE	17. 00	4, 194	0	0		5. 00
6.00	ADMINISTRATIVE & GENERAL	5. 00	30, 499	0	O		6.00
9.00	HOUSEKEEPI NG	9.00	1, 736	0	O		9. 00
10.00	DI ETARY	10.00	4, 035	0	O		10.00
11. 00	CAFETERI A	11.00	8, 935	0	O		11. 00
12.00	NURSING ADMINISTRATION	13.00	12, 041	0	O		12. 00
13.00	PHARMACY	15. 00	1, 236	0	0		13. 00
14.00	MEDICAL RECORDS & LIBRARY	16.00	393	0	0		14. 00
15. 00	ADULTS & PEDIATRICS	30.00	64, 323	0	0		15. 00
16.00	INTENSIVE CARE UNIT	31.00	5, 380	0	0		16. 00
17.00	SUBPROVI DER - I RF	41.00	7, 975	0	0		17. 00
18. 00	NURSERY	43.00	2, 045	0	O		18. 00
21. 00	RADI OLOGY-DI AGNOSTI C	54.00	8, 964	0	o		21. 00
22. 00	ELECTROCARDI OLOGY	69.00	950	0	O		22. 00
23. 00	NEUROPSYCH	90. 02	88	0	0		23. 00
24. 00	CT SCAN	57. 00	988	0	0		24. 00
25. 00	MRI	58.00	1, 336	0	Ö		25. 00
26. 00	CARDIAC CATHETERIZATION	59.00	2, 992	0			26. 00
27. 00	LABORATORY	60.00	17, 973	0	1		27. 00
			,		-1		

RECLASSI FI CATIONS

500.00 Grand Total: Decreases

Provi der CCN: 150112

Peri od:
From 01/01/2015
To 12/31/2015 Worksheet A-6
Date/Ti me Prepared:

500.00

5/24/2016 3:03 pm Decreases Cost Center 0ther Li ne # Sal ary Wkst. A-7 Ref. 10.00 6.00 7.00 8.00 9.00 28. 00 RESPIRATORY THERAPY 28. 00 65.00 6,042 0 0 29.00 PHYSI CAL THERAPY 66.00 17,669 0 29.00 OCCUPATIONAL THERAPY 67.00 3, 879 0 0 30.00 30.00 31.00 SPEECH PATHOLOGY 68.00 9,071 0 0 31.00 32.00 WOUND CENTER 90.03 132 0 0 32.00 33.00 EMERGENCY 91.00 7, 409 0 33.00 34.00 AMBULANCE SERVICES 95.00 1, 383 34.00 0 221, 668 W - RECLASS SYSV BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 191, 543 198 1.00 4.00 2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 ol 198, 021 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 0 2, 250, 696 0 3.00 4.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 333, 169 0 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 4.00 27, 934 0 5.00 ō TOTALS 3, 001, 363 X - RECLASS OT SALARIES AND OTHER EXP 1.00 PHYSI CAL THERAPY 66.00 612, 056 159, 608 0 1.00 612, 056 159, 608 Y - RECL MILLRACE FOR WELLNESS/OP/PT 1.00 WELLNESS COMMUNITY 194.00 2, 350 0 1.00 2.00 WELLNESS COMMUNITY 194.00 0 11, 472 0 2.00 0 3.00 WELLNESS COMMUNITY 194.00 711 0 3.00 <u>3, 4</u>7<u>1</u> 4.00 WELLNESS COMMUNITY 194.00 0 4.00 18, 004 Z - RECLASS LAB BLOOD SUPERVISOR LABORATORY 69, 127 1.00 60.00 0 1.00 69, 127

3, 829, 503

37, 834, 730

| Peri od: | Worksheet A-6 | From 01/01/2015 | Non-CMS Worksheet To 12/31/2015 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150112

						Т	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
	Cost Center	Incre Line #		Other	Cost Center	Decre Li ne #	ases Sal ary	Other	
	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	B - RECLASS DEPREC BLD CAP REL COSTS-BLDG &	G/EQUI F 1. 00		842, 590	INTEREST EXPENSE	113. 00	0	842, 590	1. 00
2. 00	CAP REL COSTS-MVBLE	2. 00	0	485, 105	INTEREST EXPENSE	113. 00	0	485, 105	2. 00
	0		<u> </u>	1, 327, 695	0 — — —			1, 327, 695	
1.00	C - RECLASS INSURANCE OCCUPATIONAL THERAPY	67. 00	ol	1, 241	ADMINISTRATIVE &	5.00	0	1, 241	1. 00
2. 00	CAP REL COSTS-BLDG &	1. 00	0	900, 141	GENERAL ADMINISTRATIVE &	5. 00	0	900, 141	2. 00
3. 00	AMBULANCE SERVICES	95. 00	0	32, 497	GENERAL ADMINISTRATIVE &	5. 00	0	32, 497	3. 00
4. 00	LABORATORY	60. 00	0	3, 103	GENERAL ADMINISTRATIVE & GENERAL	5. 00	0	3, 103	4. 00
	0			936, 982				936, 982	
1.00	D - RECLASS BILLING CO ADMINISTRATIVE &	ST 5. 00	674, 370	327, 509	MEDICAL RECORDS &	16. 00	674, 370	327, 509	1. 00
	GENERAL		674, 370	327, 509	LI BRARY 0	_	674, 370		
1. 00	E - RECLASS HYPERBARIC HYPERBARIC OXYGEN	90. 04	PY EXPENSE O	252 242	WOUND CENTER	90. 03	0	253, 242	1. 00
1.00	THERAPY	90.04				90.03	1		1.00
	F - RECLASS CAFETERIA	EXPENSE	0	253, 242	[0		0	253, 242	
1.00	CAFETERI A	11. 00	1, 250, 314 1, 250, 314	74 <u>6, 1</u> 59 746, 159	DI ETARY	10.00	1, 250, 314 1, 250, 314	74 <u>6, 1</u> 59 746, 159	1. 00
	G - RECLASS WELLNESS		,						
1. 00	WELLNESS COMMUNITY	194. 00			EMPLOYEE BENEFITS DEPARTMENT	4.00	159, 524	123, 137 — — — —	1. 00
	H - RECLASS PHYSICIAN	FEES	159, 524	123, 137	[0		159, 524	123, 137	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 185, 169	OPERATING ROOM	50.00	0	1, 185, 169	1. 00
2. 00	ADULTS & PEDIATRICS	30. 00	0	315, 245	ADMINISTRATIVE & GENERAL	5. 00	0	315, 245	2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	0	31, 300	ADMINISTRATIVE & GENERAL	5. 00	0	31, 300	3. 00
4.00	SUBPROVI DER - I RF	41. 00	0	80, 000	ADMINISTRATIVE & GENERAL	5. 00	0	80, 000	4. 00
5. 00	OPERATING ROOM	50. 00	0	189, 400	ADMI NI STRATI VE & IGENERAL	5. 00	0	189, 400	5. 00
6. 00 7. 00	ANESTHESI OLOGY RADI OLOGY-THERAPEUTI C	53. 00 55. 00		· ·	OPERATING ROOM ADMINISTRATIVE &	50. 00 5. 00	0	45, 000 150, 000	6. 00 7. 00
8. 00	CARDI AC	59. 00			GENERAL ADMINISTRATIVE &	5. 00	0	94, 874	8. 00
9. 00	CATHETERI ZATI ON LABORATORY-PATHOLOGI C	60. 01	0	225, 000	GENERAL ADMINISTRATIVE &	5. 00	0	225, 000	9. 00
10. 00	AL RESPIRATORY THERAPY	65. 00	O	50, 700	GENERAL ADMINISTRATIVE &	5. 00	0	50, 700	10. 00
11. 00	PHYSICAL THERAPY	66. 00	0	50, 000	GENERAL ADMINISTRATIVE &	5. 00	0	50, 000	11. 00
12. 00	ELECTROCARDI OLOGY	69. 00	0	48, 125	GENERAL ADMINISTRATIVE &	5. 00	0	48, 125	12. 00
13. 00	ELECTROENCEPHALOGRAPH	70. 00	0	11, 150	GENERAL ADMINISTRATIVE &	5. 00	0	11, 150	13. 00
14. 00	CARDI AC	76. 97	0	3, 333	GENERAL ADMINISTRATIVE &	5. 00	0	3, 333	14. 00
15. 00	REHABI LI TATI ON EMERGENCY	91. 00	0	1, 839, 917	GENERAL ADMINISTRATIVE &	5. 00	0	1, 839, 917	15. 00
16. 00	AMBULANCE SERVICES	95. 00	0	17, 500	GENERAL ADMINISTRATIVE &	5. 00	0	17, 500	16. 00
17. 00	WOUND CENTER	90. 03	0	8, 852	GENERAL ADMINISTRATIVE &	5. 00	0	8, 852	17. 00
18. 00	HYPERBARI C OXYGEN	90. 04	0	1, 323	GENERAL ADMINISTRATIVE &	5. 00	0	1, 323	18. 00
	THERAPY		<u> </u>	4, 346, 888	GENERAL			4, 346, 888	
1.00	I - RECLASS REHAB SERV OCCUPATIONAL THERAPY	1 CES 67. 00	10, 413	23, 956	ADMINISTRATIVE &	5.00	10, 413	23, 956	1. 00
2.00	PHYSICAL THERAPY	66. 00	60, 889	41, 498	GENERAL ADMINISTRATIVE &	5. 00	60, 889	41, 498	2. 00
3. 00	SPEECH PATHOLOGY	68. 00			GENERAL ADMINISTRATIVE &	5. 00	13, 616	74, 469	3. 00
					GENERAL	1 1			

Non-CMS Worksheet

From 01/01/2015 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm Increases Decreases Cost Center Line # Sal ary 0ther Cost Center Li ne # Sal ary 0ther 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 4.00 SUBPROVIDER - IRF 41.00 148.902 7. 735 ADMINISTRATIVE & 5.00 148, 902 7.735 4.00 GENERAL 5.00 ELECTROENCEPHALOGRAPH 70.00 4,805 2,578 ADMINISTRATIVE & 5.00 4,805 2.578 5.00 GENERAL 6.00 SOCIAL SERVICE 17.00 8.008 4, 297 ADMINISTRATIVE & 8.008 4.297 5.00 6.00 GENERAL 10, 314 ADMINISTRATIVE & 7.00 ADULTS & PEDIATRICS 30.00 19, 218 5.00 19, 218 10, 314 7.00 GENERAL 8.00 NEUROPSYCH 90.02 1,602 859 ADMINISTRATIVE & 5.00 1,602 859 8.00 GENERAL 9.00 WOUND CENTER 90.03 17, 940 83, 464 ADMINISTRATIVE & 5.00 17, 940 9.00 83.464 GENERAL 10.00 HYPERBARIC OXYGEN 90.04 2,082 35, 542 ADMINISTRATIVE & 5.00 2,082 35, 542 10.00 THERAPY GENERAL 287, 475 284, 712 0 287, 475 284, 712 J - RECLASS PHARMACY RES PROGRAM 1 00 PHARMACY RESIDENCY 4. 967 PHARMACY 23.02 198, 607 15.00 198, 607 4.967 1.00 PR0G 198, 607 4, 967 0 198, 607 4,967 - RECLASS MARKETING EXPENSE 1 00 NONALLOWARLE 194 05 0 125 OOO ADMINISTRATIVE & 5 00 125,000 1 00 MARKETI NG GENERAL ō o 125, 000 0 125,000 M - RECLASS DEPRECIATION EXPENSE 1.00 CAP REL COSTS-MVBLE 0 8, 671, 140 CAP REL COSTS-BLDG & 1. 00 0 8, 671, 140 1.00 2.00 EQUI P FIXT. 8, 671, 140 0 ō ō 8, 671, 140 RECLASS MAINTENANCE EXPENSE 1.00 RESPIRATORY THERAPY 65.00 19,842 OPERATION OF PLANT 7. 00 19, 842 1.00 0 ELECTROCARDI OLOGY 3. 168 OPERATION OF PLANT 7.00 0 2.00 69.00 3.168 2.00 0 287, 899 OPERATION OF PLANT 0 3.00 CARDI AC 59.00 7.00 287, 899 3.00 CATHETERI ZATI ON 4.00 ADULTS & PEDIATRICS 30.00 0 5, 760 OPERATION OF PLANT 7.00 5.760 4.00 5.00 OPERATING ROOM 50.00 0 0 0 437, 189 OPERATION OF PLANT 7.00 C 437, 189 5.00 RADI OLOGY-THERAPEUTI C 149 832 OPERATION OF PLANT 149, 832 6.00 55 00 7 00 C 6.00 7.00 LABORATORY 60.00 156, 536 OPERATION OF PLANT 7.00 C 156, 536 7.00 LABORATORY-PATHOLOGI C 10, 677 OPERATION OF PLANT 8.00 60.01 7.00 10,677 8.00 9.00 WHOLE BLOOD & PACKED 62.00 0 16, 143 OPERATION OF PLANT 7.00 0 16, 143 9.00 RED BLOOD CELL 186, 355 OPERATION OF PLANT 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 7.00 0 186, 355 10.00 MAMMOGRAPHY 54.03 0 0 0 128, 514 OPERATION OF PLANT 7.00 11.00 128.514 11.00 12.00 ULTRA SOUND 54.02 89, 539 OPERATION OF PLANT 7.00 0 89, 539 12.00 192 566 OPERATION OF PLANT 192, 566 CT SCAN 57 00 7 00 0 13.00 13 00 14.00 NUCLEAR 54.01 198, 774 OPERATION OF PLANT 7.00 198, 774 14.00 MEDI CI NE-DI AGNOSTI C 138, 527 OPERATION OF PLANT 15.00 58 00 7.00 0 138, 527 15 00 39, 142 OPERATION OF PLANT 0 0 PHARMACY 15, 00 7.00 39, 142 16.00 16, 00 66, 810 OPERATION OF PLANT 17.00 **LEMERGENCY** 91.00 7.00 0 66,810 17 00 18.00 ADMINISTRATIVE & 5.00 4, 247 OPERATION OF PLANT 7.00 4, 247 18.00 GENERAL ol 2. 131. 5200 2, 131, 520 Q - RECLASS XRAY EDUCATION EXPENSES 1.00 XRAY EDUCATION 23.01 48 O RESPIRATORY THERAPY 65.00 48 0 1.00 2.00 XRAY EDUCATION 23.01 315, 303 1, 372 RADI OLOGY-DI AGNOSTI C 54.00 315, 303 1, 372 2.00 2, 364 EMPLOYEE BENEFITS 3 00 XRAY EDUCATION 4 00 23 01 2, 364 3 00 0 DEPARTMENT 3, 736 315, 351 31<u>5,</u> 351 RECLASS ADMIN HEALTHY COMMUNITIES 1.00 ADMINISTRATIVE & OHEALTHY COMMUNITIES 194. 07 0 1.00 5.00 41, 011 41, 011 GENERAL 41, 011 OTOTALS 41, 011 0 **TOTALS** S - RECLASS NON ALLOW ADVERTISING COSTS 1.00 NONALLOWABLE 194. 05 1, 509, 274 ADMINISTRATIVE & 5.00 1, 509, 274 1.00 MARKETI NG GENERAL o 1, 509, 274 0 0 1, 509, 274 l0 RECL EQUIP RENTAL TO CHARGEABLE SUPP 952 NURSERY 1.00 MEDICAL SUPPLIES 71.00 43.00 952 1.00 CHARGED TO PATIENT ol 154, 137 ADULTS & PEDIATRICS 0 2.00 MEDICAL SUPPLIES 71.00 30.00 154, 137 2.00 CHARGED TO PATIENT 61, 137 INTENSIVE CARE UNIT 3.00 MEDICAL SUPPLIES 71.00 0 31.00 0 61, 137 3.00 CHARGED TO PATIENT MEDICAL SUPPLIES 57, 734 SUBPROVIDER - IRF 4.00 71.00 0 41.00 0 57, 734 4.00 CHARGED TO PATIENT

Health Financial Systems RECLASSIFICATIONS

Provi der CCN: 150112

| Period: | Worksheet A-6 | From 01/01/2015 | Non-CMS Worksheet | To 12/31/2015 | Date/Time Prepared: | 5/24/2016 3:03 pm

								5/24/2016 3:0	.3 pm
	Cost Center	Li ne #	eases Salary	Other	Cost Center	Decre Li ne #	Sal ary	Other	
	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	9. 00	
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	33, 901	RESPI RATORY THERAPY	65.00	0	33, 901	5. 00
	0 — — — —		o	307, 861	0			307, 861	
1. 00	U - RECLASS CHARGEABLE MEDICAL SUPPLIES	SUPPLY 71, 00		107 020	ADULTS & PEDIATRICS	30.00	ol	197, 929	1. 00
1.00	CHARGED TO PATIENT	71.00	Ĭ	177, 727	ADDETS & FEDIATRICS	30.00		177,727	1. 00
2. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	76, 245	INTENSIVE CARE UNIT	31.00	0	76, 245	2. 00
3.00	MEDICAL SUPPLIES	71. 00	О	6, 129	SUBPROVIDER - IRF	41.00	0	6, 129	3. 00
4. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	2 431	NURSERY	43.00	0	2, 431	4. 00
	CHARGED TO PATIENT						1		
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	6, 179, 002	OPERATING ROOM	50.00	0	6, 179, 002	5. 00
6. 00	IMPL. DEV. CHARGED TO	72. 00	О	2, 978, 371	OPERATING ROOM	50.00	0	2, 978, 371	6. 00
7. 00	PATI ENTS MEDI CAL SUPPLI ES	71. 00	o	2 956	RECOVERY ROOM	51.00	0	2, 956	7. 00
	CHARGED TO PATIENT								
8. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	O	79, 143	RADI OLOGY-DI AGNOSTI C	54.00	0	79, 143	8. 00
9. 00	MEDICAL SUPPLIES	71. 00	o	395, 640	NUCLEAR	54. 01	0	395, 640	9. 00
11. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	o	6. 268	MEDI CI NE-DI AGNOSTI C MAMMOGRAPHY	54. 03	o	6, 268	11. 00
	CHARGED TO PATIENT			•					
12. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	2, 520	RADI OLOGY-THERAPEUTI C	55.00	0	2, 520	12. 00
13.00	MEDICAL SUPPLIES	71. 00	o	115, 541	CT SCAN	57.00	0	115, 541	13. 00
14. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	o	44, 274	MRI	58.00	o	44, 274	14. 00
	CHARGED TO PATIENT								
15. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 115, 702	CATHETERI ZATI ON	59. 00	0	1, 115, 702	15. 00
16. 00	I MPL. DEV. CHARGED TO	72. 00	o	1, 846, 169	CARDI AC	59. 00	0	1, 846, 169	16. 00
17. 00	PATI ENTS MEDI CAL SUPPLI ES	71. 00	О	31, 330	CATHETERI ZATI ON RESPI RATORY THERAPY	65.00	o	31, 330	17. 00
10.00	CHARGED TO PATIENT	71 00		15 000	DUVELCAL THEDADY	44 00		15 000	10.00
18. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	15, 808	PHYSI CAL THERAPY	66.00	0	15, 808	18. 00
19.00	SPEECH - HEARING AIDS	194. 04			SPEECH PATHOLOGY	68.00	0	233, 619	19.00
20. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	161, 283	ELECTROCARDI OLOGY	69.00	0	161, 283	20. 00
21. 00	MEDICAL SUPPLIES	71. 00	0	15, 214	WOUND CENTER	90. 03	0	15, 214	21. 00
22. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	О	27, 303	EMERGENCY	91.00	О	27, 303	22. 00
23. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00		20 238	AMBULANCE SERVICES	95.00	o	20, 238	23. 00
23.00	CHARGED TO PATIENT	71.00	1	20, 230	AWIDULANCE SERVICES	95.00	9	20, 236	23.00
24. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 068	ANESTHESI OLOGY	53.00	0	1, 068	24. 00
25. 00	MEDICAL SUPPLIES	71. 00	О	1, 750	RENAL DIALYSIS	74.00	0	1, 750	25. 00
	CHARGED TO PATIENT	<u> </u>	<u> </u>	<u></u>			— — ₀	13, 555, 933	
	V - RECL PTO COST FOR	STD ELI	MINATION PD	13, 333, 733	Į0			13, 333, 733	
1. 00 5. 00	EMPLOYEE BENEFITS	0. 00 4. 00	l .	0 4 104	SOCIAL SERVICE	0.00 17.00	0 4, 194	0	1. 00 5. 00
	DEPARTMENT							Ĭ	3.00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	30, 499	ADMINISTRATIVE & GENERAL	5.00	30, 499	0	6. 00
9. 00	EMPLOYEE BENEFITS	4. 00	o	1, 736	HOUSEKEEPI NG	9. 00	1, 736	O	9. 00
10. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	n	4 035	DI ETARY	10.00	4, 035	0	10. 00
	DEPARTMENT								
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 935	CAFETERI A	11. 00	8, 935	0	11. 00
12. 00	EMPLOYEE BENEFITS	4. 00	О	12, 041	NURSI NG	13.00	12, 041	0	12. 00
13. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	o	1, 236	ADMI NI STRATI ON PHARMACY	15. 00	1, 236	0	13. 00
	DEPARTMENT								
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	9	393	MEDICAL RECORDS & LIBRARY	16. 00	393	0	14. 00
15. 00	EMPLOYEE BENEFITS	4. 00	O	64, 323	ADULTS & PEDIATRICS	30.00	64, 323	0	15. 00
16. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	О	5, 380	INTENSIVE CARE UNIT	31.00	5, 380	O	16. 00
	DEPARTMENT								
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		7, 975	SUBPROVI DER - I RF	41.00	7, 975	0	17. 00
	,	ı	ı <u>l</u>		T. Comments of the Comments of			l	

COLUMBUS REGIONAL HOSPITAL

Provi der CCN: 150112

		Incr	eases			Decre	2928	5/24/2016 3:0	J3 pm
	Cost Center	Li ne #		Other	Cost Center	Li ne #	Sal ary	Other	
	2.00	3.00	4.00	5. 00	6. 00	7.00	8. 00	9. 00	
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 045	NURSERY	43. 00	2, 045	0	18. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 964	RADI OLOGY-DI AGNOSTI C	54. 00	8, 964	0	21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	950	ELECTROCARDI OLOGY	69. 00	950	0	22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	88	NEUROPSYCH	90. 02	88	0	23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	988	CT SCAN	57. 00	988	0	24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 336	MRI	58. 00	1, 336	0	25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 992	CARDI AC CATHETERI ZATI ON	59. 00	2, 992	0	26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	17, 973	LABORATORY	60.00	17, 973	0	27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 042	RESPIRATORY THERAPY	65. 00	6, 042	0	28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	17, 669	PHYSI CAL THERAPY	66. 00	17, 669	0	29. 00
30. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 879	OCCUPATIONAL THERAPY	67. 00	3, 879	0	30. 00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9, 071	SPEECH PATHOLOGY	68. 00	9, 071	0	31. 00
32. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	132	WOUND CENTER	90. 03	132	0	32. 00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 409	EMERGENCY	91.00	7, 409	0	33. 00
34. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00			AMBULANCE SERVICES	95. 00	1, 383	0	34. 00
	0	1.70	0	221, 668	0		221, 668	0	
1. 00	W - RECLASS SYSV BENEF ADMINISTRATIVE &	5.00	O	101 5/2	EMPLOYEE BENEFITS	4.00	0	191, 543	1.00
2. 00	GENERAL CENTRAL SERVICES &	14. 00		•	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	191, 543	2.00
3. 00	SUPPLY OPERATING ROOM	50.00			DEPARTMENT EMPLOYEE BENEFITS	4.00	0	2, 250, 696	
4. 00	RECOVERY ROOM	51. 00			DEPARTMENT EMPLOYEE BENEFITS	4.00	0	333, 169	
5. 00	ANESTHESI OLOGY	53.00		•	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	27, 934	
0.00	TOTALS			3, 001, 363	DEPARTMENT			3, 001, 363	
	X - RECLASS OT SALARIE	S AND (0, 00 1, 000	1017120		<u> </u>	0,001,000	
1.00	OCCUPATI ONAL THERAPY	67.00	612, 056	15 <u>9, 6</u> 08	PHYSI CAL THERAPY	66.00	612, 056	15 <u>9, 6</u> 08	1.00
	0		612, 056	159, 608	0		612, 056	159, 608	
	Y - RECL MILLRACE FOR				WELL NEOD - 00188811 =: :	1404 5-1	_1		
1.00	OCCUPATIONAL THERAPY	67. 00			WELLNESS COMMUNITY	194.00	0	2, 350	1
2.00	PHYSI CAL THERAPY	66. 00			WELLNESS COMMUNITY	194. 00 194. 00	0	11, 472	1
3.00	OCCUPATIONAL THERAPY	67. 00	·		WELLNESS COMMUNITY		0	711	1
4. 00	PHYSICAL THERAPY	66. 00	├	<u>3, 471</u> 18, 004	WELLNESS COMMUNITY	194. 00		<u>3, 471</u> 18, 004	4. 00
	Z - RECLASS LAB BLOOD	SUPERVI	SOR	10, 004	I~		O ₁	10, 004	1
1. 00	WHOLE BLOOD & PACKED RED BLOOD CELL	62. 00		0	LABORATORY	60.00	69, 127	0	1. 00
	0		69, 127		0 — — — —	\vdash	69, 127		
500.00	Grand Total:		3, 607, 835	38, 056, 398	Grand Total:		3, 829, 503	37, 834, 730	500.00
	Increases				Decreases				

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150112 | Period: | Worksheet A-7 | From 01/01/2015 | Part I

Beginning Balances						rom 01/01/2015		
Beginning Balances Donation Total Disposals and Retirements					1	o 12/31/2015		
Beginning Purchases Donation Total Disposals and Retirements 1.00 2.00 3.00 4.00 5.00					Acqui ci ti onc		3/24/2010 3.0	3 pili
PART - ANALYSIS OF CHANGES N CAPITAL ASSET BALANCES			Poginning	Durchasas		Total	Di coocal c and	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1,786,052 20,000 0 20,000 0 1.00				rui Cilases	Donation	TOTAL		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				2 00	2 00	4 00		
1.00 Land 1,786,052 20,000 0 20,000 0 1.00		DART I - ANALYSIS OF CHANGES IN CARLTAL ASSE		2.00	3.00	4.00	5.00	
2.00 Land Improvements	1 00			20, 000	0	20, 000	0	1 00
3.00 Buildings and Fixtures 90,506,599 12,519,424 0 12,519,424 0 3.00 4.00 Building Improvements 93,996,507 4,492,012 0 4,492,012 0 4,492,012 0 4.00 6.00 Fixed Equipment 7,932,198 279,218 0 279,218 54,416 5.00 6.00 Movable Equipment 124,418,512 9,090,493 0 9,090,493 3,359,594 6.00 0 0 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 336,059,615 29,512,439 0 29,512,439 3,414,010 8.00 10.00 Total (line 8 minus line 9) 336,059,615 29,512,439 0 29,512,439 3,414,010 10.00 Farming Balance Fully perceiated Assets 6.00 7.00						·		
4. 00 Building Improvements 93, 996, 507 4, 492, 012 0 4, 492, 012 0 279, 218 54, 416 5. 00 6. 00 Movable Equipment 124, 418, 512 9, 090, 493 0 9, 090, 493 3, 359, 594 6. 00 9 0 0 0 0 0 0 0 7. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
5.00 Fi xed Equipment 7, 932, 198 279, 218 0 279, 218 54, 416 5.00 6.00 Movable Equipment 124, 418, 512 9,090, 493 0 9,090, 493 3,359, 594 6.00 7.00 H IT designated Assets 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 336,059,615 29,512,439 0 29,512,439 3,414,010 8.00 0 0 0 0 0 0 9.00 9.00 9.00 10.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
6.00 Movable Equipment								
7. 00 HIT designated Assets 0 0 0 0 0 0 7. 00 8. 00 Subtotal (sum of lines 1-7) 336, 059, 615 29, 512, 439 0 29, 512, 439 3, 414, 010 8. 00 9. 00 0 0 0 0 0 0 0 0 0 9. 0						·		
8.00 Subtotal (sum of lines 1-7) 336,059,615 29,512,439 0 29,512,439 3,414,010 8.00 9.00 10.00 Total (line 8 minus line 9) 336,059,615 29,512,439 0 29,512,439 3,414,010 10.00 29,512,439 3,414,010			124, 418, 512	9, 090, 493	0	9, 090, 493	1	
9. 00 Reconciling I tems 0 0 0 0 0 0 0 0 0			0	0	0	0	-	
Total (line 8 minus line 9) 336,059,615 29,512,439 0 29,512,439 3,414,010 10.00			336, 059, 615	29, 512, 439	0	29, 512, 439	3, 414, 010	1
Ending Balance		1	0	0	0	0	0	
Depreciated Assets Section Asset Asset Section Asset Asset Asset Asset Section Asset	10. 00	Total (line 8 minus line 9)			0	29, 512, 439	3, 414, 010	10. 00
Assets 6.00 7.00			Endi ng Bal ance					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1,806,052 0 1.00 2.00 Land Improvements 20,531,039 0 2.00 3.00 Buildings and Fixtures 103,026,023 0 3.00 4.00 Building Improvements 98,488,519 0 4.00 5.00 Fixed Equipment 8,157,000 0 5.00 6.00 Movable Equipment 130,149,411 0 6.00 Movable Equipment 130,149,411 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 362,158,044 0 8.00 9.00 Reconciling Items								
1.00 Land 1,806,052 0 2.00 Land Improvements 20,531,039 0 3.00 Buildings and Fixtures 103,026,023 0 4.00 Building Improvements 98,488,519 0 5.00 Fixed Equipment 8,157,000 0 6.00 Movable Equipment 130,149,411 0 7.00 HIT designated Assets 0 0 8.00 Subtotal (sum of lines 1-7) 362,158,044 0 9.00 Reconciling Items 0 0				7. 00				
2.00 Land Improvements 20,531,039 0 3.00 Buildings and Fixtures 103,026,023 0 4.00 Building Improvements 98,488,519 0 5.00 Fixed Equipment 8,157,000 0 6.00 Movable Equipment 130,149,411 0 7.00 HIT designated Assets 0 0 8.00 Subtotal (sum of lines 1-7) 362,158,044 0 9.00 Reconciling Items 0 0								
3.00 Buildings and Fixtures 103,026,023 0 3.00 4.00 Building Improvements 98,488,519 0 4.00 5.00 Fixed Equipment 8,157,000 0 5.00 6.00 Movable Equipment 130,149,411 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 362,158,044 0 8.00 9.00 Reconciling Items 0 0 9.00	1. 00	Land	1, 806, 052	0				1. 00
4.00 Building Improvements 98, 488, 519 0 5.00 Fi xed Equipment 8, 157, 000 0 5.00 6.00 Movable Equipment 130, 149, 411 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 362, 158, 044 0 8.00 9.00 Reconciling Items 0 0 9.00	2.00	Land Improvements	20, 531, 039	0				2. 00
5.00 Fi xed Equipment 8, 157,000 0 5.00 6.00 Movable Equipment 130, 149, 411 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 362, 158, 044 0 8.00 9.00 Reconciling Items 0 0 9.00	3.00	Buildings and Fixtures	103, 026, 023	0				3. 00
6.00 Movable Equipment 130,149,411 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 362,158,044 0 8.00 9.00 Reconciling Items 0 0 9.00	4.00	Building Improvements	98, 488, 519	0				4.00
7. 00 HIT designated Assets 0 0 0 8. 00 Subtotal (sum of lines 1-7) 362,158,044 0 8. 00 9. 00 Reconciling Items 0 0 9. 00	5.00	Fi xed Equipment	8, 157, 000	0				5. 00
8.00 Subtotal (sum of lines 1-7) 362,158,044 0 8.00 9.00 Reconciling Items 0 0 9.00	6.00		130, 149, 411	0				6.00
8.00 Subtotal (sum of lines 1-7) 362,158,044 0 8.00 9.00 Reconciling Items 0 0 9.00	7.00	HIT designated Assets	o	0				7.00
9.00 Reconciling Items 0 0 9.00			362, 158, 044	0				8. 00
			0	0				
1			362, 158, 044					
	,,		1 ///	-	ı		'	

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150112	Peri od: From 01/01/2015 To 12/31/2015		pared:
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9.00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	16, 527, 441	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	16, 527, 441	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	16, 527, 441				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	16, 527, 441				3. 00

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4, 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				1		
1.00	CAP REL COSTS-BLDG & FLXT	232, 008, 633					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	130, 149, 411					
3.00	Total (sum of lines 1-2)	362, 158, 044		362, 158, 04			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLILATION OF CARLTAL COCTO O	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	ENTERS			0 7, 990, 637	0	1. 00
2.00	CAP REL COSTS-BEDG & TTAT				0 8, 676, 526		2.00
3.00	Total (sum of lines 1-2)				0 16, 667, 163		3.00
0.00	Total (Sam of Fried 12)		SI	JMMARY OF CAPI		0	0.00
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00 ENTERS	12.00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	937, 977	900, 141		0 0	9, 828, 755	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	220, 182			o o		
3.00	Total (sum of lines 1-2)	1, 158, 159	l .		o o		1
				'	1		•

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150112

Desire Center Description Resis/Collect (2) Denumb Const. Center Lines Resist. A.7 Bert						0 12/31/2015	Date/lime Prep 5/24/2016 3:03	
Cost Centur Description Resis/Code (2) Answer Continue Line # Natl A-7 Bef								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.1 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.1 1.00								
1.00 Investment Income								
1.00 Investment Income								
1.00 Investment Income - CAP REL B 95,897/CAP REL COSTS-REDG & FIXI 1.00 11 1.00 12.00 12.00 13.20		Cost Center Description						
200575-BLDC & FIAT (chapter 2) 8	1.00	Investment income - CAP REL						1. 00
CRISTS MINIT FOUR (chapter 2) 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 3.00 0 0.00 0 0 0 0 0 0								
Investment income = other	2. 00		В	15, 917	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
Chapter 2)	3.00			0		0.00	o	3. 00
1.00 1.00		(chapter 2)						
Second	4.00		В	-93, 271	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
6.00 Rental of provider against by suppliers (chapter 8) 7.00 Suppliers (chapter 10) 7.00 Suppliers (chapter 12) 7.00 Suppliers (c	5.00		В	-2.578	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
Supplier's (chapter 8)		expenses (chapter 8)		•				
Telephone services (pay stations excluded) (chapter 21) Services Service Servi	6. 00			0		0. 00	0	6. 00
Stations excluded) (chapter 2) 2	7. 00		Α	-96, 366	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
Television and radio service (Chapter 21) 8				, , , , , , , , , , , , , , , , , , , ,				
Chapter 21 0.00	0 00	1 *		0.220	ODEDATION OF DIANT	7.00		0.00
Parking Inf (chapter 21) B	8.00		A	-9, 339	OPERATION OF PLANT	7.00	U	8.00
adjustment			В	-40	OPERATION OF PLANT	7. 00	0	9. 00
11.00 Sale of scrap, waste, etc. 0 0 0 0 0 0 11.00	10.00		A-8-2	-10, 646, 261			0	10.00
Chapter 23 2.00 Related organization 2.00 12.00 13.00 14.00 15.00 1	11 00			0		0.00	0	11 00
transactions (chapter 10) 13.00 Laundry and I line service	11.00			0		0.00	Ĭ	11.00
13.00 Laundry and I linen service 0 0 0 0 0 0 13.00 15.00 Rental of quarters to employee and duests 8 -770,830CAFETERIA 11.00 0 14.00 16.00 Sale of medical and surgical supplies to other than patients 0 0 0 0 15.00 17.00 Sale of medical records and abstracts 0 0 0 0 17.00 18.00 Sale of medical records and abstracts 0 0 0 0 17.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 19.00 19.00 Nursing school (fultion, fees, books, etc.) 0 0 0 0 19.00 0 19.00 19.00 0 19.00 19.00 0 19.00 19.00 0 19.00 19.00 0 19.00 19.00 0 19.00 19.00 0 19.00 19.00 0 20.00 19.00	12. 00		A-8-1	-431, 815			0	12. 00
14.00 Carter(ria-employees and guests B -770,830CAFETERIA 11.00 0 14.00	13 00			0		0.00		13 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0			В	-770, 830	CAFETERI A		1	
16.00 Sale of medical and surgical supplies to other than patients 0 0 0 0 0 0 0 0 0	15. 00	Rental of quarters to employee		0		0.00	0	15. 00
Supplies to other than Datients Sale of drugs to other than Datients Sale of drugs to other than Datients Sale of drugs to other than Datients Dati	14 00			0		0.00		14 00
patients	16.00			U		0.00	0	10.00
patients		patients						
18.00 Sale of medical records and abstracts B -23,015 MEDICAL RECORDS & LIBRARY 16.00 0 18.00 19.00 Nursing school (tuition, fees, books, etc.) 0 0.00 0 19.00 20.00 Vending machines B -408 HOUSEKEEPING 9.00 0 20.00 21.00 Interest, finance or penalty charges (chapter 21) 0 0 0.00 0 21.00 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments or verpayments or verpa	17. 00			0		0. 00	0	17. 00
abstracts	18. 00	1.	В	-23, 015	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
Dooks_ etc.) Dook				,,				
20. 00 Vending machines B	19. 00			0		0. 00	0	19. 00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpay Medic	20. 00		В	-408	 HOUSEKEEPI NG	9.00	0	20. 00
Charges (chapter 21)				0			1	
1								
Overpayments and borrowings to repay Medicare overpayments	22 00			0		0.00	0	22 00
23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT (Chapter 21) 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT (COSTS-MUBLE EQUIP (COSTS-MUBLE	22.00		,	0		0.00	Ĭ	22.00
therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT		1 . 3		_				
I imitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP COSTS-M	23. 00		A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
therapy costs in excess of								
1 imitation (chapter 14)	24. 00		A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25.00		13						
physicians' compensation (chapter 21)	25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27.00 28. 00 COSTS-MVBLE EQUIP 2.00 0 27.00 28. 00 Physicians annesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians assistant 0 OCCUPATIONAL THERAPY 67.00 30.00 30. 00 Therapy costs in excess of limitation (chapter 14) 0 ADULTS & PEDIATRICS 30.00 30.99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 32. 00 CAH HIT Adjustment for Depreciation and Interest 0 OCCUPATIONAL THERAPY 0.00 0 32.00 33. 00 TELEPHONE SERVICES B -3,900 ADMINISTRATIVE & GENERAL 5.00 0 33.00		physicians' compensation						
COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 27.00	26 00			^	CAD DEL COSTS_DIDO & ELVT	1 00		26 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 **** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 0 00 0 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	∠0. 00			U	ON RE COSIS-DEDG & FIXI	1.00		20. UU
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0 00 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 00000000000000000000000000000000000	27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 TELEPHONE SERVICES 0.00 CCUPATIONAL THERAPY 67.00 30.00 30.00 A-8-3 OCCUPATIONAL THERAPY 67.00 30.00 30.00 SPEECH PATHOLOGY 68.00 31.00 0.00 0.0	20 00			^	*** Cost Contor Doloted ***	10.00		28 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 TELEPHONE SERVICES A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		, ,		0	Cost Center Dereted			
I imitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY A-8-3 OSPEECH PATHO		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		1	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 33. 00 TELEPHONE SERVICES B OADULTS & PEDIATRICS 30. 00 SPEECH PATHOLOGY 68. 00 31. 00 30. 99 30. 99 30. 99 31. 00 31. 00 32. 00 32. 00 33. 00								
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 TELEPHONE SERVICES B -3,900 ADMINISTRATIVE & GENERAL 5.00 0 33.00	30 99			Ω	 ADULTS & PEDLATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 TELEPHONE SERVICES B -3,900 ADMINISTRATIVE & GENERAL 5.00 0 33.00		instructions)						
I i mi tati on (chapter 14) 32.00 CAH HIT Adj ustment for Depreciation and Interest 33.00 TELEPHONE SERVICES B -3,900 ADMINISTRATIVE & GENERAL 5.00 0 33.00	31. 00	, ,	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00								
Depreciation and Interest 33.00 TELEPHONE SERVICES B -3,900 ADMINISTRATIVE & GENERAL 5.00 0 33.00	32. 00			0		0. 00	o	32. 00
		Depreciation and Interest	_					
34. 00 DEPR PAT PHONES NEW EQUIP A -21, 471 CAP REL COSTS-MVBLE EQUIP 2. 00 9 34. 00							1	
51.00 DELIK 1711 THORIES NEW EQUIT 7 -21,47 DAI KEE 00313-1117 2.00 9 34.00		DELICITAL FINONES NEW EQUIF	1 7	-21,4/1	ION REE GOOTS-WINDEL EQUIP	2.00	ı ⁹ l	

From 01/01/2015 | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				To	12/31/2015	Date/Time Pre 5/24/2016 3:0	pared:
				Expense Classification on	Worksheet A	372472010 3.0	3 pili
				To/From Which the Amount is 1			
					,		
	0 1 0 1 5 11	D : (0 (0)			1. "	WI I A 7 D C	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
35. 00	TV DEPR NEW EQUIP	1. 00 A	2.00	3. 00 CAP REL COSTS-MVBLE EQUIP	4. 00	5. 00 9	35. 00
36. 00	CAFETERIA VISITORS	A		CAFETERIA	11. 00		36. 00
37. 00	OPERATING REVENUE OTHER	B		OPERATING ROOM	50.00		37. 00
07.00	REVENUE		1,007	OF ENTITIO ROOM	00.00	Ĭ	07.00
38.00	NURSING ADMIN OTHER REVENUE	В	-77, 133	NURSING ADMINISTRATION	13.00	0	38. 00
39.00	INPATIENT PT	В	-1, 031	PHYSI CAL THERAPY	66.00	0	39. 00
40.00	EAP REVENUE	В	-24, 752	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	BOND AMORTIZATION	A	110, 643	CAP REL COSTS-BLDG & FIXT	1.00	9	41. 00
42.00	LAND RENT MO	В	-2, 000	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
43. 00	RENT PATHOLOGISTS	В		LABORATORY-PATHOLOGI CAL	60. 01	0	43. 00
44. 00	LABORATORY OTHER REVENUE	В		LABORATORY	60.00		44. 00
44. 01	EMPLOY BENEFITS OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		44. 01
45. 00	XRAY EDUCATION	В		XRAY EDUCATION	23. 01	0	45. 00
45. 01	MEDICAL STAFF INCOME	B B		ADMINISTRATIVE & GENERAL RADIOLOGY-DIAGNOSTIC	5.00	0	45. 01
45. 02 45. 03	RADIOLOGY OTHER REVENUE BREAST FILM COPIES	В		MAMMOGRAPHY	54. 00 54. 03	_	45. 02 45. 03
45. 04	MEDICAL RECORDS OTHER REVENUE	В		MEDICAL RECORDS & LIBRARY	16. 00		45. 04
45. 05	FACILITIES OTHER REVENUE	В		OPERATION OF PLANT	7. 00		45. 05
45. 06	SI CK BAY	В		ADULTS & PEDIATRICS	30.00		45. 06
45. 07	CARDI AC CATH OTHER REVENUE	В		CARDIAC CATHETERIZATION	59. 00		45. 07
45. 08	ADMIN OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		45. 08
45. 09	MRES GRANT OTHER	В	-10, 500	ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
45. 10	INFO SERV OTHER REVENUE	В	-27, 720	ADMINISTRATIVE & GENERAL	5. 00	0	45. 10
45. 11	FOOD OTHER REVENUE	В	-2, 234	DI ETARY	10.00	0	45. 11
45. 12	SPEECH THERAPY OTHER REVENUE	В	-719	SPEECH PATHOLOGY	68.00	0	45. 12
45. 13	PROTECTI VE SERV OTHER REVENUE	В		OPERATION OF PLANT	7. 00		45. 13
45. 14	PHARMACY OTHER REVENUE	В		PHARMACY	15. 00		45. 14
45. 15	HUMAN RESOURCES OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		45. 15
45. 16	LACTATION AND PREPARE OTHER REVENUE	В	-5, 560	ADULTS & PEDIATRICS	30. 00	0	45. 16
45. 17	VOLUNTEER OTHER REVENUE	В	-68. 918	ADMINISTRATIVE & GENERAL	5. 00	0	45. 17
45. 18	RENTAL PROPERTIES DEPRECIATION			CAP REL COSTS-BLDG & FIXT	1. 00		45. 18
45. 19			0		0.00	0	45. 19
45. 20	PENSI ON EXPENSE	A	1, 060, 039	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 20
45. 21	LOSS ON DISPOSAL DEMOLITION	A	11, 218	CAP REL COSTS-BLDG & FIXT	1.00	9	45. 21
45. 22	UNALLOWABLE PHYS RECRUITMENT	A	-187, 010	ADMINISTRATIVE & GENERAL	5. 00	0	45. 22
45. 23	DEPRECIATION RELIFED	A		CAP REL COSTS-BLDG & FIXT	1. 00		45. 23
45. 24	DEPRECIATION RELIFED	A	64, 330	CAP REL COSTS-MVBLE EQUIP	2. 00		45. 24
45. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45. 25
45. 27	DDLOD VEAD AUDIT AD HISTMENT	Λ .	4 711	CAP REL COSTS-BLDG & FIXT	1 00	9	45. 27
45. 27	PRIOR YEAR AUDIT ADJUSTMENT NONALLOWABLE INT EXP 1993	A A		CAP REL COSTS-BLDG & FIXI	1. 00 2. 00	· ·	45. 27
43. 20	BONDS	^	-00, 030	CAL REE COSTS-WVBEE EQUIT	2.00	''	43. 20
45. 29	NONALLOWABLE INT EXP 2003/2009	Α	-192, 002	CAP REL COSTS-MVBLE EQUIP	2. 00	11	45. 29
	BONDS		,				
45. 30	UNALLOWABLE AHA MEMBERSHIP	A	-11, 550	ADMINISTRATIVE & GENERAL	5. 00	0	45. 30
	DUES						
45. 31	AMBULANCE SERVICES	В		AMBULANCE SERVICES	95.00		
45. 32	COPY CENTER OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		45. 32
45. 33	CARDI OLOGY OTHER REVENUE	В		ELECTROCARDI OLOGY	69. 00		45. 33
45. 34	HAF ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 34
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-20, 212, 774				50. 00
	column 6, line 200.)						
	100. 0 0, 11110 200.)					1	

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

 $B. \ \ \text{Amount Received - if cost cannot be determined}.$

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

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

* 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.

 p	cor anno i aria, or 2, tho amoun				
			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	TED 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	E	J BICKEL	O. OO SI HEALTH MANAGEMENT	0. 00	6. 00
7. 00	E	M HUNT	O.OOSI HEALTH MANAGEMENT	0. 00	7.00
8.00	E	Z ELLISON	O.OOSI HEALTH MANAGMENT	0. 00	8.00
9. 00	E	R SHEDD	O.OOSI HEALTH MANAGEMENT	0. 00	9. 00
10.00	E	S STARK	O.OOSI HEALTH MANAGEMENT	0. 00	10.00
10. 01	E	T SOUZA	O.OOSI HEALTH MANAGMENT	0. 00	10. 01
10. 02	E	D MI CHAEL	O.OOSI HEALTH MANAGMENT	0. 00	10.02
100.00	G. Other (financial or	NONE			100.00
	non-financial) specify:				

 $(1) \ \ \text{Use the following symbols to indicate interrelationship to related organizations:}$

Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGA	NIZATIONS AND HOME	Provider CCN: 150112	Peri od:	Worksheet A-	3-1
OFFICE	COSTS					From 01/01/2015		
						To 12/31/2015	Date/Time Pro 5/24/2016 3:0	
	Net	Wkst. A-7 Ref.				<u> </u>	3/24/2010 3.1	JS PIII
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCURI	RED AND ADJUST	MENTS REQUIRE	D AS A RESULT OF TRAN	ISACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:						
1.00	-431, 815	C)					1.00
2.00	0	C)					2. 00
3.00	0	C						3. 00
4.00	0	C)					4.00
5.00	-431, 815							5. 00
* The	amounts on line	es 1-4 (and sub	oscripts as a	ppropriate) are trans	ferred in detail to Wor	ksheet A. column	6. lines as	

* 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.

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	MANAGEMENT COMPANY	6.0
7.00	MANAGEMENT COMPANY	7.0
8.00	MANAGEMENT COMPANY	8.0
9.00	MANAGEMENT COMPANY	9.0
10.00	MANAGEMENT COMPANY	10.0
10. 01	MANAGEMENT COMPANY	10.0
10. 02	MANAGMENT COMPANY	10.0
100.00		100.0

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

Provi der CCN: 150112

Peri od: Worksheet A-8-2 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm

						10 12/31/2015	5/24/2016 3:0	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component	
				oomporterre	·		Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	10, 107, 587				852	1.00
2. 00 3. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	315, 245 31, 300				2, 335 313	2. 00 3. 00
4. 00		SUBPROVIDER - IRF	80, 000				1, 903	4. 00
5. 00		OPERATING ROOM	384, 400			246, 400	2, 437	5. 00
6.00		ANESTHESI OLOGY	45, 000			239, 400	312	6. 00
7.00		RADI OLOGY-THERAPEUTI C	150, 000	C	150, 000	271, 900	279	7. 00
8. 00		CARDI AC CATHETERI ZATI ON	94, 874		, , , , , ,	211, 500	474	8. 00
9.00		LABORATORY - PATHOLOGI CAL	225, 000		225, 000		1, 500	9.00
10. 00 11. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	50, 700 50, 000		00,700	211, 500 211, 500	507 250	10. 00 11. 00
12. 00		ELECTROCARDI OLOGY	48, 125			1	249	12. 00
13. 00		ELECTROENCEPHALOGRAPHY	11, 150				112	13. 00
14.00		CARDIAC REHABILITATION	3, 333	C	3, 333	211, 500	17	14.00
15.00	•	NEUROPSYCH	180, 416			211, 500	0	15. 00
16. 00	•	WOUND CENTER	8, 852		-,	211, 500	89	16. 00
17. 00		HYPERBARI C OXYGEN THERAPY	1, 323	0	.,	211, 500	10 524	17. 00
18. 00 19. 00		EMERGENCY AMBULANCE SERVICES	1, 839, 917 17, 500		1,007,717	211, 500 211, 500	19, 524 172	18. 00 19. 00
200.00	75.00	ANDULANCE SERVICES	13, 644, 722			1	31, 339	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	,	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	86, 634				0	1. 00
2.00		ADULTS & PEDIATRICS	221, 713			l e	0	2. 00
3.00		INTENSIVE CARE UNIT	31, 827				0	3. 00
4.00		SUBPROVI DER - I RF	193, 502				0	4. 00
5.00		OPERATING ROOM	288, 691				0	5. 00
6. 00 7. 00		ANESTHESI OLOGY RADI OLOGY-THERAPEUTI C	35, 910 36, 471	1, 796 1, 824	_		0	6. 00 7. 00
8. 00		CARDI AC CATHETERI ZATI ON	48, 198				0	8. 00
9. 00		LABORATORY-PATHOLOGI CAL	187, 644				Ö	9. 00
10.00		RESPI RATORY THERAPY	51, 553			0	0	10.00
11. 00		PHYSI CAL THERAPY	25, 421	1, 271	0	0	0	11. 00
12. 00		ELECTROCARDI OLOGY	25, 319				0	12. 00
13.00		ELECTROENCEPHALOGRAPHY	11, 388			0	0	13.00
14. 00 15. 00		CARDIAC REHABILITATION NEUROPSYCH	1, 729 0	1			0	14. 00 15. 00
16. 00		WOUND CENTER	9, 050	1		0	0	16. 00
17. 00		HYPERBARI C OXYGEN THERAPY	1, 424	71		Ō	0	17. 00
18. 00		EMERGENCY	1, 985, 253	99, 263		0	0	18. 00
19. 00	95. 00	AMBULANCE SERVICES	17, 489			0	0	19. 00
200.00	Wkot Alino#	Coat Cantar (Dhyai ai an	3, 259, 216			Adi.ustmant	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
		raditifici	Share of col.	Li iiii t	Di Sai i Owanice			
			14					
1 00	1.00	2. 00	15. 00	16. 00	17. 00	18.00		1 00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0 0					1. 00 2. 00
3. 00		INTENSIVE CARE UNIT				1		3. 00
4. 00		SUBPROVI DER - I RF	Ö			Ö		4. 00
5.00		OPERATING ROOM	0	288, 691		95, 709		5. 00
6.00		ANESTHESI OLOGY	0	35, 910		9, 090		6. 00
7. 00		RADI OLOGY-THERAPEUTI C	0	36, 471		113, 529		7. 00
8.00		CARDI AC CATHETERI ZATI ON	0			46, 676		8. 00
9. 00 10. 00		LABORATORY-PATHOLOGI CAL RESPI RATORY THERAPY	0			37, 356		9. 00 10. 00
11. 00		PHYSI CAL THERAPY				24, 579		11. 00
12. 00		ELECTROCARDI OLOGY	Ö			22, 806		12. 00
13.00		ELECTROENCEPHALOGRAPHY	0			0		13. 00
14.00	76. 97	CARDIAC REHABILITATION	0	1, 729	1, 604	1, 604		14.00
15.00		NEUROPSYCH	0	0	_	180, 416		15. 00
16.00	•	WOUND CENTER	0	9, 050		0		16.00
17. 00 18. 00		HYPERBARIC OXYGEN THERAPY EMERGENCY	0			0		17. 00 18. 00
19. 00	•	AMBULANCE SERVICES				11		19. 00
200.00			Ö			l		200. 00
					•			

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150112

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
5/24/2016 3:03 pm

					To	12/31/2015	Date/Time Pre 5/24/2016 3:0	
				CAPI TAL REI	ATED COSTS		372472010 3.0	5 PIII
		Cost Contor Description	Not Eypopsos	BLDG & FLXT	MVDLE FOLLD	EMPLOYEE	Subtotal	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXI	MVBLE EQUIP	BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7)	1.00	2.00	4. 00	4A	
	GENER	AL SERVICE COST CENTERS		1.00	2.00	4.00	77.	
1.00		CAP REL COSTS-BLDG & FIXT	9, 828, 755					1. 00
2.00	4	CAP REL COSTS-MVBLE EQUIP	8, 896, 708	l	8, 896, 708	25 422 574		2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	24, 927, 273 31, 104, 753	1		25, 122, 574 4, 020, 552	40, 294, 197	4. 00 5. 00
7. 00		OPERATION OF PLANT	5, 818, 918			716, 963	11, 575, 063	7. 00
8.00		LAUNDRY & LINEN SERVICE	694, 360			20, 461	723, 829	8. 00
9. 00 10. 00	4	HOUSEKEEPI NG DI ETARY	2, 162, 457 895, 318			600, 996 204, 213	2, 846, 512 1, 237, 673	9. 00 10. 00
11. 00		CAFETERI A	811, 296	l ·	56, 078	452, 206	1, 406, 582	11. 00
13. 00		NURSING ADMINISTRATION	3, 191, 932			1, 141, 392	4, 552, 133	
14. 00		CENTRAL SERVICES & SUPPLY	1, 055, 139	l	95, 750	3, 962	1, 264, 192	14. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	4, 737, 794 1, 650, 437	l ·		1, 088, 013 237, 916	6, 376, 336 1, 979, 443	
17. 00		SOCIAL SERVICE	513, 718	l ·		184, 304	702, 441	
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01		XRAY EDUCATION	449, 201	9, 453		169, 255	627, 930	
23. 02		PHARMACY RESIDENCY PROG LENT ROUTINE SERVICE COST CENTERS	352, 302	5, 402	0	123, 508	481, 212	23. 02
30. 00		ADULTS & PEDIATRICS	14, 309, 224	1, 097, 679	416, 640	4, 774, 354	20, 597, 897	30. 00
31. 00		INTENSIVE CARE UNIT	2, 450, 954	1	157, 833	780, 653	3, 546, 879	
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40.00		SUBPROVI DER - I PF	0	ő	0	0	0	40. 00
41.00		SUBPROVIDER - IRF	1, 600, 514	159, 249	18, 952	522, 320	2, 301, 035	41.00
42. 00 43. 00		SUBPROVI DER NURSERY	419 204	0 8, 375	0 17, 096	0 221, 872	0 865, 737	42. 00 43. 00
44. 00		SKILLED NURSING FACILITY	618, 394	0, 3/3		221, 672	000,737	
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	13, 151, 558	1		188, 034	15, 020, 941	
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	1, 352, 160 0	1		0	1, 430, 760 0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	233, 225	· ·		Ö	247, 022	
54. 00		RADI OLOGY-DI AGNOSTI C	1, 803, 939		198, 795	514, 892	2, 632, 929	
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	1, 083, 807 580, 649		8, 294 735	115, 835 169, 847	1, 256, 551 772, 838	
54. 02		MAMMOGRAPHY	1, 062, 724	l		261, 810	1, 347, 690	
55. 00		RADI OLOGY-THERAPEUTI C	1, 346, 236			383, 845	2, 195, 193	
57.00		CT SCAN	860, 975	l ·	· ·	204, 681	1, 277, 970	
58. 00 59. 00	05800	MRI CARDIAC CATHETERIZATION	403, 789 2, 096, 747			92, 509 521, 567	526, 871 2, 900, 279	
60. 00		LABORATORY	6, 829, 942	154, 566	270, 589	1, 251, 397	8, 506, 494	
60. 01	4	LABORATORY-PATHOLOGI CAL	764, 241	17, 412	43, 829	133, 518	959, 000	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	761, 596			25, 181	799, 791	62.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 908, 656 3, 678, 683	1	112, 257 26, 640	585, 321 1, 148, 378	2, 700, 534 4, 856, 962	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	1, 283, 844	1	·	396, 170	1, 688, 757	67. 00
68. 00		SPEECH PATHOLOGY	818, 929	l	- '	258, 896	1, 096, 538	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	551, 736 720, 196	1	32, 901 16, 193	167, 770 221, 986	772, 491 958, 375	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	8, 805, 635	l .	10, 193	221, 900	8, 805, 635	
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	4, 824, 540	l	O	0	4, 824, 540	
73. 00		DRUGS CHARGED TO PATIENTS	12, 698, 466	l	0	0	12, 698, 466	
74. 00 76. 00		RENAL DIALYSIS ACUPUNCTURE	494, 455 0	l	32	0	494, 487 0	74.00
76. 00	1	CARDI AC REHABI LI TATI ON	102, 286		10, 760	33, 665	169, 252	76. 00 76. 97
, 0. , ,		TIENT SERVICE COST CENTERS	102/200	22,011	.0,700	30, 300	107/202	70.77
88. 00		RURAL HEALTH CLINIC	0			0	0	
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER	704, 122	0 65, 323		0 213, 692	0 1, 006, 284	89. 00 90. 00
90. 00		DI ABETES CENTER	154, 412	l ·	902	24, 362	1, 006, 264	90.00
90. 02	09002	NEUROPSYCH	85, 251	2, 026	375	26, 589	114, 241	90. 02
90. 03		WOUND CENTER	1, 320, 877	0	·	135, 821	1, 458, 837	90. 03
90. 04 91. 00		HYPERBARI C OXYGEN THERAPY EMERGENCY	292, 189 7, 099, 905	l e	319 135, 179	758 1, 678, 522	293, 266 9, 053, 188	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	1,077, 703	137, 362	133, 179	1, 070, 322	9, 053, 188	
	OTHER	REIMBURSABLE COST CENTERS						
95. 00	09500	AMBULANCE SERVICES	2, 682, 013	92, 073	235, 079	1, 000, 989	4, 010, 154	95. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	L In Lieu of Form CMS-2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 150112	Period: Worksheet B From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:				

				rom 01/01/2015 o 12/31/2015	Part I Date/Time Pre 5/24/2016 3:0	
			_ATED COSTS	_		
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost Allocation			BENEFITS DEPARTMENT		
	(from Wkst A			DEFARTMENT		
	col . 7)					
	0	1. 00	2.00	4. 00	4A	
99. 10 09910 CORF	0	0	C	0		99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0		0		110. 00 111. 00
113. 00 11300 NTEREST EXPENSE	U	U		0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	196, 627, 230	9, 770, 371	8, 877, 698	25, 018, 975	196, 446, 237	
NONREI MBURSABLE COST CENTERS	17070277200	7,770,071	0,0,,,0,0	20/010/770	170/110/207	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 444	364	. 0	10, 808	190. 00
194.00 07950 WELLNESS COMMUNITY	264, 657	0	17, 451	58, 111	340, 219	194. 00
194. 01 07951 BUILDING RENTALS	75, 404	19, 064	C	0		194. 01
194. 02 07952 HOSPI CE	54, 239	0	C	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	C	0	1	194. 03
194. 04 07954 SPEECH - HEARING AIDS	233, 619	0	C	0	233, 619	1
194. 05 07955 NONALLOWABLE MARKETING	1, 634, 274	0	C	0	1, 634, 274	1
194. 06 07956 CRH FOUNDATION	-1, 156	11, 708				194. 06
194. 07 07957 HEALTHY COMMUNITIES	133, 580	17, 168	463	45, 488		
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	199, 021, 847	9, 828, 755	8, 896, 708	25, 122, 574		201. 00
202.00 TOTAL (sum lines 118-201)	199,021,847	9,020,755	0,090,708	23, 122, 5/4	199, 021, 847	1202.00

Provi der CCN: 150112

				T	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					I	1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	40, 294, 197				I	5. 00
7.00	00700 OPERATION OF PLANT	2, 938, 411	14, 513, 474			I	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	183, 749	33, 697	941, 275		I	8. 00
9.00	00900 HOUSEKEEPI NG	722, 607	265, 166		3, 834, 285	1 000 110	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	314, 192 357, 071	422, 041 325, 466	0	24, 542 52, 693	1, 998, 448 0	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 155, 591	533, 665		9, 384	0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	320, 924	409, 035	0	25, 264	o o	
15. 00	01500 PHARMACY	1, 618, 678	254, 471	0	53, 414	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	502, 495	212, 606		0	0	
17. 00	01700 SOCIAL SERVICE	178, 320	16, 230	0	1, 444	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	150 404	0 2E 242	0	7 040	0	
23. 01 23. 02	O2301 XRAY EDUCATION O2302 PHARMACY RESIDENCY PROG	159, 404 122, 159	35, 363 20, 207	0	7, 940 3, 609		
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS	122, 137	20, 207		3,007		25.02
30.00	03000 ADULTS & PEDIATRICS	5, 228, 993	4, 106, 316	359, 435	1, 491, 990	1, 543, 672	30.00
31.00	03100 INTENSIVE CARE UNIT	900, 400	588, 966	44, 325	118, 378	167, 086	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	1
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF	0	0	0	0	0 0	
41. 00	04100 SUBPROVIDER - I RF	584, 134	595, 737	52, 303	142, 920	_	
42. 00	04200 SUBPROVI DER	0	0,0,707	02,000	0	0	
43. 00	04300 NURSERY	219, 773	31, 332	12, 824	1, 444	0	1
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 813, 171	2, 099, 994	192, 775	-	9, 907	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	363, 208	171, 170	29, 008	93, 114	0 0	1
53. 00	05300 ANESTHESI OLOGY	62, 708	6, 395	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	668, 387	431, 339	88, 676	96, 723	464	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	318, 984	181, 865	0	77, 234	0	1
54. 02	05404 ULTRA SOUND	196, 190	80, 829	0	20, 933	0	54. 02
54. 03	05405 MAMMOGRAPHY	342, 121	14, 672		39, 700	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	557, 265	423, 761	6, 267	67, 851	2, 812	1
57. 00 58. 00	05700 CT SCAN	324, 422 133, 750	54, 119 48, 368		9, 384 9, 384	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	736, 256	564, 244	4, 489	83, 009	4, 180	
60.00	06000 LABORATORY	2, 159, 433	578, 217	0	67, 851	0	
60. 01	06001 LABORATORY-PATHOLOGI CAL	243, 449	65, 136	0	4, 331	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	203, 033	28, 161	0	2, 887	0	
65. 00	06500 RESPI RATORY THERAPY	685, 549	352, 767	0	46, 196	0	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 232, 974 428, 703	12, 200 11, 877		0	0	
68. 00	06800 SPEECH PATHOLOGY	278, 364	11,8//	9, 931	0	0	
69. 00	06900 ELECTROCARDI OLOGY	196, 102	75, 132	Ö	15, 158	_	
70. 00	07000 ELECTROENCEPHALOGRAPHY	243, 290	0	1, 254		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 235, 372	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 224, 743	0	0	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 223, 594	0	0	0	0	
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	125, 529	0	0	0	0 0	
76. 97	07697 CARDI AC REHABI LI TATI ON	42, 966	84, 322	0	12, 271	0	
70.77	OUTPATIENT SERVICE COST CENTERS	127 700	0.1, 022		12/271		1
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00	09000 CLI NI C	255, 452	244, 368	34, 908		15, 648	1
90. 01	09001 DI ABETES CENTER	48, 438	41, 651	0	2, 165	0	1
90. 02 90. 03	09002 NEUROPSYCH 09003 WOUND CENTER	29, 001 370, 336	7, 578	6, 082	0	0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	74, 448	0	909	0	0	90. 04
91. 00	09100 EMERGENCY	2, 298, 215	522, 164		409, 270	_	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95. 00	09500 AMBULANCE SERVI CES	1, 018, 006	344, 437	0	0	0	
	09910 CORF	0	0	0	0	0	1
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	101. 00
109. 00	10900 PANCREAS ACQUISITION	O	0	0	0	0	109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	O	Ö				110.00
		'					

| Peri od: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Inne Prepared:

					5/24/2016 3:03 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5.00	7.00	8. 00	9. 00	10.00
111.00 11100 SLET ACQUISITION	0	0	0	0	0 111. 00
113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	39, 640, 360	14, 295, 064	941, 275	3, 809, 022	1, 998, 448 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 744	39, 071	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	86, 367	0	0	0	0 194. 00
194. 01 07951 BUILDING RENTALS	23, 981	71, 317	0	0	0 194. 01
194. 02 07952 HOSPI CE	13, 769	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	59, 306	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	414, 872	0	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	2, 865	43, 800	0	22, 376	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	49, 933	64, 222	0	2, 887	0 194. 07
200.00 Cross Foot Adjustments				·	200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	40, 294, 197	14, 513, 474	941, 275	3, 834, 285	1, 998, 448 202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared:

			To	12/31/2015	Date/Time Pre 5/24/2016 3:0	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	э рііі
	11.00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	2, 141, 812					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	79, 715	6, 330, 488	2 150 (00			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	27, 271 73, 422	113, 004	2, 159, 690 0	8, 376, 321		14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY	60, 835	0	0	0, 370, 321	2, 755, 379	16. 00
17. 00 01700 SOCI AL SERVI CE	14, 684	60, 460	0	0	0	17. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01 02301 XRAY EDUCATI ON	14, 684	0	0	0	0	23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	10, 489	0	0	0	0	23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	516, 047	2, 060, 737	109, 861	7, 064	699, 521	30. 00
31. 00 03100 NTENSI VE CARE UNI T	71, 324	284, 329	1, 624	2, 145	64, 848	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	O	0	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	1 25/	1/2 100	40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	50, 346	202, 290	0	1, 356	163, 198 0	41. 00 42. 00
43. 00 04300 NURSERY	18, 880	74, 431	4, 149	17	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	201, 385		1, 916, 877	31, 301	708, 721	50.00
51. 00 05100 RECOVERY ROOM	31, 466	125, 628	0	93	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	2, 098	10, 070	0	44, 164	0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	46, 151	10,070	4, 149	1, 680	0	54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	8, 391	o	0	114, 776	0	54. 01
54.02 05404 ULTRA SOUND	10, 489	О	0	136	0	54. 02
54. 03 05405 MAMMOGRAPHY	25, 173	0	2, 526	144	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	25, 173	99, 977	0	(122	32, 927	55. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	16, 782 6, 293	0	0	6, 123 2, 985	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	39, 857	158, 314	16, 596	4, 126	62, 835	59. 00
60. 00 06000 LABORATORY	159, 430	0	0	202	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	14, 684	O	0	53	138, 466	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 098	0	0	1	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	58, 737	238, 696	3, 067	3, 316	129, 408	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	100, 692 29, 369	405, 761 115, 372	44, 738 0	2, 828 454	17, 111 3, 595	
68. 00 06800 SPEECH PATHOLOGY	18, 880		0	9	3, 373	68. 00
69. 00 06900 ELECTROCARDI OLOGY	14, 684	58, 943	0	3, 875	320, 787	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	18, 880	72, 010	0	5	199, 288	70. 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	0 000 107	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0	0	8, 089, 107 4, 109	0	73. 00 74. 00
74. 00 07400 RENAL BLALTSLS 76. 00 03020 ACUPUNCTURE	0	0	0	4, 109 0	0	74. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	4, 196	14, 572	0	Ö	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	07 220	0	4 527	100.005	89. 00
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES CENTER	20, 978 2, 098		0	4, 527	190, 805 0	90. 00 90. 01
90. 01 09001 DTABETES CENTER 90. 02 09002 NEUROPSYCH	2,098		0	0	23, 869	90.01
90. 03 09003 WOUND CENTER	12, 587	52, 270	46, 001	39, 973	20,007	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	90. 04
91. 00 09100 EMERGENCY	174, 114	587, 189	10, 102	4, 265	0	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	142, 648	572, 153	٥	7, 294	0	95. 00
99. 10 09910 CORF	142,046	372, 193 N	0	7, 294 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	Ö	0	Ö		101. 00
SPECIAL PURPOSE COST CENTERS	_					
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00

					5/24/2016 3:0			
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL			
		ADMI NI STRATI ON	SERVICES &		RECORDS &			
			SUPPLY		LI BRARY			
	11. 00	13. 00	14. 00	15. 00	16. 00			
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00		
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00		
113. 00 11300 I NTEREST EXPENSE						113. 00		
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 127, 128	6, 294, 775	2, 159, 690	8, 376, 128	2, 755, 379	118. 00		
NONREI MBURSABLE COST CENTERS								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00		
194.00 07950 WELLNESS COMMUNITY	8, 391	35, 713	0	0	0	194. 00		
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0	194. 01		
194. 02 07952 HOSPI CE	0	0	0	193	0	194. 02		
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03		
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0	194. 04		
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0	194. 05		
194.06 07956 CRH FOUNDATION	0	0	0	0	0	194. 06		
194.07 07957 HEALTHY COMMUNITIES	6, 293	0	0	0	0	194. 07		
200.00 Cross Foot Adjustments						200. 00		
201.00 Negative Cost Centers	0	0	0	0	0	201. 00		
202.00 TOTAL (sum lines 118-201)	2, 141, 812	6, 330, 488	2, 159, 690	8, 376, 321	2, 755, 379	202. 00		

Provider CCN: 150112

					12/31/2015	5/24/2016 3:0	
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATION	PHARMACY RESIDENCY PROG	Subtotal	
		17. 00	23. 00	23. 01	23. 02	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	l l						15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	973, 579					16. 00 17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	9/3, 5/9	0				23. 00
23. 00	02301 XRAY EDUCATION	0	O	845, 321			23. 00
23. 02	1 1	o		0.0,02.	637, 676		23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30.00	03000 ADULTS & PEDIATRICS	378, 722	C	0	0	37, 100, 255	30. 00
31. 00		117, 803	0		0	5, 908, 107	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	+ I	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	261, 893	0	0	0	0 4, 600, 461	40. 00 41. 00
42. 00	04200 SUBPROVI DER	201, 073	0	0	0	4, 000, 401	42.00
43. 00	1 1	o	Ö	l ő	0	1, 228, 587	43. 00
44. 00	1	o	0	0	Ö	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	l l	0	0	0	0	25, 382, 481	50.00
51. 00	1	0	0	0	0	2, 244, 447	51. 00
52. 00	I I	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	045 221	0	372, 457	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0	845, 321 0	0	4, 815, 819 1, 957, 801	54. 00 54. 01
54. 01	1		0	0	0	1, 937, 801	54. 01
54. 03	05405 MAMMOGRAPHY	0	0	0	0	1, 779, 893	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	54, 520	0	o o	o	3, 465, 746	55. 00
57.00	05700 CT SCAN	0	O	0	0	1, 688, 800	57. 00
58.00	05800 MRI	0	0	0	0	727, 651	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	4, 574, 185	59. 00
60.00	06000 LABORATORY	0	0	0	0	11, 471, 627	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	0	0	1, 425, 119	60. 01
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0	0	0	0	1, 035, 971 4, 218, 270	62. 00 65. 00
66. 00	+ I		0	0	0	6, 692, 927	66. 00
67. 00	1 1		Ö	o o	- 1	2, 288, 058	
68. 00	1 1	o	0	0	Ö	1, 469, 053	
69. 00	06900 ELECTROCARDI OLOGY	0	O	0	0	1, 457, 172	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 675, 000	70. 00
71. 00		0	0	0	0	11, 041, 007	71. 00
72. 00	l l	0	0	0	0	6, 049, 283	72. 00
73.00		0	0	0	637, 676	24, 648, 843	73. 00
74. 00		0	0	0	0	624, 125	74. 00 76. 00
76. 00 76. 97			0	0	0	0 327, 579	76. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		0	o _l	321, 317	70. 77
88. 00		0	C	0	0	0	88. 00
89. 00		o	0	Ō	Ö	0	89. 00
90.00	09000 CLI NI C	157, 720	0	0	0	2, 076, 486	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	294, 562	90. 01
90. 02		0	0	0	0	184, 130	90. 02
90. 03	1 1	0	0	0	0	1, 986, 086	90. 03
90. 04	1 1	2, 921	0	0	0	371, 544	90. 04
91.00	1 1	0	0	0	0	13, 138, 498	91.00
92. 00							92. 00
05 AA	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	l	0	0	ما	6, 094, 692	95. 00
	09910 CORF	0	0		ol Ol	0, 094, 692	95. 00 99. 10
	10100 HOME HEALTH AGENCY		0	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>				0	2 30
	10900 PANCREAS ACQUISITION	0	O	0			109. 00
110. 0	0 11000 INTESTINAL ACQUISITION	0	0	0	O	0	110. 00
	<u> </u>				<u> </u>	<u>-</u>	

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150112

			'	0 12/31/2015	5/24/2016 3:0	
Cost Center Description	SOCIAL SERVICE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal	
		PRGM		RESIDENCY PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	973, 579	0	845, 321	637, 676	195, 498, 137	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	52, 623	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	0	470, 690	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	189, 766	194. 01
194. 02 07952 HOSPI CE	0	0	0	0	68, 201	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	292, 925	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	2, 049, 146	194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0	80, 325	194. 06
194.07 07957 HEALTHY COMMUNITIES	0	0	0	0	320, 034	194. 07
200.00 Cross Foot Adjustments		0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	973, 579	0	845, 321	637, 676	199, 021, 847	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part I | Part I | Date/Time Prepared: | 12/31/2015 | 2:03 pm; Provi der CCN: 150112

Care Construct Prosecting Floor Provided Provid					To 12/31/2015 Date/lime Pr 5/24/2016 3:	
A POST AND ADDRESS		Cost Center Description	Intern &	Total	9,21,2010 0.	
STRUMPAL SHIPTICE CUST CENTRISTS			Residents Cost			
Description						
DEMERNE SIGN TECHNISTS 1.00 26.00 2.			· ·			
Chicago Survive Cost Centers				0/ 00		
1.00 1.00		CENEDAL SERVICE COST CENTERS	25.00	26.00		
2.00	1 00					1 00
0.0400 DIPLOYUS BEWEET IS DEPARTWENT		i i				
0.000 0.00		1 1				1
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		1 1				1
0.000 0.000 DAUGNEY & LI NEN SERVICE 9.0 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00		1 1				
9,00 00900 MUSSERPEP IN		1 1				1
11.00 0100 CAFETERIA 11.00 13.00	9.00					9. 00
13.00 01300 NURSH NO ADMINI STRATION 13.00 14.00	10.00	01000 DI ETARY				1
14.00 01400 CENTRAL SERVICE SA SUPPLY 11.00 15.00	11. 00	01100 CAFETERI A				11. 00
15. 00	13.00	01300 NURSING ADMINISTRATION				13. 00
16. 00 1600 MEDICAL RECORDS & LIBRARY 10. 00 17.00 1	14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
17.00 0700 SOCIAL SERVICE	15. 00	01500 PHARMACY				15. 00
23. 00 0300 PARAMED FD PRONT (SPECIFY) 23. 00 23.01 0300 PARAMED FD PRONT PRONT 23. 01 23.02 PARAMED PRONT PRONT PRONT 23. 02 PARAMED PRONT PRONT PRONT 23. 02 PARAMED PRONT PRONT PRONT PRONT 23. 02 PARAMED PRONT		1 1				
23.01 02301 MAY EQUATION 22.01 22.						1
23. 02						
INVALI ENT ROUTINE SERVICE COST CENTERS 33,00 00 330,00 00 330,00 00		1 1				1
30.00 30000 ADULTS & PEDIATRICS 0 37,100,255 30,00 30,00 32,00 33,00 32,00 33,00 33,00 33,00 33,00 332,00 332,00 332,00 333,00	23. 02					23. 02
31 00 03100 INTENSIVE CARE UNIT 0 5, 908, 107 0 32, 00 320 03200 CRONARY CARE UNIT 0 0 0 33, 00 330 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33, 40 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34, 40 0 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	20.00			27 100 255		30.00
32.00 03200 COROMANY CARE UNIT 0 0 0 33.00 33.00 33.00 33.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 04.00		i i	1			
33.0 0.3300 BURN INTENSIVE CARE UNIT		1 1	1	· · · · · · · · · · · · · · · · · · ·		
34.00 03400 SURGIO LAL INTENSIVE CARE UNIT 0 0 40.00 051.00 0510.00 050.00			0	-1		
40, 00 04000 SUBPROVI DER - I PF 0 0 4, 600, 461 41, 00 410, 00 42, 00 42, 00 04200 SUBPROVI DER - I RF 0 1, 228, 857 43, 00 430, 00		i i		-		
141.00 04100 SUBPROVI DER - 1 RF 0 0 0 042.00 042.00 0430.00 0430.00 SUBPROVI DER 0 0 0 0 043.00 0430.00 NURSERY 0 1, 228, 587 343.00 0430.00 NURSERY 0 0 0 0 0 0 0 0 0		1 1				
42.00 04200 04200 04400 0 0 0 0 0 0 0		1 1	1	4 600 461		1
44.00 04300 NURSERY 0 1, 228, 557 44.00 AMOU SKILLER NURSING FACILITY 0 0 44.00 AMOU SKILLER NURSING FACILITY 0 0 0 0 0 0 0 0 0		1 1	1	· · · · · · · · · · · · · · · · · · ·		
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0		1 1		-1		
ANCILLARY SERVICE COST CENTERS 50.00			1	· · · · · · · · · · · · · · · · · · ·		1
50.00 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 0500000 0500000000			<u> </u>	<u> </u>		
S1. 00 05100 RECOVERY ROOM S2. 00 05.	50.00		0	25, 382, 481		50.00
53.00 05300 ANESTHESI OLOGY 0 372, 457 53.00	51.00	1 1	O			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 815, 819 54. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM	O	o		52. 00
54.01 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0 1,957,801 54.02 54.02 ULTRA SUND	53.00	05300 ANESTHESI OLOGY	0	372, 457		53. 00
54. 02 05404 LITRA SOUND	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 815, 819		54.00
54.03 05405 MAMMOGRAPHY 0 1.779, 893 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 3.465, 746 55.00 05500 RADI OLOGY-THERAPEUTI C 0 3.465, 746 55.00 05500 RADIO OLOGY-THERAPEUTI C 0 1.688, 800 57.00 05800 MRI 0 727, 651 58.00 05800 MRI 57.00 05900 CARDI AC CATHETERI ZATI ON 0 4.574, 185 59.00 06000 CABORATORY 0 11.471, 627 60.00 06000 LABORATORY PATHOLOGI CAL 0 1.425, 119 60.01 06000 LABORATORY PATHOLOGI CAL 0 1.425, 119 60.01 06000 RESPI RATORY THERAPY 0 4.218, 270 65.00 06500 RESPI RATORY THERAPY 0 4.218, 270 65.00 06500 PHYSI CAL THERAPY 0 6.692, 927 66.00 06600 PHYSI CAL THERAPY 0 2.288, 058 67.00 06500 06500 PHYSI CAL THERAPY 0 2.288, 058 67.00 06500 06500 PHYSI CAL THERAPY 0 2.288, 058 67.00 06500 06500 PHYSI CAL THERAPY 0 2.288, 058 67.00 06500 06500 06500 PHYSI CAL THERAPY 0 2.488, 058 67.00 06500	54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	1, 957, 801		54. 01
55. 00 05500 RADI OLOGY—THERAPEUTI C 0 3, 465, 746 55. 00	54. 02	05404 ULTRA SOUND	0	1, 081, 415		54. 02
57, 00 05700 CT SCAN 0 1,688,800 57,00 58,00 05800 MRI 0 727,651 58,00 58,00 05900 CARDI AC CATHETERI ZATI ON 0 4,574,185 59,00 60,00 06000 LABORATORY 0 11,471,627 60,01 61,00 06000 LABORATORY - PATHOLOGI CAL 0 1,425,119 60,01 62,00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 1,035,971 62,00 65,00 06500 RESPI RATORY THERAPY 0 4,218,270 65,00 66,00 06600 PHYSI CAL THERAPY 0 6,92,927 66,00 67,00 06700 0CCUPATI ONAL THERAPY 0 2,288,058 67,00 68,00 06800 SPEECH PATHOLOGY 0 1,457,172 69,00 69,00 06900 ELECTROCARDI OLOGY 0 1,457,172 69,00 70,00 07000 ELECTROCARDI OLOGY 0 1,457,172 69,00 71,00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENT 0 1,675,000 70,00 72,00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 6,049,283 72,00 73,00 07300 DRUGS CHARGED TO PATI ENTS 0 6,049,283 73,00 74,00 07400 RENAL DI ALYSIS 0 624,125 74,00 76,00 030020 ACUPUNCTURE 0 0 0 80,00 08900 FEDERALLY GLAIL THE LITATI ON 0 327,579 00 07697 CARDI AC REHABIL LITATI ON 0 327,579 00 07697 CARDI AC REHABIL LITATI ON 0 1,614,100 10,000 09,00 09000 CLINIC 0 0 0 0 09,00 09000 DI ABETES CENTER 0 0 0 0 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 1,84,130 90,00 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 1,31,318,498 90,00 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 1,31,318,498 90,00 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 13,138,498 90,00 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 13,138,498 90,00 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 371,544 90,04 09,00 09000 HYPERBARI C OXYGEN THERAPY 0 3,13,138,498 90,00 09,00 09000 00,000			0	1, 779, 893		
58.00 05800 MR			0			1
59.00 05900 0ARDI AC CATHETERI ZATI ON 0 4,574, 185 60.00		1 1	0			1
60. 00 06000 LABORATORY 0 11, 471, 627 60. 00 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 1, 425, 119 60. 01 60. 01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 1, 035, 971 62. 00 65. 00 06500 RESPIRATORY THERAPY 0 4, 218, 270 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 6, 692, 927 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 6, 692, 927 68. 00 68. 00 06800 SPECH PATHOLOGY 0 1, 469, 053 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 457, 172 69, 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 675, 000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 11, 041, 007 71. 00 72. 00 7200 IMPL DEV. CHARGED TO PATIENTS 0 6, 049, 283 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 624, 125 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 00 03020 ACUPUNCTURE 0 0 0 88. 00 08800 RURAL DELAIT TATION 0 327, 579 0017PATIENT SERVICE COST CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 01 09001 DI ABETES CENTER 0 2,076, 486 90. 03 90. 02 09000 CLUROPSYCH 0 184, 130 90. 02 90. 03 09000 CLUROPSYCH 0 184, 130 90. 02 90. 04 09004 HYPERBARLC OXYGEN THERAPY 0 371, 544 90. 04 91. 00 09000 DI RRESENVICES 0 6,094,692 95. 00 99. 10 09910 CORF		1 1	0			
60.01 60.01 LABORATORY-PATHOLOGI CAL 0 1, 425, 119 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 1, 035, 971 62.00 65.00 06500 RESPIRATORY THERAPY 0 4, 218, 270 65.00 06600 PHYSI CAL THERAPY 0 6, 692, 927 66.00 66.00 06600 PHYSI CAL THERAPY 0 2, 288, 058 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 469, 053 68.00 06800 SPEECH PATHOLOGY 0 1, 469, 053 68.00 69.00 06900 ELECTROCARDI OLOGY 0 1, 457, 172 69.00 070.00 07000 ELECTROCARDI OLOGY 0 1, 457, 172 69.00 07000 ELECTROCARDI OLOGY 0 1, 675, 000 70.00 07000 ELECTROCARDI OLOGY 0 1, 675, 000 0 0 0 0 0 0 0 0		l l				1
62. 00			1			1
65.00 06500 RESPIRATORY THERAPY 0 4,218,270 66.00 66.00 06600 PHYSI CAL THERAPY 0 6,692,927 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 2,288,058 67.00 68.00 06800 SPECH PATHOLOGY 0 1,469,053 68.00 69.00 06900 ELECTROCARDI OLOGY 0 1,457,172 69.00 70.00 07000 ELECTROCARDI OLOGY 0 1,675,000 70.00 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 11,041,007 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 6,049,283 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 0 24,648,843 73.00 74.00 07400 RENAL DIALYSI S 0 624,125 74.00 76.97 07697 CARDI AC REHABI LITATI ON 0 327,579 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 90.00 09000 CLINIC 0 2,076,486 90.00 90.01 09001 DIABETES CENTER 0 294,562 90.01 90.02 09002 RURAL DIALYSIS 0 18,130 90.02 90.03 09003 WOUND CENTER 0 19,86,086 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 371,544 90.04 90.05 09000 DESERVATI ON BEDS (NON-DISTINCT PART 0 97.00 09000 DIABETES COST CENTERS 91.00 97.00 09000 DIABETES COST CENTERS 92.00 97.00 09000 DIABETES COST CENTERS 97.00 97.00 09000 DIABETES COST CENTE		i i	1			
66. 00 06600 PHYSI CAL THERAPY 0 6,692,927 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 2,288,058 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1,469,053 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1,457,172 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 1,457,172 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 11,041,007 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 6,049,283 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 24,648,843 73. 00 74. 00 07400 RENAL DI ALYSI S 0 624, 125 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 97 07697 CARDI AC REHABILITATI ON 0 327,579 77. 90 07697 CARDI AC REHABILITATI ON 0 327,579 88. 00 08800 RURAL HEALTH CLINI C 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 00 09000 CLINI C 0 2,076,486 99. 00 90. 01 09001 DI ABETES CENTER 0 294,562 99. 01 90. 02 09002 NEUROPSYCH 0 184,130 90. 02 90. 03 09003 NEUROPSYCH 0 184,130 90. 02 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 371,544 99. 04 91. 00 09000 EMERGENCY 0 13,138,498 91. 00 92. 00 09000 BERGERCY 0 0,000 0,000 99. 01 09001 OBERGERCY 0 0,000 99. 01 09001 BERGERCY 0 0,000 99. 01 09001 DIABETES CENTERS 0 0,000 99. 00 09000 MBULANCE SERVICES 0 6,094,692 95. 00 99. 00 09000 AMBULANCE SERVICES 0 0,000 0,000 99. 10 09001 ORF			1			
67. 00 06700 OCCUPATI ONAL THERAPY 0 2, 288, 058 67. 00 68. 00 06800 SPECH PATHOLOGY 0 1, 469, 053 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 467, 172 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 675, 000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 11, 041, 007 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 6, 049, 283 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 24, 648, 843 73. 00 74. 00 07400 RENAL DI ALYSIS 0 624, 125 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 97 O7697 CARDI AC REHABI LI TATI ON 0 327, 579 00179ATI ENT SERVI CE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 89. 00 08900 EDERALLY QUALI FI ED HEALTH CENTER 0 0 90. 01 09000 CLI NI C 0 0 90. 02 09000 CLI NI C 0 0 90. 03 09000 CLI NI C 0 0 90. 04 09000 LI NETER 0 0 90. 05 09000 CLI NI C 0 0 90. 07 09000 DI ABETES CENTER 0 294, 562 90. 01 90. 08 09000 CHORDERS 0 0 90. 00 09000 CHORDERS 0 0 90. 01 09000 CHORDERS 0 0 90. 02 09000 ORERGENCY 0 13, 138, 498 90. 03 90. 04 09004 HYPERBARIC CXYGEN THERAPY 0 371, 544 90. 04 90. 04 09004 HYPERBARIC CXYGEN THERAPY 0 371, 544 90. 04 90. 05 09000 OSERVATI ON BEDS (NON-DI STI NCT PART 0 90. 07 07HER REI MBURSABLE COST CENTERS 0 6, 094, 692 95. 00 99. 00 09900 OFFER 0 0 0 99. 10 09910 ORFER 0 0 0 99. 10			0			
68. 00 06800 SPEECH PATHOLOGY 0 1, 469, 053 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 457, 172 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 675, 000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 11, 041, 007 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 6, 049, 283 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 24, 648, 843 74. 00 07400 RENAL DI ALYSI S 0 624, 125 76. 00 03020 ACUPUNCTURE 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 327, 579 001741 ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 89. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 2, 076, 486 90. 01 09001 DI ABETES CENTER 0 2, 294, 562 90. 01 09000 CLINI C 0 2, 294, 562 90. 02 09002 NEUROPSYCH 0 184, 130 90. 02 09004 HYPERBARI C OXYGEN THERAPY 0 371, 544 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 13, 138, 498 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 13, 138, 498 91. 00 09100 DERREGENCY 0 13, 138, 498 95. 00 09500 MBULANCE SERVI CES 0 0 6, 094, 692 97. 00 09901 DERREGENCY 0 99. 10 99. 10 09901 ORF						
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71. 00		1 1				
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73. 00			l ől			
74. 00 07400 RENAL DIALYSIS 0 624, 125 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 00 76. 97 07697 CARDIAC REHABILITATION 0 327, 579 0UTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 89. 00 90. 00 09900 CLINIC 0 0 2, 076, 486 90. 00 90. 01 09001 DIABETES CENTER 0 294, 562 90. 01 90. 02 09002 NEUROPSYCH 0 184, 130 90. 02 90. 03 09003 WOUND CENTER 0 0 1, 986, 086 90. 03 90. 04 09004 HYPERBARIC OXYGEN THERAPY 0 371, 544 90. 04 91. 00 09100 EMERGENCY 0 13, 138, 498 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 09500 AMBULANCE SERVICES 0 6, 094, 692 99. 10 99. 10 09910 CORF 0 0 0 99. 10		1 1	o			
76. 00 76. 97 076. 97 076. 97 076. 97 076. 97 076. 97 077 077 077 077 077 077 077 077 077 0			o	· · · · · · · · · · · · · · · · · · ·		
SB. 00 OBBOO RURAL HEALTH CLINIC O O O O O O O O O O O O O O O O O O	76.00	03020 ACUPUNCTURE	O	o		76. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 089. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 97	07697 CARDIAC REHABILITATION	0	327, 579		76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0						
90. 00 09000 CLI NI C 0 2,076,486 90. 00 90. 01 09001 DI ABETES CENTER 0 294,562 90. 01 90. 02 09002 NEUROPSYCH 0 184,130 90. 02 90. 03 09003 WOUND CENTER 0 1,986,086 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 371,544 90. 04 91. 00 09100 EMERGENCY 0 13,138,498 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 000000			0	- 1		
90. 01 09001 DI ABETES CENTER 0 294, 562 90. 01 90. 02 09002 NEUROPSYCH 0 184, 130 90. 02 90. 03 09003 WOUND CENTER 0 1, 986, 086 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 371, 544 90. 04 91. 00 09100 EMERGENCY 0 13, 138, 498 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 000000			0	0		
90. 02 09002 NEUROPSYCH 0 184, 130 90. 02 90. 03 09003 WOUND CENTER 0 1, 986, 086 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 371, 544 90. 04 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 071HER REI MBURSABLE COST CENTERS 95. 00 09200 AMBULANCE SERVI CES 0 6, 094, 692 99. 10 09910 CORF 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0		1 1	0			
90. 03 09003 WOUND CENTER 0 1,986,086 90. 03 90. 04 90. 04 90. 04 90. 04 90. 04 90. 04 90. 04 90. 04 90. 00			0			
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 371, 544 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 000			0			
91. 00 09100 EMERGENCY 0 13, 138, 498 91. 00 92. 00			0			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09910 CORF 0 0 0 99. 10 09910 CORF 0 0 0 99. 10 0 99. 10 0 0 0 0 0 0 0 0 0		1 1	1			
OTHER REI MBURSABLE COST CENTERS 95. 00 6, 094, 692 95. 00 99. 10 09910 CORF 0 0 99. 10		l l	0	13, 138, 498		
95. 00 09500 AMBULANCE SERVI CES 0 6, 094, 692 95. 00 99. 10 09910 CORF 0 0 99. 10	92. 00	<u> </u>	0			92.00
99. 10 09910 CORF 0 0 99. 10	05.00			(004 (00		05.00
		1 1	1			
101. Out of the transfer of th		1 1	1	- 1		
	101.00	ALIO 100 HOWE HEALTH ADENOT	ı V	۷Į		1101.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150112	Peri od: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prepared: 5/24/2016 3:03 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25. 00	26.00			
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0 0	0 0			109. 00 110. 00 111. 00

		Residents Cost		
		& Post		
		Stepdown		
		Adjustments		
		25. 00	26.00	
SPECI A	L PURPOSE COST CENTERS			
109. 00 10900	PANCREAS ACQUISITION	0	0	109. 00
110. 00 11000	INTESTINAL ACQUISITION	0	0	110. 00
111. 00 11100	ISLET ACQUISITION	0	0	111. 00
113. 00 11300	INTEREST EXPENSE			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	195, 498, 137	118. 00
NONREI	MBURSABLE COST CENTERS			
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	52, 623	190. 00
194. 00 07950	WELLNESS COMMUNITY	0	470, 690	194. 00
194. 01 07951	BUILDING RENTALS	0	189, 766	194. 01
194. 02 07952	HOSPI CE	0	68, 201	194. 02
194. 03 07953	OUTREACH CLINICS	0	0	194. 03
194. 04 07954	SPEECH - HEARING AIDS	0	292, 925	194. 04
194. 05 07955	NONALLOWABLE MARKETING	0	2, 049, 146	194. 05
194. 06 07956	CRH FOUNDATION	0	80, 325	194. 06
194. 07 07957	HEALTHY COMMUNITIES	0	320, 034	194. 07
200.00	Cross Foot Adjustments	0	0	200. 00
201. 00	Negative Cost Centers	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	0	199, 021, 847	202. 00
		·		

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION STATISTICS	Provi der CCN: 150112	From 01/01/2015 To 12/31/2015 Date/Time Prepared:
		From 01/01/2015

			5/24/2016 3:0)3 pm
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1. 00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQ FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DEPR	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SAL	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQ FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	9	LDRY LBS	8.00
9.00	HOUSEKEEPI NG	10	TIME SPT	9.00
10.00	DI ETARY	11	MEALS	10.00
11.00	CAFETERI A	12	FTES	11.00
13.00	NURSI NG ADMI NI STRATI ON	13	NURS HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	STER SUP	14.00
15.00	PHARMACY	15	DRG COST	15. 00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPT	16.00
17.00	SOCI AL SERVI CE	17	TIME SPT	17.00
23.00	PARAMED ED PRGM-(SPECIFY)	18	PERCENT	23.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150112

				То	12/31/2015	Date/Time Pre 5/24/2016 3:0	
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	р	Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	T					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	17, 637	184, 850	10, 451	212, 938	212, 938	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	473, 264	1, 036, 019		5, 642, 156	· ·	5. 00
7.00	00700 OPERATION OF PLANT	58, 085	4, 728, 218		5, 097, 267	6, 078	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	200, 755	9, 008 70, 883		9, 008 283, 814	173 5, 095	8. 00 9. 00
10.00	01000 DI ETARY	3, 483	112, 818		141, 625	1, 731	10.00
11. 00	01100 CAFETERI A	7, 715	87, 002		150, 795	3, 833	11. 00
13.00	01300 NURSING ADMINISTRATION	21, 776	142, 656		240, 585	9, 676	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 122 4, 948	109, 341 68, 024	95, 750 482, 505	206, 213 555, 477	34 9, 223	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 468			96, 558	2, 017	16. 00
17. 00	01700 SOCI AL SERVI CE	2, 530			6, 949	1, 562	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0 453	0	0 474	0	23. 00
23. 01 23. 02	02301 XRAY EDUCATION 02302 PHARMACY RESI DENCY PROG	0	9, 453 5, 402	21	9, 474 5, 402	1, 435 1, 047	23. 01 23. 02
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS		3, 402	<u> </u>	5, 402	1,047	25.02
30.00	03000 ADULTS & PEDIATRICS	177, 962	1, 097, 679		1, 692, 281	40, 446	
31.00	03100 NTENSIVE CARE UNIT	65, 880	157, 439		381, 152	6, 618	
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0 0) 0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	Ö	o	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	64, 007	159, 249	18, 952	242, 208	4, 428	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	1, 709	8, 375	17, 096	27, 180	0 1, 881	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0, 3, 3	0	27, 100	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	390, 981 1, 145	561, 359 45, 756		2, 072, 330 79, 745	1, 594 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 145	45, 756	32, 644	79, 745	0	52.00
53.00	05300 ANESTHESI OLOGY	0	1, 710	12, 087	13, 797	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 799			317, 897	4, 365	1
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	2, 775 77	48, 615 21, 607	8, 294 735	59, 684 22, 419	982 1, 440	54. 01 54. 02
54. 02	05405 MAMMOGRAPHY	148, 995	3, 922		172, 151	2, 219	1
55.00	05500 RADI OLOGY-THERAPEUTI C	573	113, 278		465, 685	3, 254	
57. 00	05700 CT SCAN	878	14, 467	197, 847	213, 192	1, 735	
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	46 29, 735	12, 930 150, 831	17, 643 131, 134	30, 619 311, 700	784 4, 421	
60.00	06000 LABORATORY	19, 770	154, 566		444, 925	10, 608	
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 605	17, 412		62, 846		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46			13, 060	213	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	42, 657 371, 911	94, 300 3, 261		249, 214 401, 812	4, 962 9, 735	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 108			10, 851	3, 358	
68. 00	06800 SPEECH PATHOLOGY	15, 820		18, 713	34, 533	2, 195	1
69.00	06900 ELECTROCARDI OLOGY	1, 251	20, 084		54, 236	1, 422	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 616	0	16, 193	28, 809 0	1, 882 0	70.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	o	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	32	32	0	74.00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	575	0 22, 541	10, 760	0 33, 876	0 285	76. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	070	22,011	10,700	33, 370	200	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	00 ((0	1 011	
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES CENTER	198	65, 323 11, 134		88, 668 12, 073	1, 811 207	1
90. 02	09002 NEUROPSYCH	29	2, 026	375	2, 430	225	1
90. 03	09003 WOUND CENTER	2, 496	0	2, 139	4, 635	1, 151	90. 03
90. 04 91. 00	09004 HYPERBARI C OXYGEN THERAPY	230, 655		319	230, 974	14 220	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 675	139, 582	135, 179	282, 436 0	14, 229	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS	1			<u> </u>		1
	09500 AMBULANCE SERVICES	31, 180			358, 332		95. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150112	From 01/01/2015	Worksheet B Part II Date/Time Prepared:

			T	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFITS DEPARTMENT	
	Related Costs					
	0	1.00	2. 00	2A	4.00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	,					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	-	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	이	01	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	2, 425, 974	9, 770, 371	8, 877, 698	21, 074, 043	212, 059	118. 00
NONREI MBURSABLE COST CENTERS	ام		0	10.000		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54 (04	10, 444				190. 00
194. 00 07950 WELLNESS COMMUNITY	54, 681	10.0(4	17, 451			194. 00
194. 01 07951 BUI LDI NG RENTALS	32, 773	19, 064	0	51, 837	-	194. 01
194. 02 07952 HOSPI CE	U	0	0	U		194. 02
194. 03 07953 0UTREACH CLINICS 194. 04 07954 SPEECH - HEARING ALDS	0	0	0	U		194. 03 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 04
194. 06 07956 CRH FOUNDATION	-1, 156	11, 708	732	11, 284		194. 05
194. 07 07957 HEALTHY COMMUNITIES	-1, 130	17, 168				194. 00
200.00 Cross Foot Adjustments	J	17, 100	403	17,031		200. 00
201.00 Negative Cost Centers		0	0			201. 00
202.00 TOTAL (sum lines 118-201)	2, 512, 272	9, 828, 755	8, 896, 708	21, 237, 735	-	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150112

				, '		5/24/2016 3:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVI CE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 676, 238					5.00
7.00	00700 OPERATION OF PLANT	413, 936	5, 517, 281				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	25, 885	12, 810				8. 00
9.00	00900 HOUSEKEEPI NG	101, 794	100, 803		491, 506	251 200	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	44, 260 50, 301	160, 438 123, 725		3, 146 6, 755	351, 200 0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	162, 789	202, 872			0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	45, 209	155, 494	1		0	14. 00
15. 00	01500 PHARMACY	228, 024	96, 737		6, 847	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	70, 787	80, 822	1	0	0	16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	25, 120 0	6, 170	0	185	0	17. 00 23. 00
23. 00	02301 XRAY EDUCATION	22, 455	13, 443		1, 018	0	23. 00
23. 02	02302 PHARMACY RESIDENCY PROG	17, 209	7, 682	•		0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	736, 581	1, 561, 012			271, 279	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	126, 840	223, 895	2, 254	15, 175	29, 363 0	31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	O	Ö	o	0	34. 00
40.00	04000 SUBPROVI DER - I PF	o	O	0	O	0	40. 00
41.00	04100 SUBPROVI DER – I RF	82, 287	226, 469	2, 660	18, 320	43, 099	41.00
42. 00	04200 SUBPROVI DER	30.000	11 011	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	30, 960 0	11, 911 0	1	185	0	43. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	١		,,	<u> </u>		1 44.00
50.00	05000 OPERATING ROOM	537, 164	798, 311	9, 805		1, 741	50. 00
51.00	05100 RECOVERY ROOM	51, 165	65, 070		11, 936	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0 024	0	1	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	8, 834 94, 156	2, 431 163, 973		12, 399	0 82	53. 00 54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	44, 936	69, 136			0	54. 01
54. 02	05404 ULTRA SOUND	27, 637	30, 727		2, 683	0	54. 02
54. 03	05405 MAMMOGRAPHY	48, 195		1		0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	78, 502	161, 092	1		494	•
57. 00 58. 00	05700 CT SCAN 05800 MRI	45, 701 18, 841	20, 573 18, 387	1	1, 203 1, 203	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	103, 717	214, 497	1		735	59.00
60.00	06000 LABORATORY	304, 201	219, 809	1	8, 698	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	34, 295	24, 761	1	555	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	28, 601	10, 705	1	370	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	96, 574 173, 690	134, 104 4, 638	1	5, 922 0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	60, 392	4, 515		l .	0	67.00
68. 00	06800 SPEECH PATHOLOGY	39, 213		0	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	27, 625	28, 561	0	1, 943	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	34, 272	0	64	23, 317	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	314, 898 172, 530			0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	454, 110		o o	Ö	0	73. 00
74. 00	07400 RENAL DIALYSIS	17, 683	O	Ö	o	0	74. 00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	6, 053	32, 055	0	1, 573	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0) 0	٥	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				o	0	89. 00
90.00	09000 CLI NI C	35, 986	92, 896	1, 775	7, 495	2, 750	90.00
90. 01	09001 DI ABETES CENTER	6, 824	15, 833		278	0	90. 01
90. 02	09002 NEUROPSYCH	4, 085	2, 881	1		0	90. 02
90. 03 90. 04	09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY	52, 169		309		0	90. 03 90. 04
90.04	09100 EMERGENCY	10, 487 323, 751	198, 500	46 3, 589		1, 657	90.04
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	323, 731	170, 300	3, 307	52, 403	1, 007	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	143, 407	130, 937	1		0	95.00
	09910 CORF	0	0	0		0	99. 10
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0) 0	ı O	0	101. 00
109.00	10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150112

					5/24/2016 3:0	3 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9. 00	10.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 584, 131	5, 434, 252	47, 876	488, 268	351, 200	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	387	14, 853	0	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	12, 167	0	0	0	0	194. 00
194.01 07951 BUILDING RENTALS	3, 378	27, 111	0	0	0	194. 01
194. 02 07952 HOSPI CE	1, 940	0	0	0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	8, 354	0	0	0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	58, 443	0	0	0	0	194. 05
194.06 07956 CRH FOUNDATION	404	16, 651	0	2, 868	0	194. 06
194.07 07957 HEALTHY COMMUNITIES	7, 034	24, 414	0	370	0	194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	5, 676, 238	5, 517, 281	47, 876	491, 506	351, 200	202. 00

Provi der CCN: 150112

			10	12/31/2015	5/24/2016 3:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	225 400					10.00
11. 00 01100 CAFETERI A	335, 409					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	12, 483		42E 400			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	4, 271 11, 498	11, 239	425, 698	907, 806		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	9, 527	0	0	907, 800 O	259, 711	16. 00
17. 00 01700 SOCIAL SERVICE	2, 300	6, 013	0	0	237, 711	17. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	2,300	0,015	0	ol Ol	0	23. 00
23. 01 02301 XRAY EDUCATION	2, 300	Ö	0	ol	0	23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	1, 643	o o	Ö	ol	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	.,, .,		<u>-</u> ,.	-,		
30. 00 03000 ADULTS & PEDIATRICS	80, 808	204, 954	21, 655	766	65, 934	30. 00
31.00 03100 INTENSIVE CARE UNIT	11, 169	28, 278	320	233	6, 112	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	7, 884	20, 119	0	147	15, 382	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	2, 957	7, 403	818	2	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS	21 527	00.404	277 020	2 202	// 002	FO 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	31, 537 4, 928	80, 484 12, 494	377, 838 0	3, 392 10	66, 802 0	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	4, 920	12, 494	0	10	0	52. 00
53. 00 05300 ANESTHESI OLOGY	329	1, 002	0	4, 786	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	7, 227	1,002	818	182	0	54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 314	0	010	12, 439	0	54. 01
54. 02 05404 ULTRA SOUND	1, 643	Ö	0	15	0	54. 02
54. 03 05405 MAMMOGRAPHY	3, 942	o o	498	16	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 942	9, 943	0	O	3, 104	55. 00
57. 00 05700 CT SCAN	2, 628	O	0	664	0	57. 00
58. 00 05800 MRI	986	o	0	324	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 242	15, 745	3, 271	447	5, 923	59.00
60. 00 06000 LABORATORY	24, 967	0	0	22	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	2, 300	0	0	6	13, 051	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	329	0	0	0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	9, 198		604	359	12, 197	65. 00
66. 00 06600 PHYSI CAL THERAPY	15, 768		8, 818	307	1, 613	
67. 00 06700 OCCUPATI ONAL THERAPY	4, 599		0	49	339	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 957		0	100	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 300		0	420	30, 236	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 957 0	7, 162	0		18, 784 0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	0	0	876, 676	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	445	0	74.00
76. 00 03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	657	1, 449	Ö	Ö	0	76. 97
OUTPATIENT SERVICE COST CENTERS	007	1, 117	0	<u></u>		70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	О	0	o	0	89. 00
90. 00 09000 CLI NI C	3, 285	8, 685	0	491	17, 984	90.00
90. 01 09001 DI ABETES CENTER	329	935	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	329	730	0	0	2, 250	90. 02
90. 03 09003 WOUND CENTER	1, 971	5, 199	9, 067	4, 332	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0	0	O	0	90. 04
91. 00 09100 EMERGENCY	27, 266	58, 400	1, 991	462	0	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	20.000	F/ 001	2	701		05.00
95. 00 09500 AMBULANCE SERVI CES	22, 339	1	0	791	0	95. 00
99. 10 09910 CORF	0	1	0	0	0	99. 10 101. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	<u> </u>	U	U	U	101.00
109. 00 10900 PANCREAS ACQUISITION	0	O	0	0	n	109. 00
		<u> </u>	9	<u> </u>		

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared:

			10	12/31/2015	5/24/2016 3:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	333, 109	626, 056	425, 698	907, 785	259, 711	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	1, 314	3, 552	0	0	0	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	0	0	0	21	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0	194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0	0	194. 06
194.07 07957 HEALTHY COMMUNITIES	986	0	0	0	0	194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	335, 409	629, 608	425, 698	907, 806	259, 711	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150112 Peri d

Peri od: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/24/2016 3:03 pm Cost Center Description SOCIAL SERVICE PARAMED ED XRAY EDUCATION PHARMACY Subtotal **PRGM** RESI DENCY PROG 17.00 23.01 24.00 23.00 23.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 48. 299 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) C 23.00 23.01 02301 XRAY EDUCATION 0 50, 125 23.01 02302 PHARMACY RESIDENCY PROG 23.02 0 33, 446 23 02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18.789 4, 904, 042 30.00 03100 INTENSIVE CARE UNIT 31.00 5,844 837, 253 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 04000 SUBPROVI DER - I PF 40.00 0 0 40.00 04100 SUBPROVI DER - I RF 12, 992 675, 995 41.00 41.00 04200 SUBPROVI DER 42.00 0 Λ 42.00 43.00 04300 NURSERY 0 83, 949 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 4, 055, 113 50.00 51.00 05100 RECOVERY ROOM 0 226, 823 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 53 00 05300 ANESTHESI OLOGY 31 179 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 605, 609 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 198, 391 54.01 54.01 0 54.02 05404 ULTRA SOUND 86.564 54.02 05405 MAMMOGRAPHY 0 54.03 238, 087 54.03 737, 738 55.00 05500 RADI OLOGY-THERAPEUTI C 2,705 55.00 57.00 05700 CT SCAN 0 285, 696 57.00 58 00 05800 MRI 0 0 71, 144 58 00 05900 CARDIAC CATHETERIZATION 59.00 677, 567 59.00 06000 LABORATORY 1, 013, 230 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 0000000000000 138, 946 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 53, 278 62 00 62 00 65.00 06500 RESPIRATORY THERAPY 536, 874 65.00 66.00 06600 PHYSI CAL THERAPY 657, 737 66.00 06700 OCCUPATIONAL THERAPY 67.00 96,083 67.00 06800 SPEECH PATHOLOGY 68.00 86, 384 68 00 69.00 06900 ELECTROCARDI OLOGY 152, 605 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 117, 248 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 314, 898 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 172, 530 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 330, 786 73.00 73.00 74.00 07400 RENAL DIALYSIS 18, 160 74.00 03020 ACUPUNCTURE 76.00 0 76.00 76. 97 07697 CARDIAC REHABILITATION 75, 948 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 7.824 269, 650 90.00 90. 01 09001 DI ABETES CENTER 36, 479 90.01 0 09002 NEUROPSYCH 12, 930 90.02 0 90.02 90.03 09003 WOUND CENTER 0 78, 833 90.03 09004 HYPERBARIC OXYGEN THERAPY 90.04 145 241, 658 90.04 91.00 09100 EMERGENCY 964, 744 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 721, 195 95.00 99. 10 09910 CORF 0 99.10 0 101.00 10100 HOME HEALTH AGENCY 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00

					5/24/2016 3:0	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal	
		PRGM		RESIDENCY PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
111.00 11100 I SLET ACQUI SI TI ON	0				0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	48, 299	0	0	0	20, 805, 346	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				26, 048	190. 00
194.00 07950 WELLNESS COMMUNITY	0				89, 658	194. 00
194. 01 07951 BUI LDI NG RENTALS	0				82, 326	194. 01
194. 02 07952 HOSPI CE	0				1, 961	194. 02
194. 03 07953 OUTREACH CLINICS	0				0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0				8, 354	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0				58, 443	194. 05
194.06 07956 CRH FOUNDATION	0				31, 207	194. 06
194.07 07957 HEALTHY COMMUNITIES	0				50, 821	194. 07
200.00 Cross Foot Adjustments		0	50, 125	33, 446	83, 571	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	48, 299	0	50, 125	33, 446	21, 237, 735	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150112

				To 12/31/2015 Date/lime Pr 5/24/2016 3:	
	Cost Center Description	Intern &	Total	9,2,,2010 0.	J
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments	0/ 00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1. 00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00	00900 HOUSEKEEPING				9. 00
10. 00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1			16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	1			23. 00
23. 01	02301 XRAY EDUCATION				23. 01
23. 02	02302 PHARMACY RESIDENCY PROG				23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	'		
30.00	03000 ADULTS & PEDIATRICS	0	4, 904, 042		30.00
	03100 INTENSIVE CARE UNIT	0	837, 253		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	o		34.00
40.00	04000 SUBPROVI DER - I PF	0	o		40. 00
41.00	04100 SUBPROVI DER - I RF	o	675, 995		41.00
42.00	04200 SUBPROVI DER	0	o		42. 00
43.00	04300 NURSERY	О	83, 949		43.00
44.00	04400 SKILLED NURSING FACILITY	0	o		44. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	4, 055, 113		50. 00
51.00	05100 RECOVERY ROOM	0	226, 823		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	31, 179		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	605, 609		54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	198, 391		54. 01
54. 02	05404 ULTRA SOUND	0	86, 564		54. 02
54. 03	05405 MAMMOGRAPHY	0	238, 087		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	737, 738		55. 00
57. 00	05700 CT SCAN	0	285, 696		57. 00
58. 00	05800 MRI	0	71, 144		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	677, 567		59. 00
60.00	06000 LABORATORY	0	1, 013, 230		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	138, 946		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	53, 278		62. 00
	06500 RESPI RATORY THERAPY	0	536, 874		65. 00
	06600 PHYSI CAL THERAPY	0	657, 737		66. 00
	06700 OCCUPATIONAL THERAPY	0	96, 083		67. 00
	06800 SPEECH PATHOLOGY		86, 384		68. 00
	06900 ELECTROCARDI OLOGY		152, 605		69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		117, 248		70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	314, 898 172, 530		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 330, 786		73. 00
	07400 RENAL DIALYSIS		18, 160		74.00
76.00	03020 ACUPUNCTURE	0	0		76.00
	07697 CARDI AC REHABI LI TATI ON	0	75, 948		76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	J U	75, 946		- 10. 91
88 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
	09000 CLINIC		269, 650		90.00
	09001 DI ABETES CENTER		36, 479		90. 00
	09002 NEUROPSYCH		12, 930		90. 01
	09003 WOUND CENTER		78, 833		90. 02
90. 04	09004 HYPERBARI C OXYGEN THERAPY		241, 658		90. 04
	09100 EMERGENCY		964, 744		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, , , , ,		92. 00
, 2. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			72.00
95. 00	09500 AMBULANCE SERVICES	0	721, 195		95. 00
	09910 CORF	0	0		99. 10
	10100 HOME HEALTH AGENCY	0	o		101. 00
	· · · ·				<u> </u>

Health Financial Systems	COLUMBUS REGION		In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15011	
			From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:
			5/24/2016 3:03 pm
Cost Center Description	Intern &	Total	
' '	Residents Cost		
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26. 00	
SPECIAL PURPOSE COST CENTERS			
109.00 10900 PANCREAS ACQUISITION	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	20, 805, 346	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 048	190. 00
194.00 07950 WELLNESS COMMUNITY	0	89, 658	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	82, 326	194. 01
194. 02 07952 HOSPI CE	0	1, 961	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	8, 354	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	58, 443	194. 05
194. 06 07956 CRH FOUNDATION	0	31, 207	194. 06
194.07 07957 HEALTHY COMMUNITIES	0	50, 821	194. 07
200.00 Cross Foot Adjustments	0	83, 571	200. 00
201.00 Negative Cost Centers	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	21, 237, 735	202. 00

Provi der CCN: 150112 COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SO FFFT) BENEFITS & GENERAL (DFPR) DEPARTMENT (ACCUM. COST) (GROSS SAL) 1.00 2.00 4.00 5A 5.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 684, 158 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 8, 669, 888 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12,867 10, 185 68, 965, 672 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 72, 115 4, 027, 505 11, 037, 073 -40, 294, 197 158, 727, 650 5.00 00700 OPERATION OF PLANT 1, 968, 180 11, 575, 063 7 00 329, 121 303, 036 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 627 56, 170 0 723, 829 8.00 2, 846, 512 9.00 00900 HOUSEKEEPI NG 4,934 11, 866 1, 649, 833 9.00 1, 237, 673 01000 DI ETARY 24.678 0 10 00 7 853 560 598 10 00 11.00 01100 CAFETERI A 6,056 54, 648 1, 241, 379 1, 406, 582 11.00 13.00 01300 NURSING ADMINISTRATION 9,930 74, 211 3, 133, 307 4, 552, 133 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 7,611 93, 309 10, 877 0 1, 264, 192 14.00 01500 PHARMACY 470 204 15 00 4 735 2, 986, 773 6, 376, 336 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 3,956 33, 384 653, 118 1, 979, 443 16.00 01700 SOCIAL SERVICE 78 0 702, 441 17.00 302 505, 946 17.00 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 0 o 02301 XRAY EDUCATION 627, 930 23.01 658 20 464, 633 23 01 23.02 02302 PHARMACY RESIDENCY PROG 376 0 339, 051 481, 212 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 0 03000 ADULTS & PEDIATRICS 76, 407 13, 106, 479 20, 597, 897 30.00 406, 018 30.00 03100 INTENSIVE CARE UNIT 10, 959 2, 143, 019 31.00 153, 809 3, 546, 879 31 00 0 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 34.00 C 0 04000 SUBPROVIDER - IPF 40.00 0 0 40 00 04100 SUBPROVI DER - I RF 11,085 0 2, 301, 035 41.00 18, 469 1, 433, 854 41.00 42.00 04200 SUBPROVI DER 42.00 0 04300 NURSERY 583 0 865, 737 43.00 609,075 43.00 16, 660 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 39, 075 1, 091, 436 516, 185 0 15, 020, 941 50.00 05100 RECOVERY ROOM 0 51 00 3, 185 32,007 C 1, 430, 760 51 00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53 00 05300 ANESTHESI OLOGY 119 11, 779 O 0 0 247, 022 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 632, 929 54.00 8,026 193, 727 1, 413, 462 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 3.384 8,083 317, 986 1, 256, 551 54.01 54.02 05404 ULTRA SOUND 1.504 716 466, 257 0 0 0 0 0 0 0 772, 838 54.02 05405 MAMMOGRAPHY 18, 744 718, 710 1, 347, 690 54.03 273 54.03 05500 RADI OLOGY-THERAPEUTI C 2, 195, 193 7,885 55.00 342.864 1, 053, 716 55.00 57.00 05700 CT SCAN 1,007 192, 803 561, 882 1, 277, 970 57.00 58.00 05800 MRI 900 17, 193 253, 953 526, 871 58.00 05900 CARDIAC CATHETERIZATION 10, 499 127, 791 1, 431, 787 2, 900, 279 59.00 59.00 60.00 06000 LABORATORY 10, 759 263, 690 3, 435, 291 8, 506, 494 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 1, 212 42, 712 366, 529 959,000 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 524 5, 346 69, 127 0 799, 791 62.00 06500 RESPIRATORY THERAPY 109 395 2 700 534 65 00 6 564 1 606 802 65 00 06600 PHYSI CAL THERAPY 3, 152, 486 66.00 227 25, 961 4, 856, 962 66.00 06700 OCCUPATIONAL THERAPY 221 5, 426 1, 087, 551 0 0 0 0 1, 688, 757 67.00 67.00 06800 SPEECH PATHOLOGY 18, 236 710, 711 1,096,538 68.00 68.00 06900 FLECTROCARDLOLOGY 1, 398 32, 062 772, 491 69 00 460, 555 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 15, 780 609, 387 958, 375 70.00 8, 805, 635 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 Λ 0 4, 824, 540 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 C 12, 698, 466 73 00 0 74.00 07400 RENAL DIALYSIS 0 31 0 494, 487 74.00 03020 ACUPUNCTURE 0 76.00 76.00 169, 252 07697 CARDIAC REHABILITATION 92, 416 76.97 1,569 10, 486 0 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 4.547 1, 006, 284 09000 CLI NI C 22, 557 90 00 586, 619 90 00 90.01 09001 DIABETES CENTER 775 879 66,878 0 190, 810 90.01 09002 NEUROPSYCH 0 90.02 141 365 72, 991 114, 241 90.02 0 90.03 09003 WOUND CENTER 2, 084 372, 851 1, 458, 837 90.03 0 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 311 2.082 0 293, 266 90.04 9, 053, 188 09100 EMERGENCY 9,716 131, 733 4, 607, 818 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 6, 409 95 00 09500 AMBULANCE SERVICES 229, 086 2, 747, 880 0 4, 010, 154 99. 10 09910 CORF 0 99.10

Health Financial Systems	COLUMBUS RE	GI ONAL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS	FICAL BASIS		Provi der	CCN: 150112	Period: From 01/01/2015	Worksheet B-1	
					To 12/31/2015	Date/Time Prep 5/24/2016 3:03	
	CAPITAL	RELATED	COSTS				
Cost Center Description	Description BLDG & FI: (SQ FEET		BLE EQUIP (DEPR)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	

			Т	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
	CAPITAL REI	ATED COSTS			3/24/2010 3.0	3 piii
	ON TIME REE	21120 00010				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
·	(SQ FEET)	(DEPR)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SAL)			
	1. 00	2. 00	4. 00	5A	5. 00	
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	T	T				
109. 00 10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	C	0		110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0	C	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	680, 094	8, 651, 363	68, 681, 277	-40, 294, 197	156, 152, 040	1118. 00
NONREI MBURSABLE COST CENTERS	707				10.000	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	355		_	10, 808	
194. 00 07950 WELLNESS COMMUNITY	0	17, 006	159, 524	0	340, 219	
194. 01 07951 BUI LDI NG RENTALS	1, 327	0		0	94, 468	
194. 02 07952 HOSPI CE	0	0		0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0		0	233, 619	1
194. 05 07955 NONALLOWABLE MARKETI NG	015	712			1, 634, 274	1
194. 06 07956 CRH FOUNDATION	815			0	11, 284	
194.07 07957 HEALTHY COMMUNITIES 200.00 Cross Foot Adiustments	1, 195	451	124, 871	U	196, 699	200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200.00
1 9	9, 828, 755	8, 896, 708	25 122 574		40, 294, 197	
202.00 Cost to be allocated (per Wkst. B, Part I)	9, 828, 755	8, 890, 708	25, 122, 574	,	40, 294, 197	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 366206	1. 026162	0. 364277	'	0. 253857	203. 00
204.00 Cost to be allocated (per Wkst. B,			212, 938	3	5, 676, 238	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 003088	3	0. 035761	205. 00
1)						

Provi der CCN: 150112

Control Control Present pill into PRAITTIN OF LABRIPS N. BUSSEPPINE (MITS) CONTROL				10) 12/31/2015	Date/lime Pre 5/24/2016 3:0	
SEMBLAN SERVICE COST CHATES:	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		<u>Б.</u>
				(TIME SPT)	(MEALS)	(FTES)	
The Prince of Service Control of Plant				0.00	10.00	11 00	
1.00 1000 2007 REL DOSTS-BULE & FIX 2.00 2.	GENERAL SERVICE COST CENTERS	7.00	8.00	7.00	10.00	11.00	
4.00 00000 PRICE PRIFE TS DEPARTMENT							1. 00
5.00 DOUGLEARMIN STRINT IVE & CENEMAL 7.00 DOUGLEARMIN STRINT IVE & CENEMAL 8.00 DOUGLEARMIN STRINT IVE & CENEMAL 8.00 DOUGLEARMIN STRINT IVE & CENEMAL 8.00 DOUGLEARMIN STRINT IVE & CENEMAL 9.00 DOUGLEARMIN S	2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
7.00 000000 PORPATION OF PLANT 20.00 00000 HAUSEKEEPIN N 20.00 00000 H	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
8.00 0000000000000000000000000000000000							
9.00 09000 HOUSEKEEPING	l	-					
10.00 010000 DIETARY			1, 045, 796				
11.00 01100 CAFETERIA 6.056 0 73 0 1.021 11.00 14.00 01100 CAFETERIA 7.001 0 0 0 0 0 0 14.00 01100 CENTRAL SERVICES & SUPPLY 7.011 0 35 0 0 35 14.00 17.00 01100 CENTRAL SERVICES & SUPPLY 7.011 0 35 0 0 35 14.00 17.00 01100 CENTRAL SERVICES & SUPPLY 7.011 0 35 0 0 35 14.00 17.00 01100 CENTRAL SERVICES & SUPPLY 7.011 0 0 0 0 0 0 0 17.00 01100 CENTRAL SERVICES & SUPPLY 7.001 0 0 0 0 0 0 0 0 17.00 01100 CENTRAL SERVICES & SUPPLY 7.001 0 0 0 0 0 0 0 0 17.00 01100 CENTRAL SERVICES & SUPPLY 7.001 0 0 0 0 0 0 0 0 0	l i		0		154 014		
13.00 QUINES INZ. ADMINISTRATION			0		154, 914	1 021	
14.00 01400 CENTRAL SERVICES & SUPPLY 7, 611	l i	-	0		0		
16.00 01-000 MEDICAL RECORDS & LIBRARY 3.956 0 0 2 0 7 17.00 23.00 02.00 7 17.00 23.00 02.00 0 0 0 0 0 0 0 0 0	l i		Ō		0		
17.00 01700 SCOLAL SERVICE 302 0 2 0 7 17.00	15. 00 01500 PHARMACY	4, 735	0	74	0	35	15.00
23.00	1		0	0	0		
23.01 03201 RRAY EBUCATION 568 0 11 0 7 23 01			0	2	0		
23 OC PARAMICY RESIDENCY PROG 376	, , ,	_	0	I -	0		
IMPATTENT ROUTHS SERVICE COST CENTERS			0		0		
30.00		370	0	<u> </u>		5	23.02
31.00 03100 (INTENSIVE CARE UNIT 10,959 49,247 164 12,952 34 31,00 32.00 3200 (OSROVARY CARE UNIT 0 0 0 0 0 0 33.0		76, 407	399, 348	2, 067	119, 661	246	30. 00
33.00 03300 BURN INTENSIVE CARE UNIT	1	10, 959	49, 247	164		34	31. 00
34.00 03400 SURRCIAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
0.000 04000 SUBPROVIDER IPF 0	l i	0	0	0	0		
11.00 04100 SUBPROVI DER 18		0	0	0	0		
42 00 04200 SUBPROVIDER 0 0 0 0 0 0 24 : 00		11 005	50 111	0	10.011		
43.00 04300 NURSERY 583 14, 248 2 0 94.3 00 04.00 0 0 0 0 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 04.00 05		11,085	58, 111	l	19, 011		
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44. 00		583	14 248	·	0		
ANCILLARY SERVICE COST CENTERS			14, 240		0		
51.00 05100 0500 0500 0510 0500 0510 052 00 054 00 00				-	-1		
52.00 05200 05200 05200 05200 05200 05300 0530 05300		39, 075	214, 181	801	768	96	50. 00
53.00 05300 ANESTHESI OLOGY 119 0 0 0 1 53.00	51.00 05100 RECOVERY ROOM	3, 185	32, 229	129	0	15	51. 00
54.00 05400 RADIO LOGY-DI AGNOSTIC 8,026 98,528 134 36 22 54,00		_	0	· -	0		
54 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 3,384			0	I -	0	-	
54 02 05404 JULTRA SOUND		-	98, 523		36		
54 03 05405 MAMMOGRAPHY	l i		0		0		
55 00 05500 RADIOLOGY-THERAPEUTIC 7, 885 6, 963 94 218 12 55 0.0	I I		8 741		0		
57.00 05700 CT SCAN	I I				218		
59.00 05900 05900 CARDI AC CATHETERI ZATI ON 10, 499 4, 987 115 324 19 59, 00 60.00 06000 LABORATORY 10, 755 0 94 0 76 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 1, 212 0 6 0 7 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 524 0 4 0 1 62.00 62.00 66.00 05000 RESPIRATORY THERAPY 6, 564 0 64 0 28 65.00 06500 RESPIRATORY THERAPY 227 21, 844 0 0 0 48 66.00 67.00 06000 FACKED RED BLOOD CELL 1, 394 0 0 0 14 67.00 68.00 06000 FACKED RED BLOOD CELL 1, 398 0 21 0 0 0 9 68.00 68.00 06000 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0					0		
60.00 06000 LABORATORY 10,759 0 94 0 76 60.00	58. 00 05800 MRI	900	0	13	0	3	58. 00
60.01 G6001 LABORATORY-PATHOLOGICAL 1,212 0 6 0 7, 60.01	· · · · · · · · · · · · · · · · · · ·		4, 987		324		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 524 0 4 0 1 62.00 65.00 06500 RESPI RATORY THERAPY 6.564 0 64 0 28 65.00 66.00 06600 PHYSI CAL THERAPY 227 21,844 0 0 48 66.00 67.00 06700 OCCUPATI ONAL THERAPY 221 11,034 0 0 14 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 9 68.00 69.00 06900 ELECTROCARDI OLOGY 1,398 0 21 0 7 69.00 70.00 07000 ELECTROCARDI OLOGY 1,398 0 21 0 7 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07400 ERNADED TO PATIENTS 0 0 0 0 0 0 74.00 07400 ERNADED TO PATIENTS 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 76.97 07697 CARDI AC REHABILITATI ON 1,569 0 17 0 0 2 76.97 07697 CARDI AC REHABILITATI ON 1,569 0 17 0 0 0 79.00 09000 CLI NI C 4,547 38,784 81 1,213 10 90.00 79.01 09001 DIABETES CENTER 775 0 3 0 1 90.01 79.02 09002 MEUROSYCH 141 0 0 0 0 0 0 79.03 09003 WOUND CENTER 0 0 0 0 0 0 79.04 09004 HYPERBARI C OXYGEN THERAPY 0 1,010 0 0 0 0 79.05 09003 WOUND CENTER 0 0 0 0 0 0 79.00 09000 SEERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING NORTHER 0 0 0 0 0 79.00 09000 ORDING N	l i		0	94	0		
65.00 06500 RESPIRATORY THERAPY 27 21,844 0 0 48 65.00 66.00 06600 PHYSI CAL THERAPY 227 21,844 0 0 0 48 66.00 67.00 06700 OCCUPATI ONAL THERAPY 227 21,844 0 0 0 14 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 9 68.00 69.00 06900 ELECTROCARDI OLOGY 1,398 0 21 0 7 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 1,393 252 0 9 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 76.97 07697 CARDI AC REHABILITATI ON 1,569 0 17 0 2 76 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00 08900 ELEGRAPH CLINIC 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90.01 09001 DIABETES CENTER 775 0 3 0 1 90.01 90.02 09002 NURROPSYCH 141 0 0 0 0 0 90.03 09003 WOUND CENTER 0 6,757 0 0 6 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 1,010 0 0 0 0 90.05 09000 OSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 90.01 09001 DIABETES CENTER 0 0 0 0 0 0 90.02 09000 OSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 90.01 09001 OND HERBERNSABLE COST CENTERS 0 0 0 0 0 90.01 09001 OND HERBERNSABLE COST CENTERS 0 0 0 0 0 90.01 01000 HOME HEALTH AGENCY 0 0 0 0 0 0 90.01 01000 OND HEALTH AGENCY 0 0 0 0 0 90.01 01000 OND HEALTH AGENCY 0 0 0 0 0 90.01 01000 OND HEALTH AGENCY 0 0 0 0 0 90.01 01000 OND HEALTH AGENCY 0 0 0 0 0 90	l i		0	6	0		
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90. 03	· · · · · · · · · · · · · · · · · · ·		0	3	0		
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92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 6, 409 0 0 0 0 68 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 92. 00 0 0 0 0 0 0 0 0 0		_			731		
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Health Financial Systems	COLUMBUS REGIO	NAL HUSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				rom 01/01/2015		
			7	To 12/31/2015	Date/Time Pre	
	00000101101100		LUQUIGEUEEBLAIG	D. ETADY	5/24/2016 3:0	3 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	
		LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
	(SQ FEET)	(LDRY LBS)		10.00	44.00	
	7. 00	8. 00	9. 00	10.00	11. 00	
110.00 11000 INTESTINAL ACQUISITION	0	0	(0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	265, 991	1, 045, 796	5, 27	154, 914	1, 014	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	0	(0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	(0	4	194. 00
194. 01 07951 BUI LDI NG RENTALS	1, 327	0	(0	0	194. 01
194. 02 07952 HOSPI CE	0	0	(0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(o	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(o	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(o	0	194. 05
194. 06 07956 CRH FOUNDATION	815	0	3-	0	0	194. 06
194. 07 07957 HEALTHY COMMUNITIES	1, 195	l o		1 0	3	194. 07
200.00 Cross Foot Adjustments	, , , ,					200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	14, 513, 474	941, 275	3, 834, 285	1, 998, 448	2, 141, 812	
Part I)	11/010/17	, , , , , , ,	0,001,200	.,,,,,,,,,	27 7	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	53, 742660	0. 900056	721. 815700	12. 900371	2, 097. 759060	203. 00
204.00 Cost to be allocated (per Wkst. B,	5, 517, 281					1
Part II)	2,017,201	'''		301,200	000, 107	
205.00 Unit cost multiplier (Wkst. B, Part	20, 430212	0. 045779	92, 527485	2, 267064	328, 510284	205.00
	1	·				

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150112 | Period: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/24/2016 3:03 pm

Cost Center Description					10) 12/31/2015	Date/lime Pre 5/24/2016 3:0	
STATEMEN STRUCK COST CINETES 15.00 16.00 16.00 17.00		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
STATEMEL SERVICE COST. CENTERS 13.00			ADMI NI STRATI ON		(DRG COST)		(TIME COT)	
			(NITIDS HDS)				(TIME SPI)	
Designation Control					15. 00		17. 00	
2.00 CONDO CAP REL COSTS -MMSLE EQUIP		GENERAL SERVICE COST CENTERS						
4.00 00000 DEPLICATE EDITIFIES DEPARTMENT								1
5.00 0.0000 ADMINISTRATIVE & CEMERAL								1
7.00 00000 GERATION OF PLANT 9.00 00000 LINUSE KTPT INC 9.00 01000 LINUSE L								1
8.00 OBSSOOL AUMBREY & LINEN STRVICE		1						1
10.00 01000 DIETARY		1						1
11.00 01100 CAFETERIA 11.00 11.00 CAFETERIA 11.00 11.00 CINIRAL STRATION 1.569, 122 11.972 11.972 11.00 11.00 CINIRAL STRATICS & SUPPLY 28.010 11.972 11.00	9.00	00900 HOUSEKEEPI NG						9. 00
13.00 0.1300 MINES NA ZADAM IN STRATION 1.5.69, 122 1.7.702 1.1.								1
14.00 01.000 CRITINAL SERVICES & SUPPLY 28.010 11,772 12,790,401 15.00 15.00 10.000		1 1	1 540 122					ı
15.00 101500 PHARMACY 0 0 12,790,401 15,00 10.00 10.00 17.				11 972				
17.00 01700 SOCIAL SERVICE 14,996			0		12, 790, 401			1
23.00 02300 PARAMED ED PROM. (SPECIFY)	16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	19, 163		16. 00
23 OF 10 20 20 20 20 20 20 20			14, 986	0	0	ŭ		
23 02 (20302) PHARBIACY RESIDENCY PROC O O O O O 23 02 INPATIENT ROUTH BE SERVICE COST CENTERS 30.00 (30000) ADULTS A, PFEIN ATRICS 5 510, 790 30.00 (30000) INTENSIVE CARE UNIT 7 0, 476 9 3.2.76 451 121 31.00 320.00 (30000) INTENSIVE CARE UNIT 7 0 0 0 0 0 0 33.00 33.00 (33000) BIRRO INTENSIVE CARE UNIT 7 0 0 0 0 0 0 33.00 33.00 (33000) BIRRO INTENSIVE CARE UNIT 7 0 0 0 0 0 0 33.00 33.00 (33000) BIRRO INTENSIVE CARE UNIT 7 0 0 0 0 0 0 33.00 33.00 (33000) BIRRO INTENSIVE CARE UNIT 7 0 0 0 0 0 0 0 34.00 42.00 (3400) SIRRO INTENSIVE CARE UNIT 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		1
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31.00 0 3100 (INTERSI YE CARE UNIT	20.02		1 0		<u> </u>			20.02
32.00 03200 CORROMARY CARE UNIT 0 0 0 0 0 33.00 330 00 00 0	30.00			609	10, 787	4, 865	389	30. 00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 3.3.00 40.00 3000 SURRICALL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 3.4.00 40.00 3000 SURRICALL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 43.00 40.00 3000 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 440.00 40.00 3000 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 440.00 40.00 3000 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			70, 476	9				1
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41.00 04.00 SUBPROVI DER - IRF 50, 141 0 2, 071 1, 135 269 41.00				0	0	0		1
43.00 04300 NIRSERY 18, 449 23 26 0 0 44.00			50, 141	0	2, 071	1, 135	269	1
44. 00 04.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0			0	0	-	_		1
MACILLARY SERVICE COST CENTERS			18, 449			-		1
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51.00 05100 RECOVERY ROOM & LABOR ROOM 31,1339 0 142 0 0 51.00 0 0 0 0 0 0 0 0 0	50. 00		200, 583	10, 626	47, 795	4, 929	0	50.00
53.00 05300 AISTHESI OLOGY 2,496 0 67,437 0 0 53.00 54.00 55.00 54.00 54.00 55.00 54.00 55.00	51.00					0	0	51.00
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54. 01 05402 NUCLEAR MEDICINE -DIAGNOSTIC 0 0 175, 260 0 0 54, 01 54. 02 05404 ULTERA SQUID 0 0 0 207 0 0 54, 02 54. 03 05405 MAMMOGRAPHY 0 14 220 0 0 54, 03 55. 00 05500 RODIOLOGY-THERAPEUTIC 24, 781 0 0 229 56 55, 00 55. 00 05500 CT SCAN 0 0 9, 349 0 0 57, 00 58. 00 05800 ULTERA SQUID 0 0 0 4, 558 0 0 58, 00 58. 00 05800 ULTERA SQUID 0 0 0 0 4, 558 0 0 58, 00 60. 00 05800 MRI 0 0 0 0 0 309 0 0 0 60, 00 60. 00 05800 CARDIAC CATHETERI ZATION 39, 241 92 6, 300 437 0 59, 00 60. 00 06000 LABORATORY -PATHOLOGICAL 0 0 0 309 0 0 0 0 60. 01 06001 LABORATORY -PATHOLOGICAL 0 0 0 1 0 0 0 60. 00 06500 RESPIRATORY THERAPY 59, 55 248 4, 319 119 0 66, 00 65. 00 06500 PHYSI CAL THERAPY 180, 575 248 4, 319 119 0 66, 00 66. 00 06600 PHYSI CAL THERAPY 180, 575 248 4, 319 119 0 66, 00 69. 00 06700 OCCUPATI ONAL THERAPY 28, 597 0 694 25 0 67, 00 69. 00 06900 SPEECH PATHOLOGY 18, 655 0 14 0 0 68, 00 69. 00 06900 SPEECH PATHOLOGY 18, 655 0 14 0 0 68, 00 69. 00 06900 ELECTROCARDI OLOGY 14, 610 0 5, 917 2, 231 0 69, 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 07000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74. 00 07400 REVALD LIALYSIS 0 0 0 0 0 0 0 0 74. 00 07400 REVALD LIALYSIS 0 0 0 0 0 0 0 74. 00 07400 REVALD LIALYSIS 0 0 0 0 0 0 0 74. 00 07400 REVALD LIALYSIS 0 0 0 0 0 0 75. 97 **MOTHER MERCHAND LIALYSIS 0 0 0 0 0 0 0 76. 90 09000 ULINIC CENTER 18, 256 0 0 0 0 76. 90 09000 DRIBOR CHARGED TO PATIENTS 0 0 0 0 0 76. 90 09000 DRIBOR CHARGED TO PATIENTS 0 0 0 0 0 76. 90 07400 REVALD		1	2, 496	0		0	-	1
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55. 00 05500 RADIOLOGY-THERAPEUTIC 24,781 0 0 229 56 55. 00 57. 00 05700 CT SCAN 0 0 9,349 0 0 57.00 58. 00 05900 CARDIA C CATHETERI ZATION 39,241 92 6,300 437 0 59.00 60. 00 06000 LABORATORY 0 0 309 0 0 60.01 60. 01 06000 LABORATORY-PATHOLOGI CAL 0 0 81 963 0 60.01 65. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 1 0 0 62.00 66. 00 06600 RESPI RATORY THERAPY 100,575 248 4,319 119 0 66.00 66. 00 06600 PHYSI CAL THERAPY 100,575 248 4,319 119 0 66.00 66. 00 06600 PHYSI CAL THERAPY 18,655 0 14 0 0 68.00 69. 00 06900 DELECTROCACABIOLOGY 18,655 0 14		1	l o	-		_	-	1
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62. 00 06200 06200 06200 RESPI RATORY THERAPY 59, 165 17 5, 063 900 0 65. 00 065. 00 06500 RESPI RATORY THERAPY 100, 575 248 4, 319 119 0 66. 00 066. 00 06600 PHYSI CAL THERAPY 100, 575 248 4, 319 119 0 66. 00 067. 00 06700 0CCUPATI ONAL THERAPY 28, 597 0 694 25 0 67. 00 08. 00 06800 SPECH PATHOLOGY 18, 655 0 14 0 0 68. 00 08. 00 06900 ELECTROCARDI OLOGY 14, 610 0 5, 917 2, 231 0 69. 00 08. 00 06900 ELECTROENCEPHALOGRAPHY 17, 849 0 8 1, 386 0 70. 00 07. 00 07000 ELECTROENCEPHALOGRAPHY 17, 849 0 8 1, 386 0 70. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 0 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 074. 00 07400 ELECTROENCEPHALOGRAPHY 17, 849 0 12, 351, 834 0 0 0 074. 00 07400 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 075. 00 07500 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 075. 00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 075. 00 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 076. 00 07600 07600 0 0 0 0 076. 00 07600 07600 0 0 0 0 076. 00 07600 07600 0 0 0 076. 00 07600 0 0 0 0 076. 00 07600 0 0 0 0 076. 00 07600 0 0 0 076. 00 07600 0 0 0 076. 00 07600 0 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 07600 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 076. 00 0 0 0 076. 00 0 0 0 076. 00 0 0 0			0					1
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67. 00 06700 06700 06CUPATIONAL THERAPY 28, 597 0 694 25 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 18, 655 0 14 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 14, 610 0 5, 917 2, 231 0 69. 00 06900 ELECTROCARDIOLOGY 17, 849 0 8 1, 386 0 70. 00 71. 00 0 0 0 0 0 0 0 0 0								
68. 00 06800 SPEECH PATHOLOGY 18, 655 0 14 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70.			1					1
70. 00 07000 ELECTROENCEPHALOGRAPHY 17, 849 0 8 1,386 0 70. 00 71. 00 71. 00 71. 00 70700 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 71. 00 72. 00 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12,351,834 0 0 0 73. 00 74. 00 7			1	0				
71. 00			1	0	5, 917		-	1
72. 00			17, 849	0	8			1
73. 00				0	0	0		
74. 00 07400 RENAL DI ALYSIS 0 0 6, 275 0 0 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 76. 00 76. 97 ORADI AC REHABI LI TATI ON 3, 612 0 0 0 0 76. 97 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 01 09000 O9000 CLI NI C 21, 646 0 6, 912 1, 327 162 90. 00 90. 01 09001 DI ABETES CENTER 2, 330 0 0 0 0 0 90. 01 90. 02 09002 NEUROPSYCH 1, 820 0 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 12, 956 255 61, 037 0 0 90. 03 90. 04 09100 EMERGENCY 145, 545 56 6, 512 0 0				0	12, 351, 834	0		
76. 97 O7697 CARDI AC REHABI LI TATI ON 3, 612 0 0 0 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 0 88. 00 89. 00 99. 00 90. 00 0 0 0 0 0 0 88. 00 0 0 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	0	0		0	-	74. 00
88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00			0	0		_		
88. 00	76. 97	O7697 CARDI AC REHABI LI TATI ON	3, 612	0	0	0	0	76. 97
89. 00	88. 00			O	Ω	n	n	88.00
90. 00 09000 CLI NI C 21, 646 0 6, 912 1, 327 162 90. 00 90. 01 09001 DI ABETES CENTER 2, 330 0 0 0 0 0 90. 01 90. 02 09002 NEUROPSYCH 1, 820 0 0 0 166 0 90. 02 90. 03 09003 WOUND CENTER 12, 956 255 61, 037 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 3 90. 04 91. 00 09100 EMERGENCY 145, 545 56 6, 512 0 0 91. 00 92. 00 09200 0BERGYATI ON BEDS (NON-DI STI NCT PART 92. 00 09500 AMBULANCE SERVI CES 141, 818 0 11, 138 0 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 99. 10		1		0	Ö	0	-	ı
90. 02	90.00	09000 CLI NI C		0	6, 912	1, 327		
90. 03				0	0	0	-	
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 3 90. 04 91. 00 09100 EMERGENCY 145, 545 56 6, 512 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 OTHER REI MBURSABLE COST CENTERS 141, 818 0 11, 138 0 0 95. 00 09500 AMBULANCE SERVI CES 141, 818 0 0 0 0 0 99. 10 0 0 0 0 0 99. 10			1	0	61 027		-	1
91. 00			12, 930		01, 037 N	-	_	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART			145, 545	-	6, 512	_		
95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
99. 10 09910 CORF 0 0 0 99. 10	05.00		444 040		44 400			05.00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00			141, 818	-		-		
	101.00	10100 HOME HEALTH AGENCY		-	-	-	-	
			1	-1	-1	-		

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150112 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (DRG COST) RECORDS & LI BRARY SUPPLY (TIME SPT) (NURS HRS) (STER SUP) (TIME SPT) 17.00 15.00 13.00 14.00 16.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION O 0 111. 00 0 0 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 11, 972 12, 790, 107 1, 000 118. 00 118.00 1, 560, 270 19, 163 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 194. 00 07950 WELLNESS COMMUNITY 8,852 0 0 0 0 0 0 0 0 194. 00 194. 01 07951 BUILDING RENTALS 0 0 0 194. 01 194. 02 07952 HOSPI CE 0 0 194. 02 0 294 194. 03 07953 OUTREACH CLINICS 0 194. 03 0 0 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 194. 05 0 0 0 194.06 194.06 07956 CRH FOUNDATION 0 C 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 194. 07 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 6, 330, 488 2, 159, 690 8, 376, 321 2, 755, 379 973, 579 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 034414 180. 395089 0.654891 143. 786411 973. 579000 203. 00 204.00 Cost to be allocated (per Wkst. B, 48, 299 204. 00 629, 608 425, 698 907, 806 259, 711

0. 401249

35. 557802

0.070976

13. 552732

48. 299000 205. 00

Part II)

II)

Unit cost multiplier (Wkst. B, Part

205.00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150112 P

Peri od: Worksheet B-1 From 01/01/2015

Date/Time Prepared:

12/31/2015

5/24/2016 3:03 pm Cost Center Description PARAMED ED XRAY EDUCATION PHARMACY PRGM RESIDENCY PROG (PERCENT) (PERCENT) (PERCENT) 23.00 23.01 23.02 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 02301 XRAY EDUCATION 23. 01 100 23.01 02302 PHARMACY RESIDENCY PROG 100 23 02 23 02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 С 03100 INTENSIVE CARE UNIT 31.00 000000 0 31.00 0 03200 CORONARY CARE UNIT 0 32 00 Ω 32 00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 04000 SUBPROVI DER - I PF 0 40 00 0 40 00 04100 SUBPROVIDER - IRF 0 41.00 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 0 0 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 0 50.00 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000 0 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM Ω 52.00 0 53.00 05300 ANESTHESI OLOGY C 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 100 54.00 0 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC C 54.01 0 05404 ULTRA SOUND 54.02 0 54.02 0 54.03 05405 MAMMOGRAPHY 54.03 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05700 CT SCAN 57.00 0 0 57.00 05800 MRI 58.00 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 0 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 65.00 06500 RESPIRATORY THERAPY 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 100 73.00 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 0 76.00 03020 ACUPUNCTURE C 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 90.00 09000 CLI NI C 0 0 0 0 90.00 90 01 09001 DI ABETES CENTER Ω 0 90 01 0 90.02 09002 NEUROPSYCH 0 90.02 09003 WOUND CENTER 0 0 90.03 90.03 0 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 0 90.04 0 09100 EMERGENCY 0 91 00 C 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 0 0 99. 10 09910 CORF 0 99.10 0 101.00 10100 HOME HEALTH AGENCY 0 101.00

Peri od: Worksheet B-1 From 01/01/2015 Date/Time Prepared: 5/24/2016 3:03 pm

			10	5/24/2016 Date/IIme	
Cost Center Description	PARAMED ED	XRAY EDUCATION	PHARMACY	,	
	PRGM		RESI DENCY PROG		
	(PERCENT)	(PERCENT)			
			(PERCENT)		
	23. 00	23. 01	23. 02		
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUISITION	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	100	100		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0		194. 00
194. 01 07951 BUILDING RENTALS	0	0	0		194. 01
194. 02 07952 HOSPI CE	0	0	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETI NG	0	0	0		194. 05
194.06 07956 CRH FOUNDATION	0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0		194. 07
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	0	845, 321	637, 676		202. 00
Part I)		0 450 04000	, , , , , , , , , , , , ,		
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	8, 453. 210000			203. 00
204.00 Cost to be allocated (per Wkst. B,	0	50, 125	33, 446		204. 00
Part II)	0.000000	E01 2E0000	224 440000		205 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	501. 250000	334. 460000		205. 00
)					I

Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm Provi der CCN: 150112

					''	0 12/31/2015	5/24/2016 3:0	
				Ti tl	e 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	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37, 100, 255		37, 100, 255	93, 532	37, 193, 787	30. 00
31.00	03100	INTENSIVE CARE UNIT	5, 908, 107		5, 908, 107	0	5, 908, 107	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	O	0	34.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40. 00
41.00	04100	SUBPROVIDER - IRF	4, 600, 461		4, 600, 461	o	4, 600, 461	41.00
42.00	04200	SUBPROVI DER	0		0	o	0	42.00
43.00	04300	NURSERY	1, 228, 587		1, 228, 587	o	1, 228, 587	43.00
44.00		SKILLED NURSING FACILITY	0		0	o	0	44.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATI NG ROOM	25, 382, 481		25, 382, 481	95, 709	25, 478, 190	50.00
51.00	05100	RECOVERY ROOM	2, 244, 447		2, 244, 447	o	2, 244, 447	51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	0		0	o	0	52.00
53. 00		ANESTHESI OLOGY	372, 457		372, 457	9, 090	381, 547	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	4, 815, 819		4, 815, 819	0	4, 815, 819	54. 00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	1, 957, 801		1, 957, 801	0	1, 957, 801	
54. 02	1	ULTRA SOUND	1, 081, 415		1, 081, 415	0	1, 081, 415	
54. 03		MAMMOGRAPHY	1, 779, 893		1, 779, 893	0	1, 779, 893	
55. 00	1	RADI OLOGY-THERAPEUTI C	3, 465, 746		3, 465, 746	113, 529	3, 579, 275	
57. 00		CT SCAN	1, 688, 800		1, 688, 800	113, 327	1, 688, 800	
58. 00	05800		727, 651		727, 651		727, 651	58.00
59. 00		CARDI AC CATHETERI ZATI ON	4, 574, 185		4, 574, 185	46, 676	4, 620, 861	
60.00		LABORATORY	11, 471, 627		11, 471, 627	40, 070	11, 471, 627	60.00
60. 00	1	LABORATORY-PATHOLOGI CAL	1, 425, 119		1, 425, 119	37, 356	1, 462, 475	
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	1, 425, 119		1, 425, 119	37, 350	1, 462, 473	
						· · · · · · · · · · · · · · · · · · ·		
65. 00		RESPI RATORY THERAPY	4, 218, 270				4, 218, 270	
66.00		PHYSI CAL THERAPY	6, 692, 927	0		24, 579	6, 717, 506	
67. 00		OCCUPATIONAL THERAPY	2, 288, 058			0	2, 288, 058	
68. 00		SPEECH PATHOLOGY	1, 469, 053		1, 469, 053	l .	1, 469, 053	
69.00		ELECTROCARDI OLOGY	1, 457, 172		1, 457, 172	22, 806	1, 479, 978	
70.00	1	ELECTROENCEPHALOGRAPHY	1, 675, 000		1, 675, 000	0	1, 675, 000	70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	11, 041, 007		11, 041, 007	0	11, 041, 007	71.00
72.00		I MPL. DEV. CHARGED TO PATIENTS	6, 049, 283		6, 049, 283	0	6, 049, 283	
73.00		DRUGS CHARGED TO PATIENTS	24, 648, 843		24, 648, 843	0	24, 648, 843	
74.00		RENAL DI ALYSI S	624, 125	l .	624, 125	0	624, 125	74.00
76.00		ACUPUNCTURE	0	•	0	0	0	76.00
76. 97		CARDI AC REHABI LI TATI ON	327, 579		327, 579	1, 604	329, 183	76. 97
00 00		TIENT SERVICE COST CENTERS		I			0	00.00
88. 00		RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER CLINIC	2 07/ 40/		0	0	0	89. 00
90.00			2, 076, 486		2, 076, 486		2, 076, 486	
90. 01		DI ABETES CENTER	294, 562		294, 562	l .	294, 562	
90. 02	1	NEUROPSYCH	184, 130		184, 130		184, 130	
90. 03		WOUND CENTER	1, 986, 086		1, 986, 086	0	1, 986, 086	
90. 04	1	HYPERBARI C OXYGEN THERAPY	371, 544		371, 544	0	371, 544	
91. 00		EMERGENCY	13, 138, 498		13, 138, 498	0	13, 138, 498	
92.00		OBSERVATION BEDS (NON-DISTINCT PART	4, 452, 670		4, 452, 670		4, 452, 670	92.00
		REIMBURSABLE COST CENTERS	1					
95. 00		AMBULANCE SERVICES	6, 094, 692	l .	6, 094, 692	11	6, 094, 703	
99. 10	09910		0		0		0	
101.00		HOME HEALTH AGENCY	0		0		0	101. 00
		AL PURPOSE COST CENTERS						
		PANCREAS ACQUISITION	0		0		0	109. 00
		INTESTINAL ACQUISITION	0		0		0	110. 00
		ISLET ACQUISITION	0		0		0	111. 00
		INTEREST EXPENSE						113. 00
200.00	1	Subtotal (see instructions)	199, 950, 807			444, 892	200, 395, 699	
201.00	1	Less Observation Beds	4, 452, 670		4, 452, 670	l .	4, 452, 670	
202.00)	Total (see instructions)	195, 498, 137	0	195, 498, 137	444, 892	195, 943, 029	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/24/2016 3:03 pm Provi der CCN: 150112

					'	0 12/31/2013	5/24/2016 3:0	
				Ti tl	e XVIII	Hospi tal	PPS	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col . 7)	Ratio	Inpati ent	
			4 00	7.00	0.00	0.00	Ratio	
	INDAT	ENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		ADULTS & PEDIATRICS	53, 686, 432		53, 686, 432			30.00
31. 00	4	INTENSIVE CARE UNIT	10, 972, 026		10, 972, 026			31. 00
32. 00		CORONARY CARE UNIT	0		0			32. 00
33. 00		BURN INTENSIVE CARE UNIT	0		C			33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		C			34.00
40.00		SUBPROVI DER - I PF	0		C			40.00
41.00		SUBPROVI DER - I RF	6, 739, 227		6, 739, 227			41. 00
42. 00		SUBPROVI DER	0		C			42. 00
43.00		NURSERY	2, 544, 742		2, 544, 742			43. 00
44. 00		SKILLED NURSING FACILITY	0		C			44. 00
50. 00	ANCI LI	LARY SERVICE COST CENTERS OPERATING ROOM	22 442 275	EO EE7 412	92 100 007	0.205079	0.000000	50.00
51. 00		RECOVERY ROOM	23, 642, 375 2, 071, 981	59, 557, 612 4, 072, 434			0. 000000 0. 000000	
52. 00	4	DELIVERY ROOM & LABOR ROOM	2,071,901	4, 072, 434			0. 000000	
53. 00		ANESTHESI OLOGY	4, 031, 641	6, 189, 510	1		0. 000000	
54. 00	05400	RADI OLOGY-DI AGNOSTI C	1, 521, 775	3, 860, 269			0. 000000	
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	1, 329, 771	5, 765, 678			0.000000	
54.02	05404	ULTRA SOUND	869, 719	3, 877, 508	4, 747, 227	0. 227799	0.000000	54. 02
54. 03		MAMMOGRAPHY	776	2, 878, 062	2, 878, 838	0. 618268	0.000000	54. 03
55.00	4	RADI OLOGY-THERAPEUTI C	169, 391	8, 756, 937			0.000000	
57. 00		CT SCAN	3, 907, 615	16, 407, 070			0. 000000	
58. 00	05800		1, 250, 381	5, 525, 392			0. 000000	
59. 00	1	CARDI AC CATHETERI ZATI ON	10, 313, 945	8, 827, 614			0.000000	
60. 00 60. 01	1	LABORATORY LABORATORY-PATHOLOGI CAL	11, 233, 595	25, 940, 826 4, 275, 241			0. 000000 0. 000000	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	490, 116 1, 622, 554	944, 438			0. 000000	
65. 00	4	RESPIRATORY THERAPY	8, 640, 514	2, 334, 460			0. 000000	
66. 00	4	PHYSI CAL THERAPY	3, 539, 996	11, 428, 170			0. 000000	1
67. 00		OCCUPATI ONAL THERAPY	2, 320, 695	68, 055			0. 000000	
68. 00		SPEECH PATHOLOGY	805, 560	546, 883			0. 000000	
69.00	06900	ELECTROCARDI OLOGY	4, 978, 739	7, 782, 090	12, 760, 829	0. 114191	0.000000	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	169, 143	5, 982, 833	6, 151, 976	0. 272270	0.000000	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	10, 030, 357	8, 982, 558			0. 000000	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	9, 770, 855	6, 091, 055			0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	30, 134, 181	37, 066, 611			0. 000000	
74.00		RENAL DI ALYSI S	1, 643, 263	0			0.000000	
76. 00 76. 97		ACUPUNCTURE CARDI AC REHABI LI TATI ON	0 4, 332	713, 595	1		0. 000000 0. 000000	
70. 77		TIENT SERVICE COST CENTERS	4, 332	713, 575	/1/, 72/	0. 430203	0.000000	70. 77
88. 00		RURAL HEALTH CLINIC	0	0	C			88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000	CLINIC	33, 390	4, 180, 455	4, 213, 845	0. 492777	0.000000	90.00
90. 01	09001	DI ABETES CENTER	0	73, 275	73, 275	4. 019952	0.000000	90. 01
90. 02		NEUROPSYCH	3, 091	253, 424			0. 000000	
		WOUND CENTER	38, 322	4, 924, 708			0. 000000	
90. 04		HYPERBARI C OXYGEN THERAPY	8, 348	1, 956, 420			0. 000000	
91.00	1	EMERGENCY	12, 773, 853	47, 970, 396			0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0	9, 428, 947	9, 428, 947	0. 472234	0. 000000	92.00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	10, 408, 035	10, 408, 035	0. 585576	0. 000000	95. 00
99. 10			0	10, 400, 039		0. 303370	0.000000	99. 10
	1	HOME HEALTH AGENCY	0	0				101.00
		AL PURPOSE COST CENTERS	-,	<u> </u>	_			
109.00		PANCREAS ACQUISITION	0	0	C			109. 00
		INTESTINAL ACQUISITION	0	0	C			110. 00
		ISLET ACQUISITION	0	0	C			111. 00
		INTEREST EXPENSE						113. 00
200.00	4	Subtotal (see instructions)	221, 292, 701	317, 070, 561	538, 363, 262			200. 00
201. 00 202. 00		Less Observation Beds Total (see instructions)	221, 292, 701	317, 070, 561	538, 363, 262			201. 00 202. 00
202.00	۲۱	Total (See Histiactions)	221, 272, 101	317,070,301	1 550, 505, 202	ı I		1202.00

Heal th Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150112 | Period: From 01/01/2015 | Part I To 12/31/2015 | Date/Time Prepared:

5/24/2016 3:03 pm Title XVIII Hospi tal PPS Cost Center Description PPS Inpatient Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41.00 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.306228 50.00 05100 RECOVERY ROOM 0. 365282 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.037329 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.894794 54.00 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0.275923 54.01 05404 ULTRA SOUND 54.02 0.227799 54 02 54.03 05405 MAMMOGRAPHY 0.618268 54.03 05500 RADI OLOGY-THERAPEUTI C 55.00 0.400980 55.00 05700 CT SCAN 57.00 57.00 0.083132 58.00 05800 MRI 0. 107390 58.00 59.00 05900 CARDIAC CATHETERIZATION 0. 241405 59.00 60.00 06000 LABORATORY 0. 308589 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 0.306897 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.403574 62.00 06500 RESPIRATORY THERAPY 0. 384354 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.448786 66.00 06700 OCCUPATI ONAL THERAPY 0.957847 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 1.086222 68.00 06900 ELECTROCARDI OLOGY 69.00 0. 115978 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 272270 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.580711 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 381372 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.366794 73.00 07400 RENAL DIALYSIS 74.00 0.379808 74.00 0.000000 76.00 03020 ACUPUNCTURE 76.00 07697 CARDIAC REHABILITATION 76. 97 0. 458519 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0. 492777 90.00 09001 DIABETES CENTER 4 019952 90 01 90 01 90.02 09002 NEUROPSYCH 0.717814 90.02 90.03 09003 WOUND CENTER 0. 400176 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0. 189103 90.04 91.00 09100 EMERGENCY 91.00 0.216292 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 472234 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 585577 95.00 99. 10 09910 CORF 99 10 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110. 00 111.00 11100 I SLET ACQUISITION 111.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 202.00

	00111111110 0001				6.5	0550 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COLUMBUS REGIO		CCN: 150112	Period: From 01/01/2015 To 12/31/2015	w of Form CMS-: Worksheet D Part I Date/Time Pre 5/24/2016 3:0	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
'	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost	:		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 904, 042		.,, -		164. 04	30.00
31.00 INTENSIVE CARE UNIT	837, 253		837, 25	2, 875	291. 22	1
32.00 CORONARY CARE UNIT	0			0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	1
34.00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	
40. 00 SUBPROVI DER - I PF	0	C)	0	0.00	
41. 00 SUBPROVI DER - I RF	675, 995	[C	675, 99	95 4, 220	160. 19	
42. 00 SUBPROVI DER	0	C)	0	0.00	
43. 00 NURSERY	83, 949		83, 94	19 3, 324	25. 26	
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30-199)	6, 501, 239		6, 501, 23	39 40, 315		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	_			
LAIDATI ENT. DOUTLAIS CEDULOS COCT. CENTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	10.0/0	2 012 442				30.00
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	12, 268 1, 367					30.00
	1, 367					31.00
32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT	0					33. 00
34. 00 SURGICAL INTENSIVE CARE UNIT	0					34. 00
	0					40. 00
40. 00 SUBPROVI DER - I PF 41. 00 SUBPROVI DER - I RF	2, 825	452, 537	,			41. 00
42. 00 SUBPROVI DER	2, 623		1			42.00
43. 00 NURSERY						43. 00
44.00 SKILLED NURSING FACILITY						44. 00
200.00 Total (lines 30-199)	16, 460	2, 863, 078				200. 00
200.00 10141 (111163 30-177)	10,400	2,003,070	' 1			1200.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	E CAPITAL COSTS	Provider CCN: 150112	Peri od:	Worksheet D

From 01/01/2015 | Part II To 12/31/2015 | Date/Time Prepared: 5/24/2016 3:03 pm Title XVIII Hospi tal Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C. to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 + col Charges Part II, col. 8) 2) 26) 3.00 4.00 5.00 1.00 2.00 ANCILLARY SERVICE COST CENTERS 4, 055, 113 50.00 05000 OPERATING ROOM 83, 199, 987 0.048739 11, 869, 060 578, 486 50.00 51.00 05100 RECOVERY ROOM 226, 823 6, 144, 415 0.036915 1, 090, 118 40, 242 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 31, 179 10, 221, 151 0.003050 1, 954, 216 5, 960 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 605, 609 5, 382, 044 0.112524 863, 971 97, 217 54.00 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 198, 391 7, 095, 449 0.027960 851, 511 23,808 54.01 54.02 05404 ULTRA SOUND 86, 564 4, 747, 227 0.018235 480, 606 8,764 54.02 05405 MAMMOGRAPHY 238.087 2, 878, 838 0.082702 54 03 Ω 54 03 05500 RADI OLOGY-THERAPEUTI C 55.00 737, 738 8, 926, 328 0.082647 69, 107 5, 711 55.00 57.00 05700 CT SCAN 285, 696 20, 314, 685 0.014064 2, 170, 692 30, 529 57.00 58.00 05800 MRI 71, 144 6, 775, 773 0.010500 639, 653 6,716 58.00 05900 CARDIAC CATHETERIZATION 677 567 0.035398 4, 642, 794 59 00 19, 141, 559 59 00 164 346 60.00 06000 LABORATORY 1,013,230 37, 174, 421 0.027256 5, 579, 904 152, 086 60.00 06001 LABORATORY-PATHOLOGI CAL 4, 765, 357 0.029158 60.01 138, 946 244, 780 7, 137 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 53.278 0.020755 869, 224 62 00 2, 566, 992 18.041 62 00 65.00 06500 RESPIRATORY THERAPY 536, 874 10, 974, 974 0.048918 4, 714, 024 230, 601 65.00 06600 PHYSI CAL THERAPY 657, 737 14, 968, 166 0.043942 1, 302, 505 57, 235 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 96,083 2, 388, 750 0.040223 445, 702 17, 927 67.00 06800 SPEECH PATHOLOGY 86, 384 8, 457 1, 352, 443 0.063873 68 00 132, 396 68 00 69.00 06900 ELECTROCARDI OLOGY 152, 605 12, 760, 829 0.011959 2, 796, 901 33, 448 69.00 07000 ELECTROENCEPHALOGRAPHY 117, 248 6, 151, 976 0.019059 108, 857 2,075 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 314, 898 19, 012, 915 0.016562 5, 297, 796 87, 742 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 172, 530 15, 861, 910 0.010877 5, 193, 858 56, 494 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 330, 786 67, 200, 792 0.019803 15, 165, 589 300, 324 73.00 07400 RENAL DIALYSIS 74.00 18, 160 1,643,263 0.011051 868, 675 9,600 74.00 03020 ACUPUNCTURE 76.00 0.000000 0 76.00 07697 CARDIAC REHABILITATION 75, 948 717, 927 0.105788 1, 433 152 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0.000000 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 269, 650 4, 213, 845 90 00 09000 CLI NI C 0.063991 15, 645 1,001 90 00 36, 479 09001 DIABETES CENTER 73, 275 0.497837 90.01 90.01 09002 NEUROPSYCH 90.02 12, 930 256, 515 0.050406 1, 686 85 90.02 09003 WOUND CENTER 90.03 78.833 4, 963, 030 0.015884 90.03 0 09004 HYPERBARI C OXYGEN THERAPY 90.04 241, 658 1, 964, 768 0.122996 4.780 588 90.04 964, 744 91.00 09100 EMERGENCY 60, 744, 249 0.015882 7, 376, 783 117, 158 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 587, 089 92.00 92.00 9, 428, 947 0.062265 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50-199) 14, 170, 001 454, 012, 800 74, 752, 266 2, 061, 930 200. 00

Health Financial Systems	COLUMBUS REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Fi	eriod: rom 01/01/2015	Worksheet D	
			To	12/31/2015	Date/Time Pre 5/24/2016 3:0	pared: 3 nm
		Ti tl	e XVIII	Hospi tal	PPS	о ріп
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost	Amount (see	1 through 3,	
	1.00	2. 00	3. 00	instructions) 4.00	minus col. 4) 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0		0	31.00
32.00 03200 CORONARY CARE UNIT	0	0			0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0		0	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	0	0	0	0	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	
43. 00 04300 NURSERY	0	0	0	J	Ö	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	Ō		0	44. 00
200.00 Total (lines 30-199)	0	0	0		0	200. 00
Cost Center Description	Total Patient F		Inpati ent	I npati ent	PSA Adj.	
	Days	5 ÷ col. 6)	Program Days		Nursing School	
				Pass-Through Cost (col. 7 x		
				cost (cor. 7 x		
	6.00	7. 00	8. 00	9. 00	11. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	29, 896	0. 00		0		
31. 00 03100 I NTENSI VE CARE UNI T	2, 875	0.00		0		31.00
32. 00 03200 CORONARY CARE UNIT	0	0.00		0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0. 00 0. 00		0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF	0	0.00		0	0	40.00
41. 00 04100 SUBPROVI DER - RF	4, 220	0.00		Ö	Ö	41. 00
42. 00 04200 SUBPROVI DER	0	0.00		0	0	
43. 00 04300 NURSERY	3, 324	0.00	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0	0	
200.00 Total (lines 30-199)	40, 315	504 4 11 411	16, 460	0	0	200. 00
Cost Center Description		PSA Adj. All Other Medical				
		Education Cost				
	12.00	13. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDIATRICS	0	0				30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	1			31. 00
32. 00 03200 CORONARY CARE UNIT	0	0				32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0				33. 00 34. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0	0				40.00
41. 00 04100 SUBPROVI DER - 1 FF	0	0	•			41.00
42. 00 04200 SUBPROVI DER	o	0	•			42. 00
43. 00 04300 NURSERY	0	0				43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30-199)	0	0				200. 00

Health Financial Systems	COLUMBUS REGIONAL H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150112	From 01/01/2015	
	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150112	From 01/01/2015	

				Т	o 12/31/2015	Date/Time Pre 5/24/2016 3:0	
			Ti tl	e 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		
		1.00		0.00		4)	
	ANGLILLARY CERVICE COCT CENTERS	1.00	2.00	3.00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM					0	50.00
51. 00	05100 RECOVERY ROOM		1		0		00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM					0	
53. 00	05300 ANESTHESI OLOGY				0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C			845, 321	0	845, 321	1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC			043, 321		043, 321	1
54. 02	05404 ULTRA SOUND					0	1
54. 03	05405 MAMMOGRAPHY					١	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C				0	0	55.00
57. 00	05700 CT SCAN				0	j o	57. 00
58. 00	05800 MRI				0	o o	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON				0	j o	59.00
60.00	06000 LABORATORY				0	j o	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL				0	,	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0	,	62.00
65. 00	06500 RESPIRATORY THERAPY				0	,	65. 00
66. 00	06600 PHYSI CAL THERAPY				0	o o	66.00
67. 00	06700 OCCUPATI ONAL THERAPY				0	Ō	67. 00
68. 00	06800 SPEECH PATHOLOGY				0	o	68. 00
69.00	06900 ELECTROCARDI OLOGY				0	o	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY				0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS			ol c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS			637, 676	0	637, 676	73. 00
74.00	07400 RENAL DI ALYSI S				0	0	74. 00
76.00	03020 ACUPUNCTURE	C) (ol c	0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	C) () c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	C	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER) (0	0	0	89. 00
90.00	09000 CLI NI C) () c	0	0	90.00
90. 01	09001 DI ABETES CENTER) () c	0	0	90. 01
90. 02	09002 NEUROPSYCH	C) c) c	0	0	90. 02
90. 03	09003 WOUND CENTER	C) c) c	0	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	(C) c) c	0	0	90. 04
91.00	09100 EMERGENCY	(C) c) c	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	C) ()	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	_		_			1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	(C) C	1, 482, 997	0	1, 482, 997	200. 00

Health Financial Systems	COLUMBUS REGIONAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150112	From 01/01/2015	Worksheet D Part IV Date/Time Prepared: 5/24/2016 3:03 pm

			[1	o 12/31/2015	Date/Time Prep 5/24/2016 3:03	pared:
		Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description	Total		Ratio of Cost		Inpatient	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col . 5 ÷ col .	to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.	3	
	4)	- 7	ĺ	7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	0	83, 199, 987	0.000000	0.000000	11, 869, 060	50.00
51.00 05100 RECOVERY ROOM	0	6, 144, 415	0.000000	0. 000000	1, 090, 118	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 000000	0. 000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	10, 221, 151	0.000000	0. 000000	1, 954, 216	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	845, 321	5, 382, 044	0. 157063	0. 157063	863, 971	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			0. 000000	851, 511	54. 01
54. 02 05404 ULTRA SOUND	0	4, 747, 227	0.000000	0. 000000	480, 606	54. 02
54. 03 05405 MAMMOGRAPHY	0	2, 878, 838	0.000000	0. 000000	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	8, 926, 328	0.000000	0. 000000	69, 107	55. 00
57. 00 05700 CT SCAN	0	20, 314, 685	0.000000	0. 000000	2, 170, 692	57.00
58. 00 05800 MRI	0	6, 775, 773	0.000000	0. 000000	639, 653	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	19, 141, 559	0.000000	0. 000000	4, 642, 794	59. 00
60. 00 06000 LABORATORY	0		1		5, 579, 904	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0		1		244, 780	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				869, 224	62. 00
65. 00 06500 RESPIRATORY THERAPY	0				4, 714, 024	65. 00
66. 00 06600 PHYSI CAL THERAPY	0				1, 302, 505	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		1		445, 702	67. 00
68.00 06800 SPEECH PATHOLOGY	0		1		132, 396	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		1		2, 796, 901	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1		108, 857	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1		5, 297, 796	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		1		5, 193, 858	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	637, 676		1		15, 165, 589	73. 00
74.00 07400 RENAL DIALYSIS	0		1		868, 675	74.00
76. 00 03020 ACUPUNCTURE	0		0.000000		0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	717, 927	1		1, 433	76. 97
OUTPATIENT SERVICE COST CENTERS		,			, , , , ,	
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0. 000000	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	l .		0	89. 00
90. 00 09000 CLI NI C	0				15, 645	90.00
90. 01 09001 DI ABETES CENTER	0				0	90. 01
90. 02 09002 NEUROPSYCH	0				1, 686	90. 02
90. 03 09003 WOUND CENTER	0		1		0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	o o		1		4, 780	90. 04
91. 00 09100 EMERGENCY	0		l .		7, 376, 783	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o o				0	92. 00
OTHER REIMBURSABLE COST CENTERS		., .==,,,,,	1. 220000	2: 223000	J	
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 482, 997	454, 012, 800			74, 752, 266	
	1 11 12=1 777	,	1	1	,	

Heal th Finan	ial Systems	COLUMBUS F	REGIONAL HOSPIT	ΓAL	In Lieu	of Form CMS-2552-10
APPORTI ONMEN THROUGH COST		ANCILLARY SERVICE OTHER	PASS Provi	ider CCN: 150112	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

			'	0 12/31/2013	5/24/2016 3:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program	Physi ci an	Nursing School	
	Pass-Through	Charges	Pass-Through	Anestheti st	,	
	Costs (col. 8		Costs (col. 9	Cost		
	x col. 10)		x col. 12)			
	11. 00	12.00	13.00	21.00	22. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	17, 018, 310	0	C	0	50.00
51.00 05100 RECOVERY ROOM	0	827, 202	2 0	C	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	C	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	1, 448, 578	0	C	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	135, 698	1, 268, 046		C	0	54.00
54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 201, 223	0	C	0	54. 01
54.02 05404 ULTRA SOUND	0	1, 183, 044	0	C	0	54. 02
54. 03 05405 MAMMOGRAPHY	0	241, 681	0	C	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	3, 862, 068	0	C	0	55. 00
57. 00 05700 CT SCAN	0	4, 909, 756	0	C	0	57.00
58. 00 05800 MRI	0	1, 669, 938	0	C	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 750, 873	0	C	0	59. 00
60. 00 06000 LABORATORY	0	3, 274, 650	0	C	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	1, 142, 293	0	C	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	414, 296		C	0	62.00
65. 00 06500 RESPIRATORY THERAPY	o	900, 636	0	C	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 339	1	C	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	282		C	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	137, 218	0	C	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 605, 635		C	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 502, 810	0	C	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 672, 956	0	C	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 633, 230	1	C	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	143, 906	15, 779, 820	149, 735	C	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	C	0	74.00
76. 00 03020 ACUPUNCTURE	0	0	0	C	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	272, 479	0	C	0	76. 97
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	•				
88. 00 08800 RURAL HEALTH CLINIC	0	C	0	C	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	C	0	89. 00
90. 00 09000 CLI NI C	0	1, 963, 256	0	C	0	90.00
90. 01 09001 DI ABETES CENTER	0	4, 422	2 0	C	0	90. 01
90. 02 09002 NEUROPSYCH	o	143, 369		C	0	90. 02
90. 03 09003 WOUND CENTER	o	2, 401, 204	1	C	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	o	1, 055, 424			Ō	90. 04
91. 00 09100 EMERGENCY	o	10, 540, 456		C	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	2, 178, 865			Ō	92. 00
OTHER REIMBURSABLE COST CENTERS				·		1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	279, 604	88, 006, 359	348, 898	C	0	200. 00
		,,		1		

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 150112 Period: From 01/01/2015 To 12/31/2015 Part IV Date/Time Prepared: 5/24/2016 3:03 pm

						5/24/2016 3:0	03 pm
				XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj .		dj . Al I				
	Allied Health						
			ion Cost				
ANOLLI ADV. CEDVI OF COCT. CENTEDO	23. 00	24	4. 00				
ANCILLARY SERVICE COST CENTERS	1 0	\	0				
50. 00 05000 OPERATING ROOM	0	1	0				50.00
51. 00 05100 RECOVERY ROOM	0	()	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	(0				52.00
53. 00 05300 ANESTHESI OLOGY	0	(0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	(0				54. 01
54. 02 05404 ULTRA SOUND	0	(0				54. 02
54. 03 05405 MAMMOGRAPHY	0	(O				54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		O				55. 00
57. 00 05700 CT SCAN	0		0				57. 00
58. 00 05800 MRI	0		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	2	0				59.00
60. 00 06000 LABORATORY	0	(O				60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	(O				60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0				62.00
65. 00 06500 RESPIRATORY THERAPY	0		0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	2	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(O				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(O				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	(O				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0				73. 00
74. 00 07400 RENAL DI ALYSI S	0		0				74.00
76. 00 03020 ACUPUNCTURE	0	1	0				76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	<u>/</u>	0				76. 97
OUTPATIENT SERVICE COST CENTERS	1						
88. 00 08800 RURAL HEALTH CLINIC	0	1	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0				89. 00
90. 00 09000 CLI NI C	0	(0				90.00
90. 01 09001 DI ABETES CENTER	0	(0				90. 01
90. 02 09002 NEUROPSYCH	0	(O				90. 02
90. 03 09003 WOUND CENTER	0	(O				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0		O				90. 04
91. 00 09100 EMERGENCY	0	1	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	ــــــــــــــــــــــــــــــــــــــ	0				92. 00
OTHER REIMBURSABLE COST CENTERS							05.00
95. 00 09500 AMBULANCE SERVI CES	0	1					95. 00
200.00 Total (lines 50-199)	1	기	0				200. 00

Cost Center Description						10 12/31/2015	5/24/2016 3:0	
Cost Center Description				Ti tl	e XVIII	Hospi tal		
Ratio From Worksheet C, Part I, col. Part I,		·			Charges	•	Costs	
March Marc		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Part I		·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
Ded. & Coins. Ded. & Coins. See inst. See inst			Worksheet C,	inst.)	Servi ces	Services Not		
Cyber 1,00 2,00 3,00 4,00 5,00			Part I, col. 9		Subject To	Subject To		
MACI LLARY SERVICE COST CENTERS					Ded. & Coins.	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS					(see inst.)	(see inst.)		
50. 00 055000 0FEATH NG ROOM			1.00	2.00	3. 00	4. 00	5. 00	
51 00 05100 RECOVERY ROOM ALBOR ROOM 0.365282 827, 202 0 0 302, 162 51.00 52 00 05200 DELL'UERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53 00 05300 DELL'UERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 54 00 05400 RADI DIGOCY DIACNOSTI C 0.844794 1,448,578 0 0 52.786 53.00 54 00 05400 RADI DIGOCY DIACNOSTI C 0.844794 1,268,046 0 0 1.344,640 54.00 54 00 05400 RADI DIGOCY DIACNOSTI C 0.277593 2,201,223 0 0 607,368 54.01 54 02 05404 UITERA SOUND 0.227799 1.183,044 0 0 229,496 54.02 54 03 05405 MAMMOGRAPHY 0.618268 241,681 0 0 149,424 54.03 55 00 05500 RADI DIGOCY THERAPEUTI C 0.388261 3.862,068 0 0 1.499,490 55.00 55 00 05500 RADI DIGOCY THERAPEUTI C 0.388261 3.862,068 0 0 1.499,490 55.00 55 00 05500 RADI DIGOCY THERAPEUTI C 0.388261 3.862,068 0 0 179,335 85.00 55 00 05500 RADI DIGOCY THERAPEUTI C 0.388261 3.750,873 0 0 408,158 87.00 55 00 05900 CARDI JAC CATHETERI ZATI ON 0.238946 3.750,873 0 0 896,331 89.00 50 05900 CARDI JAC CATHETERI ZATI ON 0.238946 3.750,873 0 0 896,331 89.00 50 05900 CARDINATORY 0.308689 3.724,650 0 0 1.010,521 50 05900 CARDINATORY PATHOLOGI CAL 0.299058 1.142,293 0 0 341,612 0.00 50 06500 RESPIRATORY THERAPY 0.384354 414,290 0 0 341,612 0.00 50 06500 RESPIRATORY THERAPY 0.97644 2.3399 0 0 167,199 62.00 50 06500 DESPIRATORY THERAPY 0.97644 2.3399 0 0 1.046 66.00 50 06500 RESPIRATORY THERAPY 0.97644 2.3399 0 0 1.046 66.00 50 06500 DESPIRATORY THERAPY 0.97644 2.3399 0 0 1.046 66.00 50 06500 DESPIRATORY THERAPY 0.97644 2.3399 0 0 1.046 66.00 50 06500 DESPIRATORY THERAPY 0.97644 2.3399 0 0 1.046 66.00 50 06500 DESPIRATORY THERAPY 0.97644				1	1			
S2 00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 52,786 53 00			l .					1
53.00 08300 ANESTHESI OLOGY 0.036440 1.448, 578 0 0 52, 766 53.00								
54. 00 05400 RADI OLOGY-DI AGNOSTIC 0. 894794 1. 26.8, 046 0 0 1. 134, 640 54. 00		I I	l .					
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 2757993 2. 201, 223 0 0 607, 368 54. 01 54. 02 05404 ULTRA SQUIND 0. 2277799 1. 183, 044 0 0. 269, 496 54. 02 54. 03 05405 MAMINGERAPHY 0. 618268 241, 681 0 0 1.49, 424 54. 03 55. 00 05500 RADIOLOGY-THERAPEUTIC 0. 388261 3. 862, 068 0 0. 1.499, 490 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTIC 0. 388261 3. 862, 068 0 0. 1.499, 490 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTIC 0. 388261 3. 862, 068 0 0. 1.499, 490 55. 00 59. 00 05900 CARDIAC CATHETERIZATION 0. 238966 3. 750, 873 0 0. 896, 331 59. 00 59. 00 05900 CARDIAC CATHETERIZATION 0. 238966 3. 750, 873 0 0. 896, 331 59. 00 60. 01 06001 LABORATORY-PATHOLOGICAL 0. 299058 1. 142, 293 0 0. 341, 612 60. 00 60. 01 06001 LABORATORY-PATHOLOGICAL 0. 299058 1. 142, 293 0 0. 341, 612 60. 00 60. 00 062000 RESPIRATORY HERAPY 0. 447144 2. 339 0 0. 167, 199 62. 00 66. 00 06600 RESPIRATORY HERAPY 0. 447144 2. 339 0 0. 1, 046 66. 00 66. 00 06600 06600 RESPIRATORY HERAPY 0. 447144 2. 339 0 0. 1, 046 66. 00 66. 00 06600 06					1			1
S4. 02 05404 ILTRA SOUND						1		1
54.03 05405 MAMMOGRAPHY 0.618,268 241,681 0 0 149,424 54,03 55.00 05500 ROJO LOGY-THERAPEUTIC 0.388261 3.862 068 0 0 1,499,490 55,00 57.00 05700 CT SCAN 0.083132 4,909,756 0 0 408,158 57,00 58.00 05800 MRI 0.107390 1,669,938 0 0 179,335 58,00 60.00 05000 CARDIAC CATHETERI ZATI ON 0.238966 3,750,873 0 0 896,331 59,00 60.00 05000 LABORATORY-PATHOLOGI CAL 0.299058 1,142,293 0 0 341,612 60,01 60.01 05000 LABORATORY-PATHOLOGI CAL 0.299058 1,142,293 0 0 341,612 60,01 60.00 05000 LABORATORY-PATHOLOGI CAL 0.403574 414,296 0 0 167,199 62,00 60.00 05000 ESDOR ESPI RATORY THERAPY 0.384354 900,636 0 0 346,153 65,00 60.00 05000 CEDOR ATHORAPY 0.447144 2,339 0 0 167,199 62,00 60.00 05000 SECOL PATHOLOGY 0.447144 2,339 0 0 1,046 66,00 60.00 05000 SEECH PATHOLOGY 0.975847 282 0 270,670 60.00 05000 SEECH PATHOLOGY 0.114191 2,605,635 0 297,540 69,00 60.00 05000 ELECTROCARDI OLOGY 0.114191 2,605,635 0 297,540 69,00 60.00 05000 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 297,540 69,00 71.00 07000 CELECTROCERPHIALOGRAPHY 0.580711 2,672,956 0 0 1,552,215 71,00 71.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.381372 2,633,230 0 0 0 0,76,00 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.381372 2,633,230 0 0 0 0 0,76,00 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0.580711 2,672,956 0 0 1,552,215 71,00 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0.580711 2,672,956 0 0 0 74,00 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0.580711 2,633,230 0 0 0 0 0 76,00 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0.580711 2,633,230 0 0 0 0 0 0 0 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIE		1 1						
55.00 05500 RADIOLOGY-THERAPEUTI C 0.388261 3.862.068 0 0 1.499, 490 55.00 57.00			· ·					
57.00 05700 CT SCAN 0.083132 4,909.756 0 0.408.158 57.00		1 1	·		1			
58. 00 05900 05900 CARDIA C CATHETERI ZATI ON 0 0.107390 1, 669, 938 0 0 179, 335 58. 00			1				1, 499, 490	
59.00 0590	57. 00	I I			1		408, 158	57. 00
60. 00 06000 LABORATORY 0. 308589 3, 274, 650 0 0 1, 010, 521 60. 00 60. 01 06001 LABORATORY-PATHOLGICAL 0. 299058 1, 142, 293 0 0 341, 612 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 403574 414, 296 0 0 167, 199 62. 00 65. 00 06500 RESPI RATORY THERAPY 0. 384354 900, 636 0 0 346, 163 65. 00 66. 00 06600 PMYSI CAL THERAPY 0. 447144 2, 339 0 0 1, 016, 66. 00 66. 00 06600 PMYSI CAL THERAPY 0. 447144 2, 339 0 0 270 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 957847 282 0 0 270 67. 00 68. 00 06800 SPECET PATHOLOGY 1. 086222 137, 218 0 0 149, 049 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 114191 2, 605, 635 0 0 297, 540 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 114191 2, 605, 635 0 0 297, 540 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 0. 272270 1, 502, 810 0 0 409, 170 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 580711 2, 672, 956 0 0 1, 552, 215 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 381372 2, 633, 230 0 0 1, 004, 240 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 3616794 15, 779, 820 0 0 5, 787, 943 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 379808 0 0 0 0 76. 00 76. 07 07697 CARDIA CREHABI LITATION 0. 466285 272, 479 0 0 124, 328 76. 97 07697 CARDIA CREHABI LITATION 0. 466285 272, 479 0 0 17, 776 90. 01 90. 01 09000 DIABETES CENTER 0. 000000 0 0 0 77, 776 90. 01 90. 02 09000 09000 09000 09000 00 00 00 00 00 00 90. 01 09001 DIABETES CENTER 0. 000000 0 0 0 17, 776 90. 01 90. 02 09000 09000 09000 00 00			1		l .		179, 335	58. 00
60.01 06001 LABORATORY-PATHOLOGICAL 0.299058 1,142,293 0 0 341,612 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.403574 414,296 0 0 167,199 62.00 65.00 06500 RESPI RATORY THERAPY 0.384354 900,636 0 0 346,163 65.00 66.00 06600 PHYSI CAL THERAPY 0.447144 2,339 0 0 1,046 66.00 66.00 06600 PHYSI CAL THERAPY 0.447144 2,339 0 0 1,046 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.957847 282 0 0 270 67.00 68.00 06800 SPEECH PATHOLOGY 1.086222 137,218 0 0 149,049 68.00 69.00 06900 ELECTROCARDIOLOGY 0.114191 2,605,635 0 0 297,540 69.00 69.00 06900 ELECTROCARDIOLOGY 0.114191 2,605,635 0 0 297,540 69.00 69.00 07000 ELECTROCARDIOLOGY 0.722770 1,502,810 0 0 409,170 70.00 67.00 07000 ELECTROCARDEPHALOGRAPHY 0.272270 1,502,810 0 0 409,170 70.00 67.00 07200 IMPL DEV. CHARGED TO PATIENT 0.580711 2,672,956 0 0 1,552,215 71.00 67.00 07200 IMPL DEV. CHARGED TO PATIENTS 0.3861372 2,633,230 0 0 1,004,240 72.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.3866794 15,779,820 0 0 5,787,943 73.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 5,787,943 73.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 5,787,943 73.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 5,787,943 73.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 0 0 0 74.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 0 0 0	59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 238966	3, 750, 873	(0	896, 331	59. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.403574 414, 296 0 0 167, 199 62.00 65.00 06500 RESPI RATORY THERAPY 0.447144 2,339 0 0 346, 163 65.00 66.00 06600 PHYSI CAL THERAPY 0.447144 2,339 0 0 1,046 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.957847 282 0 0 270 67.00 68.00 06800 SPECH PATHOLOGY 1.086222 137, 218 0 0 149,049 68.00 69.00 06900 ELECTROCARDI OLOGY 0.114191 2,605,635 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 297,540 69.00 71.00 070100 MEDICAL SUPPLIES CHARGED TO PATI ENT 0.580711 2,672,956 0 0 1,552,215 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.381372 2,633,230 0 0 1,004,240 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.366794 15,779,820 0 0 5,787,943 73.00 74.00 07400 RENAL DIALYSIS 0.379808 0 0 0 0,74.00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 0 76.00 76.07 07697 CARDI ACR BEHABILITATI ON 0.456285 272,479 0 0 124,328 76.97 001747 ESTRUCE COST CENTERS 88.00 08800 RIPAL HEALTH CLINI C 0.000000 0 0 0 967,447 90.01 09900 CLINI C 0.492777 1,963,256 0 0 967,447 90.00 90.00 099000 CLINI C 0.492777 1,963,256 0 0 967,447 90.00 90.01 099001 DIABETES CENTER 4.019952 4.422 0 0 17,776 90.01 90.02 09002 NEUROPSYCH 0.717814 143,369 0 0 960,904 90.03 90.03 09003 WOUND CENTER 0.400176 2,401,204 0 0 960,904 90.03 90.04 09004 HYPERBARI C CNYGEN THERAPY 0.189103 1,055,424 0 0 199,584 90.04 90.05 09000 OSERVATI ON BEDS (NON-DISTINCT PART 0.472234 2,178,865 0 0 27,439,771 200.00 90.00 09000 OSERVATI ON BEDS (NON-DISTINCT PART 0.472234 2,178,865 0 0 27,439,771 200.00 90.00 0010 CLINIC CES 0.585576 0 0 27,439,771 200.00 90.00 0010 CLINIC CES 0.585576 0 0 27,439,771	60.00	06000 LABORATORY	0. 308589	3, 274, 650)	0	1, 010, 521	60.00
65.00 06500 RESPIRATORY THERAPY 0.384354 900,636 0 0 346,163 65.00 66.00 06600 PHYSI CAL THERAPY 0.447144 2.339 0 0 1,046 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.957847 282 0 0 270 67.00 68.00 06800 SPECH PATHOLOGY 1.866222 137,218 0 0 149,049 68.00 69.00 06900 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 2297,540 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.272270 1,502,810 0 0 409,170 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.580711 2,672,956 0 0 1,552,215 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0.381372 2,633,230 0 0 1,004,240 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.381372 2,633,230 0 0 1,004,240 72.00 74.00 07400 RENAL DIALYSIS 0.376908 0 0 5,787,943 73.00 74.00 07400 RENAL DIALYSIS 0.376908 0 0 0 76.00 76.00 03022 ACUPUNCTURE 0.000000 0 0 0 76.00 76.00 03022 ACUPUNCTURE 0.000000 0 0 124,328 76.90 07697 CARDI AC REHABILITATI ON 0.456285 272,479 0 0 124,328 76.90 08800 RURAL HEALTH CLINIC 0.0492777 1,963,256 0 0 960,447 90.00 90.00 90000 CLINIC C.0492777 1,963,256 0 0 960,447 90.00 90.01 09001 DIABETES CENTER 4.019952 4.422 0 0 17,776 90.01 90.02 09002 NEUROPSYCH 0.717814 143,369 0 0 102,912 90.03 09003 WOUND CENTER 0.400176 2,401,204 0 0 960,904 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0.189103 1,055,424 0 0 199,584 90.04 91.00 09100 MERGENCY 0.216392 10,540,456 0 0 2,279,816 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.472234 2,178,865 0 0 2,279,816 91.00 91.00 09100 MERGENCY 0.216392 10,540,456 0 0 2,279,816 91.00 91.00 09001 DIABETES CENTERS 0.05000000000000000000000000000000000	60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 299058	1, 142, 293	(0	341, 612	60. 01
66.00 06600 PHYSICAL THERAPY 0.447144 2,339 0 0 1,046 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.957847 282 0 0 270 67.00 68.00 06800 SPEECH PATHOLOGY 1.086222 137,218 0 0 149,049 68.00 69.00 06900 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0.1414191 2,605,635 0 0 297,540 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.580711 2,672,956 0 0 1,552,215 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.381372 2,633,230 0 0 1,004,240 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.366794 15,779,820 0 0 5,787,943 73.00 74.00 07400 RENAL DI ALYSIS 0.379808 0 0 0 0 74.00 76.00 03020 ACUPPUNCTURE 0.000000 0 0 0 0 0 76.97 07697 CARDIA C REHABI LITATION 0.456285 272,479 0 0 124,328 76.97 07697 CARDIA C REHABI LITATI CHITC 0.000000 89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.492777 1,963,256 0 0 967,447 90.00 90.01 09001 DI ABETES CENTER 4.019952 4,422 0 0 17,776 90.01 90.02 09002 MUIND CENTER 4.019952 4,422 0 0 17,776 90.01 90.03 09003 WOUND CENTER 4.019952 4,422 0 0 17,776 90.01 90.04 09004 HYPERBARI C OXYGEN THERAPY 0.189103 1,055,424 0 0 199,584 90.02 90.03 09003 WOUND CENTER 0.400176 2,401,204 0 0 2,279,816 91.00 91.00 09000 DISSERVATI ON BEDS (NON-DISTINCT PART 0.472234 2,178,865 0 0 2,279,816 91.00 91.00 09500 AMBULANCE SERVI CES 0.585576 0 0 27,439,771 200.00 0010 VCharges 0010 CLER SERVI CES 0.585576 0 0 27,439,771 200.00 0010 VCharges 0010 CLER SERVI CES 0.000000 0 0 0 0 0 0 0	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 403574	414, 296	,	0	167, 199	62. 00
67.00 06700 OCCUPATI ONAL THERAPY 0.957847 282 0 0 270 67.00 68.00 06800 SPEECH PATHOLOGY 1.086222 137, 218 0 0 149,049 68.00 70.00 06900 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0.114191 2,605,635 0 0 297,540 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.580711 2,672,956 0 0 1,552,215 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.580711 2,672,956 0 0 1,552,215 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.580711 2,672,956 0 0 1,552,215 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.381372 2,633,230 0 0 0 0,04,240 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.366794 15,779,820 0 0 5,787,943 73.00 74.00 07400 RENAL DI ALYSI S 0.379808 0 0 0 0 0 74.00 76.00 30200 ACUPINCTURE 0.000000 0 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.456285 272,479 0 0 124,328 76.97 001PATI ENT SERVI CE COST CENTERS 88.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 0 0 967,447 90.00 90.01 09000 CLI NI C 0.492777 1,963,256 0 0 967,447 90.00 90.02 09000 CLI NI C 0.492777 1,963,256 0 0 102,912 90.02 90.03 09003 WOUND CENTER 4.019952 4,422 0 0 102,912 90.02 90.04 09000 LUROPERBARI COXYGEN THERAPY 0.189103 1,055,424 0 0 102,912 90.02 90.04 09000 HAPPERBARI COXYGEN THERAPY 0.189103 1,055,424 0 0 1,028,934 91.00 09100 DEMERGENCY 0.216292 10,540,456 0 0 27,439,771 071.00 07100 CLESS PBP CI I in C Lab. Services-Program 0 0 0 0 0 0 0 071.00 07100 CLESS PBP CI I in C Lab. Services-Program 0 0 0 0 0 0 0 071.00 07100 CLESS PBP CI I in C Lab. Services-Program 0 0 0 0 0 0 0 071.00 07100 07100 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	0. 384354	900, 636	,	0	346, 163	65. 00
68.00 06800 SPEECH PATHOLOGY 1. 086222 137, 218 0 0 149,049 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 114191 2, 605,635 0 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0. 114191 2, 605,635 0 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0. 114191 2, 605,635 0 0 297,540 69.00 70.00 07000 ELECTROCARDI OLOGY 0. 114191 2, 605,635 0 0 0 409,170 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 580711 2, 672,956 0 0 0 1, 552,215 71.00 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 381372 2, 633,230 0 0 1, 004,240 72.00 73.00 DRUGS CHARGED TO PATI ENTS 0. 366794 15,779,820 0 0 5,787,943 73.00 74.00 74.00 74.00 74.00 RENAL DI ALYSI S 0. 379808 0 0 0 0 5,787,943 73.00 74.00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 0 74.00 74.00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 0 0 74.00 7	66.00	06600 PHYSI CAL THERAPY	0. 447144	2, 339)	0	1, 046	66. 00
69. 00 06900 ELECTROCARDIOLOGY 0.114191 2,605,635 0 0 297,540 69. 00 70. 00 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0.272270 1,502,810 0 0 409,170 70. 00 71. 00 71. 00 70. 00 71. 00 71. 00 70. 00 71.	67.00	06700 OCCUPATI ONAL THERAPY	0. 957847	282	(0	270	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 272270 1, 502, 810 0 0 409, 170 70. 00 71. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 580711 2, 672, 956 0 0 1, 552, 215 71. 00 72. 00 72. 00 72. 00 72. 01 MPL. DEV. CHARGED TO PATI ENTS 0. 381372 2, 633, 230 0 0 1, 004, 240 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 366794 15, 779, 820 0 0 5, 787, 943 73. 00 74	68.00	06800 SPEECH PATHOLOGY	1. 086222	137, 218	:	0	149, 049	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0. 114191	2, 605, 635	(0	297, 540	69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 272270	1, 502, 810)	0	409, 170	70.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 580711	2, 672, 956	,	0	1, 552, 215	71.00
74. 00 07400 RENAL DI ALYSI S 0. 379808 0 0 0 0 74. 00 76. 00 03020 ACUPUNCTURE 0. 0000000 0 0 0 0 76. 07 07697 CARDI AC REHABI LI TATI ON 0. 456285 272, 479 0 0 124, 328 88. 00 08800 RURAL HEALTH CLINI C 0. 0000000 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0. 0000000 0 88. 00 90. 00 09000 CLINI C 0. 492777 1, 963, 256 0 0 967, 447 90. 00 90. 01 09001 DI ABETES CENTER 4. 019952 4, 422 0 0 17, 776 90. 01 90. 02 09002 NEUROPSYCH 0. 717814 143, 369 0 0 102, 912 90. 02 90. 03 09003 WOUND CENTER 0. 400176 2, 401, 204 0 0 960, 904 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 472234 2, 178, 865 0 0 27, 439, 771 200. 00 201. 00 Only Charges 0. 00 0. 00 0. 00 201. 00 00 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 202. 00 00 00 00 203. 00 00 00 00 204. 00 00 00 00 205. 00 00 00 00 206. 00 00 00 00 207. 439, 771 000 001 201. 00 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 201. 00 00 00 201. 00 00 201. 00 00 00 201. 00 00 00 201. 00 00 202. 00 00 00 203. 00 00 00 204. 00 00 00 205. 00 00 00 206. 00 00 00 207. 439, 771 000 201. 00 00 201. 00 00 00 202. 00 00 00 203. 00 00 00 204. 00 00 00 205. 00 00 00 206. 00 00 00 207. 439	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 381372	2, 633, 230)	0	1, 004, 240	72.00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 366794	15, 779, 820)	0	5, 787, 943	73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON O. 456285 272, 479 O O 124, 328 76. 97 OUTPATI ENT SERVI CE COST CENTERS 88. 00 O8800 RURAL HEALTH CLINI C O. 000000 O9000 CLI NI C O. 492777 1, 963, 256 O O 967, 447 90. 00 990. 01 O9001 DI ABETES CENTER O. 0000000 O10 O9000 CLI NI C O. 717814 143, 369 O O 0 09002 NEUROPSYCH O. 717814 143, 369 O O 0 09003 WOUND CENTER O. 400176 2, 401, 204 O O 960, 904 90. 03 O9003 WOUND CENTER O. 400176 2, 401, 204 O O 99004 HYPERBARI C OXYGEN THERAPY O. 189103 1, 055, 424 O O 1999, 584 90. 04 O9100 EMERGENCY O. 216292 10, 540, 456 O O 2, 279, 816 91. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART O. 472234 2, 178, 865 O O 1, 028, 934 92. 00 O101 Cless PBP Clinic Lab. Services-Program Only Charges	74.00	07400 RENAL DIALYSIS	0. 379808	0)	0	0	74.00
SERVICE COST CENTERS SERVICE COST CENTER SERVICE CENTER SERVICE COST CENTER SERVICE CENTE	76.00	03020 ACUPUNCTURE	0. 000000	0)	0	0	76.00
88. 00	76. 97	07697 CARDIAC REHABILITATION	0. 456285	272, 479)	0	124, 328	76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 90. 00 09000 CLINIC 0. 492777 1, 963, 256 0 0 967, 447 90. 00 90. 01 09001 DI ABETES CENTER 4. 019952 4, 422 0 0 17, 776 90. 01 90. 02 09002 NEUROPSYCH 0. 717814 143, 369 0 0 102, 912 90. 02 90. 03 09003 WOUND CENTER 0. 400176 2, 401, 204 0 0 960, 904 90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 07 000 DEMERGENCY 0. 216292 10, 540, 456 0 0 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0, 1, 028, 934 92. 00 000 DEMERGENCY 0. 189103 2, 178, 865 0 0 0 0 0, 1, 028, 934 92						_		
90. 00 09000 CLINIC 0.492777 1,963,256 0 0 967,447 90.00 90.01 09001 DI ABETES CENTER 4.019952 4.422 0 0 17,776 90.01 90.02 09002 NEUROPSYCH 0.717814 143,369 0 0 102,912 90.02 90.03 09003 WOUND CENTER 0.400176 2,401,204 0 0 960,904 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0.189103 1,055,424 0 0 199,584 90.04 91.00 09100 EMERGENCY 0.216292 10,540,456 0 0 2,279,816 91.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.472234 2,178,865 0 0 1,028,934 92.00 09500 AMBULANCE SERVICES 0.585576 0.585			l .	l .				1
90. 01 09001 DI ABETES CENTER 4. 019952 4, 422 0 0 17, 776 90. 01 90. 02 09002 NEUROPSYCH 0. 717814 143, 369 0 0 102, 912 90. 02 90. 03 09003 WOUND CENTER 0. 400176 2, 401, 204 0 0 960, 904 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 472234 2, 178, 865 0 0 1, 028, 934 95. 00 09500 AMBULANCE SERVI CES 0. 585576 88, 006, 359 0 0 27, 439, 771 200. 00 201. 00 CHER REI MBURSABLE COST CENTERS 0 0 0 0 001 V Charges 0 0 0 0 0 002 003 004 005 005 005 005 005 005 003 004 005 005 005 005 005 005 005 005 005 005 005 005 006 007 007 007 007 007 007 007 007 007 007 007 007 007 008 009 007 007 007 007 007 007 009	89. 00	I I	0. 000000				0	89. 00
90. 02 09002 NEUROPSYCH 0. 717814 143, 369 0 0 102, 912 90. 02 90. 03 09003 WOUND CENTER 0. 400176 2, 401, 204 0 0 960, 904 90. 03 90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 472234 2, 178, 865 0 0 1, 028, 934 92. 00 09500 AMBULANCE SERVI CES 0. 585576 Subtotal (see instructions) 88, 006, 359 0 0 27, 439, 771 200. 00 201. 00 001 y Charges	90.00	09000 CLI NI C	0. 492777	1, 963, 256	,	0	967, 447	90. 00
90. 03 09003 WOUND CENTER 0. 400176 2, 401, 204 0 0 960, 904 90. 03 90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 472234 2, 178, 865 0 0 1, 028, 934 92. 00 07500 AMBULANCE SERVI CES 0. 585576 0 0 27, 439, 771 200. 00 201. 00 Cless PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0	90. 01	09001 DI ABETES CENTER	4. 019952	4, 422	(0	17, 776	90. 01
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0. 189103 1, 055, 424 0 0 199, 584 90. 04 91. 00 09100 EMERGENCY 0. 216292 10, 540, 456 0 0 2, 279, 816 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 472234 2, 178, 865 0 0 1, 028, 934 95. 00 09500 AMBURSABLE COST CENTERS 0. 585576 0 0 27, 439, 771 200. 00 201. 00 Cless PBP Clinic Lab. Services-Program 0 0 0 0 001 V Charges 0 0 0 0 002 09500 003 003 003 003 003 003 003 003 003 004 005 004 005 005 005 005 004 005 00	90. 02	09002 NEUROPSYCH	0. 717814	143, 369	1	0	102, 912	90. 02
91. 00	90. 03	09003 WOUND CENTER				0	960, 904	90. 03
92. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART 0. 472234 2, 178, 865 0 0 1, 028, 934 92. 00	90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 189103	1, 055, 424		0	199, 584	90. 04
OTHER REIMBURSABLE COST CENTERS O O9500 AMBULANCE SERVICES O Subtotal (see i nstructions) 88,006,359 O O 27,439,771 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges O O O O Control of the cont	91.00	09100 EMERGENCY	0. 216292	10, 540, 456	,	0	2, 279, 816	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 472234	2, 178, 865	(0	1, 028, 934	92. 00
200.00 Subtotal (see instructions) 88,006,359 0 0 27,439,771 200.00 201.00 0 0 0 0 0 0 0 0 0								
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		I I	0. 585576		1			
Only Charges	200.00			88, 006, 359		0	27, 439, 771	200. 00
	201.00					0		201. 00
202.00 Net Charges (line 200 +/- line 201) 88,006,359 0 0 27,439,771 202.00								
	202. 00	Net Charges (line 200 +/- line 201)		88, 006, 359	' '	0 اد	27, 439, 771	202.00

 Heal th Financial
 Systems
 COLUMBUS
 REGIO

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 COLUMBUS REGIONAL HOSPITAL Provi der CCN: 150112

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: | 5/24/2016 3:03 pm |

						5/24/2016 3:0	3 pm
			Ti tl	e XVIII	Hospi tal	PPS	
		Cos	· · · · · · · · · · · · · · · · · · ·				
	Cost Center Description	Cost	Cost				
	0001 0011101 20001 pt on	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLILIADY OFFICE OF CONT. OFFITEDO	6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS		_	ı			
50. 00	05000 OPERATI NG ROOM	0	0				50. 00
51. 00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	o	0				54. 01
54. 02	05404 ULTRA SOUND	0	0				54. 02
54. 03	05405 MAMMOGRAPHY	0	0				54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57. 00		0	0				57. 00
	05700 CT SCAN	0	_				•
58. 00	05800 MRI	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0	•			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0				60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65.00	06500 RESPI RATORY THERAPY	0	0				65. 00
66.00	06600 PHYSI CAL THERAPY	o	0				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	0	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
		0	_				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74. 00	07400 RENAL DIALYSIS	0	0				74. 00
76. 00	03020 ACUPUNCTURE	0	0				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000 CLI NI C	0	0				90.00
90. 01	09001 DI ABETES CENTER	0	0				90. 01
90. 02	09002 NEUROPSYCH	0	0				90. 02
90. 03	09003 WOUND CENTER	0	0				90. 03
90.03	09004 HYPERBARI C OXYGEN THERAPY		0				90.03
		0					•
91.00	09100 EMERGENCY	0	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0					95. 00
200.00	,	0	0				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0	0				202. 00

Health Financial Systems	COLUMBUS REGIO				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der		Peri od: From 01/01/2015	Worksheet D Part II	
		Component		To 12/31/2015		pared:
		Ti tl	e XVIII	Subprovider -	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	9	Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILARY OFFICE OFFICE	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 055 440	00 400 007	0.04070	7 ((4	07.4	F0 00
50. 00 05000 OPERATING ROOM	4, 055, 113		1	•		
51. 00 05100 RECOVERY ROOM	226, 823				49	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	01 170	_			0	
53. 00 05300 ANESTHESI OLOGY	31, 179				4	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	605, 609				3, 071	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	198, 391				74	
54. 02 05404 ULTRA SOUND 54. 03 05405 MAMMOGRAPHY	86, 564 238, 087				392 0	1
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C			1		0	
55. 00 05500 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN	737, 738				549	
58. 00 05800 MRI	285, 696 71, 144					1
59. 00 05900 CARDI AC CATHETERI ZATI ON	677, 567		1		02	
60. 00 06000 LABORATORY	1, 013, 230				7, 965	
60. 01 06001 LABORATORY-PATHOLOGI CAL	138, 946				37	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	53, 278		1	•	359	
65. 00 06500 RESPIRATORY THERAPY	536, 874				5, 216	
66. 00 06600 PHYSI CAL THERAPY	657, 737				43, 683	
67. 00 06700 OCCUPATI ONAL THERAPY	96, 083		1			1
68. 00 06800 SPEECH PATHOLOGY	86, 384					
69. 00 06900 ELECTROCARDI OLOGY	152, 605				373	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	117, 248		1	•		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	314, 898				1, 947	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	172, 530			•	3	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 330, 786				17, 200	73. 00
74.00 07400 RENAL DIALYSIS	18, 160				950	
76. 00 03020 ACUPUNCTURE	0	0	0.00000	0 0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	75, 948	717, 927	0. 10578	8 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89. 00
90. 00 09000 CLI NI C	269, 650	4, 213, 845	0. 06399	1 0	0	90.00
90. 01 09001 DI ABETES CENTER	36, 479	73, 275	0. 49783	7 0	0	90. 01
90. 02 09002 NEUROPSYCH	12, 930		1		17	90. 02
90. 03 09003 WOUND CENTER	78, 833				0	
90. 04 09004 HYPERBARI C OXYGEN THERAPY	241, 658				0	
91. 00 09100 EMERGENCY	964, 744		1	•	105	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9, 428, 947	0.00000	0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		ı				
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	13, 582, 912	454, 012, 800	1	3, 963, 538	144, 601	[200. 00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	COLUMBUS REGIONARY SERVICE OTHER PASS		CCN: 150112	Peri od:	w of Form CMS- Worksheet D	
HROUGH COSTS		Component	CCN: 15T112	From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre 5/24/2016 3:0	pared:
		Ti tl	e XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist Cost			Medical Education Cost	(sum of col 1 through col.	
	0031			Education cost	4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			T			ļ
0. 00 05000 OPERATING ROOM	0	0		0 0	0	
1.00 05100 RECOVERY ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
3. 00 05200 DELI VERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	845, 3		845, 321	
4. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	Ö	0	043, 3	0 0	043, 321	
4. 02 05404 ULTRA SOUND		0		0 0	0	
4. 03 05405 MAMMOGRAPHY	ol	0		0 0	0	54. 03
5. 00 05500 RADI OLOGY-THERAPEUTI C	o	0		0 0	0	55. 00
7.00 05700 CT SCAN	0	0		0 0	0	
8. 00 05800 MRI	0	0		0 0	0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
0. 00 06000 LABORATORY	0	0		0 0	0	
O.O1 06001 LABORATORY-PATHOLOGICAL 2.O0 06200 WHOLE BLOOD & PACKED RED BLOOD CE	O ELL O	0		0 0	0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CE 5.00 06500 RESPIRATORY THERAPY		0		0 0	0	
6. 00 06600 PHYSI CAL THERAPY	Ö	0			0	1
7. 00 06700 OCCUPATI ONAL THERAPY	l ol	0		0 0	0	
8. 00 06800 SPEECH PATHOLOGY	o	0		0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	o	0		0 0	0	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	1	0		0	0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
3.00 07300 DRUGS CHARGED TO PATIENTS 4.00 07400 RENAL DIALYSIS	0	0	637, 6		637, 676	
6. 00 03020 ACUPUNCTURE	0	0		0 0	0	
6. 97 O7697 CARDIAC REHABILITATION	0	0	1		0	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.77
8. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0		0 0	0	89. 00
0. 00 09000 CLI NI C	0	0		0 0	0	1
0. 01 09001 DI ABETES CENTER	0	0		0	0	
0. 02 09002 NEUROPSYCH	0	0		0 0	0	
0. 03 09003 WOUND CENTER	0	0		0	0	
0.04 09004 HYPERBARI C OXYGEN THERAPY 1.00 09100 EMERGENCY	0	0		0 0	0	
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	· · · · · · · · · · · · · · · · · · ·	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS				<u>υ</u> υ	0	1 /2.00
5. 00 09500 AMBULANCE SERVICES						95.00
00.00 Total (lines 50-199)	ol	0	1, 482, 9	97 0	1, 482, 997	

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS			Period: From 01/01/2015	Worksheet D Part IV	
			Component	t CCN: 15T112	To 12/31/2015	Date/Time Pre 5/24/2016 3:0	pared: 3 pm
			Ti tl	e XVIII	Subprovi der - I RF	PPS	•
	Cost Center Description	Total	Total Charges		t Outpatient	I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col . 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4) 6. 00	7. 00	8.00	7) 9. 00	10.00	
	ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00	05000 OPERATING ROOM	0	83, 199, 987	0.00000	0. 000000	7, 664	50.00
51. 00	05100 RECOVERY ROOM					1, 326	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			1		1, 320	1
53. 00	05300 ANESTHESI OLOGY			1		1, 202	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	845, 321				27, 292	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0.07.021	1			2, 645	
54. 02	05404 ULTRA SOUND					21, 479	
54. 03	05405 MAMMOGRAPHY		1			0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				0	
57. 00	05700 CT SCAN	0		1		39, 015	
58. 00	05800 MRI	0		1		7, 792	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				. 0	
60.00	06000 LABORATORY	0				292, 228	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	4, 765, 357	0.00000	0. 000000	1, 266	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	2, 566, 992	0.00000	0. 000000	17, 274	62.00
65. 00	06500 RESPI RATORY THERAPY	0	10, 974, 974	0.00000	0. 000000	106, 635	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	14, 968, 166	0.00000		994, 104	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0				968, 586	
68. 00	06800 SPEECH PATHOLOGY	0				362, 508	
69. 00	06900 ELECTROCARDI OLOGY	0	1 1 1 1 1 1 1 1 1			31, 229	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0				1, 986	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				117, 559	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				254	
73. 00	07300 DRUGS CHARGED TO PATIENTS	637, 676				868, 565	
74. 00	07400 RENAL DI ALYSI S	0				85, 950	
76. 00	03020 ACUPUNCTURE	0				0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	717, 927	0.00000	0.000000	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			0.00000	0.00000	0	88. 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	1		0	
90.00	09000 CLINIC					0	
90.00	09001 DI ABETES CENTER					0	
90. 01	09001 DI ABETES CENTER			1		340	
90. 02	09003 WOUND CENTER					0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY					0	
91. 00	09100 EMERGENCY					6, 639	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			1		0,037	
, 00	OTHER REIMBURSABLE COST CENTERS		7, 120, 747	3. 00000	3. 333000		1 /2.00
95. 00							95. 00
200.00		1, 482, 997	454, 012, 800	1	1	3, 963, 538	1

Health Financial Systems	COLUMBUS REGION	NAL F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS		Provi der	CCN: 150112	Peri od: From 01/01/2015	Worksheet D	
INKUUGH CUSIS			Component	CCN: 15T112	To 12/31/2015		
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	I npati ent	0u1	tpati ent	Outpati ent			
	Program		rogram	Program	Physi ci an	Nursing School	

				I RF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program	Physi ci an	Nursing School	
	Pass-Through	Charges	Pass-Through	Anesthetist		
	Costs (col. 8	ŭ	Costs (col. 9	Cost		
	x col. 10)		x col. 12)			
	11.00	12. 00	13.00	21.00	22. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	C	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 287	C	0	0	0	54.00
54. O1 O5402 NUCLEAR MEDICINE-DIAGNOSTIC	0	C	0	0	0	54. 01
54.02 05404 ULTRA SOUND	0	C	0	0	0	54.02
54. 03 05405 MAMMOGRAPHY	0	C	0	0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	O	C	o o	0	0	55.00
57. 00 05700 CT SCAN	O	C	0	0	0	57. 00
58. 00 05800 MRI	0	C	ol o	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	ol o	0	0	59. 00
60. 00 06000 LABORATORY	o	C	ol o	0	l 0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	o	C	ol o	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	Ċ	ol o	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	Ċ		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	Č		0	Ö	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Č		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	Č			Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY		Č	ál ő		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		Č	ál ő		Ö	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 242				0	73. 00
74. 00 07400 RENAL DI ALYSI S	0, 242				0	74. 00
76. 00 03020 ACUPUNCTURE	0				0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON					0	76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u>, </u>			70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1	_	1	89. 00
90. 00 09000 CLINI C		Č			0	90.00
90. 01 09001 DI ABETES CENTER					Ö	90. 01
90. 02 09002 NEUROPSYCH					Ö	90. 02
90. 03 09003 WOUND CENTER					0	90. 02
90. 04 09004 HYPERBARI C OXYGEN THERAPY					0	90. 03
91. 00 09100 EMERGENCY	0				0	90.04
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	91.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u>'l</u>		1 0	72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	12, 529	C	0	0	0	200. 00
200.00 10(a) (11163 30-177)	12, 329	C	ή Θ	1	1	200.00

Health Financial Systems	COLUMBUS REGIONAL H	In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150112		Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV
		Component CCN: 15T112	To 12/31/2015	Date/Time Prepared:
				5/24/2016 3:03 pm
		Title XVIII	Subprovi der -	PPS

		11 ti	e xviii	I RF	PPS	
Cost Center Description	PSA Adj.	PSA Adj. All		TIM		
'	Allied Health					
		Education Cost	t			
	23. 00	24. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	1	1			50.00
51. 00 05100 RECOVERY ROOM	0	1				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0					53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0					54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0					54. 01
54. 02 05404 ULTRA SOUND	0					54. 02
54. 03 05405 MAMMOGRAPHY						54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C						55. 00
57. 00 05700 CT SCAN						57. 00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON						58. 00 59. 00
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL						60. 00 60. 01
						62.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65.00 06500 RESPIRATORY THERAPY						65.00
						66.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY						67.00
68. 00 06800 SPEECH PATHOLOGY						68.00
69. 00 06900 ELECTROCARDI OLOGY						69.00
70. 00 07000 ELECTROEARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY						70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS						73.00
74. 00 07400 RENAL DIALYSIS						74.00
76. 00 03020 ACUPUNCTURE		1				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		ł .	1			76. 97
OUTPATIENT SERVICE COST CENTERS			71			70.77
88. 00 08800 RURAL HEALTH CLINIC	0) (88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89. 00
90. 00 09000 CLI NI C	0					90.00
90. 01 09001 DI ABETES CENTER	0					90. 01
90. 02 09002 NEUROPSYCH	0					90. 02
90. 03 09003 WOUND CENTER	0					90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0					90. 04
91. 00 09100 EMERGENCY	0) (91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0) (200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150112	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/24/2016 3:0	pared: 3 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			29, 896	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vata room days	29, 896 0	2. 00 3. 00
3.00	do not complete this line.). IT you have only pri	vate room days,	٥	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		26, 317	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 '	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember t	or or the cost	٥	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
0.00	reporting period	D 21			0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) arter becember 3	i oi the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	12, 268	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent	er O on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	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	only (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar yea				10.00
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed of	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16.00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through 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 th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			37, 193, 787	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
00.00	5 x line 17)	4 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	i or the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	of the cost reporting	period (line 8	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 (I	ine 21 minus line 26)		37, 193, 787	27. 00
00.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		```		00.00
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruct	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line			0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	= :/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dit	fferential (line	37, 193, 787	37. 00
37.00	27 minus line 36)	a private room cost uri	Totellial (Tille	31, 173, 101	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructions)	\neg	1, 244. 11	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	8)		15, 262, 741	39. 00
40. 00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	I	15, 262, 741	41.00

	Financial Systems	COLUMBUS REGION		00N 450::-		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150112	Period: From 01/01/2015	Worksheet D-1	
					To 12/31/2015	Date/Time Pre 5/24/2016 3:0	pared: 3 pm
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent costi	impatrent bays	col. 2)	-	4)	
10.00	Indipositive of the second of	1.00	2. 00	3.00	4. 00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	5, 908, 107	2, 875	2, 054.	99 1, 367	2, 809, 171	43. 00
44.00	CORONARY CARE UNIT	0		0.		l	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0 0	(0.		0	
	OTHER SPECIAL CARE (SPECIFY)					_	47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	, line 200)			24, 645, 781	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		42, 717, 693	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine (services (from	m Wkst D su	m of Parts I and	2, 410, 541	50.00
00.00			•				
51. 00	Pass through costs applicable to Program inp	atient ancillary	y services (fi	rom Wkst. D,	sum of Parts II	2, 341, 534	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				4, 752, 075	52. 00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anest	hetist, and	37, 965, 618	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
	Target amount per discharge Target amount (line 54 x line 55)					l e	55. 00 56. 00
56. 00 57. 00		ing cost and tai	rget amount (I	ine 56 minus	line 53)		
58. 00	Bonus payment (see instructions)	o .			ŕ	0	58. 00 59. 00
59. 00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the r	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
	Relief payment (see instructions)	ŕ				0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	or 31 of the (cost reporting	a neriod (See	0	65. 00
03.00	instructions) (title XVIII only)			•			05.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line d	64 plus line 6	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost r	eporting period	0	67. 00
40.00	(line 12 x line 19)	a accta often D	aaambar 21 af	the cost was	anting paried		40.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 01	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (li			,		71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(lino 14 v li	no 25)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from V	Worksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi don rocon	46)			78. 00 79. 00
	Total Program routine service costs for comp	, ,		•	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`		•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		-,				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)			<u> </u>	86. 00
87. 00	Total observation bed days (see instructions)				3, 579	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 244. 11 4, 452, 670	
57.00	Tobaci varion bod coar (Time of A Time oo) (se	c matructions)				1 7,432,070	1 07.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015			
	_	Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	4, 904, 042	37, 193, 787	0. 13185	1 4, 452, 670	587, 089	90.00	
91.00 Nursing School cost	0	37, 193, 787	0. 00000	4, 452, 670	0	91.00	
92.00 Allied health cost	0	37, 193, 787	0. 00000	4, 452, 670	0	92.00	
93.00 All other Medical Education	0	37, 193, 787	0. 00000			93. 00	

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1501		Worksheet D-1
	Component CCN: 15T	12 From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/24/2016 3:03 pm
	Title XVIII	Subprovi der -	PPS

2001 1.00			litle XVIII	I RF	PPS		
		Cost Center Description					
PRATERT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00		
Impation tidays (including private room days, excluding saring-bed and nebborn days) 1.7 put have not only private room days. 0.30							
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.0							
do not complete this line. 4. 00 Selectivitate room days (excluding swing-bed and observation bed days) hrough December 31 of the cost 7. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 8. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost 10. 01 Total swing-bed SNF type inputient days applicable to the Program (excluding swing-bed and private room days) after swing-bed SNF type inputient days applicable to the Program (excluding private room days) 10. 02 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruction through December 31 of the cost reporting period (see Instruct							
	3.00). IT you have only pr	ivate room days,	U	3.00	
reporting period (if calendar year, enter 0 on this line) 7.00 7	4.00		days)		4, 220	4. 00	
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 1 ine)	5.00		days) through December	er 31 of the cost	0	5. 00	
1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of	6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	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)	7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00	
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room 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) 11.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Medically necessary private room days applicable to services through December 31 of the cost 16.00 Neurory days (title V or XIX only) 17.00 Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicar rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x X IIne 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X IIne 17) 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x X IIne 18) 2	8. 00	Total swing-bed NF type inpatient days (including private room of	days) after December 3	1 of the cost	0	8. 00	
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after brown becember 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost after December 31 of the cost reporting period (see instructions) after December 31 of the cost after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (line 6 x x x x x x x x x x x x x x x x x x	9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 825	9. 00	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 11ine 18) 20.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x 11ine 18) 21.00 Total general inpatient routine service cost (see	10. 00	1	y (including private r	room days)	0	10. 00	
December 31 of the cost reporting period (If calendar year, enter 0 on this line) 0 12.00	11. 00			oom 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 Noursery days (title V or XIX only) 17.00 Ledicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Noursery days (title V or XIX only) 18.00 Noursery days (title V or XIX only) 19.00 Noursery days (title Vor XIX only) 19.00 Noursery days (title Vore X only) 19.00 Noursery days (title Vor X only) 19.00 Noursery		December 31 of the cost reporting period (if calendar year, enter	er O on this line)				
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18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 19.	17. 00	Medicare rate for swing-bed SNF services applicable to services	0.00	17. 00			
19.00 Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 19.00 20.00 2	18. 00		0. 00	18. 00			
20. 00 Medical d'rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20. 00 20. 0	19. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00			
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) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23.00 X line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 7 x line 19) 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) 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 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 2	20. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	20. 00			
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x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 cost 25.00 x line 20) 26.01 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 31.00 Average per diem private room cost differential (line 32 minus line 33) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 600, 461) 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 per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		31 of the cost report	ing period (line	0	22. 00	
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 3,079,702 41.00							
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		3, 079, 702	41. 00	

Heal th	Financial Systems	COLUMBUS REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN		iod: m 01/01/2015	Worksheet D-1		
			Component CC	N: 15T112 To	12/31/2015	Date/Time Prep 5/24/2016 3:03		
			Title X\	/III Su	ıbprovi der - I RF	PPS		
	Cost Center Description	Total		9	Program Days	Program Cost		
		Inpatient CostIn		col . 2)		(col. 3 x col. 4)		
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42. 00	
	Intensive Care Type Inpatient Hospital Units							
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0 0	0. 00 0. 00	0	0		
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	ol ol	0. 00 0. 00	0	0	•	
	OTHER SPECIAL CARE (SPECIFY)		<u> </u>	0.00		0	47. 00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wk					2, 368, 621		
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(Se	e instructions)			5, 448, 323	49. 00	
50. 00	Pass through costs applicable to Program inp.	atient routine se	ervices (from Wks	st. D, sum of	Parts I and	452, 537	50. 00	
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from N	Wkst. D, sum	of Parts II	157, 130	51. 00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				609, 667	52. 00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ited, non-physici	ian anestheti	st, and	4, 838, 656	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				-		
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	•	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	uot amount (lino	56 minus lin	ıo 52)	0	56. 00 57. 00	
58. 00	Bonus payment (see instructions)	o o	•		ŕ	0 0.00	58. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60.00	o.0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
61.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							62. 00 63. 00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the cos	st reporting	period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost	reporting pe	eriod (See	0	65. 00	
	instructions)(title XVIII only)				·	0		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		•					
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through D	ecember 31 of th	ne cost repor	ting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	ember 31 of the	cost reporti	ng period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00	
71. 00 72. 00	Adjusted general inpatient routine service corrogram routine service cost (line 9 x line	, ,	e 70 ÷ line 2)				71. 00 72. 00	
73. 00	Medically necessary private room cost application	abĺe to Program (35)			73. 00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	sheet B. Part	II. column		74. 00 75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li		`				76. 00	
77. 00	Program capital-related costs (line 9 x line	76)					77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		vi der records)				78. 00 79. 00	
80.00	O Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							
81. 00 82. 00								
83. 00 84. 00								
85. 00	Utilization review - physician compensation	(see instructions					84. 00 85. 00	
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugn 85)				86. 00	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0, 00	87. 00 88. 00	
	Observation bed cost (line 87 x line 88) (se		- /				89. 00	

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Componen	t CCN: 15T112	From 01/01/2015 To 12/31/2015		
			e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	675, 995	4, 600, 46	0. 14694	11 0	0	90. 00
91.00 Nursing School cost	0	4, 600, 46	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 600, 46	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 600, 46	0. 00000	00	0	93. 00

Health Financial Systems	COLUMBUS REGIONAL H	UMBUS REGIONAL HOSPITAL In Lie			u of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 150112	Peri od: From 01/01/2015	Worksheet D-3	
				To 12/31/2015	Date/Time Prep 5/24/2016 3:03	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	

				5/24/2016 3:0	3 pm
		Title XVIII	Hospi tal	PPS	
	Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			orial ges	2)	
		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	
20.00			21 (41 700		20.00
30.00	03000 ADULTS & PEDI ATRI CS		21, 641, 788		30.00
31. 00	03100 INTENSIVE CARE UNIT		5, 303, 663		31.00
32. 00	03200 CORONARY CARE UNIT	1	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34. 00
40.00	04000 SUBPROVI DER - I PF		0		40. 00
41.00	04100 SUBPROVI DER - I RF		0		41.00
42.00	04200 SUBPROVI DER		0		42.00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 306228	11, 869, 060	3, 634, 639	50.00
51. 00	05100 RECOVERY ROOM	0. 365282	1, 090, 118		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0. 037329	1, 954, 216	_	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 894794	863, 971	72, 949	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 275923	851, 511	234, 951	54. 01
54. 02	05404 ULTRA SOUND	0. 227799	480, 606	109, 482	54. 02
54. 03	05405 MAMMOGRAPHY	0. 618268	0	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 400980	69, 107	27, 711	55. 00
57.00	05700 CT SCAN	0. 083132	2, 170, 692	180, 454	57. 00
58.00	05800 MRI	0. 107390	639, 653	68, 692	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 241405	4, 642, 794	1, 120, 794	59. 00
60.00	06000 LABORATORY	0. 308589	5, 579, 904	1, 721, 897	60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 306897	244, 780	75, 122	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 403574	869, 224	350, 796	62. 00
65. 00	06500 RESPI RATORY THERAPY	0. 384354	4, 714, 024	1, 811, 854	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 448786	1, 302, 505	584, 546	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 957847	445, 702		67. 00
68. 00	06800 SPEECH PATHOLOGY	1. 086222	132, 396		68. 00
69. 00	06900 ELECTROCARDI OLOGY		2, 796, 901	324, 379	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 115978	108, 857	29, 638	70.00
		0. 272270	·		
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 580711	5, 297, 796		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 381372	5, 193, 858		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 366794	15, 165, 589		73. 00
74. 00	07400 RENAL DI ALYSI S	0. 379808	868, 675		
76. 00	03020 ACUPUNCTURE	0. 000000	0	_	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 458519	1, 433	657	76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0. 000000		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		0	89. 00
90.00	09000 CLI NI C	0. 492777	15, 645	7, 709	90.00
90. 01	09001 DI ABETES CENTER	4. 019952	0	0	90. 01
90. 02	09002 NEUROPSYCH	0. 717814	1, 686	1, 210	90. 02
90. 03	09003 WOUND CENTER	0. 400176	0	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0. 189103	4, 780		90. 04
91. 00	09100 EMERGENCY	0. 216292	7, 376, 783		91. 00
91.00			7, 376, 783 O		91.00
92. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 472234	0	0	92.00
05.00	OTHER REIMBURSABLE COST CENTERS				05.00
	09500 AMBULANCE SERVI CES		7. 750		95. 00
200.00	,		74, 752, 266	24, 645, 781	•
201.00		ne 61)	0		201. 00
202.00	Net Charges (line 200 minus line 201)		74, 752, 266		202. 00

	Financial Systems COLUMBUS ENT ANCILLARY SERVICE COST APPORTIONMENT	REGIONAL HOSPITAL Provider	CCN: 150112	Peri od:	u of Form CMS- Worksheet D-3	
				From 01/01/2015		
		Component	t CCN: 15T112	To 12/31/2015	Date/Time Pre 5/24/2016 3:0	epareu: 13 pm
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT			0		32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER – I RF			4, 504, 759		41. 00
42. 00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS		1 0000			
50.00	05000 OPERATING ROOM		0. 3062	· ·	2, 347	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM		0. 3652 0. 0000		484 0	1
53. 00	05300 ANESTHESI OLOGY		0.0000		45	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 8947		24, 421	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2759		730	1
54. 02	05404 ULTRA SOUND		0. 2277	99 21, 479	4, 893	54. 02
54. 03	05405 MAMMOGRAPHY		0. 6182		0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 4009		0	
57. 00	05700 CT SCAN		0. 0831		3, 243	
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON		0. 1073 0. 2414		837 0	
59.00	06000 LABORATORY		0. 3085		90, 178	
60. 01	06001 LABORATORY - PATHOLOGI CAL		0. 3068		389	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 4035		6, 971	
65. 00	06500 RESPI RATORY THERAPY		0. 3843	54 106, 635	40, 986	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 4487		446, 140	
67. 00	06700 OCCUPATI ONAL THERAPY		0. 9578		927, 757	
68. 00	06800 SPEECH PATHOLOGY		1. 0862		393, 764	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0. 1159 0. 2722		3, 622	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2722		541 68, 268	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3813		97	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3667			1
74. 00	07400 RENAL DI ALYSI S		0. 3798		32, 644	1
76. 00	03020 ACUPUNCTURE		0.0000		0	
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 4585	19 0	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS		0.0000	100	^	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 0000 0. 0000		0 0	
	09000 CLINIC		0. 0000		0	
90. 01	09001 DI ABETES CENTER		4. 0199		0	
90. 02	I I		0. 7178		244	
90. 03	09003 WOUND CENTER		0. 4001		0	1
90. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 1891		0	
	09100 EMERGENCY		0. 2162 0. 4722			
1.1 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.0

0

92.00 95.00

200. 00

201. 00

202. 00

2, 368, 621

3, 963, 538

3, 963, 538

0. 472234

200.00

201.00

202.00

Net Charges (line 200 minus line 201)

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

		Title	YVLLL	Hospi tal	5/24/2016 3: 0 PPS	3 pm
			AVIII	nospi tai	FF3	
	DADT A LANDATIONT HOSPITAL SERVICES HADED LDDS		0	1. 00	2. 00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1. 00
1.01	DRG amounts other than outlier payments for discharges occurring	g prior		23, 193, 873		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	n on or		7, 731, 291		1. 02
1.02	after October 1 (see instructions)	, 611 61		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCl for			o		1. 04
	discharges occurring on or after October 1 (see instructions)					
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 104, 516		2. 00 2. 01
2. 01	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0		2. 01
3.00	Managed Care Simulated Payments			0		3. 00
4. 00	Bed days available divided by number of days in the cost reporti period (see instructions)	ng		140. 19		4. 00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most r			0.00		5. 00
6. 00	cost reporting period ending on or before 12/31/1996. (see instru FTE count for allopathic and osteopathic programs which meet the			0.00		6. 00
0.00	criteria for an add-on to the cap for new programs in accordance			0.00		0.00
7.00	CFR 413.79(e)					7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified und CFR $\S412.105(f)(1)(iv)(B)(1)$	der 42		0. 00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified ur	nder 42		0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1	1, 2011				
8. 00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi	c and		0.00		8. 00
0.00	osteopathic programs for affiliated programs in accordance with			0.00		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67	FR 50069				
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots	sunder		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 20					
0.00	instructions.	. from a		0.00		8. 02
8. 02	The amount of increase if the hospital was awarded FTE cap slots closed teaching hospital under section 5506 of ACA. (see instruc			0.00		0. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the current	Vear		0.00		10. 00
10.00	from your records	. year		0.00		10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00		11. 00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0. 00 0. 00		12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
	or after September 30, 1997, otherwise enter zero.					
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0. 00 0. 00		15. 00 16. 00
17. 00	Adjustment for residents displaced by program or hospital closur	-e		0.00		17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0.000000		19. 00
21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20. 00 21. 00
22. 00	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	122 of the	MANAAA	0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resident		IVIIVIA	0.00		23. 00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
24. 00	IME FTE Resident Count Over Cap (see instructions)	uon of		0.00		24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low line 23 or line 24 (see instructions)	ver or		0. 00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000		27. 00 28. 00
28. 00	IME add-on adjustment amount - Managed Care (see instructions)			ol		28. 00
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		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ent days		6. 07		30. 00
	(see instructions)	23,0				
31.00	Percentage of Medicaid patient days (see instructions)			21. 94		31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			28. 01 12. 32		32. 00 33. 00
	Disproportionate share adjustment (see instructions)			952, 495		34. 00

	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150112	Peri od: From 01/01/2015 To 12/31/2015		
			10 12/31/2013	5/24/2016 3:03	3 pm
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
		0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment	0	1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		7, 647, 644, 885	6, 406, 145, 534	35. 00
35. 01	Factor 3 (see instructions)		0. 000225986		
35. 02	Hospital uncompensated care payment (If line 34 is zero,		1, 728, 261		1
	enter zero on this line) (see instructions)		1, 120, 201	1, 102, 010	
35. 03	Pro rata share of the hospital uncompensated care payment		1, 292, 644	360, 034	35. 03
	amount (see instructions)				
36.00	Total uncompensated care (sum of columns 1 and 2 on line		1, 652, 678		36.00
	35. 03)				
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throug	jh 46)		
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)		_		
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
44 04	682, 683, 684 an 685. (see instructions)				44 04
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
42.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0.00		12.00
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
+J. UU	682, 683, 684 an 685. (see instructions)				-3.00
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
1 1. 00	divided by line 41 divided by 7 days)		0.00000		'-' 00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
	instructions)		0.00		
46.00	Total additional payment (line 45 times line 44 times line		0		46.00
	41.01)				
47.00	Subtotal (see instructions)		34, 634, 853		47.00
48.00	Hospital specific payments (to be completed by SCH and		0		48.00
	MDH, small rural hospitals only. (see instructions)				
49.00	Total payment for inpatient operating costs (see		34, 634, 853		49.00
	instructions)				
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		2, 840, 252		50.00
	and Pt. II, as applicable)				
51.00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
F0 00	line 49 see instructions).		07.400		F0 00
53.00	Nursing and Allied Health Managed Care payment		37, 100		53.00
54.00	Special add-on payments for new technologies		12, 121		54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
E/ 00	line 69) Cost of physicians' services in a teaching hospital (see		0		F / 00
56. 00	intructions)		0		56.00
57. 00	Routine service other pass through costs (from Wkst. D,		0		57.00
37.00	Pt. III, column 9, lines 30 through 35).		0		37.00
58 00	Ancillary service other pass through costs from Wkst. D,		279, 604		58. 00
55.50	Pt. IV, col. 11 line 200)		277,004		55.00
59. 00	Total (sum of amounts on lines 49 through 58)		37, 803, 930		59. 00
60.00	Primary payer payments		42, 006		60.00
61.00	Total amount payable for program beneficiaries (line 59		37, 761, 924	1	61.00
	minus line 60)		,		
62.00	Deductibles billed to program beneficiaries		3, 431, 916		62.00
63.00	Coinsurance billed to program beneficiaries		66, 582		63.00
64.00	Allowable bad debts (see instructions)		246, 291		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		160, 089		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see		149, 074		66.00
	instructions)				
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		34, 423, 515		67.00
68. 00	Credits received from manufacturers for replaced devices		0		68.00
(0.55	for applicable to MS-DRGs (see instructions)				, -
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
70.00	96). (For SCH see instructions)		_		70 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	1	70.00
70. 50	RURAL DEMONSTRATION PROJECT		0	1	70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
	instructions)		_		70 00
	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70. 90	I : 4 : 1		1		70.00
	instructions)		^		
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)		0		70. 92
70. 91 70. 92 70. 93	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)		0 86, 901		70. 92 70. 93
70. 91 70. 92 70. 93 70. 94	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)		0		

Heal th	Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150112		eriod: rom 01/01/2015	Worksheet E Part A	pared:
			Ti tl	e XVIII	L,	Hospi tal	PPS	
						Prior to	On/After	
						October 1	October 1	
				0		1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (Enter in column 0 the corresponding federal period prior to 10/1)	year for the			0	0		70. 96
70. 97	Low volume adjustment for federal fiscal year (Enter in column 0 the corresponding federal year od ending on or after 10/1)				0	0		70. 97
70. 98	Low Volume Payment-3					0		70. 98
70. 99	HAC adjustment amount (see instructions)					0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 p lines 69 & 70)	lus/minus				34, 446, 531		71. 00
71. 01	Sequestration adjustment (see instructions)					688, 931		71. 01
72.00	Interim payments					33, 560, 163		72.00
73.00	Tentative settlement (for contractor use only))				0		73. 00
74. 00	Balance due provider (Program) (line 71 minus 72, and 73)	lines 71.01,				197, 437		74. 00
75. 00	Protested amounts (nonallowable cost report i accordance with CMS Pub. 15-2, chapter 1, §11	5. 2				2, 155, 386		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through							
90.00	Operating outlier amount from Wkst. E, Pt. A,	line 2 (see				0		90. 00
	instructions)							
91. 00	Capital outlier from Wkst. L, Pt. I, line 2					0		91. 00
92. 00	Operating outlier reconciliation adjustment an instructions)	`				0		92. 00
93. 00	Capital outlier reconciliation adjustment amount instructions)	unt (see				0		93. 00
94. 00	The rate used to calculate the time value of instructions)	money (see				0.00		94. 00
95. 00	Time value of money for operating expenses (so instructions)	ee				0		95. 00
96. 00	Time value of money for capital related expensionstructions)	ses (see				0		96. 00
	[THISTI UCTI OHS]					D-: +- 10/1	0- /16+ 10 /1	

			0010001	OCTOBCI I	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)	0	0		70. 96
	(Enter in column 0 the corresponding federal year for the				
	period prior to 10/1)				
0. 97	Low volume adjustment for federal fiscal year (yyyy)	0	0		70. 97
	(Enter in column 0 the corresponding federal year for the				
	period ending on or after 10/1)				
	Low Volume Payment-3		0		70. 98
	HAC adjustment amount (see instructions)		0		70. 99
	Amount due provider (line 67 minus lines 68 plus/minus		34, 446, 531		71. 00
	lines 69 & 70)				
	Sequestration adjustment (see instructions)		688, 931		71. 01
	Interim payments		33, 560, 163		72. 00
	Tentative settlement (for contractor use only)		0		73. 00
	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		197, 437		74. 00
5. 00	Protested amounts (nonallowable cost report items) in		2, 155, 386		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
Ī	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
	instructions)				
1.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91. 00
	Operating outlier reconciliation adjustment amount (see instructions)		0		92. 00
3. 00	Capital outlier reconciliation adjustment amount (see		0		93. 00
	instructions)				
4. 00	The rate used to calculate the time value of money (see		0.00		94.00
	instructions)				
5. 00	Time value of money for operating expenses (see		0		95. 00
	instructions)				
	Time value of money for capital related expenses (see		0		96. 00
	instructions)				
			Prior to 10/1		
			1. 00	2. 00	
	HSP Bonus Payment Amount				
	HSP bonus amount (see instructions)		0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment				
	HVBP adjustment factor (see instructions)		1. 0038863678		
	HVBP adjustment amount for HSP bonus payment (see instructi	ons)	0	0	102. 00
- 1	HRR Adjustment for HSP Bonus Payment				
			0. 9975	0. 9992	103.00
03.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)		0. 7770		104.00

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provi der		Period: From 01/01/2015	Worksheet DSH	
					To 12/31/2015	Date/Time Pre 5/24/2016 3:0	
				e XVIII	Hospi tal	PPS	3 piii
		Original .mcrxAdj Values	usted .mcax Values	HFS Look Up	Overri de Val ue	Revi sed Value	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	CALCULATION OF THE DSH PAYMENT PERCENTAGE Percentage of SSI patient days to Medicare	6. 07	0.00	0.0	0.00	0.00	1.00
1.00	Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.07	0.00	0.0	0.00	0.00	1.00
2. 00	Percentage of Medicaid patient days to total days (From line 27)	21. 94	0. 00			21. 94	2. 00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	28. 01	0. 00			21. 94	3. 00
4. 00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4. 00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	140. 19	0. 00			140. 19	5. 00
6. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12. 32	0. 00			7. 32	6. 00
7. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes	•			Yes	7. 00
8.00	S-2, Li ne 22	Yes				Yes	8. 00
9. 00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9. 00
10.00	S-2, Line 45	Yes				Yes	10.00
11. 00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I,	Yes				Yes	11. 00
12.00	line 1 geater than -0-)	6. 07	0. 00	0.0	0.00	0. 00	12.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	6.07	0.00	0.0	0.00	0.00	12.00
13. 00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line	Yes				Yes	13. 00
14. 00	75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part	1. 43	0. 00	0.0	0.00	0.00	14. 00
	III, line 2 - Revised from CMS) CALCULATION OF THE PERCENTAGE OF MEDICAID DAY	/S TO TOTAL DAYS					
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1, 499	0			1, 499	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	2, 835	0			2, 835	16. 00
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	7	0			7	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	О	0			0	18. 00
18. 01	N/A	О	0			0	18. 01
19. 00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2, 738	0			2, 738	19. 00
20. 00	Other Medicaid days (Worksheet S-2, line 24, column 6)	54	0			54	20. 00
21. 00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	7, 133	0			7, 133	21. 00
22. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	32, 516	0			32, 516	22. 00
23. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	O	0			0	23. 00
24. 00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	O	0			0	24. 00
25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	0	0			0	25. 00
26. 00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	32, 516	0			32, 516	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	21. 94	0. 00			21. 94	27. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provi der CCN: 150112	Peri od: Worksheet DSH
		From 01/01/2015

	ATTON OF DOTT FAINERT FERGENTAGE				From 01/01/2015 To 12/31/2015	5/24/2016 3:0	pared:
				e XVIII	Hospi tal	PPS	
		Original .m	ncrx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3.00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	12. 32		0.00	True	28. 00
29. 00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0. 00		0.00	Fal se	29. 00
30.00	Line 28 or 29 as applicable		12. 32		0.00		30. 00
31.00	If Urban and fewer than 100 beds, Rural and		12. 32		0.00		31.00
	fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise						
	enter line 30.						
		Original .mcrx	Adjusted .mcax	HFS Look Up	Overri de Val ue	Revi sed Value	
		Val ues	Val ues				
		1.00	2. 00	3. 00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32. 00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32. 00
33. 00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33. 00
34. 00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34. 00
35. 00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35. 00
36. 00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36. 00

Health Financial Systems	COLUMBUS REGIONAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provi der CCN: 150112	Peri od: From 01/01/2015	Worksheet DSH
			To 12/31/2015	Date/Time Prepared: 5/24/2016 3:03 pm
		Title XVIII	Hospi tal	PPS

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	7. 32				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29. 00	If line 3 is less than 20.2% - 2.5% plus 65%	0. 00				29. 00
	of the difference between 15% and line 3					
30.00	Line 28 or 29 as applicable	7. 32				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	7. 32				31. 00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150112	From 01/01/2015	Worksheet E Part B Date/Time Pre 5/24/2016 3:0	
		Title XVIII	Hospi tal	PPS	
				1 00	

			127 017 2010	5/24/2016 3:0	3 pm
		Title XVIII	Hospi tal	PPS	
	DADT D. MEDICAL AND OTHER HEALTH OFFILIA			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	one)		27, 090, 873	1. 00 2. 00
3. 00	PPS payments	ons)		22, 572, 469	3.00
4. 00	Outlier payment (see instructions)			149, 882	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	
6. 00	Line 2 times line 5	1013)		0.000	1
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	. col. 13. line 200		348, 898	
10.00	Organ acqui si ti ons	,		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e charges				1
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa			0	
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		443. /	0	
19. 00	Excess of customary charges over reasonable cost (complete only	If line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions)	if line 11 evecede li	no 10) (ooo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	II Tine II exceeds II	ne 18) (See	ا	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		0	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	01.03)		23, 071, 249	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			20/0/1/21/	1 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			4, 637, 605	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	18, 433, 644	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			18, 433, 644	
31. 00	Primary payer payments			5, 824	
32. 00	Subtotal (line 30 minus line 31)			18, 427, 820	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)			1 22 00
33.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			407.007	
34. 00 35. 00	Adjusted reimbursable bad debts (see instructions)			487, 097 316, 613	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		419, 702	
37. 00	Subtotal (see instructions)	Cti ons)		18, 744, 433	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ö	l
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			Ö	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	Ö	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			o	39. 99
40.00	Subtotal (see instructions)			18, 744, 433	
40. 01	Seguestration adjustment (see instructions)			374, 889	1
41.00	Interim payments			18, 228, 300	1
42. 00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			141, 244	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	423, 250	44.00
	§115. 2]
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	l
94.00	94.00 Total (sum of lines 91 and 93)				
				Overri des	
	MODEST OVEDDIDE VALUES			1.00	
112 00	WORKSHEET OVERRIDE VALUES Override of Ancillary service charges (line 12)				112 00
112.00	povertiue of Afficitiary Service charges (Title 12)			, 01	112. 00

Provider CCN: 150112 | Period: | Worksheet E-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: | 5/24/2016 3:03 pm

					5/24/2016 3:03	3 pm
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		33, 492, 563		18, 045, 600	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,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/29/2015	67, 600	07/29/2015	182, 700	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3.04			C		0	3.04
3.05			C		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3.51			C		0	3. 51
3.52			C		0	3. 52
3.53			d		0	3. 53
3.54			d		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		67, 600		182, 700	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		33, 560, 163		18, 228, 300	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	_	T	_	
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03			C		0	5. 03
	Provi der to Program			T		
5.50	TENTATI VE TO PROGRAM		O		0	5. 50
5. 51			O		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER		107 407		141 244	6. 01
6. 01			197, 437		141, 244	
6. 02	SETTLEMENT TO PROGRAM		22 757 (00		0	6. 02
7. 00	Total Medicare program liability (see instructions)		33, 757, 600		18, 369, 544	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
0.00	Indine of Contractor	1		1	1 1	0.00

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 536, 750 0		0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0)	0	3. 02
3.03			0)	0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
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		4, 536, 750		0	4. 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0			5. 02 5. 03
5.03	Provider to Program				0	3.03
5. 50	TENTATI VE TO PROGRAM		0	1	0	5. 50
5. 51	TENTITIVE TO TROOM WIT				0	5. 51
5. 52			ĺ			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		35, 826		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		Ö	6. 02
7.00	Total Medicare program liability (see instructions)		4, 572, 576		0	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150112 Period: From 01/01/2015				
			To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. S		14	8, 612	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	12		13, 635	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 652	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	12		29, 192	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			538, 363, 262	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir			15, 799, 419	
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			1, 003, 773	8. 00
9.00	Sequestration adjustment amount (see instructions)			20, 075	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		983, 698	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			996, 838	30. 00
31.00	31.00 Other Adjustment (specify)				
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				
				Overri des	
				1. 00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0	108. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITA	AL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 150112		Worksheet E-3
	Compo	nent CCN: 15T112	From 01/01/2015 To 12/31/2015	Date/Time Prepared:
				5/24/2016 3:03 pm
		Title XVIII	Subprovi der -	PPS
			IRF	

		l RF				
			1. 00			
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	3, 888, 837	1. 00			
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0143	2.00		
3.00	, , , , , , , , , , , , , , , , , , , ,			3.00		
4. 00	Inpatient Rehabilitation LIP Payments (see instructions) Outlier Payments		76, 221 721, 165	4.00		
5.00		nding on or prior	0.00	5.00		
5.00	O Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)					
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that we	re displaced by	0.00	5. 01		
5.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42					
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	tillorit under 12				
6. 00	New Teaching program adjustment. (see instructions)		0.00	6. 00		
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth	period of a "new	0.00	7. 00		
7.00	teaching program" (see instructions)	porrou or a mon	0.00	,		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth	period of a "new	0.00	8. 00		
	teaching program" (see instructions)	•				
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00		
10.00	Average Daily Census (see instructions)		11. 561644	10.00		
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00		
12.00	Teaching Adjustment (see instructions)		0	12.00		
13.00	Total PPS Payment (see instructions)		4, 686, 223	13.00		
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00		
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00		
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16. 00		
17.00	Subtotal (see instructions)		4, 686, 223	17. 00		
18. 00	Pri mary payer payments		0	18. 00		
19. 00	Subtotal (line 17 less line 18).		4, 686, 223	19. 00		
20.00	Deducti bl es		30, 240	20.00		
21. 00	Subtotal (line 19 minus line 20)			21.00		
22. 00	Coinsurance		4, 256	22. 00		
23. 00	Subtotal (line 21 minus line 22)		4, 651, 727			
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		2, 520			
25. 00	Adjusted reimbursable bad debts (see instructions)		1, 638			
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2, 520			
27. 00	Subtotal (sum of lines 23 and 25)		4, 653, 365			
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28. 00		
29. 00	Other pass through costs (see instructions)		12, 529			
30. 00	Outlier payments reconciliation		0	30.00		
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00		
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31. 50		
31. 99	Recovery of Accel erated Depreciation		0	31. 99		
32.00	Total amount payable to the provider (see instructions)		4, 665, 894			
32. 01	Sequestration adjustment (see instructions)		93, 318			
33.00	Interim payments		4, 536, 750			
34.00	Tentative settlement (for contractor use only)		0	34.00		
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)		35, 826			
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	chapter 1,	0	36. 00		
	§115. 2 TO BE COMPLETED BY CONTRACTOR					
EO 00			721, 165	E0 00		
50. 00 51. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)		/21, 165	50.00		
	The rate used to calculate the Time Value of Money	0.00	51.00			
	00 Time Value of Money (see instructions)					
55.00	53.00 Time Value of Money (see instructions) 0 53					

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

| Period: | Worksheet G | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/24/2016 3:03 pm

					5/24/2016 3:0	3 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21, 898, 563	1	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	53, 102, 855	0	0	0	4. 00
5.00	Other recei vabl e	16, 048, 308	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-24, 103, 316		0	0	6. 00
7.00	Inventory	3, 322, 963	0	0	0	7. 00
8.00	Prepai d expenses	3, 816, 790	0	0	0	8. 00
9.00	Other current assets	2, 419, 580	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	76, 505, 743	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	1, 806, 052	0	0	0	12.00
13.00	Land improvements	20, 531, 039	0	0	0	13. 00
14.00	Accumulated depreciation	-11, 255, 764	0	0	0	14.00
15. 00	Bui I di ngs	201, 514, 543	0	0	0	15. 00
16.00	Accumul ated depreciation	-115, 494, 901	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	8, 156, 999	0	0	0	19. 00
20.00	Accumul ated depreciation	-5, 398, 102	0	0	0	20. 00
21.00	Automobiles and trucks	1, 714, 030	0	0	0	21. 00
22.00	Accumul ated depreciation	-1, 284, 514	0	o	0	22. 00
23.00	Major movable equipment	128, 435, 381	0	o	0	23. 00
24.00	Accumul ated depreciation	-96, 091, 441	0	o	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	o	0	25. 00
26.00	Accumulated depreciation	0	0	o	0	26. 00
27.00	HIT designated Assets	0	0	o	0	27. 00
28. 00	Accumulated depreciation	0	0	o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	o o	o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	132, 633, 322	0	o	0	
	OTHER ASSETS	, , , , , , , , , , , , , , , , , , , ,		-1		
31.00	Investments	10, 356, 201	0	0	0	31. 00
32. 00	Deposits on Leases	0	Ó	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	172, 308, 151	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	182, 664, 352	1	Ö	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	391, 803, 417	1	-	0	36. 00
00.00	CURRENT LI ABI LI TI ES	071,000,117		9		00.00
37. 00	Accounts payable	12, 304, 905	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	7, 688, 088	1	0	0	38. 00
39. 00	Payrol I taxes payable	918, 993		0	0	39. 00
40. 00	Notes and Loans payable (short term)	5, 465, 000	1	0	0	40.00
41. 00	Deferred income	3, 403, 000		0	0	41. 00
42. 00	Accel erated payments			ŏ	O	42. 00
43. 00	Due to other funds		0	0	0	
44. 00	Other current liabilities	7, 471, 574		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	33, 848, 560		_		45. 00
43.00	LONG TERM LIABILITIES	33, 040, 300	<u> </u>	<u> </u>		43.00
46. 00	Mortgage payable	67, 735, 000	0	O	0	46. 00
47. 00	Notes payable	07, 733, 000	ő	0	0	47. 00
48. 00	Unsecured Loans		0	0	0	48. 00
		2 274 504		0	0	
49.00	Other long term liabilities	2, 376, 584 70, 111, 584		-		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49		1	0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	103, 960, 144	1 0	U	0	51. 00
E2 00	CAPITAL ACCOUNTS General fund balance	207 042 272	1			E2 00
52.00		287, 843, 273	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0			53. 00 54. 00
				U		
55. 00	Donor created - endowment fund balance - unrestricted			U		55. 00
56.00	Governing body created - endowment fund balance			O	2	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
E0 00	replacement, and expansion	207 042 272	_		^	50.00
59.00	Total fund balances (sum of lines 52 thru 58)	287, 843, 273	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	391, 803, 417		۱	0	60. 00
	l∝,\	I	I	ı		ı

Provi der CCN: 150112

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

					То	12/31/2015	Date/Time Prep 5/24/2016 3:03	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	5 p
				·				
		1 00		0.00				
1 00	Trund halanan at hankankan as anni ad	1.00	2.00	3.00		4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		282, 891, 486 4, 951, 787			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)		4, 951, 787 287, 843, 273			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	201, 043, 213		0	U	0	4. 00
5.00	Additions (credit adjustments) (specify)				0		0	5. 00
6. 00					0		0	6. 00
7. 00					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)	1	0			0	·	10. 00
11. 00	Subtotal (line 3 plus line 10)		287, 843, 273			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0		ol	12. 00
13.00	, , , , , , , , , , , , , , , , , , , ,	0			0		o	13.00
14.00		0			0		o	14.00
15.00		o			0		0	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)		0			0		18.00
19. 00	Fund balance at end of period per balance		287, 843, 273			0		19. 00
	sheet (line 11 minus line 18)	E	DI 1					
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			0					8.00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13. 00			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)		O		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				J			17.00
	10.000 (1.1.0 11 111100 11110 10)	1		I	1		1	

Health Financial Systems CO STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			To 12/31/2015		
	Cost Center Description	Inpati ent	Outpati ent	5/24/2016 3:0 Total	3 pm
	COST Center Description	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				1
1.00	Hospi tal	53, 685, 94	2	53, 685, 942	1.00
2.00	SUBPROVI DER - I PF		0	0	2. 00
3.00	SUBPROVIDER - IRF	6, 739, 22	7	6, 739, 227	3.00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF		0	0	
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY		0	0	
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)	60, 425, 16	9	60, 425, 169	1
	Intensive Care Type Inpatient Hospital Services		<u>'</u>		
11.00	INTENSIVE CARE UNIT	10, 972, 02	6	10, 972, 026	11. 00
12.00	CORONARY CARE UNIT		0	0	
13.00	BURN INTENSIVE CARE UNIT		0	0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT		0	0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	10, 972, 02	6	10, 972, 026	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	71, 397, 19	5	71, 397, 195	17. 00
18.00	Ancillary services	134, 416, 11	8 260, 309, 314	394, 725, 432	18. 00
19.00	Outpati ent servi ces	12, 773, 85	3 47, 970, 396	60, 744, 249	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22.00	HOME HEALTH AGENCY		0	0	22. 00
23.00	AMBULANCE SERVI CES		0 10, 408, 035	10, 408, 035	23. 00
24.00	CMHC				24. 00
24. 10	CORF		0 0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27. 00	LEVEL II NURSERY	2, 544, 74	2 0	2, 544, 742	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	221, 131, 90	8 318, 687, 745	539, 819, 653	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		219, 234, 621		29. 00
30.00	ADD (SPECIFY)	1	0		30. 00
31. 00	PROVISION FOR BAD DEBT	10, 209, 36	6		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)		10, 209, 366		36. 00
37. 00	DEDUCT (SPECIFY)	1	0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40. 00			0		40. 00
41. 00			0		41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		229, 443, 987		43. 00
	to Wkst. G-3, line 4)	1			I

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-255.						
STA	EMENT OF REVENUES AND EXPENSES	Provider CCN: 150112	Peri od:	Worksheet G-3		
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:	
			10 12/31/2013	5/24/2016 3:0		
				1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		539, 819, 653	1. 00	
2.00	Less contractual allowances and discounts on patients' accounts	5		289, 839, 298	2. 00	
3.00				249, 980, 355	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		229, 443, 987	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)			20, 536, 368	5. 00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			79, 001	6. 00	
7.00	Income from investments			6, 668, 524	7. 00	
8.00		servi ces		31, 620		
9.00	Revenue from television and radio service			0	9. 00	
10. (0 Purchase di scounts			93, 271	10.00	
11. (O Rebates and refunds of expenses			2, 578	11. 00	
12. (40	12. 00 13. 00	
13. (13.00 Revenue from Laundry and Linen service					
	14.00 Revenue from meals sold to employees and guests					
	15.00 Revenue from rental of living quarters					
	16.00 Revenue from sale of medical and surgical supplies to other than patients					
17. (9			0		
18. (23, 265	1	
	19.00 Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00	
	0.00 Revenue from gifts, flowers, coffee shops, and canteen				20. 00	
21. (195		
22. (75, 579	•	
23. (436, 612		
24. (` '			-8, 694, 145	1	
24. (1 WELLNESS REVENUE			232, 034	24. 01	
24. (-5, 696, 505		
24. (-194, 061	1	
24. (-7, 314		
24. (24, 752		
24. (517, 104		
25. (· · · · · · · · · · · · · · · · · · ·			-5, 342, 726	1	
26. (15, 193, 642	1	
27. (122, 815		
27. (16, 198, 884	•	
27 (2 FOLLITY TRANSFER			-6 079 844	I 27 ∩2	

-6, 079, 844 27. 02 10, 241, 855 28. 00 4, 951, 787 29. 00

27.02 EQUITY TRANSFER
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 COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 150112	Peri od:	Worksheet L		
			From 01/01/2015 To 12/31/2015		pared·	
	5/24/2016 3:0					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD			11.00		
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			2, 474, 640	•	
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 221, 340		
2. 00	Model 4 BPCI Capital DRG outlier payments			221, 340		
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructions)	79. 98		
4.00	Number of interns & residents (see instructions)	3	,	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	sum of lines 1 and 1.01	, columns 1 and	0	6. 00	
7.00	1.01) (see instructions)	+:+	·	/ 07	7.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	tient days (worksneet E	, part A line	6. 07	7. 00	
8. 00	Percentage of Medicaid patient days to total days (see instruc	tions)		21. 94	8. 00	
9.00	Sum of lines 7 and 8	•		28. 01	9. 00	
10.00	Allowable disproportionate share percentage (see instructions)			5. 83	1	
11. 00	Disproportionate share adjustment (see instructions)			144, 272		
12. 00	Total prospective capital payments (see instructions)			2, 840, 252	12. 00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)			0		
2. 00 3. 00						
4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0		
5.00	Total inpatient program capital cost (line 3 x line 4)			0		
				1. 00		
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1 00	
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0		
3.00	Net program inpatient capital costs (line 1 minus line 2)	3 (See Thistructions)		0		
4. 00	Applicable exception percentage (see instructions)			0.00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00	
6.00	Percentage adjustment for extraordinary circumstances (see ins			0.00		
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	(line 6)	0		
8.00	Capital minimum payment level (line 5 plus line 7)			0		
9. 00 10. 00				0		
11. 00	Carryover of accumulated capital minimum payment level over ca			0		
11.00	Worksheet L, Part III, line 14)	prtar payment (110m pri	or year		11.00	
12.00	Net comparison of capital minimum payment level to capital pay	0				
13. 00	Current year exception payment (if line 12 is positive, enter	0				
14. 00	Carryover of accumulated capital minimum payment level over ca	pital payment for the f	following period	0	14. 00	
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see inst	ructions)		0	15. 00	
16. 00						
	Current year exception offset amount (see instructions)			-	17. 00	
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