Health Financia	al Syst	ems	COLUMBUS REGIONAL	HOSPI TAL			In Lieu	u of Form	CMS-	2552-10
This report is	requi r	red by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can r	esul t	in all	interim	FORM APP	ROVE)
payments made :	since 1	the beginning of the co	st reporting period being o	leemed overpayments	s (42 l	JSC 1395	g).	OMB NO. (0938-	-0050
HOSPITAL AND H	OSPI TAL	HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN: 150°	112 F	eri od:		Workshee	t S	
AND SETTLEMENT	SUMMAF	RY						Parts I-l		
					T	o 12/		Date/Time		
								5/28/201	<u> 4:3</u>	37 pm
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	5/28/20	15 Tim	ie:	4:37 pm
use only	2. [] Manually submitted co	st report							
			I report enter the number of		er res	ubmitted	d this co	st report		
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.						
Contractor	5. [1	1Cost Report Status	6. Date Received:		10. NPF	R Date:				
use only		As Submitted					's Vendo			4
	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CCN	12. [(]lf li	ne 5, co	lumn 1 is	4:	Enter
		Settled with Audit	9. [N] Final Report for the	nis Provider CCN				es reopen		
	(4)	Reopened								

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (150112) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	•
Title	<u> </u>
11 (16	•
Date	

			Title	XVIII			
		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	278, 703	483, 751	-94, 360	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	-5, 985	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	272, 718	483, 751	-94, 360	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.

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the								
	method of identifying the days in this cost reporting	g period di	fferent fro	om the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	or "N" for m	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d	,	days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	3, 074	755	3	0	3, 099	55	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	132	94	0	О (35		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							
			•	•			•	·

23.00

hospital contain at least 100 but not more than 499 beds (as counted in accordance with

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

HUCDI T	Financial Systems COLUMBUS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		NAL HOSPITAL Provider (CN: 150112 Pe	eri od:	n Lie	u of For Workshe		
110351 17	AL AND HOSFITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	A	Flovidei		om 01/01		Part I Date/Ti		
							5/28/20	015 3:3	
					Urban/Rui 1.00		Date of 2.0		-
	Enter your standard geographic classification (not was			nning of the	11.00	1	2.,		26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the end or rural. If app			1			27. 00
35. 00	enter the effective date of the geographic reclassifical of this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
					Begi nni 1. 00		Endi 2. (
	Enter applicable beginning and ending dates of SCH sta		Subscript line :	36 for number	11.00		2		36.00
	of periods in excess of one and enter subsequent date: If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		umber of periods	s MDH status		0			37.00
	Enter applicable beginning and ending dates of MDH states of periods in excess of one and enter subsequent dates		Subscript line :	38 for number					38.00
					Y/N		Υ/		
	Does this facility qualify for the inpatient hospital				1. 00 N		2. (39. 00
	hospitals in accordance with 42 CFR $\S412.101(b)(2)(ii)$ or "N" for no. Does the facility meet the mileage requer CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes of	uiremer or "N"	nts in accordand for no. (see i	ce with 42 nstructions)					
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob- no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for ye		N		N		40.00
						1. 00	XVIII 2. 00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce		• •			N N	Y N	N N	45. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	L, P	t. III and Wkst.	L-1, Pt. I t	hrough				
48. 00	Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment. Teaching Hospitals				0.	N N	N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in a or "N" for no.	approve	ed GME programs	? Enter "Y" f	or yes	N			56. 00
57. 00	If line 56 is yes, is this the first cost reporting po GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first montl	yes or h of th	r "N" for no in his cost reporti	column 1. If ng period? E	column 1 nter "Y"				57. 00
	for yes or "N" for no in column 2. If column 2 is "Y' "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, If line 56 is yes, did this facility elect cost reimb	, if a	opl i cabl e.			N			58. 00
	defined in CMS Pub. 15–1, § 2148? If yes, complete Wk: Are costs claimed on line 100 of Worksheet A? If yes,	st. D-5	5.			N			59.00
60.00	Are you claiming nursing school and/or allied health or provider-operated criteria under §413.85? Enter "Y"	costs 1	for a program tl	nat meets the	tions)	Y			60.00
	provider-operated criteria under 9413.65? Enter 1	Y/N	I ME	Direct GME	IME		Di rec	t GME	
		1. 00	2. 00	3. 00	4.00)	5. (00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00			61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.0
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.00	,				61. 02
51. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.00	•				61. 03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00					61. 04
61. 05	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.00					61. 05
	primary care and/or general surgery FTE counts (line		I						1

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 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 3:32 pm Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to

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

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150112 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 3:32 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0. 00 0.00 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 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Ν Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

alth Financial Systems COLUMBUS REGION SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150112	Period: From 01/01/2	2014	Worksheet Part I	5-2
			To 12/31/2		Date/Ti me	Prepare
			V		5/28/2015 XI X	3: 32 pii
T: II V I VIV C			1. 00		2. 00	
Title V and XIX Services .00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	l services? E	nter "Y" for	N		Υ	90.
.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appliance.			N		N	91.
.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applical	al certificati				N	92.
.00 Does this facility operate an ICF/MR facility for purposes or "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N		N	93.
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.			N		N	94.
.00 If line 94 is "Y", enter the reduction percentage in the app .00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	o in the	N	0. 00	N	0. 00 95 96
.00 If line 96 is "Y", enter the reduction percentage in the app	licable column	n		0. 00		0. 00 97
5.00 Does this hospital qualify as a Critical Access Hospital (CA) 6.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	*	hod of paymen	t N			105 106
7.00 Column 1: If this facility qualifies as a CAH, is it eligib for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on Wks the program would be cost reimbursed. If yes complete Wkst. I this facility is a CAH, do I&Rs in an approved medical educa	in column 1. st. B, Pt. I, D-2, Pt. II. (tion program	(see col. 25 and Column 2: If train in the				107
CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "I instructions) 8.00 Is this a rural hospital qualifying for an exception to the		`				108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	I Speech	1	Respi rato	ory
	1.00	2.00	3. 00 N		4. 00	
9.00 If this hospital qualifies as a CAH or a cost provider, are					N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N			.,	109
therapy services provided by outside supplier? Enter "Y"	Demonstratio			-	1. 00 N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"	Demonstratio		10A Demo)for	1. 00	1.00 N	110.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information	l Demonstratio	on project (4	10A Demo)for	1. 00	1.00 N	110
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" with the current cost reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers.	Demonstration for no. "N" for no in the column 2 in the for long tenders."	on project (4 n column 1. I is "E", enter rm care (incl	f column 1 in column udes		1.00 N	110
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, §2208.1. D. 00 Is this facility classified as a referral center? Enter "Y" for yes or a control of the provider in the provi	I Demonstration for no. "N" for no in the second of the s	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no.	f column 1 in column udes in CMS	1. 00	1.00 N	110 .00 0 115
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208. 1. 6. 00 Is this facility classified as a referral center? Enter "Y" 7. 00 Is this facility legally-required to carry malpractice insurance.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	n column 1. I is "E", enter m care (incl he definition "for no.	f column 1 in column udes in CMS	1. 00 N	1.00 N	110 . 00 0 115
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, §2208. 1. 6.00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry malpractice insurance. 8.00 Is the malpractice insurance a claims-made or occurrence policy.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	n column 1. I is "E", enter m care (incl he definition "for no.	f column 1 in column udes in CMS	1.00 N Y Y	1.00 N	110 .00 0 115 116 117 118
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" solution with the current cost reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, §2208. 1. D.00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry mal practice insurance. B.00 Is the mal practice insurance a claims-made or occurrence policy.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums	f column 1 in column udes in CMS "N" for is	1.00 N Y Y	1.00 N	110 .00 0 115 116 117 118
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" so the current cost reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208.1. D.00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry malpractice insurance. D.00 Is the malpractice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums 1.00	f column 1 in column udes in CMS "N" for is Losses	1.00 N Y Y	1.00 N	110 .00 0 115 116 117 118
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" so the current cost reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208.1. D.00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry mal practice insurance. D.00 Is the mal practice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.	"N" for no in If column 2 it for long tens) based on the for yes or "N" ance? Enter ""	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums	f column 1 in column udes in CMS "N" for is Losses	1.00 N Y Y	1.00 N 2.00 3	110 .00 0 115 116 117 118
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for ye	I Demonstration for no. "N" for no in the second of the second on the s	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums 1.00 617,9	f column 1 in column udes in CMS "N" for is Losses 2.00	1.00 N Y Y	1.00 N	110 .00 0 115 116 117 118 ce
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" so the current cost reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, §2208.1. D.00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry malpractice insurance. D.00 Is the malpractice insurance a claims-made or occurrence policialm-made. Enter 2 if the policy is occurrence.	"N" for no ii If column 2 it for long tel s) based on the for yes or "N' ance? Enter "' icy? Enter 1 i	n column 1. I is "E", enter rm care (include definition refer to yes or if the policy Premiums 1.00 617,9	f column 1 in column udes in CMS "N" for is Losses	1.00 N Y Y	1.00 N 2.00 3	110 .00 0 115 116 117 118 ce
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for yes or "Syes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208. 1. D.00 Is this facility classified as a referral center? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208. 1. D.00 Is this facility legally-required to carry malpractice insurance. D.00 Is the malpractice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence. D.00 Is the malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedular and amounts contained therein. D.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelled Hold Harmless provision in ACA \$3121 and applicable amendments?	"N" for no in If column 2 it for long tents) based on the solumn 2 it for yes or "N" ance? Enter "" icy? Enter 1 it column 1 it is the solumn 1, "Y" alifies for the solumn 1, "Y" alifies	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums 1.00 617,9 than the ost centers vision in ACA " for yes or he Outpatient	f column 1 in column udes in CMS "N" for is Losses 2.00 13	1.00 N Y Y	1.00 N 2.00 3	110 .00 0 115 116 117 118 ce 0
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for ye	"N" for no in If column 2 it for long tets) based on the for yes or "N" ance? Enter "" icy? Enter 1 if tets and the listing of the listing column 1, "Y" alifies for the tes? (see institute)	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums 1.00 617,9 than the best centers vision in ACA " for yes or he Outpatient ructions)	f column 1 in column udes in CMS "N" for is Losses 2.00 13	1.00 N Y Y	1.00 N 2.00 3	110 .00 0 115 116 117 118 2e
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" is west and all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider. Pub. 15-1, §2208.1. 6.00 Is this facility legally-required to carry malpractice insurance. 7.00 Is the malpractice insurance a claims-made or occurrence policalim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedular and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. Transplant Center Information 5.00 Dobes this facility operate a transplant center? Enter "Y" for	"N" for no in If column 2 it for long tenses based on the standard second secon	on project (4 n column 1. I is "E", enter rm care (incl he definition " for no. Y" for yes or if the policy Premiums 1.00 617,9 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to	f column 1 in column udes in CMS "N" for is Losses 2.00 13	1.00 N Y Y	1.00 N 2.00 3	110 .00 0 115 116 117 118
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, \$2208.1. 6.00 Is this facility classified as a referral center? Enter "Y" for yold in this facility legally-required to carry malpractice insurance. 8.00 Is the malpractice insurance a claims-made or occurrence policialm-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schediand amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implaint patients? Enter "Y" for yes or "N" for no.	"N" for no in If column 2 it for long tells) based on the for yes or "N" ance? Enter "Viance? Enter 1 it icy? (see institute) if it is for the certification of the formulation of the interest of the certification of the interest of the certification of the interest of t	n column 1. I is "E", enter rm care (include definition reference of the definition reference of the policy remaiss. 1.00	f column 1 in column udes in CMS "N" for is Losses 1.00 N	1.00 N Y Y	1.00 N 2.00 3	0 115 116 117 118 00 0 115 118 119 120

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der C		eriod: com 01/01/2014	Worksheet S- Part I	2
			To		Date/Time Pr	
					5/28/2015 3:	32 pm
				1. 00	2.00	1
128.00 If this is a Medicare certified li in column 1 and termination date,			cation date			128. 00
129.00 If this is a Medicare certified I	ung transplant center, ent		ation date in			129. 00
column 1 and termination date, if 130.00 If this is a Medicare certified pa		enter the certi	fi cati on			130. 00
date in column 1 and termination of 131.00 If this is a Medicare certified in			rti fi coti on			131. 00
date in column 1 and termination of			tiiication			131.00
132.00 If this is a Medicare certified is in column 1 and termination date,			cation date			132. 00
133.00 If this is a Medicare certified of			cation date			133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or			n column 1			134. 00
and termination date, if applicabl		The of of Hamber 11				134.00
All Providers 140.00 Are there any related organization	or home office costs as	defined in CMS [Pub 15_1	Υ		140. 00
chapter 10? Enter "Y" for yes or '				ı		140.00
are claimed, enter in column 2 the	e home office chain number. 2.0		ons)	3. 00		
If this facility is part of a chai			gh 143 the nam		of the	
home office and enter the home of		ontractor number	Contractor	La Numbara		141. 00
141. 00 Name: 142. 00 Street:	Contractor's Name: PO Box:		Contractor	S Number:		141.00
143. 00 Ci ty:	State:		Zi p Code:			143. 00
					1.00	_
144.00 Are provider based physicians' cos					Y	144. 00
145.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for		e 74, are the co	osts for inpat	ient services	Y	145. 00
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
146.00 Has the cost allocation methodolog	ny changed from the previous	usly filed cost	report?	1. 00 N	2. 00	146. 00
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Pub.			14		140.00
the approval date (mm/dd/yyyy) in 147.00 Was there a change in the statisti	column 2.	vos or "N" for r	20	N		147. 00
148.00 Was there a change in the order of				N		148. 00
149.00 Was there a change to the simplifi	ed cost finding method? En	nter "Y" for yes	or "N" for	N		149. 00
no.		Part A	Part B	Title V	Title XIX	
Dana this facility and in a grayi		1.00	2.00	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '						
155. 00 Hospi tal	·	N	N	N	N	155. 00
156. 00 Subprovi der - I PF 157. 00 Subprovi der - I RF		N N	N N	N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF 160. 00 HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161. 00 CMHC		l N	N	N	N N	161. 00
161. 10 CORF			N	N	N	161. 10
					1.00	+
Multicampus			! !! 66	-+ CDCA C		1/5 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has on	e or more campus	ses in dittere	nt CBSAS?	N	165. 00
	Name	County	State Zip		FTE/Campus	
166.00 fline 165 is yes, for each	0	1. 00	2.00 3.	00 4.00	5.00	0 166. 00
campus enter the name in column						
O, county in column 1, state in column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	
Health Information Technology (HI 167.00) s this provider a meaningful user	T) incentive in the Americ	an Recovery and	Rei nvestment	Act	Υ	167.00
168.00 If this provider is a CAH (line 10					Y	167. 00 0168. 00
reasonable cost incurred for the H	HIT assets (see instruction	ns)				
169.00 If this provider is a meaningful transition factor. (see instruction		is not a CAH (I	THE TUS IS "N), enter the	0. /	75169.00
	•				•	

Health Financial Systems	, , , , , , , , , , , , , , , , , , ,				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN: 150112	Peri od:	Worksheet S-2	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/28/2015 3:3	
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begineriod respectively (mm/dd/yyyy)	06/30/2014	170. 00			
				1. 00	
171.00 If line 167 is "Y", does this provide Medicare cost plans reported on Wkst. (see instructions)	N	171. 00			

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			F	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre	2 epared:
					Y/N	5/28/2015 3:3 Date	
					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 lf	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., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N						
				Y/N 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	Υ			5. 00
	those on the filed financial statements? If	yes, submit reconci	liation.				
					Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1.00	2.00	
6.00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N		6. 00
7 00	the legal operator of the program?	2 f "V" 000 not nu	ati ana		V		7 00
7. 00 8. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'			d during the	Y		7.00
0.00	cost reporting period? If yes, see instruction		0 000	a dan mg the			0.00
9. 00	Are costs claimed for Intern-Resident program	ms claimed on the c	urrent cos	st report? If	N		9. 00
10. 00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the	current o	cost reporting	N		10.00
	period? If yes, see instructions.						10.00
11. 00	Are GME cost directly assigned to cost center		in an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see	I NSTructi ons.				Y/N	
	I					1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad	d dahte2 lf vas sa	a instruct	ions		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad del				t reporting	N N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? If	yes, see inst	ructi ons.	N	14. 00
15. 00	Did total beds available change from the price	or cost reporting p	eriod? If	yes, see instr	ructions.	N	15. 00
					rt A	Part B	
		Description 0	on	Y/N 1.00	2. 00	Y/N 3. 00	
	PS&R Data	Ŭ		1.00	2.00	0.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	05/01/2015	Y	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			Y	05/01/2015	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

Health Financial Systems	COLUMBUS REGIONAL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/28/2015 3:3	pared:
			Pa	rt A	Part B	
	Descriptio	n	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			N		N	21. 00

21.00	was the cost report prepared only using the			IN IN		l N	21.00
	provider's records? If yes, see					ĺ	
	i nstructi ons.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXCE	PT CHILDRENS H	OSPLTALS)			
	Capital Related Cost	(2,102					
22. 00	Have assets been relifed for Medicare purpose	as2 If was sad	instructions			l N	22. 00
				ala mada dunin	a +ba aaa+		
23. 00	Have changes occurred in the Medicare deprec	ration expense	due to apprais	ars made durrn	g the cost	N	23. 00
	reporting period? If yes, see instructions.						
24. 00	Were new Leases and/or amendments to existing	g Leases entere	ed into during	this cost repo	rting period?	N	24. 00
	If yes, see instructions						
25. 00	Have there been new capitalized leases enter	ed into during	the cost repor	ting period? I	f yes, see	N	25. 00
	i nstructi ons.						
26.00	Were assets subject to Sec. 2314 of DEFRA acq	uired during th	ne cost reporti	ng period? If	yes, see	N	26. 00
	instructions.						
27.00	Has the provider's capitalization policy cha	nged during the	e cost reportin	g period? If y	es, submit	N	27. 00
	сору.	3		3			
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Lette	rs of credit er	ntered into dur	ing the cost r	enorti na	Y	28. 00
20.00	period? If yes, see instructions.	is or crear t er	recrea riito aar	ring the cost r	opor tring	· ·	20.00
29. 00	Did the provider have a funded depreciation	account and/or	hand funds (De	ht Sarvica Pas	erve Fund)	Y	29. 00
29.00	treated as a funded depreciation account? If			bt service kes	erve runu)	· '	29.00
20.00				dob+2 l f voo		Y	30.00
30. 00	Has existing debt been replaced prior to its	scheduled matt	arity with new	debt? IT yes,	see	į ^Y	30.00
	instructions.						
31. 00	Has debt been recalled before scheduled matu	rity without is	ssuance of new	debt? If yes,	see	N	31. 00
	instructions.					<u> </u>	
	Purchased Services						
32.00	Have changes or new agreements occurred in p			d through cont	ractual	Y	32. 00
	arrangements with suppliers of services? If						
33.00	If line 32 is yes, were the requirements of	Sec. 2135.2 app	olied pertainin	g to competiti	ve bidding? If	N	33. 00
	no, see instructions.						
	Provi der-Based Physi ci ans						
34.00		itv under an ar	rangement with	provi der-base	d physicians?	Y	34.00
	If yes, see instructions.	.,	3				
35. 00	If line 34 is yes, were there new agreements	or amended exi	sting agreemen	its with the pr	ovi der-based	lγ	35. 00
00.00	physicians during the cost reporting period?			то ш ти тио рг	ov. do. bacca		00.00
	physicians darring the cost reporting period.	11 705, 500 11	isti doti ons.		Y/N	Date	
					1, 00	2. 00	
	Home Office Costs				1.00	2.00	
24 00	Were home office costs claimed on the cost re	onort2			N		36.00
36. 00					IN		
37. 00	If line 36 is yes, has a home office cost st	atement been pr	repared by the	nome office?			37. 00
	If yes, see instructions.						
38. 00	If line 36 is yes , was the fiscal year end	of the home off	fice different	from that of			38. 00
	the provider? If yes, enter in column 2 the					1	
39. 00	If line 36 is yes, did the provider render s	ervices to othe	er chain compon	ents? If yes,		1	39. 00
	see instructions.						
40.00	If line 36 is yes, did the provider render s	ervices to the	home office?	If yes, see		1	40. 00
	instructions.			*		1	
			1.	00	2.	00	

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	CATHERI NE	SIMMONS	41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report	COLUMBUS REGIONAL HOSPITAL		42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost	812-376-5248	CSI MMONS@CRH. ORG	43.00
	report preparer in columns 1 and 2, respectively.			

Health Financial Systems	COLUMBUS REGIONAL	L HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSE	EMENT QUESTIONNAIRE	Provi der CCN: 150112	From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 3:32 pm
	Part B		-	
	Date			
	4. 00			
PS&R Data				

		Part B		, , , , , , , , , , , , , , , , , , , ,	
		Date			
		4. 00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R	05/01/2015			16. 00
	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)				
17. 00	Was the cost report prepared using the PS&R	05/01/2015			17. 00
	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				
18. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments				18. 00
16.00	made to PS&R Report data for additional				16.00
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19.00	If line 16 or 17 is yes, were adjustments				19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
	instructions.				
20.00					20. 00
	made to PS&R Report data for Other? Describe				
	the other adjustments:				
21. 00	Was the cost report prepared only using the				21. 00
	provider's records? If yes, see				
	instructions.			,	
			3.00		
	Cost Report Preparer Contact Information		3.00		
41. 00	Enter the first name, last name and the title	/nosition	MANAGER ACCOUNTING		41. 00
41.00	held by the cost report preparer in columns 1		MANAGER ACCOUNTING		41.00
	respectively.	, 2, 414 0,			
42. 00	Enter the employer/company name of the cost r	report			42. 00
	preparer.				
43.00	Enter the telephone number and email address	of the cost			43.00
	report preparer in columns 1 and 2, respective	el y.			

Provider CCN: 150112	Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	Non-CMS HFS Workshee		
Cost Report Preparer Contact Information	VOLUNT	CARY CONTACT INFORMATION		Provi der CCN: 150112	From 01/01/2014 Part V To 12/31/2014 Date/Ti	me Prep	
1. 00					1.00		
2.00		Cost Report Preparer Contact Information					
3. 00	1.00	First Name			CATHERI NE		1.00
4. 00 Employer COLUMBUS REGIONAL HOSPITAL 4. 00 5. 00 Phone Number (812) 376-5248 5. 00 Femail Address CSIMMONS⊕CRH. ORG 6. 00 7. 00 Department 2400 EAST 17TH STREET 8. 00 7. 00 Mailing Address 2 9. 00 11. 00 State 18. 00 Mailing Address 2 18. 00 Mailing Address 2 19. 00 Mailing Address 2 19. 00 19. 00 Mailing Address 2 19. 00	2.00	Last Name			SIMMONS		2.00
S. 00 Phone Number (812)376-5248 S. 00 6. 00 E-mail Address CSI MMONS@CRH. ORG 6. 00 7. 00 Department 2400 EAST 17TH STREET 8. 00 9. 00 Mailing Address 2 9. 00 11. 00 2ip A7201 12. 00 2ip A7201 12. 00 2ip A7201 12. 00 2ip A7201 2ip A7201	3.00	Ti tl e			MANAGER ACCT/REPORT/RE	IMB	3.00
Columbus Columbus	4.00	Empl oyer			COLUMBUS REGIONAL HOSP	ITAL	4.00
7. 00 Department 2400 EAST 17TH STREET 8. 00 9. 00	5.00	Phone Number			(812) 376-5248		5.00
8.00 Mailing Address 1 2400 EAST 17TH STREET 8.00 9.00 Mailing Address 2 9.00 10.00 City COLUMBUS 10.00 11.00 City COLUMBUS 11.00 Columbus Col	6.00	E-mail Address			CSI MMONS@CRH. ORG		6.00
9.00 Mailing Address 2 9.00 10.00 11.00 State IN 11.00 State IN 11.00 In In In In In In In	7.00	00 Department					7.00
10.00 City State COLUMBUS 10.00 11.00 State IN 11.00 12.00 Zip 47201 12.00 Officer or Administrator of Provider Contact Information 13.00 First Name MARLENE 13.00 14.00 Last Name WEATHERWAX 14.00 15.00 Title VP FINANCE & CFO 15.00 16.00 Employer COLUMBUS REGIONAL HOSPITAL 16.00 17.00 Phone Number (812)376-5205 17.00 18.00 E-mail Address MWEATHERWAX@CRH. ORG 18.00 19.00 Department 2400 EAST 17TH STREET 20.00 20.00 Mail ing Address 2 21.00 22.00 City COLUMBUS 22.00 23.00 State IN 23.00 23.00 State IN 23.00 24.00 COLUMBUS 22.00 COLUMBUS COLUMBUS 22.00 COLUMBUS COLUMBUS 22.00 COLUMBUS COLUMBUS 22.00 COLUMBUS COLUMBUS COLUMBUS COLUMBUS COLUMBUS COLUMBUS COL	8.00	3.00 Mailing Address 1 2400 EAST 17TH STREET					8.00
11. 00 State	9.00	Mailing Address 2					
12.00 Zip					COLUMBUS		10.00
Officer or Administrator of Provider Contact Information						I N	
13.00	12.00				47201		12.00
14.00 Last Name WEATHERWAX 14.00 15.00 Title VP FINANCE & CFO 15.00 16.00 Employer COLUMBUS REGIONAL HOSPITAL 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 STREET 20.00 21.00 Mailing Address 2 21.00 22.00 City COLUMBUS 22.00 23.00 State IN 23.00		Officer or Administrator of Provider Contact	Information				
15. 00 Title	13.00	First Name			MARLENE		13.00
16. 00 Employer COLUMBUS REGIONAL HOSPITAL (812) 376-5205 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 STREET 20. 00 21. 00 Mailing Address 2 21. 00 22. 00 City COLUMBUS 22. 00 23. 00 State IN 23. 00							14.00
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 STREET 20. 00 21. 00 Mailing Address 2 21. 00 City COLUMBUS 22. 00 23. 00 State IN 23. 00		Ti tl e					
18.00 E-mail Address MWEATHERWAX@CRH. ORG 18.00 19.00 Department 19.00 20.00 Mailing Address 1 2400 EAST 17TH STREET 20.00 21.00 Mailing Address 2 21.00 22.00 City COLUMBUS 22.00 23.00 State IN 23.00						ITAL	
19.00 Department	17. 00	Phone Number			(812) 376-5205		17.00
20. 00 Mailing Address 1 2400 EAST 17TH STREET 20. 00 21. 00 Mailing Address 2 21. 00 22. 00 City COLUMBUS 22. 00 23. 00 State IN 23. 00		E-mail Address			MWEATHERWAX@CRH. ORG		
21. 00 Mailing Address 2 21. 00 22. 00 City COLUMBUS 22. 00 23. 00 State IN 23. 00							
22. 00 Ci ty COLUMBUS 22. 00 23. 00 State IN 23. 00	20.00	Mailing Address 1			2400 EAST 17TH STREET		20.00
23. 00 State IN 23. 00		3					
		22.00 Ci ty COLUMBUS					
24. 00 Zi p 47201 24. 00		23.00 State				I N	
	24. 00	Zi p			47201		24.00

Heal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL		Non-CMS HFS Wor	ksheet
HFS Su	upplemental Information	Provider CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part IX Date/Time Pre 5/28/2015 3:3	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 Interns 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 reporti Part I (e.g. net of Physician's component)? Enter Y/N in column in column 2 for Title XIX.	1 for Title V and Y/N		Υ	2. 00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calcula Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Ti 2 for Title XIX.		Υ	3. 00	
			I npati ent	Outpati ent	
			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 inpatient for outpatient.		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Acces reimbursed 101% of cost? Enter Y or N in column 1 for inpatient for outpatient.			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 Disallow column 4? Enter Y/N in column 1 for Title V and Y/N in column 2		Y	Υ	6. 00
	PASS THROUGH COST				
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (payment worksheets D, parts I through IV? Enter Y/N in column 1 for Tit 2 for Title XIX.		Y	Υ	7. 00

					To	12/31/2014	Date/Time Prep 5/28/2015 3:32	
							I/P Days / 0/P	z piii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Compensite	Line Number	110.	or beas	Avai I abl e	oran nodi s	11 110 1	
		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	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			132	48, 180	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE 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	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			150	54, 750	0.00	0	14.00
15.00	CAH visits						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	0		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 Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days		l		1			33. 00

				'	0 12/31/2014	5/28/2015 3:3	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	55p6.1.5112			Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11, 628	0	26, 090			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 593	4, 742				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	346	0	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	44 (00	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	11, 628	O	26, 090			7. 00
0.00	beds) (see instructions)	1 10/	404	2, 491			0.00
8. 00 9. 00	INTENSIVE CARE UNIT	1, 106	404	2, 491			8.00
10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0			9. 00 10. 00
11. 00			0	0			11.00
12. 00	1	٩	ď	U			12.00
13. 00	, ,		1, 840	3, 348			13.00
14. 00	l e	12, 734	2, 244	31, 929		1, 219. 00	
15. 00		12, 734	2, 244	31, 727		1, 219.00	15. 00
16. 00	i e		0	0		0.00	16.00
17. 00	i e	2, 015	261	3, 500	0.00	l e	
18. 00	l e	2,010	0	0, 550	0.00	l e	
19. 00	1		0	0	0.00	l .	
20. 00]	_	·			20.00
21. 00	i i						21. 00
22. 00	i e	o	0	0	0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	25. 10
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
26. 25		0	0	0	0.00	0.00	26. 25
27. 00	,				0.00	1, 242. 00	
28. 00	9		565	3, 563			28. 00
29. 00	·	3, 225					29. 00
30. 00	, ,			0			30. 00
31. 00				0			31.00
32. 00		0	0	0			32. 00
32. 01				0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

10311	AL AND HOSTITAL HEALTH CARL COMMERC STATISTICA	AL DATA	11 ovi dei		From 01/01/2014 Fo 12/31/2014		
		Full Time		Di sc	harges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 589	9 1, 391	8, 416	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			740	0		2.00
3. 00	HMO IPF Subprovider						3.00
1.00	HMO IRF Subprovider						4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
	heds) (see instructions)						

2. 3. 5. 6. 7. beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 3, 589 1, 391 8, 416 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 0.00 16.00 16.00 0 17.00 SUBPROVIDER - IRF 300 17.00 0.00 172 17 18.00 SUBPROVI DER 0.00 18.00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20 00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25.00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25. 10 RURAL HEALTH CLINIC 0.00 26.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 27.00 Observation Bed Days 28.00 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 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

	AL WAGE INDEX INFORMATION		COLUMBO2 KEGI			Peri od:	Worksheet S-3	
						From 01/01/2014 To 12/31/2014		pared: 2 pm
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries			Average Hourly Wage (col. 4 ÷	
		El lie Mainber	Ropor tou	(from Worksheet A-6)	(col.2 ± col.		col . 5)	
	DADT III WAS DATA	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see instructions)	200. 00	69, 023, 843	-322, 302	68, 701, 54	1 2, 538, 003. 00	27. 07	1. 00
2. 00	Non-physician anesthetist Part		(0	,	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		(0		0.00	0.00	3. 00
4.00	Physician-Part A - Administrative		(0		0.00	0.00	4. 00
4. 01	Physicians - Part A - Teaching		(-	1	0.00		1
5. 00 6. 00	Physician-Part B Non-physician-Part B		183, 031	0	183, 03	1 4, 320. 00 0 0. 00		
7. 00	Interns & residents (in an	21. 00	Ó	0		0.00		
7. 01	approved program) Contracted interns and		(0		0.00	0.00	7. 01
	residents (in an approved programs)							
8. 00 9. 00	Home office personnel	44. 00	(0. 00 0 0. 00		
10. 00	Excluded area salaries (see instructions)		4, 065, 667	707, 917	4, 773, 58	4 216, 093. 00	22. 09	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		10, 812, 266	0	10, 812, 26	6 233, 850. 00	46. 24	11. 00
12. 00	Contract Labor: Top Level management and other		1, 295, 141	0	1, 295, 14	1 31, 918. 00	40. 58	12. 00
	management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		2, 908, 771	0	2, 908, 77	1 22, 866. 00	127. 21	13. 00
14. 00	Home office salaries &		3, 571, 785	0	3, 571, 78	5 17, 680. 00	202. 02	14. 00
15. 00	wage-related costs Home office: Physician Part A		(0		0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		(0		0.00	0. 00	16. 00
	WAGE-RELATED COSTS			_		_		
17. 00	Wage-related costs (core) (see instructions)		24, 131, 615	0	24, 131, 61	5		17. 00
18. 00	Wage-related costs (other) (see instructions)		(0		0		18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 622, 725 (ı	1 ' ' '	5 0		19. 00 20. 00
21. 00	A Non-physician anesthetist Part		(0		21. 00
22. 00	B Physician Part A -		(0		22. 00
	Admi ni strati ve							
22. 01 23. 00	Physician Part A - Teaching Physician Part B		68, 472	-		2		22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		(1	0		24. 00 25. 00
20.00	approved program)					<u> </u>		20.00
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 967, 181	-161, 709	1, 805, 47	2 7, 426. 00	243. 13	26. 00
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	10, 290, 510 3, 019, 957			· ·		27. 00 28. 00
	contract (see inst.)		3,014,43					
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	1, 830, 617	0 7 -9, 831	1	0.00 6 67,935.00		29. 00 30. 00
31. 00	Laundry & Linen Service	8. 00	60, 290	-1, 367	58, 92	3, 966. 00	14. 86	31.00
32. 00 33. 00	Housekeepi ng under contract	9. 00	1, 567, 888 (-8, 041 0	1	7 113, 192. 00 0 0. 00		32. 00 33. 00
34. 00	(see instructions) Dietary	10. 00	1, 738, 525	-1, 242, 814	495, 71			34. 00
35. 00	Dietary under contract (see instructions)		(0		0.00		35. 00
36. 00 37. 00	Cafeteria Maintenance of Personnel	11. 00 12. 00	(1, 202, 979	1, 202, 97	9 83, 423. 00 0 0. 00		36. 00 37. 00
38. 00	Nursing Administration	13. 00	3, 053, 292	1		6 73, 912. 00	40. 96	38. 00
39. 00 40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	3, 828 3, 078, 927		3, 82 2, 890, 39			39. 00 40. 00
	· · ····	13. 30	3, 370, 72	1 .50, 527		, 755. 00	1 33. 30	

Health Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150112 F	Peri od:	Worksheet S-3	
					From 01/01/2014	Part II	
				-	Γo 12/31/2014		
						5/28/2015 3: 3:	
	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	16. 00	1, 320, 920	-775, 367	545, 553	3 28, 447. 00	19. 18	41. 00
Records Library							
42.00 Social Service	17. 00	501, 833	3, 723	505, 556	14, 157. 00	35. 71	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

near th	Financiai Systems		COLUMBO2 REGIC	MAL HUSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	TAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
						From 01/01/2014		
						To 12/31/2014		
				h 1 6 11		T 5 1 1 11	5/28/2015 3: 32	
		Worksheet A		Recl assi fi cati	, ,		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		71, 860, 769	-322, 302	71, 538, 46	2, 565, 541. 00	27. 88	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 065, 667	707, 917	4, 773, 58	216, 093. 00	22. 09	2.00
	instructions)							
3.00	Subtotal salaries (line 1		67, 795, 102	-1, 030, 219	66, 764, 88	33 2, 349, 448. 00	28. 42	3.00
	minus line 2)							
4.00	Subtotal other wages & related		18, 587, 963	0	18, 587, 96	306, 314. 00	60. 68	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 131, 615	0	24, 131, 61	5 0.00	36. 14	5.00
	(see inst.)							
6 00	Total (sum of lines 3 thru 5)		110 514 680	-1 030 219	109 484 46	1 2 655 762 00	ار 41 23	6 00

109, 484, 461

27, 695, 711

-1, 030, 219

-738, 057

2, 655, 762. 00 931, 711. 00

41. 23

29. 73

6. 00

7.00

110, 514, 680

28, 433, 768

6.00

7.00

Total (sum of lines 3 thru 5)
Total overhead cost (see

instructions)

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150112		Worksheet S-3
		From 01/01/2014	
		To 10/01/001/	Data /Tima Dranarad.

	To 12/31/2014	Date/Time Prep 5/28/2015 3:3	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 338, 983	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	3, 728, 392	
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6. 00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	8, 702, 012	
9.00	Prescription Drug Plan	2, 246, 236	
10.00	Dental, Hearing and Vision Plan	512, 692	
11. 00	Life Insurance (If employee is owner or beneficiary)	62, 139	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 288, 234	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	637, 517	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	5, 074, 247	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	88, 805	
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	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	78, 302	
23. 00	Tuition Reimbursement	563, 102	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	26, 320, 661	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Pre	pared:
	Cost Center Description			Contract Labor	5/28/2015 3:3: Benefit Cost	2 piii
	oost center bescriptron			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		8, 649, 813	2, 162, 453	1. 00
2.00	Hospi tal			8, 649, 813	2, 162, 453	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

HOSPLT	Financial Systems COLUMBUS REGIONAL HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	vider CCN: 15011.	2 Peri od		u of Form CMS-2 Worksheet S-10	
1103111	AL DIVOCOMI ENGATED AND TRUTGENT CARE DATA	vider con. 15011.		1/01/2014	Worksheet 3-10	O
			To 1	2/31/2014	Date/Time Pre	
					5/28/2015 3: 3	2 pm
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 col	umn 8)		0. 396988	1.00
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				12, 228, 505	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.0
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payr		ai d?		N	4.0
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medi	caid			7, 816, 112	5.0
6.00	Medicaid charges				60, 454, 110	
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line	7 minus sum of	lines 2 a	nd E. if	23, 999, 556 3, 954, 939	
0.00	<pre>< zero then enter zero)</pre>	/ IIII IIuS Suiii UI	TITIES 2 a	nu s, ii	3, 934, 939	0.0
	State Children's Health Insurance Program (SCHIP) (see instructions	for each line)				
9. 00	Net revenue from stand-alone SCHIP	Tor cacir rine)			0	9.0
10.00	Stand-allone SCHIP charges				Ö	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 0
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line	e 11 minus line	9; if < z	ero then	0	12.0
	enter zero)					
	Other state or local government indigent care program (see instructi					
13. 00	Net revenue from state or local indigent care program (Not included	· ·	,		0	
14. 00	Charges for patients covered under state or local indigent care prog	gram (Not includ	ed in lin	es 6 or	0	14. 0
45 00	10)					45.0
15.00	State or local indigent care program cost (line 1 times line 14)		1: 15		0	
16. 00	Difference between net revenue and costs for state or local indigental; if < zero then enter zero)	t care program (line 15 m	inus iine	0	16. 0
	Uncompensated care (see instructions for each line)					l
17. 00	Private grants, donations, or endowment income restricted to funding	charity care			0	17.0
18. 00	Government grants, appropriations or transfers for support of hospit				0	18. 0
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local inc		rams (sum	of lines	3, 954, 939	19.0
	8, 12 and 16)					
		Uni nsur		nsured	Total (col. 1	
		patient		iti ents	+ col . 2)	
		1.00		2.00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (at the species available approved for the entire feet		, 302 3	2, 853, 157	45, 859, 459	20. 0
21. 00	charges excluding non-reimbursable cost centers) for the entire faci Cost of initial obligation of patients approved for charity care (Ii		346 1	3, 042, 309	18, 205, 655	21. 0
21.00	times line 20)	5, 103	, 540 1	5, 042, 309	10, 200, 000	21.00
22. 00		7.6	, 361 1	2, 279, 672	12, 356, 033	22.00
23. 00	1 1 3 1 1 1	5, 086		762, 637	5, 849, 622	
		,				
					1.00	
24. 00	Does the amount in line 20 column 2 include charges for patient days		h of stay	limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care progr					
25. 00	If line 24 is "yes," charges for patient days beyond an indigent ca		ngth of s	tay limit	0	
26. 00	Total bad debt expense for the entire hospital complex (see instruc-				17, 141, 005	
27. 00	Medicare bad debts for the entire hospital complex (see instructions				339, 627	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 20	,			16, 801, 378	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	(line 1 times l	ıne 28)		6, 669, 945	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				12, 519, 567	1
	Total unreimbursed and uncompensated care cost (line 19 plus line 30	2)			16, 474, 506	1 24 2

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 150112	Peri od:	Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
					12/31/2014	5/28/2015 3:3	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	2 piii
				+ col . 2)	ons (See A-6)	Trial Balance	
				,	, ,	(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		16, 600, 713	16, 600, 713	-6, 890, 832	9, 709, 881	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0) (9, 717, 456	9, 717, 456	2. 00
3.00	00300 OTHER CAP REL COSTS		0) (0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 967, 181	24, 132, 481	26, 099, 662	-115, 638	25, 984, 024	4. 00
5. 01	00540 NONPATI ENT TELEPHONES	335, 021	344, 884			679, 723	5. 01
5.02	00550 DATA PROCESSING	3, 007, 619	4, 513, 358	7, 520, 97	4, 535	7, 525, 512	5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	988, 112	358, 617	1, 346, 729	-1, 741	1, 344, 988	5. 03
5. 04	00570 ADMI TTI NG	980, 170	501, 803			1, 481, 973	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 484, 533	1, 803, 330			4, 054, 808	5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	3, 495, 055	39, 189, 798			38, 059, 438	5. 06
7.00	00700 OPERATION OF PLANT	1, 830, 617	6, 135, 004			5, 814, 776	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	60, 290	573, 442			632, 365	
9.00	00900 HOUSEKEEPI NG	1, 567, 888	450, 718			2, 010, 565	
10.00	01000 DI ETARY	1, 738, 525	1, 038, 077	1		805, 674	
11.00	01100 CAFETERI A	0 050 000	100.000	1	1, 931, 093	1, 931, 093	
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 053, 292	139, 029			3, 166, 755	
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 828	884, 379			888, 207	
15.00	01500 PHARMACY	3, 078, 927	1, 772, 494			4, 706, 130	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 320, 920	983, 277			1, 528, 830	
17. 00	01700 SOCIAL SERVICE	501, 833	2, 612	504, 44	4, 130	508, 575	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	140 540	4 705	154 27	0 244 072	0	23. 00
23. 01 23. 02	02301 XRAY EDUCATION 02302 PHARMACY RESIDENCY PROG	149, 568	4, 705			421, 145	
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	138, 377	714	139, 09	182, 106	321, 197	23. 02
30. 00	03000 ADULTS & PEDIATRICS	13, 227, 728	1, 226, 706	14, 454, 434	-152, 650	14, 301, 784	30.00
31. 00	03100 NTENSIVE CARE UNIT	2, 105, 842	253, 649			2, 288, 709	
32. 00	03200 CORONARY CARE UNIT	2, 103, 642	253, 049	2, 339, 49	-70, 762	2, 288, 709	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0			0	34.00
40. 00	04000 SUBPROVI DER - I PF	l ől	0			0	40.00
41. 00	04100 SUBPROVI DER – I RF	1, 226, 071	80, 884	1, 306, 95	165, 813	1, 472, 768	
42. 00	04200 SUBPROVI DER	1,220,071	00,001	1,000,700	0	0	42.00
43. 00	04300 NURSERY	580, 958	13, 325	594, 283	-3, 668	590, 615	
44. 00	04400 SKILLED NURSING FACILITY	0	0	(0	0	
	ANCILLARY SERVICE COST CENTERS				•		1
50.00	05000 OPERATING ROOM	456, 452	22, 576, 781	23, 033, 233	-10, 179, 099	12, 854, 134	50.00
51.00	05100 RECOVERY ROOM	464	1, 295, 202	1, 295, 666	-13, 574	1, 282, 092	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	163, 081	163, 08	43, 490	206, 571	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 664, 307	233, 078	1, 897, 38	-135, 989	1, 761, 396	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	315, 075	1, 081, 741				
	05404 ULTRA SOUND	460, 538	20, 820				
	05405 MAMMOGRAPHY	699, 214	236, 497		·		
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 019, 046	29, 690			1, 386, 900	
57. 00	05700 CT SCAN	549, 856	180, 558			812, 966	
58. 00	05800 MRI	247, 881	49, 852			408, 119	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 375, 812	3, 298, 052			2, 154, 081	
60.00	06000 LABORATORY	3, 448, 676	3, 347, 990			6, 865, 645	1
60. 01	06001 LABORATORY-PATHOLOGI CAL	354, 809	223, 752			739, 846	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1 407 707	732, 041	1		816, 192	62.00
65.00	06500 RESPIRATORY THERAPY	1, 697, 787	293, 807			2, 004, 331	
66.00	06600 PHYSI CAL THERAPY	3, 537, 512	597, 801			3, 535, 665	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	431, 460	11, 605	1		1, 202, 840 702, 500	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	600, 222 459, 818	239, 332 153, 851			702, 500 545, 506	
70.00	07000 ELECTROCARDI OLOGY	572, 775	83, 042			681, 440	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	572,775	03, U42 ^	000,81		6, 595, 288	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0)	7, 343, 940		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	12, 136, 287	12, 136, 28		12, 136, 287	
74. 00	07400 RENAL DIALYSIS	0	366, 261			366, 261	
76. 00	03020 ACUPUNCTURE		0 0	i .		0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	92, 900	10, 377		-	108, 089	
	OUTPATIENT SERVICE COST CENTERS	, ,	. 3, 3. 7		., ., ., .		1 //
88. 00	08800 RURAL HEALTH CLINIC	Ol	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0)	o o	Ö	89. 00
90.00	09000 CLI NI C	570, 118	105, 122	675, 240	365, 000		
90. 01	09001 DI ABETES CENTER	68, 002	102, 679			170, 681	
90. 02	09002 NEUROPSYCH	251, 525	6, 866			272, 849	1
90. 03	09003 WOUND CENTER	304, 694	1, 171, 051			1, 274, 289	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	1	302, 300		
91. 00	09100 EMERGENCY	4, 450, 894	568, 402	5, 019, 29			
-							

Health Financial Systems	COLUMBUS REGION				u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Period: From 01/01/2014	Worksheet A	
				To 12/31/2014	Date/Time Pre 5/28/2015 3:3	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 378, 679	395, 148	2, 773, 82	7 31, 034	2, 804, 861	
99. 10 09910 CORF	0	0		0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
SPECIAL PURPOSE COST CENTERS				_		1
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		0		111. 00
113.00 11300 INTEREST EXPENSE		1, 899, 864	1, 899, 86	4 -1, 899, 864	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	68, 850, 871	152, 614, 629	221, 465, 50	2, 350, 755	219, 114, 745	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		255, 949		
194. 01 07951 BUI LDI NG RENTALS	0	55, 812	55, 81:	2 0	55, 812	194. 01
194. 02 07952 HOSPI CE	0	57, 993	57, 99	3 0	57, 993	194. 02
194. 03 07953 OUTREACH CLINICS	0	0		0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0		218, 666		
194. 05 07955 NONALLOWABLE MARKETING	0	0		1, 911, 110	1, 911, 110	194. 05
194.06 07956 CRH FOUNDATION	0	1, 156	1, 15	6 0		194. 06
194.07 07957 HEALTHY COMMUNITIES	172, 972	11, 169	184, 14	1 -34, 970	149, 171	194. 07
200.00 TOTAL (SUM OF LINES 118-199)	69, 023, 843	152, 740, 759	221, 764, 60	2 0	221, 764, 602	200. 00

Provi der CCN: 150112 Peri od: From 01/01/2014 To 12/31/2014

Worksheet A Date/Time Prepared: 5/28/2015 3:32 pm

				5/28/2015 3:3	2 pm
	Cost Center Description	Adj ustments	Net Expenses		
		(See A-8)	For Allocation	<u>1</u>	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	320, 989	10, 030, 870		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-323, 320			2. 00
3.00	00300 OTHER CAP REL COSTS	023,020			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-60, 573	25, 923, 451		4. 00
5. 01	00540 NONPATI ENT TELEPHONES	-90, 085			5. 01
5.02	00550 DATA PROCESSING	-33, 608	7, 491, 904		5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	-1, 081	1, 343, 907	,	5. 03
5.04	00570 ADMITTI NG	C			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	C			5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL	-18, 285, 237			5. 06
7. 00	00700 OPERATION OF PLANT	-39, 253			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	-142			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	-3, 395 -1, 104, 584			10.00
13. 00	01300 NURSING ADMINISTRATION	-1, 104, 584			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-30, 374	i e		14. 00
15. 00	01500 PHARMACY	-51, 956			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-20, 391			16. 00
17. 00	01700 SOCIAL SERVICE	-81			17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	C	0		23. 00
23. 01	02301 XRAY EDUCATION	-21, 109	400, 036	,	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	C	321, 197	7	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	-145, 243			30. 00
31. 00	03100 INTENSIVE CARE UNIT	-6, 440	l .	1	31.00
32. 00	03200 CORONARY CARE UNIT	C			32.00
33.00	03300 BURN INTENSIVE CARE UNIT	C	1		33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	C			34. 00 40. 00
41. 00	04100 SUBPROVI DER - I PF				41. 00
42. 00	04200 SUBPROVI DER				42. 00
43. 00	04300 NURSERY		 		43. 00
44. 00	04400 SKILLED NURSING FACILITY				44. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-132, 643	12, 721, 491		50. 00
51.00	05100 RECOVERY ROOM	C	1, 282, 092		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0		52. 00
53. 00	05300 ANESTHESI OLOGY	-14, 955			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-25, 281			54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	C			54. 01
54. 02	05404 ULTRA SOUND	2 112			54. 02
54. 03	05405 MAMMOGRAPHY	-2, 112			54. 03
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	-107, 558			55. 00 57. 00
58. 00	05800 MRI			l control of the cont	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-81, 903		l e e e e e e e e e e e e e e e e e e e	59.00
60.00	06000 LABORATORY	-15, 901		.	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	-672	i e		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C		I and the second	62.00
65.00	06500 RESPI RATORY THERAPY	-13, 226	1, 991, 105	5	65. 00
66.00	06600 PHYSI CAL THERAPY	-29, 234	3, 506, 431		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	1, 202, 840		67. 00
68. 00	06800 SPEECH PATHOLOGY	-1, 268			68. 00
69. 00	06900 ELECTROCARDI OLOGY	-54, 690			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-1, 601			70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C			71.00
72.00	07200 DRUCS CHARGED TO PATIENTS	C			72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	C	12, 100, 20,		73.00
76. 00	03020 ACUPUNCTURE		1		76.00
76. 00	07697 CARDI AC REHABI LI TATI ON	-2, 834	1	l e e e e e e e e e e e e e e e e e e e	76. 00
, 0. 7/	OUTPATIENT SERVICE COST CENTERS	-2,034	100, 200	<u></u>	, 0. 7/
88. 00	08800 RURAL HEALTH CLINIC	C	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	l e e e e e e e e e e e e e e e e e e e	89. 00
90. 00	09000 CLINIC	-291, 496	1	l e e e e e e e e e e e e e e e e e e e	90.00
90. 01	09001 DI ABETES CENTER	-22, 591		•	90. 01
90. 02	09002 NEUROPSYCH	-182, 991			90. 02
90. 03	09003 WOUND CENTER	-1, 109	1, 273, 180		90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	-158		•	90. 04
91. 00	09100 EMERGENCY	-60, 081	6, 003, 766		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1		92. 00

Health FinancialSystemsCOLUMBUS REPORTEDRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150112 | Period: | Worksheet A | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/28/2015 3: 32 pm

Net Expenses For Al location See A-8 See A-8 For Al location See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 See A-8 Se				5/28/2015 3:32 pm
OTHER REIMBURSABLE COST CENTERS 95.00 99500 AMBULANCE SERVI CES -360, 271 2, 444, 590 99.10 999.10 999.10 10100 CORF 0 0 0 99.10 10100 HOME HEALTH AGENCY 0 0 0 10100 HOME HEALTH AGENCY 0 0 0 1010.00 SPECI AL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 110.00 1110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 111.00 11100 ISLET ACQUI SI TI ON 0 0 0 111.00 11100 ISLET ACQUI SI TI ON 0 0 0 1113.00 113.00 11300 INTEREST EXPENSE 0 0 0 113.00 113.00 INTEREST EXPENSE 0 0 0 113.00 113.00 INTEREST EXPENSE 0 0 0 113.00 113.00 1100 SUBTOTALS (SUM OF LINES 1-117) -21, 318, 658 197, 796, 087 118.00 118.00 1900.00 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 55, 812 194.01 194.00 197951 BUI LDI NG RENTALS 0 0 55, 812 194.01 194.00 194.00 197951 BUI LDI NG RENTALS 0 0 57, 993 194.02 194.03 194.04 07954 SPEECH - HEARI NG AI DS 0 218, 666 194.03 194.04 07955 NONALLOWABLE MARKETI NG 0 1, 911, 110 194.05 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 07956 CRH FOUNDATION 0 1, 156 194.06 194.06 194.06 194.06 194.06 194.06 194.06 194.06 194.06 194.06	Cost Center Description	Adjustments	Net Expenses	
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES -360, 271 2, 444, 590 95.00 99.10 09910 CORF 0 0 0 99.10 00910 CORF 0 0 0 0 0 0 0 0 0 0		(See A-8)	or Allocation	
95. 00 99. 10 99. 10 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 109. 00 110. 0		6.00	7. 00	
99. 10 101. 00 10100 HOME HEALTH AGENCY	OTHER REIMBURSABLE COST CENTERS			
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00 110. 00 110. 00 111. 00 110. 00 111. 00 110. 00 111. 00 110. 00 111. 00 111. 00 110. 01	95. 00 09500 AMBULANCE SERVI CES	-360, 271	2, 444, 590	95. 00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00	99. 10 09910 CORF	0	0	99. 10
109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113. 00	101.00 10100 HOME HEALTH AGENCY	0	0	101. 00
110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113. 00 114. 00 115. 0	SPECIAL PURPOSE COST CENTERS			
111. 00 113. 00 113. 00 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 190. 00 194. 00 194. 00 197950 194. 01 197. 7991 194. 02 197951 194. 02 197952 194. 03 197953 194. 04 197954 1956 1966 197956 197	109.00 10900 PANCREAS ACQUISITION	0	0	109. 00
113. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117)	110.00 11000 INTESTINAL ACQUISITION	0	0	110. 00
118. 00 NONREI MBURSABLE COST CENTERS 197, 796, 087 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 255, 949 194. 00 194. 01 07951 BUI LDI NG RENTALS 0 55, 812 194. 01 194. 02 07952 HOSPI CE 0 57, 993 194. 02 194. 03 07953 OUTREACH CLI NI CS 0 0 194. 03 194. 04 07954 SPEECH - HEARI NG AI DS 0 218, 666 194. 04 194. 05 07956 KONALLOWABLE MARKETI NG 0 1, 911, 110 194. 05 194. 06 07956 CRH FOUNDATI ON 0 1, 156 194. 06 194. 06 07956 CRH FOUNDATI ON 0 1, 156 194. 06 195. 00 197. 087 197. 087 197. 087 197. 087 198. 00 199. 087 199. 087 199. 087 195. 00 197. 087 197. 087 196. 00 197. 087 197. 087 198. 00 199. 087 198. 00 199. 087 198. 00 199. 087 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00 199. 00	111.00 11100 ISLET ACQUISITION	0	0	111. 00
NONRET MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 194. 00 194. 00 195. 00 194. 00 194. 01 194. 01 194. 01 194. 02 194. 02 194. 03 194. 03 194. 03 194. 04 194. 04 194. 04 194. 05 194. 05 194. 05 194. 05 194. 05 194. 06	113.00 11300 INTEREST EXPENSE	0	0	113. 00
190. 00 194. 00 1950 SIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 194. 00 194. 01 07950 WELLNESS COMMUNI TY 0 255, 949 194. 00 194. 01 07951 BUI LDI NG RENTALS 0 55, 812 194. 01 194. 02 07952 HOSPI CE 0 57, 993 194. 02 194. 03 07953 OUTREACH CLI NI CS 0 0 194. 02 194. 04 07954 SPEECH - HEARI NG AI DS 0 218, 666 194. 04 194. 05 07955 NONALLOWABLE MARKETI NG 0 1, 911, 110 194. 05 194. 06 07956 CRH FOUNDATI ON 0 1, 156 194. 06	118.00 SUBTOTALS (SUM OF LINES 1-117)	-21, 318, 658	197, 796, 087	118. 00
194. 00 07950 WELLNESS COMMUNITY 0 255, 949 194. 00 194. 01 194. 01 194. 02 194. 02 194. 03 194. 03 194. 03 194. 04 194. 05 194. 05 194. 06 19	NONREI MBURSABLE COST CENTERS			
194. 01 07951 BUI LDI NG RENTALS 0 55, 812 194. 01 194. 02 194. 03 194. 03 194. 03 194. 04 194. 04 194. 05 194. 06 194	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
194. 02 07952 HOSPI CE 0 57, 993 194. 02 194. 03 07953 OUTREACH CLINICS 0 0 194. 03 194. 04 07954 SPEECH - HEARING AIDS 0 218, 666 194. 05 07955 NONALLOWABLE MARKETING 0 1, 911, 110 194. 05 194. 06 07956 CRH FOUNDATION 0 1, 156 194. 06	194. 00 07950 WELLNESS COMMUNITY	0	255, 949	194. 00
194. 03 07953 OUTREACH CLINICS	194. 01 07951 BUI LDI NG RENTALS	0	55, 812	194. 01
194. 04 07954 SPEECH - HEARING AIDS 0 218, 666 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 1, 911, 110 194. 05 194. 06 07956 CRH FOUNDATION 0 1, 156 194. 06	194. 02 07952 HOSPI CE	0	57, 993	194. 02
194. 05 07955 NONALLOWABLE MARKETING 0 1, 911, 110 194. 05 194. 06 07956 CRH FOUNDATION 0 1, 156 194. 06	194. 03 07953 OUTREACH CLINICS	0	o	194. 03
194. 06 07956 CRH FOUNDATION 0 1, 156 194. 06	194.04 07954 SPEECH - HEARING AIDS	0	218, 666	194. 04
	194. 05 07955 NONALLOWABLE MARKETING	0	1, 911, 110	194. 05
	194.06 07956 CRH FOUNDATION	0	1, 156	194. 06
194. 07 07957 HEALTHY COMMUNI TIES 0 149, 171 194. 07	194. 07 07957 HEALTHY COMMUNITIES	0	149, 171	194. 07
200.00 TOTAL (SUM OF LINES 118-199) -21, 318, 658 200, 445, 944 200.00	200.00 TOTAL (SUM OF LINES 118-199)	-21, 318, 658	200, 445, 944	200. 00

Provi der CCN: 150112 | Peri od: | Worksheet Non-CMS W | To | 12/31/2014 | Date/Time Prepared: |

			To 12/31/2014 Date/Time F 5/28/2015 3	
	Cost Center Description	CMS Code	Standard Label For	5. 52 piii
			Non-Standard Codes	
		1. 00	2.00	
1 00	GENERAL SERVICE COST CENTERS	00100		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	00100 00200		1. 00 2. 00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4. 00
5. 01 5. 02	NONPATI ENT TELEPHONES DATA PROCESSI NG	00540 00550	NONPATIENT TELEPHONES DATA PROCESSING	5. 01 5. 02
5. 02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND	5. 03
	1000 77100	00570	STORES	
5. 04 5. 05	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	00570 00580	ADMITTING CASHIERING/ACCOUNTS	5. 04 5. 05
5.05	CASHI ERINO ACCOUNTS RECEI VADEE	00300	RECEI VABLE	3.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	00590		5. 06
7. 00 8. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	00700 00800		7. 00 8. 00
9. 00	HOUSEKEEPI NG	00900		9.00
10.00	DI ETARY	01000		10. 00
11.00	CAFETERIA	01100		11.00
13. 00 14. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	01300 01400		13. 00 14. 00
15. 00	PHARMACY	01500		15. 00
16.00	MEDICAL RECORDS & LIBRARY	01600		16. 00
17. 00 23. 00	SOCIAL SERVICE PARAMED ED PRGM-(SPECIFY)	01700 02300		17. 00 23. 00
23. 01	XRAY EDUCATION	02301		23. 01
23. 02	PHARMACY RESIDENCY PROG	02302		23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	02000		20.00
30. 00 31. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	03000 03100		30. 00 31. 00
32. 00	CORONARY CARE UNIT	03200		32. 00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34. 00 40. 00	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	03400 04000		34. 00 40. 00
41. 00	SUBPROVI DER – I RF	04100		41.00
42. 00	SUBPROVI DER	04200		42. 00
43. 00 44. 00	NURSERY SKILLED NURSING FACILITY	04300 04400		43. 00 44. 00
44. 00	ANCI LLARY SERVI CE COST CENTERS	04400		14.00
50.00	OPERATI NG ROOM	05000		50.00
51. 00 52. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	05100 05200		51. 00 52. 00
53. 00	ANESTHESI OLOGY	05300		53. 00
54.00	RADI OLOGY-DI AGNOSTI C	05400		54. 00
54. 01 54. 02	NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	05402 05404		54. 01 54. 02
	MAMMOGRAPHY	05404		54. 02
55.00	RADI OLOGY-THERAPEUTI C	05500		55. 00
57. 00	CT SCAN	05700		57. 00
58. 00 59. 00	MRI CARDI AC CATHETERI ZATI ON	05800 05900		58. 00 59. 00
60.00	LABORATORY	06000		60.00
60. 01	LABORATORY-PATHOLOGICAL	06001		60. 01
62. 00 65. 00	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	06200 06500		62. 00 65. 00
66. 00	PHYSI CAL THERAPY	06600		66.00
67. 00	OCCUPATIONAL THERAPY	06700		67. 00
68. 00	SPEECH PATHOLOGY	06800		68. 00
69. 00 70. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	06900 07000		69. 00 70. 00
71. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73. 00 74. 00	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	07300 07400		73. 00 74. 00
76. 00	ACUPUNCTURE	03020	ACUPUNCTURE	76.00
76. 97	CARDI AC REHABI LI TATI ON	07697	CARDIAC REHABILITATION	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS	00000		00 00
88. 00 89. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	08800 08900		88. 00 89. 00
90.00	CLINIC	09000		90. 00
90. 01	DI ABETES CENTER	09001		90. 01
90. 02 90. 03	NEUROPSYCH WOUND CENTER	09002 09003		90. 02 90. 03
	1	1 0,000	ı	11 70.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In lieu	ı of Form CMS-2552-10
COST CENTERS USED IN COST REPORT		CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet Non-CMS W Date/Time Prepared: 5/28/2015 3:32 pm
Cost Center Description		CMS Code	Standard L Non-Standa	
		1.00	2.0	0
90.04 HYPERBARIC OXYGEN THERAPY		09004		90.04
91. 00 EMERGENCY		09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART		09200		92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 AMBULANCE SERVICES		09500		95.00
99. 10 CORF		09910		99. 10
101.00 HOME HEALTH AGENCY		10100		101. 00
SPECIAL PURPOSE COST CENTERS				
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				
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
		1	1	11

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/28/2015 3:32 pm Provi der CCN: 150112

					10 12/3	5/28/2015 3:32 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	B - RECLASS DEPREC BLDG/EQUIP					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 233, 109		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		•	66 <u>6, 7</u> 55		2. 00
	0		0	1, 899, 864		
	C - RECLASS INSURANCE					
1.00	OCCUPATI ONAL THERAPY	67. 00	0	1, 200		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	926, 760		2. 00
3.00	AMBULANCE SERVICES	95.00	0	32, 877		3.00
4.00	LABORATORY	60.00		<u>2, 9</u> 92		4.00
	0		0	963, 829		
	D - RECLASS BILLING COST			-		
1. 00	CASHI ERI NG/ACCOUNTS	5. 05	768, 363	0		1.00
	RECEIVABLE	+				
	U DECLACE LIVEEDBADI C THEDAD	/ EVDENCE	768, 363	0		
1 00	E - RECLASS HYPERBARI C THERAPY		ما	2// 107		1.00
1. 00	HYPERBARI C OXYGEN THERAPY	<u>90.</u> 04		<u>266, 187</u>		1.00
	U		0	266, 187		
1 00	F - RECLASS CAFETERIA EXPENSE	11 00	1 210 401	720 114		1.00
1. 00	CAFETERI A		1, 219, 401	728, 114		1.00
	C DECLASS WELLNESS		1, 219, 401	728, 114		
1 00	G - RECLASS WELLNESS	104 00	1/1 700	114 021		1 00
1. 00	WELLNESS COMMUNITY	194.00	161, 709	11 <u>4, 021</u>		1.00
	U DECLASS DUVELCLAN FEE		161, 709	114, 021		
1 00	H - RECLASS PHYSICIAN FEES	E 0/	O	1 142 705		1 00
1. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	U	1, 143, 705		1.00
2 00	ADULTS & PEDIATRICS	20.00		200 124		2.00
2.00		30.00	0	290, 136		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	36, 600		3.00
4.00	SUBPROVI DER - I RF	41.00	0	51, 250		4.00
5.00	OPERATING ROOM	50.00	0	145, 300		5. 00
6.00	ANESTHESI OLOGY	53. 00	0	45, 000		6. 00
7.00	RADI OLOGY-THERAPEUTI C	55.00	0	150, 000		7. 00
8.00	CARDI AC CATHETERI ZATI ON	59. 00	0	139, 338		8.00
9.00	LABORATORY-PATHOLOGI CAL	60. 01	0	150, 000		9. 00
10.00	RESPI RATORY THERAPY	65.00	0	60, 700		10.00
11.00	PHYSI CAL THERAPY	66.00	0	50, 000		11. 00
12.00	ELECTROCARDI OLOGY	69.00	o	61, 450		12. 00
13.00	ELECTROENCEPHALOGRAPHY	70.00	o	9, 100		13.00
14.00	CARDIAC REHABILITATION	76. 97	o	4, 812		14.00
15.00	CLINIC	90.00	o	365, 000		15. 00
16. 00	EMERGENCY	91.00	0	1, 044, 560		16. 00
17. 00	AMBULANCE SERVICES	95. 00	ō	17, 500		17. 00
18. 00	WOUND CENTER	90. 03	o	6, 300		18. 00
19. 00	HYPERBARIC OXYGEN THERAPY	90. 04	Ö	900		19. 00
17.00	O OXIGEN THEIRAIT		— —	3, 771, 651		17.00
	I - RECLASS REHAB SERVICES		<u> </u>	0, 771, 001		
1.00	OCCUPATI ONAL THERAPY	67.00	20, 581	22, 851		1.00
2. 00	PHYSI CAL THERAPY	66.00	57, 858	22, 115		2. 00
3. 00	SPEECH PATHOLOGY	68. 00	18, 720	66, 780		3.00
4. 00	SUBPROVI DER - I RF	41. 00	149, 831	2, 444		4.00
5. 00	ELECTROENCEPHALOGRAPHY	70. 00	14, 894	1, 629		5.00
6. 00	SOCIAL SERVICE	17. 00	3, 723	407		6.00
7. 00	ADULTS & PEDIATRICS	30.00	24, 203	2, 648		7.00
8. 00	NEUROPSYCH	90. 02	13, 032	1, 426		8.00
9. 00	WOUND CENTER	90. 02	15, 164	62, 207		9.00
9. 00 10. 00	HYPERBARI C OXYGEN THERAPY	90.03	1, 694	33, 519		10.00
10.00	O LUDANI C ON IGEN THE KAP!					10.00
	J - RECLASS PHARMACY RES PROGI	DAM	319, 700	216, 026		
1 00	PHARMACY RESI DENCY PROG		100 700	1 200		1 00
1. 00	O KEST DENCY PRUG	23.02	18 <u>0, 7</u> 08 180, 708	<u>1, 398</u> 1, 398		1.00
	K - RECLASS PENSION EXPENSE		160, 708	1, 398		
1 00	OTHER ADMINISTRATIVE AND	5. 06	٥١	201 074		1 00
1. 00	I I	5.06	0	201, 074		1.00
	GENERAL	+				
	I DECLASS MADVETING EVDENCE		U	201, 074		
1 00	L - RECLASS MARKETING EXPENSE	104 05	ما	120,000		1 00
1. 00	NONALLOWABLE MARKETING	194.05		130, 000		1.00
	U DECLACE DEPOSE AT AN EXTEN	VICE	0	130, 000		
4 00	M - RECLASS DEPRECIATION EXPER			0.050.75		
1. 00	CAP REL COSTS-MVBLE EQUIP		0_	9, 050, 701		1.00
	0		0	9, 050, 701		
	IN DECLACE MAINTENANCE EVDEN	SI-				
	N - RECLASS MAINTENANCE EXPENS					
1. 00	RESPI RATORY THERAPY	65. 00	0	24, 509		1.00
1. 00 2. 00 3. 00			0 0 0	24, 509 90 310, 752		1. 00 2. 00 3. 00

Health Financial Systems RECLASSIFICATIONS

					5/28/2015 3:32 pm
		Increases	6.1	0.11	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00	
5. 00	OPERATING ROOM	50.00	4.00	363, 982	5. 00
6.00	RADI OLOGY-THERAPEUTI C	55.00	0	197, 859	6. 00
7.00	LABORATORY	60.00	0	182, 371	7.00
8.00	LABORATORY-PATHOLOGI CAL	60. 01	0	11, 285	8.00
9. 00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	14, 269	9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	189, 623	10.00
11. 00	MAMMOGRAPHY	54. 03	O	133, 730	11. 00
12.00	ULTRA SOUND	54.02	0	90, 207	12.00
13.00	CT SCAN	57.00	0	162, 928	13.00
14. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	231, 572	14.00
15. 00 16. 00	MRI PHARMACY	58. 00 15. 00	0	149, 681 44, 636	15. 00 16. 00
17. 00	EMERGENCY	91.00	0	28, 711	17.00
18. 00	DATA PROCESSING	5. 02	Ö	4, 809	18.00
	0			2, 141, 014	
1 00	Q - RECLASS XRAY EDUCATION EX		4.1	0	1.00
1. 00 2. 00	XRAY EDUCATION XRAY EDUCATION	23. 01 23. 01	41 264, 467	0	1.00
3.00	XRAY EDUCATION	23. 01	204, 407	<u>2, 364</u>	3.00
0.00	TOTALS		264, 508	$\frac{2}{2},364$	5.00
	R - RECLASS ADMIN HEALTHY COM				
1.00	OTHER ADMINISTRATIVE AND	5. 06	34, 970	0	1.00
	GENERAL	+		— — _o	
	S - RECLASS NON ALLOW ADVERTI	SING COSTS	34, 970	U	
1.00	NONALLOWABLE MARKETING	194. 05	0	1, 781, 110	1.00
	0		0	1, 781, 110	
	T - RECL EQUIP RENTAL TO CHAR				
1.00	MEDICAL SUPPLIES CHAPCED TO	0. 00 71. 00	0	107 004	1.00
2. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	٥	186, 994	2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	34, 775	3.00
	PATI ENT			·	
4.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	23, 736	4.00
5. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	0	21, 998	5. 00
3.00	PATI ENT	71.00	J	21, 990	3.00
	0			267, 503	
	U - RECLASS CHARGEABLE SUPPLY				
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	195, 895	1.00
2. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	0	66, 535	2.00
2.00	PATI ENT	71.00	Š	00, 000	2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	5, 066	3.00
	PATI ENT		_		
4. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2, 471	4.00
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 847, 923	5. 00
	PATI ENT			2, 2 ,	
6.00	IMPL. DEV. CHARGED TO	72. 00	0	5, 619, 557	6. 00
7 00	PATIENTS	71 00	0	(OF 2	7.00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	6, 052	7.00
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	61, 145	8.00
	PATI ENT]	·	
9. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	530, 408	9.00
10.00	PATIENT MEDICAL SUPPLIES CHARGED TO	71 00	0	9 EE1	10.00
10. 00	PATIENT	71. 00	٥	3, 551	10.00
11. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 902	11.00
	PATI ENT			·	
12. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 499	12.00
13. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71.00	o	78, 776	13.00
13.00	PATIENT	71.00	٩	10, 110	13.00
14.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	39, 295	14. 00
	PATI ENT			·	
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 244, 255	15. 00
16. 00	PATIENT IMPL. DEV. CHARGED TO	72. 00	0	1, 724, 383	16. 00
10.00	PATIENTS	72.00	U	1, 724, 303	16.00
17 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	45, 810	17. 00
17. 00					l l

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2014 Date/Time Prepared: 5/28/2015 3:32 pm Provi der CCN: 150112

						5/28/2015 3:32 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	18, 423		18.
	PATI ENT					
9. 00	SPEECH - HEARING AIDS	194. 04	0	218, 666		19.
0. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	129, 613		20.
	PATI ENT	74 00		47.004		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	17, 024		21.
2 00	PATI ENT	71 00		14 750		22
2. 00	MEDICAL SUPPLIES CHARGED TO	71.00	۷	14, 758		22.
3. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71 00	0	14 204		23.
5. 00	PATIENT	71.00	٥	14, 384		23.
		+		13, 890, 391		
	V - RECL PTO COST FOR STD ELI	MINATION PD	<u> </u>	10,070,071		
00	TREES THE SECTION STEED	0.00	0	0		1.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	182		2.
00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ö	274		3.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	1, 741		4.
00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ö	1, 418		5.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	11, 553		6.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	9, 831		7.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 367		8.
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol O	8, 041		9.
0. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	23, 413		10.
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	16, 422		11.
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	25, 566		12.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	7, 821		13.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 004		14.
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	86, 748		15.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 072		16.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	8, 910		17.
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 197		18.
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	32, 196		19.
0. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	7, 522		20.
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 510		21.
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 967		22.
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	968		23.
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	7, 196		24.
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	1, 600		25.
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 235		26.
7. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	46, 502		27.
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 623		28.
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	12, 194		29.
0. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 642		30.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	3, 978		31.
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 916		32.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 962		33.
. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0_	4, 959		34.
	0		0	363, 530		
	X - RECLASS OT SALARIES AND O	THER EXP				
00	OCCUPATI ONAL THERAPY	67. 00	<u>585, 9</u> 30	<u>129, 4</u> 92		1.
	0		585, 930	129, 492		
	Y - RECL MILLRACE FOR WELLNES					
00	OCCUPATI ONAL THERAPY	67. 00	0	2, 350		1.
00	PHYSI CAL THERAPY	66.00	0	11, 472		2.
00	OCCUPATI ONAL THERAPY	67. 00	0	1, 013		3.
00	PHYSICAL THERAPY	6600		<u>4, 9</u> 46		4.
	0		0	19, 781		
	Z - RECLASS LAB BLOOD SUPERVI					
00	WHOLE BLOOD & PACKED RED	62. 00	69, 882	0		1.
	BLOOD CELL					
	0		69, 882	0		
000	Grand Total: Increases		3, 605, 171	35, 938, 050		500.

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provi der CCN: 150112

						o 12/31/2014 Date/lime F 5/28/2015 3	
	Cook Cooker	Decreases	C-1	0+1	WI+ A 7 D-6		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	B - RECLASS DEPREC BLDG/EQUIP		0.00				
1. 00 2. 00	INTEREST EXPENSE INTEREST EXPENSE	113. 00 113. 00	0	1, 233, 109 666, 755			1. 00 2. 00
2.00	0	113.00		1, 899, 864			2.00
1 00	C - RECLASS INSURANCE	E 0/1	ما	4 000			
1. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	1, 200	0		1. 00
2.00	OTHER ADMINISTRATIVE AND	5. 06	0	926, 760	12		2. 00
3. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	32, 877	0		3. 00
4 00	GENERAL	5.04					4 00
4. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	O	2, 992	0		4. 00
	0		0	963, 829			
1. 00	D - RECLASS BILLING COST MEDICAL RECORDS & LIBRARY	16. 00	768, 363	0	O		1.00
1.00	0	10.00	768, 363	0	<u> </u>		1.00
1 00	E - RECLASS HYPERBARI C THERAP		ما	2// 107			1 00
1. 00	WOUND CENTER	90. 03	0	<u>266, 1</u> 87 266, 187			1. 00
	F - RECLASS CAFETERIA EXPENSE						
1. 00	DI ETARY		1, 219, 401 1, 219, 401	72 <u>8, 1</u> 14 728, 114			1. 00
	G - RECLASS WELLNESS		1, 217, 401	720, 114			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	161, 709	114, 021			1. 00
	H - RECLASS PHYSICIAN FEES		161, 709	114, 021			
1.00	OPERATING ROOM	50. 00	0	1, 143, 705			1. 00
2. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	290, 136	0		2. 00
3.00	OTHER ADMINISTRATIVE AND	5. 06	0	36, 600	О		3. 00
4. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	51, 250	0		4. 00
4.00	GENERAL GENERAL	5.00	o l	51, 250	o o		4.00
5.00	OTHER ADMINISTRATIVE AND	5. 06	0	145, 300	0		5. 00
6. 00	GENERAL OPERATING ROOM	50.00	0	45, 000	О		6. 00
7. 00	OTHER ADMINISTRATIVE AND	5. 06	0	150, 000	O		7. 00
8. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	139, 338	o		8. 00
	GENERAL						
9. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	O	150, 000	0		9. 00
10.00	OTHER ADMINISTRATIVE AND	5. 06	0	60, 700	О		10. 00
11. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	50, 000	0		11. 00
	GENERAL			•			
12. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	61, 450	0		12. 00
13. 00	OTHER ADMINISTRATIVE AND	5. 06	0	9, 100	О		13. 00
14. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	4, 812	o		14. 00
14.00	GENERAL ADMINISTRATIVE AND	5.00		4, 012			14.00
15. 00	OTHER ADMINISTRATIVE AND	5. 06	0	365, 000	0		15. 00
16. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	1, 044, 560	О		16. 00
47.00	GENERAL	5.04		47.500			47.00
17. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	O	17, 500	0		17. 00
18. 00	OTHER ADMINISTRATIVE AND	5. 06	0	6, 300	О		18. 00
19. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	900	o		19. 00
17.00	GENERAL		1				17.00
	O		0	3, 771, 651			
1.00	OTHER ADMINISTRATIVE AND	5. 06	20, 581	22, 851	0		1.00
2 00	GENERAL	E 0/	E7 0E0	20 145			2.00
2. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	57, 858	22, 115	0		2. 00
3.00	OTHER ADMINISTRATIVE AND	5. 06	18, 720	66, 780	0		3. 00
4. 00	GENERAL OTHER ADMINISTRATIVE AND	5. 06	149, 831	2, 444	0		4. 00
	GENERAL						
5. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	14, 894	1, 629	0		5. 00
	JOENEIVIE	I	I		1		1

RECLASSI FI CATIONS

Provi der CCN: 150112

Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Ti me Prepared:

5/28/2015 3:32 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 6.00 OTHER ADMINISTRATIVE AND 5.06 3.723 407 0 6.00 GENERAL 7.00 OTHER ADMINISTRATIVE AND 5.06 0 24, 203 2,648 7.00 GENERAL OTHER ADMINISTRATIVE AND 8.00 13, 032 1, 426 5.06 0 8.00 GENERAL OTHER ADMINISTRATIVE AND 9.00 5.06 15, 164 62, 207 0 9.00 GENERAL 10.00 OTHER ADMINISTRATIVE AND 5.06 1,694 33, 519 10.00 GENERAL 319, 700 216, 026 J - RECLASS PHARMACY RES PROGRAM 1.00 PHARMACY 15.00 180, 708 1, 398 0 1.00 180, 708 1, 398 K - RECLASS PENSION EXPENSE 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 201, 074 0 1.00 201, 074 L - RECLASS MARKETING EXPENSE OTHER ADMINISTRATIVE AND 1.00 5.06 0 130,000 \cap 1.00 GENERAL ō 130, 000 - RECLASS DEPRECIATION EXPENSE CAP REL COSTS-BLDG & FLXT 1. 00 1.00 0 9, 050, 701 1.00 9, 050, 701 N - RECLASS MAINTENANCE EXPENSE 1.00 OPERATION OF PLANT 7.00 0 24, 509 0 1.00 OPERATION OF PLANT 7.00 0 2.00 90 0 2.00 OPERATION OF PLANT 0 0 3.00 7.00 310, 752 3.00 OPERATION OF PLANT 0 0 5.00 7.00 363, 982 5.00 0 OPERATION OF PLANT 7.00 0 197.859 6.00 6.00 7.00 OPERATION OF PLANT 7.00 0 182, 371 7.00 8.00 OPERATION OF PLANT 7.00 0 11, 285 0 8.00 9.00 OPERATION OF PLANT 7.00 o 14, 269 0 9.00 OPERATION OF PLANT 0 0 7.00 10.00 189, 623 10.00 OPERATION OF PLANT 0 11.00 7.00 0 133.730 11 00 12.00 OPERATION OF PLANT 7.00 90, 207 0 12.00 13.00 OPERATION OF PLANT 7.00 o 162, 928 0 13.00 OPERATION OF PLANT 0 14.00 7.00 0 231.572 14.00 0 15.00 OPERATION OF PLANT 7.00 0 149, 681 15.00 16.00 OPERATION OF PLANT 7.00 0 44,636 0 16.00 OPERATION OF PLANT 7.00 0 28, 711 0 17.00 17.00 OPERATION OF PLANT 4, 809 0 18.00 7.00 18.00 0 2, 141, 014 Q - RECLASS XRAY EDUCATION EXPENSES 1.00 0 65.00 0 1.00 RESPIRATORY THERAPY 41 2.00 RADI OLOGY-DI AGNOSTI C 54.00 264, 467 0 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 2, 364 0 3.00 TOTALS 264, 508 2, 364 R - RECLASS ADMIN HEALTHY COMM SALARY 1.00 HEALTHY COMMUNITIES 194.07 34, 970 0 1.00 34, 970 S - RECLASS NON ALLOW ADVERTISING COSTS 1 00 OTHER ADMINISTRATIVE AND 5.06 1, 781, 110 O 1 00 0 GENERAL o 1, 781, 110 T - RECL EQUIP RENTAL TO CHARGEABLE SUPP 1.00 1.00 0.000 186, 994 2.00 ADULTS & PEDIATRICS 30.00 0 0 2.00 3.00 INTENSIVE CARE UNIT 31.00 0 34, 775 0 3.00 0 4.00 SUBPROVIDER - IRF 41.00 23, 736 0 4.00 21, 998 RESPIRATORY THERAPY 5.00 65.00 0 0 5.00 ō 267, 503 U - RECLASS CHARGEABLE SUPPLY COST 1.00 30.00 0 195, 895 0 1.00 ADULTS & PEDIATRICS INTENSIVE CARE UNIT 0 0 2.00 31.00 66, 535 2.00 3.00 SUBPROVIDER - IRF 41.00 0 5,066 0 3.00 4.00 NURSERY 43.00 0 2, 471 0 4.00 OPERATING ROOM 3, 847, 923 0 5.00 50.00 0 5.00 0 6.00 OPERATING ROOM 50.00 0 5, 619, 557 6.00 7.00 RECOVERY ROOM 51.00 0 6,052 0 7.00 0 RADI OLOGY-DI AGNOSTI C 0 8.00 54.00 61, 145 8.00 0 0 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 9.00 530, 408 9 00 10.00 ULTRA SOUND 54.02 0 3, 551 0 10.00 MAMMOGRAPHY 11.00 54.03 3, 902 11.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-0 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm Provi der CCN: 150112

						5/28/2015 3:3	2 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
12. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	2, 499			12. 00
13. 00	CT SCAN	57. 00	0	78, 776	0		13. 00
14.00	MRI	58. 00	0	39, 295	0		14. 00
15. 00	CARDIAC CATHETERIZATION	59. 00	0	1, 244, 255	0		15. 00
16.00	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 724, 383	0		16.00
17. 00	RESPIRATORY THERAPY	65. 00	0	45, 810	0		17. 00
18.00	PHYSI CAL THERAPY	66.00	0	18, 423	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	218, 666	l		19. 00
20.00	ELECTROCARDI OLOGY	69. 00	0	129, 613	0		20.00
21. 00	WOUND CENTER	90. 03	U	17, 024	0		21. 00
22. 00 23. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	14, 758	0		22. 00 23. 00
23.00	AWIBULANCE SERVICES	95.00	0	1 <u>4, 3</u> 84 13, 890, 391	<u> </u>		23.00
	V - RECL PTO COST FOR STD ELI	MINATION DD	<u> </u>	13, 670, 371			
1.00	V - RECE FIO COST TOR STD EET	0.00	0	0	0		1. 00
2. 00	NONPATIENT TELEPHONES	5. 01	182	0			2. 00
3.00	DATA PROCESSING	5. 02	274	0			3. 00
4. 00	PURCHASING RECEIVING AND	5. 03	1, 741	0	0		4. 00
1. 00	STORES	0.00	', ' ' '	Ü			1. 00
5.00	CASHI ERI NG/ACCOUNTS	5. 05	1, 418	0	o		5. 00
	RECEI VABLE	3. 33	.,	_			
6.00	OTHER ADMINISTRATIVE AND	5. 06	11, 553	0	0		6.00
	GENERAL						
7.00	OPERATION OF PLANT	7. 00	9, 831	0	0		7.00
8.00	LAUNDRY & LINEN SERVICE	8. 00	1, 367	0	o		8.00
9.00	HOUSEKEEPI NG	9.00	8, 041	0	o		9. 00
10.00	DI ETARY	10.00	23, 413	0	o		10.00
11. 00	CAFETERI A	11, 00	16, 422	0	0		11. 00
12. 00	NURSING ADMINISTRATION	13.00	25, 566	0	0		12.00
13. 00	PHARMACY	15. 00	7, 821	0	O		13. 00
14. 00	MEDICAL RECORDS & LIBRARY	16. 00	7, 004	0	O		14. 00
15. 00	ADULTS & PEDIATRICS	30.00	86, 748	0	o		15. 00
16. 00	INTENSIVE CARE UNIT	31.00	6, 072	0	o		16. 00
17. 00	SUBPROVI DER - I RF	41. 00	8, 910	0	o		17. 00
18. 00	NURSERY	43. 00	1, 197	0	o		18. 00
19. 00	OPERATING ROOM	50.00	1, 17,	32, 196			19. 00
20. 00	RECOVERY ROOM	51.00	0	7, 522	o		20. 00
21. 00	ANESTHESI OLOGY	53. 00	0	1, 510	o		21. 00
22. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	1, 967	1, 510	0		22. 00
23. 00	ULTRA SOUND	54. 02	968	0	0		23. 00
24. 00	RADI OLOGY-THERAPEUTI C	55.00	7, 196	0	0		24. 00
25. 00	CT SCAN	57. 00	1, 600	0	0		25. 00
	CARDIAC CATHETERIZATION	59. 00		0	0		26. 00
26. 00 27. 00	1		1, 235	0	· ·		
	LABORATORY	60.00	46, 502	0	0		27. 00
28. 00	RESPIRATORY THERAPY	65.00	4, 623	0			28. 00
29. 00	PHYSI CAL THERAPY	66.00	12, 194	0	0		29. 00
30.00	OCCUPATI ONAL THERAPY	67. 00	3, 642	0	0		30.00
31.00	SPEECH PATHOLOGY	68. 00	3, 978	0	0		31. 00
32.00	WOUND CENTER	90. 03	1, 916	0	0		32.00
33. 00	EMERGENCY	91.00	13, 962	0	0		33. 00
34. 00	AMBULANCE SERVICES	95.00	<u>4, 9</u> 59	0	<u> </u>		34.00
	V DECLASS OF SALADIES AND O	THED EVD	322, 302	41, 228			
1 00	X - RECLASS OT SALARIES AND C PHYSICAL THERAPY		E0E 020	120 402			1 00
1. 00	PHYSICAL THERAPY	66.00	58 <u>5, 9</u> 30	129, 492	9		1. 00
	V DECLIMILIDACE FOR WELLINGS	CS /OD /DT	585, 930	129, 492			
1 00	Y - RECL MILLRACE FOR WELLNES		~1	2 252			1 00
1.00	WELLNESS COMMUNITY WELLNESS COMMUNITY	194.00	0	2, 350	0		1.00
2.00	l I	194.00	0	11, 472	0		2.00
3.00	WELLNESS COMMUNITY	194.00	0	1, 013	0		3.00
4. 00	WELLNESS COMMUNITY	194.00	— — — Š		├─ — — 🎙		4. 00
	Z - RECLASS LAB BLOOD SUPERVI	SOP	U U	19, 781			
1. 00	LABORATORY		69, 882	^	0		1. 00
1.00	0	60.00	69, 882 69, 882	— — <u> </u>	<u></u>		1.00
500 00	Grand Total: Decreases		3, 927, 473	35, 615, 748			500.00
555.00	12. 2 10.01. 2001.00000	ı	5, 72,, 175	33, 313, 140	ı	1	200.00

Provi der CCN: 150112

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 5/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 |

		I ncreas	ses			Decrea		5/28/2015 3: 3	32 p
	Cost Center	Li ne #	Salary	Other	Cost Center	Li ne #	Salary	Other	
	2.00	3. 00	4. 00	5. 00	6.00	7. 00	8. 00	9. 00	
	B - RECLASS DEPREC BLD	G/EQUI P							
00	CAP REL COSTS-BLDG &	1. 00	0	1, 233, 109	INTEREST EXPENSE	113. 00	0	1, 233, 109	
00	FIXT CAP REL COSTS-MVBLE	2. 00	o	444 755	INTEREST EXPENSE	113. 00	0	666, 755	
,0	EQUIP	2.00	U	000, 755	INTEREST EXPENSE	113.00	٥	000, 755	
	0			1, 899, 864	0 — — — —			1, 899, 864	
	C - RECLASS INSURANCE								
00	OCCUPATI ONAL THERAPY	67. 00	0	1, 200	OTHER ADMINISTRATIVE	5. 06	0	1, 200	
00	CAP REL COSTS-BLDG &	1. 00	o	026 760	AND GENERAL OTHER ADMINISTRATIVE	5. 06	0	926, 760	
,0	FIXT	1.00	٥	720, 700	AND GENERAL	3.00	٥	920, 700	
00	AMBULANCE SERVICES	95. 00	o	32, 877	OTHER ADMINISTRATIVE	5.06	0	32, 877	
					AND GENERAL				
00	LABORATORY	60. 00	0	2, 992	OTHER ADMINISTRATIVE	5. 06	0	2, 992	
		-		963, 829	AND GENERAL			963, 829	
	D - RECLASS BILLING CO	ST	<u> </u>	703, 027	10		<u> </u>	703, 027	
0	CASHI ERI NG/ACCOUNTS	5. 05	768, 363	C	MEDICAL RECORDS &	16.00	768, 363	0	
	RECEI VABLE				LI BRARY				
	0		768, 363	0	0		768, 363	0	
00	E - RECLASS HYPERBARIC HYPERBARIC OXYGEN	90. 04	EXPENSE 0	244 107	WOUND CENTER	90. 03	0	266, 187	
10	THERAPY	70.04	٩	200, 107	WOOND CENTER	90.03	٩	200, 107	
	0			266, 187	0 — — — —			266, 187	
	F - RECLASS CAFETERIA								
00	CAFETERI A	11. 00	<u>1, 219, 4</u> 01		DI ETARY	10.00	<u>1, 219, 4</u> 01	72 <u>8, 1</u> 14	
	O DECLACE WELLNESS		1, 219, 401	728, 114	.[0		1, 219, 401	728, 114	
00	G - RECLASS WELLNESS WELLNESS COMMUNITY	194. 00	161, 709	11/ 021	EMPLOYEE BENEFITS	4.00	161, 709	114, 021	
,0	WELLINESS COMMONT IT	174.00	101, 709	114, 021	DEPARTMENT	4.00	101, 709	114, 021	
	0		161, 709	114, 021			161, 709	114, 021	
	H - RECLASS PHYSICIAN	FEES							
00	OTHER ADMINISTRATIVE	5. 06	0	1, 143, 705	OPERATING ROOM	50.00	0	1, 143, 705	
	AND GENERAL	00.00		000 404	OTHER ARMINI CTRATIVE	F 04		000 404	
00	ADULTS & PEDIATRICS	30. 00	0	290, 136	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	290, 136	
00	INTENSIVE CARE UNIT	31.00	o	36, 600	OTHER ADMINISTRATIVE	5. 06	o	36, 600	
					AND GENERAL				
00	SUBPROVI DER - I RF	41. 00	0	51, 250	OTHER ADMINISTRATIVE	5.06	0	51, 250	
00	ODERATING DOOM	FO 00	o	145 200	AND GENERAL	5. 06	0	145 200	
00	OPERATING ROOM	50. 00	U	145, 300	OTHER ADMINISTRATIVE AND GENERAL	5.06	۷	145, 300	
00	ANESTHESI OLOGY	53. 00	o	45, 000	OPERATING ROOM	50.00	o	45, 000	
00	RADI OLOGY-THERAPEUTI C	55. 00	o		OTHER ADMINISTRATIVE	5.06	0	150, 000	
					AND GENERAL				
00	CARDI AC	59. 00	0	139, 338	OTHER ADMINISTRATIVE	5. 06	0	139, 338	
00	CATHETERI ZATI ON LABORATORY-PATHOLOGI C	60. 01	0	150 000	AND GENERAL OTHER ADMINISTRATIVE	5. 06	0	150, 000	
,0	AL	00.01			AND GENERAL	3.00	٩	150,000	
00	RESPIRATORY THERAPY	65. 00	0		OTHER ADMINISTRATIVE	5.06	0	60, 700	1
					AND GENERAL				
00	PHYSI CAL THERAPY	66. 00	0	50, 000	OTHER ADMINISTRATIVE	5. 06	0	50, 000	1
00	ELECTROCARDI OLOGY	69. 00	o	61 450	AND GENERAL OTHER ADMINISTRATIVE	5. 06	0	61, 450	1
00	LEECTROCARDI GEGGI	09.00	٩	01, 430	AND GENERAL	3.00	٩	01, 430	'
00	ELECTROENCEPHALOGRAPH	70. 00	О	9, 100	OTHER ADMINISTRATIVE	5.06	0	9, 100	1
	Υ				AND GENERAL				
00	CARDI AC	76. 97	0	4, 812	OTHER ADMINISTRATIVE	5. 06	0	4, 812	1
00	REHABI LI TATI ON CLI NI C	90. 00	0	365 000	AND GENERAL OTHER ADMINISTRATIVE	5. 06	o	365, 000	1
00	CLINIC	70.00	٥	303, 000	AND GENERAL	3.00	٥	303,000	'
00	EMERGENCY	91.00	О	1, 044, 560	OTHER ADMINISTRATIVE	5.06	0	1, 044, 560	1
					AND GENERAL				
00	AMBULANCE SERVICES	95. 00	0	17, 500	OTHER ADMINISTRATIVE	5. 06	0	17, 500	1
00	WOUND CENTER	00.00		/ 222	AND GENERAL			/ 202	_
00	WOUND CENTER	90. 03	0	6, 300	OTHER ADMINISTRATIVE AND GENERAL	5. 06	٥	6, 300	1
00	HYPERBARI C OXYGEN	90. 04	o	900	OTHER ADMINISTRATIVE	5. 06	o	900	1
7. 00	THERAPY	. 3. 3	Ĭ	,50	AND GENERAL	3.33	Ĭ	,30	
	0			3, 771, 651				3, 771, 651	
	I - RECLASS REHAB SERV								
00	OCCUPATI ONAL THERAPY	67. 00	20, 581	22, 851	OTHER ADMINISTRATIVE	5. 06	20, 581	22, 851	
	PHYSI CAL THERAPY	66. 00	57, 858	22 11 11	AND GENERAL OTHER ADMINISTRATIVE	5. 06	57, 858	22, 115	
00			2/ 8281	// 115	WILDER AUNITALISTRATIVE			// [15]	

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 5/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | 1/2015 | Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150112

							0 12/31/2014	Date/lime Pre 5/28/2015 3:3	
		Increase				Decre			
		Li ne #	Salary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4.00	5. 00	6.00	7.00	8. 00	9. 00	_
00	SPEECH PATHOLOGY	68. 00	18, 720	66, 780	OTHER ADMINISTRATIVE AND GENERAL	5. 06	18, 720	66, 780	3
00	SUBPROVI DER - I RF	41. 00	149, 831	2, 444	OTHER ADMINISTRATIVE	5. 06	149, 831	2, 444	4
00	ELECTROENCEPHALOGRAPH	70. 00	14, 894	1, 629	AND GENERAL OTHER ADMINISTRATIVE	5. 06	14, 894	1, 629	5
00	Y SOCIAL SERVICE	17. 00	3, 723	407	AND GENERAL OTHER ADMINISTRATIVE	5. 06	3, 723	407	6
00	ADULTS & PEDIATRICS	30. 00	24, 203	2, 648	AND GENERAL OTHER ADMINISTRATIVE	5. 06	24, 203	2, 648	7
00	NEUROPSYCH	90. 02	13, 032	1, 426	AND GENERAL OTHER ADMINISTRATIVE	5. 06	13, 032	1, 426	8
00	WOUND CENTER	90. 03	15, 164	62, 207	AND GENERAL OTHER ADMINISTRATIVE	5. 06	15, 164	62, 207	9
00	HYPERBARIC OXYGEN	90. 04	1, 694	33, 519	AND GENERAL OTHER ADMINISTRATIVE	5. 06	1, 694	33, 519	10
	THERAPY		319, 700	 216, 026	AND GENERAL		319, 700		
	J - RECLASS PHARMACY R	ES PROGRAM			-	-11		2.37.020	
00	PHARMACY RESIDENCY	23. 02	180, 708	1, 398	PHARMACY	15.00	180, 708	1, 398	1
	PROG					\perp			
	0 K - RECLASS PENSION EX	DENCE	180, 708	1, 398	0		180, 708	1, 398	
00	OTHER ADMINISTRATIVE	5. 06	0	201 074	EMPLOYEE BENEFITS	4.00	0	201, 074	1
	AND GENERAL_		1_		DEPARTMENT				
	0		0	201, 074	0		0	201, 074	
	L - RECLASS MARKETING			400.000	OTHER ARMAN CTRATILIE	1 5 0/1	ام	400.000	
00	NONALLOWABLE MARKETI NG	194. 05	0	130, 000	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	130, 000	1
	0		- — 	130, 000		\vdash		130,000	
	M - RECLASS DEPRECIATION	ON EXPENSE		100,000	10		<u> </u>	1007 000	
00	CAP REL COSTS-MVBLE EQUI P	2. 00	0	9, 050, 701	CAP REL COSTS-BLDG & FLXT	1.00	0	9, 050, 701	1
	0			9, 050, 701	0			9, 050, 701	
	N - RECLASS MAINTENANC	E EXPENSE							
00	RESPIRATORY THERAPY	65. 00	0		OPERATION OF PLANT	7.00	0	24, 509	1
00	SPEECH PATHOLOGY	68. 00	0		OPERATION OF PLANT	7.00	0	90	2
00	CARDI AC	59. 00	0	310, 752	OPERATION OF PLANT	7. 00	0	310, 752	3
00	CATHETERIZATION OPERATING ROOM	50. 00	0	363 983	OPERATION OF PLANT	7.00	0	363, 982	Ę
00	RADI OLOGY-THERAPEUTI C	55. 00	Ö		OPERATION OF PLANT	7.00	o	197, 859	
00	LABORATORY	60.00	o o		OPERATION OF PLANT	7.00	Ö	182, 371	7
00	LABORATORY-PATHOLOGIC	60. 01	ol		OPERATION OF PLANT	7.00	o	11, 285	8
	AL			,				,	
00	WHOLE BLOOD & PACKED RED BLOOD CELL	62. 00	0	14, 269	OPERATION OF PLANT	7. 00	0	14, 269	Ç
. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	189, 623	OPERATION OF PLANT	7.00	0	189, 623	10
. 00	MAMMOGRAPHY	54. 03	0		OPERATION OF PLANT	7.00	0	133, 730	
. 00	ULTRA SOUND	54. 02	0		OPERATION OF PLANT	7. 00	0	90, 207	
00	CT SCAN	57. 00	0		OPERATION OF PLANT	7. 00	0	162, 928	
00	NUCLEAR	54. 01	0	231, 572	OPERATION OF PLANT	7. 00	0	231, 572	14
00	MEDI CI NE-DI AGNOSTI C MRI	58. 00		1/10 691	OPERATION OF PLANT	7.00	0	149, 681	15
00	PHARMACY	15. 00			OPERATION OF PLANT	7.00	0	44, 636	
00	EMERGENCY	91. 00	ol		OPERATION OF PLANT	7.00	Ö	28, 711	17
00	DATA PROCESSING	5. 02	ol		OPERATION OF PLANT	7. 00	o	4, 809	
	0			2, 141, 014				2, 141, 014	
	Q - RECLASS XRAY EDUCA		NSES						
00	XRAY EDUCATION	23. 01	41		RESPIRATORY THERAPY	65.00	41	0	1
00 00	XRAY EDUCATION XRAY EDUCATION	23. 01 23. 01	264, 467 0		RADIOLOGY-DIAGNOSTIC EMPLOYEE BENEFITS	54. 00 4. 00	264, 467 0	0 2, 364	3
	TOTAL C	\vdash			DEPARTMENT	\vdash \downarrow			
	TOTALS	TUV COMM C	264, 508	2, 364	TOTALS		264, 508	2, 364	
00	R - RECLASS ADMIN HEAL OTHER ADMINISTRATIVE	5. 06	34, 970		HEALTHY COMMUNITIES	194. 07	34, 970	0	1
,0	AND GENERAL	5.00				194.07			'
	0		34, 970	C	0		34, 970	0	
	S - RECLASS NON ALLOW				lotues as	1 - 1	1	,	
00	NONALLOWABLE MARKETING	194. 05	0		OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1, 781, 110	1
	DECL FOUR STREET	TO CUADOS	0	1, 781, 110	10		0	1, 781, 110	
00	T - RECL EQUIP RENTAL			_	ı	0.00	-1	_	
00	MEDICAL CURRENCE	0.00	0	107.004	ADULTO & DEDUATOROS	0.00	0	104 004	1
00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	186, 994	ADULTS & PEDIATRICS	30.00	0	186, 994	2

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 RECLASSI FI CATIONS Provider CCN: 150112 Peri od: Worksheet A-6 From 01/01/2014 Non-CMS Worksheet Date/Time Prepared: 12/31/2014 5/28/2015 3:32 pm Increases Decreases Cost Center Line # Sal ary 0ther Cost Center Sal ary 0ther Line# 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 3.00 MEDICAL SUPPLIES 71.00 0 34, 775 INTENSIVE CARE UNIT 31.00 C 34.775 3 00 CHARGED TO PATIENT MEDICAL SUPPLIES 0 23, 736 SUBPROVI DER - I RF 0 4.00 71.00 41.00 23.736 4.00 CHARGED TO PATIENT MEDICAL SUPPLIES 21, 998 RESPIRATORY THERAPY C 21, 998 5.00 71.00 0 65.00 5.00 CHARGED TO PATIENT ō ō 267, 503 0 267, 503 RECLASS CHARGEABLE SUPPLY COST 1.00 MEDICAL SUPPLIES 0 195, 895 ADULTS & PEDIATRICS 30.00 0 195, 895 1.00 71.00 CHARGED TO PATIENT 0 0 66, 535 INTENSIVE CARE UNIT 2.00 MEDICAL SUPPLIES 71.00 31.00 66, 535 2.00 CHARGED TO PATIENT

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150112

							0 12/31/2014	5/28/2015 3:3	
		Incre				Decre			
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	6. 00	7.00	8. 00	9. 00	
12.00	EMPLOYEE BENEFITS	4. 00	0	25, 566	NURSI NG	13.00	25, 566	0	12. 00
13. 00	DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 821	ADMI NI STRATI ON PHARMACY	15. 00	7, 821	0	13. 00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 004	MEDICAL RECORDS &	16. 00	7, 004	0	14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	86, 748	ADULTS & PEDIATRICS	30.00	86, 748	0	15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 072	INTENSIVE CARE UNIT	31.00	6, 072	0	16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 910	SUBPROVI DER - I RF	41.00	8, 910	0	17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		NURSERY	43.00	1, 197	0	18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		OPERATING ROOM	50.00	0	32, 196	19. 00
20. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		RECOVERY ROOM	51.00	0	7, 522	20. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		ANESTHESI OLOGY	53.00	0	1, 510	
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		MEDI CI NE-DI AGNOSTI C	54. 01	1, 967	0	22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS	4.00	0		ULTRA SOUND	54.02	968	0	23. 00
24. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	•	RADI OLOGY-THERAPEUTI C	55.00	7, 196	0	24. 00
25. 00 26. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0		CT SCAN CARDI AC	57. 00 59. 00	1, 600	0	25. 00 26. 00
	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0		CATHETERI ZATI ON LABORATORY		1, 235	0	27. 00
27. 00 28. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0		RESPI RATORY THERAPY	60. 00 65. 00	46, 502 4, 623	0	28. 00
29. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	•	PHYSICAL THERAPY	66.00		0	29. 00
30. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0		OCCUPATIONAL THERAPY	67.00	12, 194 3, 642	0	30. 00
31. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0	•	SPEECH PATHOLOGY	68.00	3, 978	0	31. 00
32. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	•	WOUND CENTER	90. 03		0	32. 00
33. 00	DEPARTMENT EMPLOYEE BENEFITS	4.00	0	•	EMERGENCY	91.00	1, 916 13, 962	0	33. 00
34. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0		AMBULANCE SERVICES	95.00	4, 959	0	34. 00
34.00	DEPARTMENT			363, 530		75.00	322, 302	41, 228	34.00
	X - RECLASS OT SALARIE	S AND O	-1	300, 300	1-		322, 302	11, 220	
1. 00	OCCUPATIONAL THERAPY	67. 00	585, 930	129, 492	PHYSI CAL THERAPY	66.00	585, 930	129, 492	1. 00
	0		585, 930	129, 492			585, 930		
	Y - RECL MILLRACE FOR		S/UP/PT		luci i vicos com un en				
1.00	OCCUPATI ONAL THERAPY	67. 00	0		WELLNESS COMMUNITY	194.00	0	2, 350	1. 00
2.00	PHYSI CAL THERAPY	66. 00	0		WELLNESS COMMUNITY	194. 00	0	11, 472	2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00	0	1, 013	WELLNESS COMMUNITY	194.00	ol	1, 013	3.00
4.00	PHYSICAL THERAPY	66. 00	o		WELLNESS COMMUNITY	194.00	ol	4, 946	4.00
50	0		— — — #	19, 781		F	— — —		00
	7 DECLASS LAD DLCCD	CHDEDVI	U O	17, /81	IO		U	19, 781	
4 60	Z - RECLASS LAB BLOOD				L ABODATODY	1000		_	4 00
1. 00	WHOLE BLOOD & PACKED RED BLOOD CELL	62. 00	69, 882	0	LABORATORY	60.00	69, 882	0	1. 00
	0	\vdash	69, 882	<u> </u>	0 — — — —	\vdash		— — _—	
500.00	•		3, 605, 171		Grand Total:		3, 927, 473	35, 615, 748	500 00
300.00	Increases		3, 003, 171	33, 736, 030	Decreases		5, 721, 413	33, 013, 740	300.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150112 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 3:32 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 770, 052 16, 000 16, 000 0 1.00 17, 322, 405 67, 198 0 164, 540 2.00 Land Improvements 164, 540 2.00 0 227, 990 3.00 82, 128, 139 8, 606, 450 8, 606, 450 3.00 Buildings and Fixtures 0 4.00 Building Improvements 92, 833, 285 1, 171, 663 1, 171, 663 8, 441 4.00 5.00 Fixed Equipment 7, 871, 719 184, 739 184, 739 124, 260 5.00 122, 365, 143 0 6.00 Movable Equipment 4, 692, 089 4, 692, 089 2, 638, 720 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 324, 290, 743 14, 835, 481 14, 835, 481 3, 066, 609 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 324, 290, 743 14, 835, 481 O 14, 835, 481 10.00 3, 066, 609 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 786, 052 0 1.00 2.00 Land Improvements 17, 419, 747 0 2.00 3.00 Buildings and Fixtures 90, 506, 599 0 3.00 0 4.00 Building Improvements 93, 996, 507 4.00 5.00 Fi xed Equipment 7, 932, 198 0 5.00 Movable Equipment 124, 418, 512 6.00 0 6.00 7. 00 7.00 HIT designated Assets 0

336, 059, 615

336, 059, 615

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150112	Peri od: From 01/01/2014	Worksheet A-7 Part II		
					To 12/31/2014	Date/Time Pre 5/28/2015 3:3		
SUMMARY OF CAPITAL								
	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	IN 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	16, 600, 713	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, 600, 713	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	16, 600, 713				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00	
3.00	Total (sum of lines 1-2)	0	16, 600, 713				3. 00	

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/28/2015 3:32	
		COMI	PUTATION OF RA	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	ENTERS				9. 55	
1.00	CAP REL COSTS-BLDG & FLXT	211, 641, 103	C	211, 641, 10	0. 629772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	124, 418, 512		124, 418, 51			2.00
3.00	Total (sum of lines 1-2)	336, 059, 615		336, 059, 61			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAP					F CAPITAL		
	Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS 0	0	N .	0 7, 773, 466	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0 9, 089, 969		2. 00
3.00	Total (sum of lines 1-2)	0	1		0 16, 863, 435		3. 00
<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		SI	JMMARY OF CAPI			7. 7.
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•) Capi tal -Relate		
					d Costs (see	through 14)	
					instructions)		
	DART III DECONOLILIATION OF CARLTY COCTO	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT		02/ 7/0			10,020,070	1 00
2. 00	CAP REL COSTS-BLDG & FIXT	1, 330, 644 304, 167		1	0 0	10, 030, 870 9, 394, 136	1. 00 2. 00
3.00	Total (sum of lines 1-2)	1, 634, 811		1	0 0	19, 425, 006	2. 00 3. 00
3.00	Total (Sum Of Titles 1-2)	1,034,011	720, 700	' I	0	17,425,000	3.00

In Lieu of Form CMS-2552-10 Health Financial Systems COLUMBUS REGIONAL HOSPITAL ADJUSTMENTS TO EXPENSES Provi der CCN: 150112 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL 97.535 CAP REL COSTS-BLDG & FIXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В 16, 275 CAP REL COSTS-MVBLE EQUIP 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -135, 152 OTHER ADMINISTRATIVE AND 4 00 5 06 discounts (chapter 8) GENERAL 5.00 Refunds and rebates of В -1, 081 PURCHASING RECEIVING AND 5.03 5.00 expenses (chapter 8) STORES Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -86, 185 NONPATI ENT TELEPHONES 7.00 5.01 7.00 Α stations excluded) (chapter 8.00 Tel evi si on and radio servi ce -10, 187 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 -95 OPERATION OF PLANT 9.00 В 7.00 Provider-based physician A-8-2 -9, 456, 812 10.00 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 667,657 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -767, 496 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents -15, 163 MEDI CAL RECORDS & LI BRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines В -142 HOUSEKEEPI NG 9.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A - 8 - 365.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 66.00 24.00 Adjustment for physical A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29. 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 68 00 31.00 A-8-3 pathology costs in excess of limitation (chapter 14)

-3. 900 NONPATIENT TELEPHONES

-18, 016 CAP REL COSTS-MVBLE EQUIP

0.00

5 01

2.00

32.00

33 00 O

34.00

CAH HIT Adjustment for

TELEPHONE SERVICES

34.00 DEPR PAT PHONES NEW EQUIP

Depreciation and Interest

В

Α

32.00

33 00

Provi der CCN: 150112 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

				To	12/31/2014	Date/Time Prep 5/28/2015 3:3:	
				Expense Classification on	Worksheet A	372072013 3. 3.	2 (2111
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
35. 00	TV DEPR NEW EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	35. 00
36. 00	CAFETERIA VISITORS	Α		CAFETERI A	11. 00	0	36. 00
37. 00	OPERATING REVENUE OTHER	В	-2, 919	OPERATING ROOM	50. 00	0	37. 00
38. 00	REVENUE NURSING ADMIN OTHER REVENUE	В	EO E74	NUIDSI NC ADMI NI STRATI ON	12 00	0	38. 00
39. 00	SOCIAL SERVICES OTHER REVENUE	В		NURSING ADMINISTRATION SOCIAL SERVICE	13. 00 17. 00	0	39. 00
40. 00	EAP REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	40. 00
41. 00	BOND AMORTIZATION	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	41. 00
42. 00	LAND RENT MO	В		OTHER ADMINISTRATIVE AND	5. 06	0	42.00
			,	GENERAL			
43.00	RENT PATHOLOGISTS	В	-672	LABORATORY-PATHOLOGI CAL	60. 01	0	43.00
44. 00	LABORATORY OTHER REVENUE	В		LABORATORY	60.00	0	44.00
44. 01	EMPLOY BENEFITS OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	44. 01
45. 00	XRAY EDUCATION	В		XRAY EDUCATION	23. 01	0	45. 00
45. 01	MEDICAL STAFF INCOME	В	-91, 490	OTHER ADMINISTRATIVE AND	5. 06	0	45. 01
45. 02	RADI OLOGY OTHER REVENUE	В	_25_281	GENERAL RADI OLOGY-DI AGNOSTI C	54.00	0	45. 02
45. 02	BREAST FILM COPIES	В		MAMMOGRAPHY	54.00	0	45. 02
45. 04	MEDICAL RECORDS OTHER REVENUE	В		MEDICAL RECORDS & LIBRARY	16. 00	ő	45. 04
45. 05	FACILITIES OTHER REVENUE	В	· ·	OPERATION OF PLANT	7. 00	o	45. 05
45.06	SICK BAY	В	-80	ADULTS & PEDIATRICS	30.00	О	45. 06
45. 07	LUNG INST OTHER REVENUE	В	-2, 545	RESPIRATORY THERAPY	65.00	0	45. 07
45. 08	DI ABETES OTHER REVENUE	В		DI ABETES CENTER	90. 01	0	45. 08
45. 09	MRES GRANT OTHER	В	-16, 500	OTHER ADMINISTRATIVE AND	5. 06	0	45. 09
45 40	LNEO CERVI OTHER REVENUE		20 (00	GENERAL	F 00		45 40
45. 10 45. 11	I NFO SERV OTHER REVENUE FOOD OTHER REVENUE	B B		DATA PROCESSING	5. 02	0	45. 10 45. 11
45. 11	SPEECH THERAPY OTHER REVENUE	В		DI ETARY SPEECH PATHOLOGY	10. 00 68. 00	0	45. 11
45. 13	PROTECTI VE SERV OTHER REVENUE	В		OPERATION OF PLANT	7. 00	0	45. 13
45. 14	PHARMACY OTHER REVENUE	В		PHARMACY	15. 00	ő	45. 14
45. 15	HUMAN RESOURCES OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ō	45. 15
45. 16	LACTATION AND PREPARE OTHER	В	-7, 645	ADULTS & PEDIATRICS	30.00	0	45. 16
	REVENUE						
45. 17	VOLUNTEER OTHER REVENUE	В	-76, 866	OTHER ADMINISTRATIVE AND	5. 06	0	45. 17
4E 10	DENTAL DEODEDTIES DEDDESLATION	Δ.	41 701	GENERAL	1 00	9	4E 10
45. 18 45. 19	RENTAL PROPERTIES DEPRECIATION NEUROPSYCH	A B		CAP REL COSTS-BLDG & FIXT NEUROPSYCH	1. 00 90. 02	9	45. 18 45. 19
45. 19	PENSION EXPENSE	A		OTHER ADMINISTRATIVE AND	5. 06	0	45. 19
43. 20	LIVET ON EXITENSE	Α	4,000,720	GENERAL	3.00		45. 20
45. 21	LOSS ON DISPOSAL DEMOLITION	Α	11, 218	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 21
45. 22	UNALLOWABLE PHYS RECRUITMENT	A	-171, 742	OTHER ADMINISTRATIVE AND	5. 06	0	45. 22
				GENERAL			
	DEPRECIATION RELIFED	Α		CAP REL COSTS-BLDG & FIXT	1. 00		
45. 24	DEPRECIATION RELIFED	A	88, 976	CAP REL COSTS-MVBLE EQUIP	2.00		
45. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	45. 25
45. 27	(3) PRIOR YEAR AUDIT ADJUSTMENT	A	6 711	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 27
45. 28	NONALLOWABLE INT EXP 1993	A	· ·	CAP REL COSTS-MVBLE EQUIP	2. 00	11	
10. 20	BONDS		101/211	NEE	2.00		10.20
45. 29	NONALLOWABLE INT EXP 2003/2009	A	-247, 652	CAP REL COSTS-MVBLE EQUIP	2.00	11	45. 29
	BONDS						
45. 30	UNALLOWABLE AHA MEMBERSHIP	A	-11, 441	OTHER ADMINISTRATIVE AND	5. 06	0	45. 30
45 06	DUES		057 400	GENERAL	05.00	_	45 04
45. 31 45. 32	AMBULANCE SERVICES	B B	· ·	AMBULANCE SERVICES	95. 00 5. 06	0	45. 31
40. 32	COPY CENTER OTHER REVENUE	D	-000	OTHER ADMINISTRATIVE AND GENERAL	5.06		45. 32
45. 33	CARDI OLOGY OTHER REVENUE	В	-19, 280	ELECTROCARDI OLOGY	69. 00	0	45. 33
45. 34	HAF ADJUSTMENT	A		OTHER ADMINISTRATIVE AND	5. 06	0	45. 34
				GENERAL			
50.00	TOTAL (sum of lines 1 thru 49)		-21, 318, 658				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

* 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.

 The been posted to worksheet N, cordinas i did of 2, the disease should be indicated in cordinar i or this part.								
			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED 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	E	J BICKEL	O. OO SI HEALTH MANAGEMENT	0. 00	6.00
7.00	E	J NASH	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 1	10. 00
10.01	E	T SOUZA	O.OOSI HEALTH MANAGMENT	0.00 1	10. 01
10.02	E	D MI CHAEL	O.OOSI HEALTH MANAGMENT	0.00 1	10. 02
100.00	G. Other (financial or			10	00.00
	non-financial) specify:				

(1) 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 Lieu	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FRO	M RELATED	ORGANIZATIONS AND HOME	Provi der CCN: 150112	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
						10 12/31/2014	5/28/2015 3:3	
	Net	Wkst. A-7 Re	F					
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUS	TMENTS RE	QUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE COS	STS:						
1.00	667, 657		0					1. 00
2.00	0		0					2. 00
3.00	0		0					3. 00
4.00	0		0					4. 00
5.00	667, 657							5. 00

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

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.

	Comonit under the Arrive	
6.00	MANAGEMENT COMPANY	6.00
7.00	MANAGEMENT COMPANY	7.00
8.00	MANAGEMENT COMPANY	8.00
9.00	MANAGEMENT COMPANY	9.00
10.00	MANAGEMENT COMPANY	10.00
10. 01	MANAGEMENT COMPANY	10.01
10. 02	MANAGMENT COMPANY	10.02
100.00		100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

L HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150112 | Period: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/28/2015 3: 32 pm

BISST. A Line Cost Center/Physical and Indirect Professional Component Recomponent Professional Component Recomponent Professional Component Recomponent Professional Component							12/31/2014	5/28/2015 3:3	
1.00 3.00 7.00		Wkst. A Line #					RCE Amount	Physi ci an/Prov	
1.00					·	·			
College Coll	1 00								1 00
2.00	1.00	5.06		8, 439, 519	8, 284, 944	154, 575	171, 400	966	1.00
3 00	2. 00	30. 00		290, 136	0	290, 136	154, 100	2, 060	2. 00
5.00 50.00 OPERATING ROOM 340,300 0 340,300 204,100 2,146 5.00 0.00 0.00 312 5.00 327 5.00 327 5.00 328 5.00 32									
6.00									
7.00									
B. DO									
9.00 6.0 of LASBORTORY-PATHOLOGIC ALL 150,000 0 150,000 219,500 1,736 9.00 110.00 6.0 of Depts Call THERAPY 50,000 0 0,000 171,400 607 10 of Depts Call THERAPY 50,000 0 0,000 171,400 607 10 of Depts Call THERAPY 50,000 0 0,000 171,400									
11.00									
12.00 99.00 ELECTROCARBIOLOGY 01.450 0 01.450 171.400 316 12.00 17.00 17.00 171.400 171.400 91.30.01 17.00 17.00 171.400 91.30.01 17.00 17.00 171.400 91.30.01 17.00 17.00 171.400 91.30.01 17.00 90.00 17.0						,			
13.00 70.00ELECTROENCEPHALOGRAPHY 9,100 0 9,100 171,400 24 14 0.0 15.00 40.00ELINIC SEMBLITIATION 3.65,000 0 3.65,000 171,400 2.94 14 0.0 15.00 171,400 2.94 14 0.0 15.00 171,400 171,400 171,400 171,400 180,410 180,011 18									
14.00 76.97 AND IAC RETIRABILITATION 4.817 0 4.817 171, 400 24 14.00 16.00 90.00 AND INCOMPSYCH 183, 031 183, 031 0 0 171, 400 0 14.00 171, 400 0 16.00 171, 400 0 18.00 171, 400 0 18.00 171, 400 0 171, 400 0 18.00 171, 400 171,									
15.00 90.00 CLINIC 365,000 0 345,000 171,400 15.00 16.00 17.00 90.03 MOUND CENTER 18.3,031 18.3,031 0 0 171,400 17.00 17.00 18.00 19.00 MOUND CENTER 18.3,031 18.3,031 0 0 0 0 0 0 171,400 17.00 18.00 19.00 MOUND CENTER 18.00 18									
17. 00 90. 03 00.00 00.00 17.1, 400 6.3 17. 00 19. 00 90. 04 17. 17. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 19. 00 17. 17. 00 17. 17. 00 19. 00 17. 17. 00 17. 00									
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Next									
		70.00	7 IIII DOLY IVOL OLIVI OLO				171,100		
1.00		Wkst. A Line #	Cost Center/Physician				Provi der		
1.00			ldenti fi er	Limit	, ,				
1.00					Limit			Insurance	
1.00		1. 00	2.00	8. 00	9, 00			14.00	
2.00 30.00 ADULTS & PEDIATRICS 152,618 7,631 0 0 0 0 2.00	1. 00								1. 00
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4.00							_		
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11 00 66. 00 PHYSI CAL THERAPY 20, 766 1, 038 0 0 0 11. 00 12. 00 69. 00 ELECTROCARDIO LOCKY 26, 040 1, 302 0 0 0 0 12. 00 13. 00 70. 00 ELECTROCARDIO LOCKY 7, 499 375 0 0 0 0 13. 00 14. 00 76. 97 CARDI AC REHABI LI TATI ON 1, 978 99 0 0 0 0 14. 00 15. 00 90. 00 CLINI C 73, 504 3, 675 0 0 0 0 15. 00 16. 00 90. 02 NEUROPSYCH 0 0 0 0 0 0 0 17. 00 90. 03 NOUND CENTER 5, 191 260 0 0 0 0 0 18. 00 90. 04 HYPERBARI C 0XYGEN THERAPY 742 37 0 0 0 18. 00 19. 00 91. 00 DEMERGENCY 984, 479 49, 224 0 0 0 0 0 20. 00 95. 00 AMBULANCE SERVI CES 14, 338 717 0 0 0 0 0 20. 00 95. 00 OMBULANCE SERVI CES 14, 338 717 0 0 0 0 0 20. 00 95. 00 OMBULANCE SERVI CES 15. 00 15. 00 17. 00 0 20. 00 1. 00 S. 06 OTHER ADMIN IS STRATI VE AND GENERAL Share of Col. 14 15. 00 15. 00 17. 00 18. 00 1. 00 30. 00 ADJULTS & PEDI ATRI CS 15. 00 15. 00 17. 00 18. 00 17. 00 1. 00 30. 00 ADJULTS & PEDI ATRI CS 0 15. 00 17. 00 18. 00 17. 00 1. 00 41. 00 SUBPROVI DER - IRF 0 77. 460 0 0 0 4. 00 5. 00 50. 00 OTHER ADMINISTRATI VE AND GENERAL 5. 00 0 0 0 0 6. 00 53. 00 AMBULANCE CARE UNIT 0 30. 160 6.440 6.440 6.440 6. 00 53. 00 AMBULANCE CARE UNIT 0 30. 160 6.440 6.440 6.440 6. 00 55. 00 CARDI AC CARTELETI LATION 0 210. 576 129. 724 129. 724 5. 00 6. 00 65. 00 CARDI AC CARTELETI LATION 0 57. 455 81. 903 81. 903 8. 00 9. 00 60. 01 LABORATORY - PATHOLOGI CAL 0 183. 198 0 0 0 10. 00 66. 00 CRESPI RATORY THERAPY 0 50. 19 10. 681 10. 681 10. 00 10. 00 66. 00 CRESPI RATORY THERAPY 0 50. 19 10. 681 10. 681 10. 00 10. 00 69. 00 ELECTROCARDIAL CARL LITATION 0 73. 504 291. 496 291. 496 15) 0	_	
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17. 00				/3,504			0		
18. 00				5. 191			0	_	
20.00		90. 04	HYPERBARIC OXYGEN THERAPY		1		0	0	
200.00 Component Share of Col. Provider Component Share of Col. 1.00 15.00 16.00 17.00 18.00 18.00 18.00					1				
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. Limit Limit Disallowance Adjustment Disallowance Disa		95. 00	AMBULANCE SERVICES						
1.00	200.00	Wkst Aline#	Cost Center/Physician					0	200. 00
1. 00		WKSt. A LITTO #					Adj d3 tillorit		
1.00									
1.00		1.00	2.00		1/ 00	17.00	10.00		
CENERAL 2.00 30.00 ADULTS & PEDI ATRI CS 0 152,618 137,518 137,518 2.00 3.00 31.00 INTENSI VE CARE UNI T 0 30,160 6,440 6,440 3.00 41.00 SUBPROVI DER - I RF 0 77,460 0 0 4.00 5.00 ODERATI ING ROOM 0 210,576 129,724 129,724 5.00 6.00 53.00 ANESTHESI OLOGY 0 30,045 14,955 14,955 14,955 6.00 7.00 55.00 RADI OLOGY-THERAPEUTI C 0 42,442 107,558 107,558 7.00 8.00 59.00 CARDI AC CATHETERI ZATI ON 0 57,435 81,903 81,903 8.00 9.00 60.01 LABORATORY-PATHOLOGI CAL 0 183,198 0 0 9.00 9.00 10.00 65.00 RESPI RATORY THERAPY 0 50,019 10,681 10,681 10.00 11.00 66.00 PHYSI CAL THERAPY 0 20,766 29,234 29,234 11.00 12.00 69.00 ELECTROCARDI OLOGY 0 26,040 35,410 35,410 12.00 13.00 70.00 ELECTROENCEPHALOGRAPHY 0 7,499 1,601 1,601 13.00 14.00 76.97 CARDI AC REHABI LI TATI ON 0 1,978 2,834 2,834 14.00 15.00 90.00 NEUROPSYCH 0 0 0 0 183,031 16.00 17.00 90.03 WOUND CENTER 0 5,191 1,109 1,109 17.00 17.0	1. 00								1, 00
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7. 00 55. 00 RADI OLOGY-THERAPEUTI C 0 42, 442 107, 558 107, 558 7. 00 8. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 57, 435 81, 903 81, 903 8. 00 9. 00 60. 01 LABORATORY-PATHOLOGI CAL 0 183, 198 0 0 9. 00 10. 00 65. 00 RESPI RATORY THERAPY 0 50, 019 10, 681 10, 681 10. 00 11. 00 66. 00 PHYSI CAL THERAPY 0 20, 766 29, 234 29, 234 11. 00 12. 00 69. 00 ELECTROCARDI OLOGY 0 26, 040 35, 410 35, 410 12. 00 13. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 7, 499 1, 601 1, 601 13. 00 14. 00 76. 97 CARDI AC REHABI LI TATI ON 0 1, 978 2, 834 2, 834 2, 834 14. 00 15. 00 90. 00 CLI NI C 0 73, 504 291, 496 291, 496 15. 00 16. 00 90. 03 WOUND CENTER 0 5, 191 1, 109 1, 109 17. 00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
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11. 00 66. 00 PHYSI CAL THERAPY 0 20, 766 29, 234 29, 234 11. 00 12. 00 69. 00 ELECTROCARDI OLOGY 0 26, 040 35, 410 35, 410 12. 00 13. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 7, 499 1, 601 1, 601 13. 00 14. 00 76. 97 CARDI AC REHABI LI TATI ON 0 1, 978 2, 834 2, 834 14. 00 15. 00 90. 00 CLI NI C 0 73, 504 291, 496 291, 496 15. 00 16. 00 90. 02 NEUROPSYCH 0 0 183, 031 16. 00 17. 00 90. 03 WOUND CENTER 0 5, 191 1, 109 1, 109 17. 00				0			_		
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17. 00 90. 03 WOUND CENTER 0 5, 191 1, 109 1, 109 17. 00									
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10. 00 70. 04 III ENDANTO ONTOLIN ITILINATI 0 742 130 130 130 10. 00									
		70.04	PITT ENDARGO OKTOLIN THERAFT		1 /42	156	136	I	10.00

Heal th	Financial Syste	ems	COLUMBUS REGI	ONAL HOSPITAL		In Lieu of Form CMS-2552-10		
PROVI DE	ER BASED PHYSIC	IAN ADJUSTMENT				Peri od:	Worksheet A-8	8-2
						From 01/01/2014 To 12/31/2014		
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
19.00	91. 00	EMERGENCY	0	984, 479	60, 08	60, 081		19. 00
20.00	95. 00	AMBULANCE SERVICES	0	14, 338	3, 162	3, 162		20. 00
200. 00			0	2, 048, 092	988, 837	9, 456, 812		200. 00

Health Financial Systems		COLUMBUS REGIO	u of Form CMS-2	2552-10			
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	Fr	eriod: com 01/01/2014	Worksheet B Part I	nanad.
				To	12/31/2014	Date/Time Pre 5/28/2015 3:3	pareu: 2 pm
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
	'	for Cost			BENEFI TS	TELEPHONES	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2. 00	4. 00	5. 01	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	10, 030, 870	10, 030, 870				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	9, 394, 136	10, 030, 670	9, 394, 136			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	25, 923, 451	193, 307		26, 210, 130		4. 00
5. 01	00540 NONPATI ENT TELEPHONES	589, 638	37, 481		131, 551	921, 058	5. 01
5. 02 5. 03	OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES	7, 491, 904 1, 343, 907	302, 930 165, 754		1, 181, 523 387, 524	29, 690 16, 194	5. 02 5. 03
5. 04	00570 ADMITTING	1, 481, 973	36, 259		384, 531	15, 520	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 054, 808	95, 379		885, 116	35, 763	5. 05
5. 06 7. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	19, 774, 201 5, 775, 523	387, 671 4, 744, 049		1, 256, 730 715, 349	124, 157 25, 641	5. 06 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	632, 365	9, 461		23, 150	23, 041	8. 00
9.00	00900 HOUSEKEEPI NG	2, 010, 423	69, 531		612, 831	5, 398	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	802, 279 826, 509	118, 495 91, 380		194, 754 472, 625	2, 024 4, 723	10. 00 11. 00
	01300 NURSING ADMINISTRATION	3, 116, 181	150, 198		1, 189, 530	14, 170	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	888, 207	114, 844		1, 504	6, 748	14. 00
	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	4, 654, 174 1, 508, 439	72, 685 59, 693		1, 135, 577 214, 336	16, 869 23, 617	15. 00 16. 00
	01700 SOCIAL SERVICE	508, 494	4, 557		198, 622	2, 024	17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	02301 XRAY EDUCATION 02302 PHARMACY RESIDENCY PROG	400, 036 321, 197	10, 925	·	162, 682 125, 362	1, 350	23. 01 23. 02
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	321, 197	4, 436	9, 608	125, 302	1, 350	23.02
	03000 ADULTS & PEDIATRICS	14, 156, 541	1, 153, 144		5, 172, 305	151, 822	30. 00
31.00	03100 INTENSIVE CARE UNIT	2, 282, 269	165, 362	226, 646	824, 956	23, 617 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	O	0	0	O	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	1/7 2/2	0 4(0	0	15 520	40.00
	04100 SUBPROVI DER	1, 472, 768	167, 263 0	80, 460 0	537, 062 0	15, 520 0	41. 00 42. 00
43.00	04300 NURSERY	590, 615	8, 797	17, 671	227, 776	675	43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000 OPERATING ROOM	12, 721, 491	610, 643	1, 567, 042	179, 330	81, 647	50. 00
51.00	05100 RECOVERY ROOM	1, 282, 092	48, 059		182	10, 796	51.00
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 191, 616	0 1, 796	0 80, 518	0	0 2, 699	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	1, 736, 115	120, 110		549, 968	22, 942	
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 096, 013	51, 062	228, 559	123, 014	4, 723	
	05404 ULTRA SOUND	567, 046	22, 694		180, 555	2, 024	
	O5405 MAMMOGRAPHY O5500 RADI OLOGY-THERAPEUTI C	1, 063, 427 1, 279, 342	4, 119 119, 250		274, 706 397, 535		54. 03 55. 00
57. 00	05700 CT SCAN	812, 966	15, 195	232, 487	215, 398	4, 723	57. 00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	408, 119 2, 072, 178	13, 580		97, 387 540, 042	1, 350 24, 966	58. 00 59. 00
	06000 LABORATORY	6, 849, 744	158, 421 162, 148		1, 309, 188	41, 836	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	739, 174	18, 288	79, 737	139, 397	4, 723	60. 01
	O6200 WHOLE BLOOD & PACKED RED BLOOD CELL O6500 RESPIRATORY THERAPY	816, 192 1, 991, 105	7, 907 99, 075		27, 455	2, 699	62.00
	06600 PHYSI CAL THERAPY	3, 506, 431	3, 425		665, 192 1, 177, 555	18, 893 32, 389	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 202, 840	3, 335	47, 895	406, 366	10, 796	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	701, 232	0		241, 606	6, 073	68. 00
	07000 ELECTROCARDI OLOGY	490, 816 679, 839	21, 095 0		180, 653 230, 883	14, 170 14, 845	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 595, 288	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 343, 940	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	12, 136, 287 366, 261	0	0	0 0	0	73. 00 74. 00
76.00	03020 ACUPUNCTURE	0	0	-	o	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	105, 255	12, 041	15, 508	36, 498	4, 723	76. 97
88 NN	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	ol	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
	09000 CLINIC	748, 744	65, 487		223, 987	18, 219	
	09001 DI ABETES CENTER 09002 NEUROPSYCH	148, 090 89, 858	11, 694 1, 554		26, 717 32, 030	675 1. 350	90. 01 90. 02
	09003 WOUND CENTER	1, 273, 180	0				90. 03

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150112 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** NONPATI ENT Cost Center Description Net Expenses MVBLE EQUIP for Cost **BENEFITS TELEPHONES** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 90. 04 09004 HYPERBARI C OXYGEN THERAPY 302, 142 4, 695 675 90. 04 666 91. 00 09100 EMERGENCY 1, 743, 177 6,003,766 255, 420 28, 340 91.00 146, 606 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 444, 590 245, 092 95.00 96, 706 932, 585 4, 723 99. 10 |09910 CORF 99. 10 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 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 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 9, 309, 384 901, 489 118. 00 SUBTOTALS (SUM OF LINES 1-117) 197, 796, 087 9, 977, 891 26, 092, 381 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 10, 970 1, 350 190. 00 369 22, 794 194. 00 07950 WELLNESS COMMUNITY 255, 949 2, 699 194. 00 63, 532 4, 049 194. 01

55, 812

57, 993

218, 666

149, 171

1, 156

1, 911, 110

200, 445, 944

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5, 398 194. 06

6, 073 194. 07

921, 058 202. 00

194. 01 07951 BUILDING RENTALS

194. 03 07953 OUTREACH CLINICS

194.06 07956 CRH FOUNDATION

194. 04 07954 SPEECH - HEARING AIDS

194. 07 07957 HEALTHY COMMUNITIES

194. 05 07955 NONALLOWABLE MARKETING

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

194. 02 07952 HOSPI CE

200.00

201.00

202.00

Provi der CCN: 150112

				'	0 12/31/2014	Date/lime Pre 5/28/2015 3:3	
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	
		PROCESSI NG	RECEIVING AND		OUNTS		
		5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS	0.02	0.00	0.01	0.00	<i>071.</i> 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. 01	00540 NONPATI ENT TELEPHONES	0.07/.040					5. 01
5. 02	00550 DATA PROCESSING	9, 376, 318	l				5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	0	2, 103, 532 1, 716	1			5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 067, 963	2, 246	1			5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL	813, 864	3, 357		0, 270, 200	22, 777, 900	5. 06
7. 00	00700 OPERATION OF PLANT	0	400		ol ol	11, 625, 735	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	40		o	665, 016	8. 00
9.00	00900 HOUSEKEEPI NG	0	33, 665	C	0	2, 827, 119	9. 00
10.00	01000 DI ETARY	0	602	C	-	1, 171, 369	10.00
11.00	01100 CAFETERI A	0	1, 412	(-	1, 521, 411	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 986, 326	ł .		-	9, 614, 159	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	121, 892	1, 751 24, 351			1, 122, 081 6, 587, 596	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268, 163	3, 950			2, 206, 365	16. 00
17. 00	01700 SOCIAL SERVICE	0	0, 700		ol ol	723, 386	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	Ō	d	ol	0	23. 00
23. 01	02301 XRAY EDUCATION	0	18		o	584, 639	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	0	C	0	461, 953	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	155, 647	208, 645	230, 842		22, 923, 221	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	41, 543	36, 219	114, 441	3, 715, 053 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		ol ol	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		ol ol	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	11, 578	20, 713	65, 447	2, 370, 811	41.00
42.00	04200 SUBPROVI DER	0	0	C	o	0	42.00
43.00	04300 NURSERY	0	l e	9, 519	30, 076	885, 344	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0) 0	0	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	363, 182	301, 656	952, 661	16, 777, 652	50.00
51. 00	05100 RECOVERY ROOM	0	6, 951	20, 187		1, 503, 415	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	34, 408	108, 718	419, 755	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 823			2, 818, 940	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	495			1, 623, 902	54. 01
54. 02	05404 ULTRA SOUND	0	2, 744	18, 650		858, 795	54. 02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	0	1, 179 591	10, 781 37, 69 <i>6</i>		1, 453, 708 2, 143, 986	54. 03 55. 00
57. 00	05700 CT SCAN	0	24. 985	76, 061		1, 622, 142	57. 00
58. 00	05800 MRI	0	633				
	05900 CARDI AC CATHETERI ZATI ON	0					
60.00	06000 LABORATORY	1, 962, 463				11, 408, 538	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	4, 171	18, 335		1, 061, 757	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	709			908, 923	62.00
65. 00	06500 RESPIRATORY THERAPY	0	15, 526			3, 146, 098	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		5, 828 727	46, 572 14, 991		5, 120, 342 1, 734, 315	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	300			1, 734, 315	
69. 00	06900 ELECTROCARDI OLOGY	0	l			968, 032	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 061	21, 455		1, 070, 031	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	918, 301	79, 251	250, 408	7, 843, 248	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	34, 393	59, 820		7, 627, 166	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	92, 130				73. 00
74.00	07400 RENAL DIALYSIS	0	55	5, 153		387, 751	74.00
76.00	03020 ACUPUNCTURE	0		2 503	-	100 710	76.00
76. 97	O7697 CARDI AC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	751	3, 592	2 11, 350	189, 718	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ċ	o	0	89. 00
90.00	09000 CLI NI C	0	19, 851	17, 574	55, 528	1, 183, 383	90. 00
90. 01	09001 DI ABETES CENTER	0	65			196, 733	90. 01
90. 02	09002 NEUROPSYCH	0	27	822		130, 110	90. 02
90. 03	09003 WOUND CENTER	0	7, 758			1, 521, 500	90. 03
90. 04 91. 00	09004 HYPERBARI C OXYGEN THERAPY 09100 EMERGENCY	0	1, 159 121, 794			336, 719 9, 192, 180	90. 04 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		121, 794	214, 099	0/8, 3/8		91.00
, 2. 00	1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	1	I	1	1		, ,

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150112 | Period: | Worksheet B | From 01/01/2014 | Part I

				Fo 12/31/2014	Date/Time Pre 5/28/2015 3:3	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	
	PROCESSI NG	RECEIVING AND		OUNTS		
		STORES		RECEI VABLE		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	7, 756	31, 528	99, 619	3, 862, 599	
99. 10 09910 CORF	0	0	(0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
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	0	111. 00
113.00 11300 INTEREST EXPENSE					1	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 376, 318	2, 088, 706	1, 985, 14	6, 271, 930	197, 500, 504	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	203	(0	345, 177	
194. 01 07951 BUILDING RENTALS	0	0	(0	74, 280	
194. 02 07952 HOSPI CE	0	14, 534	(0	-	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	1, 372	4, 336		
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0	1, 911, 110	
194.06 07956 CRH FOUNDATION	0	56	(0	-	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	33	(0	261, 617	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	(0		201. 00
202.00 TOTAL (sum lines 118-201)	9, 376, 318	2, 103, 532	1, 986, 519	6, 276, 266	200, 445, 944	202. 00

Provi der CCN: 150112

				'	0 12/31/2014	5/28/2015 3:3	
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	Z piii
		AND GENERAL 5.06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
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. 01	00540 NONPATI ENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTI NG						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	22, 777, 900					5. 06
7. 00	00700 OPERATION OF PLANT	1, 490, 477	13, 116, 212				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	85, 258	30, 504				8. 00
9. 00	00900 HOUSEKEEPI NG	362, 451	224, 182		-,,		9. 00
10. 00	01000 DI ETARY	150, 175	382, 053			1, 722, 451	
11. 00	01100 CAFETERI A	195, 052	294, 628		44, 620	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 232, 583	484, 268		8, 798	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	143, 856	370, 280			0	14. 00
15. 00	01500 PHARMACY	844, 563	234, 350		55, 932	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	282, 867	192, 462		_	0	16. 00
17. 00	01700 SOCIAL SERVICE	92, 742	14, 692	0	1, 257	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	74.054	0	0	0 170	0	23. 00
23. 01	02301 XRAY EDUCATION	74, 954	35, 223		8, 170	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	59, 225	14, 303	0	U	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 020 020	2 717 070	201 054	1, 303, 409	1 2/0 /71	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 938, 838	3, 717, 979			1, 369, 671 129, 599	
32.00	03200 CORONARY CARE UNIT	476, 288 0	533, 162	37, 035	100, 552	129, 599	32.00
32.00	03300 BURN INTENSIVE CARE UNIT	1	0	0	0	0	32.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	0		0	0	40.00
41. 00	04100 SUBPROVIDER - I PF	202 050	539, 292	42 701	124 424	182, 199	
41.00	04200 SUBPROVI DER	303, 950	339, 292	43, 701	124, 434	162, 199	42.00
43. 00	04300 NURSERY	113, 506	28, 363	10, 515	1, 257	0	43. 00
44. 00	04400 SKI LLED NURSING FACILITY	113, 500	20, 303			0	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	0	<u> </u>	0	44.00
50. 00	05000 OPERATI NG ROOM	2, 150, 979	1, 968, 843	156, 267	634, 737	8, 250	50.00
51. 00	05100 RECOVERY ROOM	192, 745	154, 952		82, 956	0, 230	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	02,700	0	52. 00
53. 00	05300 ANESTHESI OLOGY	53, 815	5, 789	1	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	361, 402	387, 259		92, 382	1, 002	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	208, 192	164, 634		74, 157	0	54. 01
54. 02	05404 ULTRA SOUND	110, 102	73, 171	0	19, 482	0	54. 02
54. 03	05405 MAMMOGRAPHY	186, 373	13, 282	5, 379	35, 193	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	274, 870	384, 486	5, 990	49, 648	3, 519	55. 00
57.00	05700 CT SCAN	207, 967	48, 991	0	8, 170	0	57.00
58.00	05800 MRI	85, 444	43, 786	0	8, 170	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	463, 037	510, 783	3, 751	77, 300	3, 414	59. 00
60.00	06000 LABORATORY	1, 462, 632	522, 800	0	50, 276	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	136, 123	58, 965	0	3, 771	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	116, 528	25, 493	0	1, 885	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	403, 345	319, 440		38, 336	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	656, 453	11, 044		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	222, 348	10, 752	8, 097	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	130, 701	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	124, 107	68, 014		13, 197	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	137, 183	0	1, 737	123, 177	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 005, 544	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	977, 841	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 706, 189	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	49, 712	0	0	0	0	74. 00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	24, 323	38, 823	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		=	-		-	00 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	151, 716	211, 144			16, 675	
90. 01	09001 DI ABETES CENTER	25, 222	37, 704	0	1, 885	0	90. 01
90. 02	09002 NEUROPSYCH	16, 681	5, 011	0	0	0	
90. 03	09003 WOUND CENTER	195, 064	0	4, 337	0	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	43, 169	0	648		0 122	90.04
91.00	09100 EMERGENCY	1, 178, 483	472, 690	58, 956	352, 562	8, 122	
72. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART			I			92. 00

Provider CCN: 150112 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Part I | Par

			Ť	0 12/31/2014	Date/Time Pre 5/28/2015 3:3	pared:
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10. 00	
OTHER REIMBURSABLE COST CENTERS	,					
95. 00 09500 AMBULANCE SERVI CES	495, 205	311, 802	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	1 , , ,
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	1	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	l	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)	22, 400, 280	12, 945, 399	780, 778	3, 391, 756	1, 722, 451	118. 00
NONREI MBURSABLE COST CENTERS	, , ,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 627	35, 369	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	44, 253	0	0	0	l	194. 00
194. 01 07951 BUILDING RENTALS	9, 523	37, 656	0	0		194. 01
194. 02 07952 HOSPI CE	9, 298	0	0	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	28, 766	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETI NG	245, 014	0	0	0	•	194. 05
194. 06 07956 CRH FOUNDATION	5, 598	39, 650		19, 482		194. 06
194. 07 07957 HEALTHY COMMUNITIES	33, 541	58, 138	0	2, 514	0	194. 07
200.00 Cross Foot Adjustments		_	_	_	_	200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	22, 777, 900	13, 116, 212	780, 778	3, 413, 752	1, 722, 451	J202. 00

					Io	12/31/2014	Date/lime Pre 5/28/2015 3:3	
		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	_ p
				ADMI NI STRATI ON	SERVICES &		RECORDS &	
			11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES						4. 00 5. 01
5. 02	1	DATA PROCESSING						5. 01
5. 03	1	PURCHASING RECEIVING AND STORES						5. 03
5.04	00570	ADMI TTI NG						5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 7. 00	1	OTHER ADMINISTRATIVE AND GENERAL						5. 06 7. 00
8.00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPING						9. 00
10.00		DI ETARY						10. 00
11. 00	1	CAFETERI A	2, 055, 711					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON	86, 797		4 (5(000			13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	82, 228	3, 482	1, 656, 039 0	7, 804, 669		14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	66, 240		0	7, 804, 669	2, 747, 934	16. 00
17. 00		SOCIAL SERVICE	15, 989		0	Ö	0	17. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	О	0	23. 00
23. 01		XRAY EDUCATION	15, 989		0	0	0	23. 01
23. 02		PHARMACY RESIDENCY PROG	11, 421	0	0	0	0	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	580, 169	5, 806, 224	96, 017	5, 617	867, 466	30. 00
31. 00		INTENSIVE CARE UNIT	77, 660		283	1, 172	79, 034	31. 00
32. 00		CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	1	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40.00		SUBPROVI DER - I PF SUBPROVI DER - I RF	0	0 517 240	0	0 77	100 100	40.00
41. 00 42. 00	1	SUBPROVIDER - TRF	52, 535	517, 360 0	0	0	199, 180 0	41. 00 42. 00
43. 00		NURSERY	20, 557	197, 050	3, 818	7	0	43. 00
44.00	1	SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
		LARY SERVICE COST CENTERS		1				
50.00	1	OPERATING ROOM	15, 989		1, 448, 874	18, 837	611, 561	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	220	0	239 0	0	51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	Ö	l o	0	36, 257	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	50, 251	0	848	1, 268	0	54.00
54. 01	1	NUCLEAR MEDICINE-DIAGNOSTIC	9, 136		0	82, 686	0	54. 01
54. 02		ULTRA SOUND	11, 421	0	0	671	0	54. 02
54. 03 55. 00	1	MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	27, 409 25, 125	278, 550 261, 712	2, 687	163 0	0 24, 008	54. 03 55. 00
57. 00	1	CT SCAN	18, 273		0	4, 729	24, 000	57. 00
58. 00	05800		6, 852		0	354	0	
59. 00	05900	CARDI AC CATHETERI ZATI ON	43, 398	429, 204	14, 424	1, 508	30, 275	59. 00
60.00		LABORATORY	171, 309		0	169	0	
60. 01 62. 00	1	LABORATORY-PATHOLOGICAL WHOLE BLOOD & PACKED RED BLOOD CELL	13, 705		0	31 98	186, 645 0	60. 01 62. 00
65. 00	1	RESPIRATORY THERAPY	2, 284 66, 240		14, 424	3, 592	158, 281	
66. 00		PHYSI CAL THERAPY	109, 638		24, 888	933	0	66. 00
67. 00		OCCUPATIONAL THERAPY	27, 409	0	0	1, 469	30, 594	67. 00
68. 00	1	SPEECH PATHOLOGY	18, 273		0	0	0	68. 00
69.00		ELECTROCARDI OLOGY	18, 273		0	1, 670	255, 906	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	18, 273	0	0	5	143, 622 0	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00	1	DRUGS CHARGED TO PATIENTS	0	O	0	7, 615, 498	0	73. 00
74.00	1	RENAL DIALYSIS	0	0	0	2, 550	0	74. 00
76. 00		ACUPUNCTURE	0	0	0	0	0	76.00
76. 97		CARDIAC REHABILITATION	4, 568	41, 574	0	0	0	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	Ō	o	0	Ö	0	89. 00
90.00	09000	CLINIC	22, 841		0	1, 418	148, 296	90. 00
90. 01		DI ABETES CENTER	2, 284		0	O	0	90. 01
90. 02	1	NEUROPSYCH	2, 284		30 030	14 173	12, 004	90. 02
90. 03 90. 04	1	WOUND CENTER HYPERBARI C OXYGEN THERAPY	11, 421	0	38, 039 0	14, 173 0	0 1, 062	90. 03 90. 04
91. 00	1	EMERGENCY	187, 298	1, 882, 353	11, 737	3, 578	0	91. 00
		OBSERVATION BEDS (NON-DISTINCT PART					-	92. 00
					·			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Cost Center Description CAFETERIA NURSING CENTRAL SERVICES & SUPPLY SERVICES & LIBRARY
ADMINISTRATION SERVICES & SUPPLY LI BRARY
SUPPLY LI BRARY
11.00 13.00 14.00 15.00 16.00
OTHER REIMBURSABLE COST CENTERS 95.00 995.00 AMBULANCE SERVICES 146,184 0 0 5,719 0 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 0 101.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109.00 109.
95. 00 09500 AMBULANCE SERVI CES 146, 184 0 0 5, 719 0 95. 00 99. 10 101. 00 101. 00 101. 00 101. 00 101. 00 109. 00 109. 00 109. 00 109. 00 109. 00 0 0 0 0 0 109. 00
99. 10 09910 CORF 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00
SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 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 1111.00
113. 00 11300 I NTEREST EXPENSE 113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 2, 039, 723 11, 426, 605 1, 656, 039 7, 804, 488 2, 747, 934 118. 00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00
194. 00 07950 WELLNESS COMMUNITY 9, 136 0 0 0 0 194. 00
194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 0 194. 01
194. 02 07952 H0SPI CE 0 0 0 181 0 194. 02
194. 03 07953 OUTREACH CLINICS 0 0 0 0 194. 03
194. 04 07954 SPEECH - HEARING AIDS 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 0 194. 06
194. 07 07957 HEALTHY COMMUNI TI ES 6, 852 0 0 0 0 194. 07
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 0 0 0 0 201.00
202. 00 TOTAL (sum lines 118-201) 2, 055, 711 11, 426, 605 1, 656, 039 7, 804, 669 2, 747, 934 202. 00

Provi der CCN: 150112

					12/31/2014	5/28/2015 3:3	
	Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	XRAY EDUCATION	PHARMACY RESI DENCY 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 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
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 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE	848, 066					17.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0)			23. 00
23. 01	02301 XRAY EDUCATION	0	0	· ·			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	0	0	546, 902		23. 02
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	205 074			ما	40.005.507	00.00
30.00	03000 ADULTS & PEDIATRICS	385, 871	0		0	40, 295, 536	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	55, 972 0	0	0	0	5, 971, 306 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0		Ö	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	o	Ö	0	40. 00
41.00	04100 SUBPROVI DER - I RF	267, 989	0	0	О	4, 601, 528	41. 00
42.00	04200 SUBPROVI DER	0	0	0	o	0	42.00
43.00	04300 NURSERY	0	0	_	0	1, 260, 417	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.544			ما	00 045 440	F0 00
50.00	05000 OPERATING ROOM	2, 544	0	1	0	23, 945, 143	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	1, 958, 764 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	515, 616	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	718, 975	0	4, 506, 360	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	o	2, 162, 707	54. 01
54. 02	05404 ULTRA SOUND	0	O	0	O	1, 073, 642	54. 02
54.03	05405 MAMMOGRAPHY	0	0	0	0	2, 002, 744	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	56, 820	0	0	0	3, 230, 164	55. 00
57. 00	05700 CT SCAN	0	0	0	0	1, 910, 272	57. 00
58. 00	05800 MRI	0	0	0	0	811, 071	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0	5, 188, 784	
60. 00 60. 01	06000 LABORATORY-PATHOLOGI CAL	0	0		0	13, 615, 724 1, 460, 997	60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	1, 460, 447	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	0		Ö	4, 821, 867	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	o	ō	5, 939, 926	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	O	2, 034, 984	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	1, 168, 439	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	1, 624, 863	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 494, 028	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8, 848, 792	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		E44 002	8, 605, 007	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0		546, 902	23, 176, 877 440, 013	73. 00 74. 00
76. 00	03020 ACUPUNCTURE		0		0	440,013	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	o o	0	1	0	299, 006	76. 97
. 3 ,	OUTPATIENT SERVICE COST CENTERS	, J			<u> </u>	277,000	,,
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	67, 845	0	0	o	2, 097, 672	90. 00
90. 01	09001 DI ABETES CENTER	0	0	0	0	283, 731	90. 01
90. 02	09002 NEUROPSYCH	0	0	0	O	166, 090	90. 02
90. 03	09003 WOUND CENTER	0	0	0	0	1, 784, 534	90. 03
90. 04 91. 00	09004 HYPERBARI C OXYGEN THERAPY 09100 EMERGENCY	11 025	0		0	381, 598	90.04
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 025	Ü	,	O ₁	13, 358, 984	91. 00 92. 00
72. UU	OTHER REIMBURSABLE COST CENTERS			I			72. UU
95. 00	09500 AMBULANCE SERVICES	0	C	0	0	4, 821, 509	95. 00
	<u> </u>				-1	,	

Provider CCN: 150112 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Part I | Par

			T	o 12/31/2014	Date/Time Pre 5/28/2015 3:3	
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	
99. 10 09910 CORF	0	0	0	0	0	//. 10
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	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)	848, 066	0	718, 975	546, 902	196, 913, 906	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	0	398, 566	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	121, 459	194. 01
194. 02 07952 HOSPI CE	0	0	0	0	82, 006	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0	253, 140	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	2, 156, 124	194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0	108, 396	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	362, 662	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)	848, 066	0	718, 975	546, 902	200, 445, 944	202. 00

Heal th Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150112 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/28/2015 3: 32 pm

Cost Center Description | Intern & Residents Cost | Residents Cost | Total | To

				5/28/2015 3: 3:	2 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total		
		Adj ustments			
	CENIEDAL CEDIMOE COCT CENTEDO	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 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. 01	00540 NONPATIENT TELEPHONES				5. 01
5. 02	00550 DATA PROCESSING				5. 02
5.03	00560 PURCHASING RECEIVING AND STORES				5. 03
5. 04	00570 ADMITTING				5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5. 06 7. 00	OO590 OTHER ADMINISTRATIVE AND GENERAL OO700 OPERATION OF PLANT				5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
	01000 DI ETARY				10. 00
11.00	01100 CAFETERI A				11.00
	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY				14. 00
	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16. 00
	02300 PARAMED ED PRGM-(SPECIFY)				17. 00 23. 00
	02301 XRAY EDUCATION				23. 00
	02302 PHARMACY RESIDENCY PROG				23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	1	<u>'</u>		
30.00	03000 ADULTS & PEDIATRICS	0	40, 295, 536		30. 00
	03100 INTENSIVE CARE UNIT	0	5, 971, 306		31. 00
	03200 CORONARY CARE UNIT	0	0		32. 00
	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0		34. 00 40. 00
	04100 SUBPROVI DER – I RF		4, 601, 528		41.00
	04200 SUBPROVI DER	o	0		42. 00
	04300 NURSERY	0	1, 260, 417		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCILLARY SERVICE COST CENTERS		00.045.440		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	23, 945, 143 1, 958, 764		50. 00 51. 00
	05200 DELIVERY ROOM & LABOR ROOM		1, 956, 764		52.00
	05300 ANESTHESI OLOGY	o	515, 616		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	4, 506, 360		54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 162, 707		54. 01
	05404 ULTRA SOUND	0	1, 073, 642		54. 02
	05405 MAMMOGRAPHY	0	2, 002, 744		54. 03
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	3, 230, 164		55. 00
	05800 MRI		1, 910, 272 811, 071		57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON		5, 188, 784		59. 00
	06000 LABORATORY	o	13, 615, 724		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	1, 460, 997		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 055, 211		62. 00
	06500 RESPI RATORY THERAPY	0	4, 821, 867		65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	5, 939, 926 2, 034, 984		66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	1, 168, 439		68. 00
	06900 ELECTROCARDI OLOGY		1, 624, 863		69. 00
	07000 ELECTROENCEPHALOGRAPHY	o	1, 494, 028		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8, 848, 792		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 605, 007		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	23, 176, 877		73.00
	07400 RENAL DI ALYSI S	0	440, 013		74.00
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0	0 299, 006		76. 00 76. 97
10.71	OUTPATIENT SERVICE COST CENTERS	<u> </u>	277, 000		10.71
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	o		89. 00
	09000 CLI NI C	0	2, 097, 672		90. 00
	09001 DI ABETES CENTER	0	283, 731		90. 01
	09002 NEUROPSYCH	0	166, 090		90. 02
	09003 WOUND CENTER	0	1, 784, 534		90. 03
	09004 HYPERBARI C OXYGEN THERAPY 09100 EMERGENCY	0	381, 598 13, 358, 984		90. 04 91. 00
		1 0	.0,000,701	<u> </u>	700

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150112	From 01/01/2014	Worksheet B Part I Date/Time Pre 5/28/2015 3:3	
Cost Center Description	Intern & Residents Cost & Post Stepdown	Total				

			5/28/2	2015 3:32 pm
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	4, 821, 509		95. 00
99. 10 09910 CORF	0	O		99. 10
101.00 10100 HOME HEALTH AGENCY	0	O		101.00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	O		110. 00
111.00 11100 ISLET ACQUISITION	0	O		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	196, 913, 906		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49, 685		190. 00
194.00 07950 WELLNESS COMMUNITY	0	398, 566		194. 00
194. 01 07951 BUI LDI NG RENTALS	o	121, 459		194. 01
194. 02 07952 HOSPI CE	l	82, 006		194, 02
194. 03 07953 OUTREACH CLINICS	l	ol		194. 03
194. 04 07954 SPEECH - HEARING ALDS	O	253, 140		194. 04
194. 05 07955 NONALLOWABLE MARKETING	O	2, 156, 124		194, 05
194. 06 07956 CRH FOUNDATION	0	108, 396		194, 06
194. 07 07957 HEALTHY COMMUNITIES	أ	362, 662		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	200, 445, 944		202. 00
202. 00 TOTAL (Suil TITIES TTO-201)	١	200, 440, 744		1202.00

			5/28/2015 3: 3	32 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
5.01	NONPATI ENT TELEPHONES	5	PHONES	5. 01
5.02	DATA PROCESSING	6	DP COST	5. 02
5.03	PURCHASING RECEIVING AND STORES	7	SUP COST	5. 03
5.04	ADMI TTI NG	8	REVENUE	5. 04
5.05	CASHI ERI NG/ACCOUNTS RECEI VABLE	8	REVENUE	5. 05
5.06	OTHER ADMINISTRATIVE AND GENERAL	-1	ACCUM. COST	5. 06
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	MEDI CAL RECORDS & LI BRARY	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

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					T	12/31/2014	Date/Time Pre	
				CAPI TAL REI	_ATED COSTS		5/28/2015 3: 3:	2 pm
			5				511D1 01/55	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	0.00			
	GENER	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES	18, 337 745	193, 307 37, 481		305, 016 200, 614	305, 016 1, 531	4. 00 5. 01
5. 02		DATA PROCESSING	47, 113	302, 930		720, 314	13, 750	5. 02
5.03		PURCHASING RECEIVING AND STORES	70	165, 754		355, 977	4, 510	5. 03
5.04		ADMITTING	568	36, 259		103, 347	4, 475	5. 04
5. 05 5. 06		CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL	7, 026 173, 712	95, 379 387, 671	134, 991 417, 920	237, 396 979, 303	10, 300 14, 625	5. 05 5. 06
7. 00		OPERATION OF PLANT	62, 332	4, 744, 049		5, 171, 154	8, 325	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	9, 461	0	9, 461	269	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	4, 220 3, 226	69, 531 118, 495		169, 022 174, 936	7, 132 2, 266	9. 00 10. 00
11. 00		CAFETERI A	7, 564	91, 380		223, 706	5, 500	
13. 00		NURSING ADMINISTRATION	1, 652	150, 198		308, 798	13, 843	13. 00
14. 00 15. 00		CENTRAL SERVI CES & SUPPLY PHARMACY	3, 417 9, 375	114, 844 72, 685		227, 288 644, 108	18 13, 215	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	749	59, 693	·	188, 609	2, 494	16. 00
17. 00	01700	SOCIAL SERVICE	60, 694	4, 557	· ·	74, 940	2, 311	17. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)	0	10.005		0 553	1 003	23. 00
23. 01 23. 02		XRAY EDUCATION PHARMACY RESIDENCY PROG	0	10, 925 4, 436		20, 553 14, 044	1, 893 1, 459	23. 01 23. 02
20.02	_	I ENT ROUTI NE SERVI CE COST CENTERS		1, 100	7,000	11,011	1, 107	20.02
30.00	1	ADULTS & PEDIATRICS	196, 463	1, 153, 144		2, 314, 498	60, 191	30.00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	36, 050	165, 362	226, 646	428, 058 0	9, 600 0	31. 00 32. 00
33. 00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF	0 26, 589	147 242	_	0 274, 312	0 6, 250	40. 00 41. 00
41.00		SUBPROVI DER	20, 369	167, 263 0		274, 312	0, 250	41.00
43.00	04300	NURSERY	1, 005	8, 797	17, 671	27, 473	2, 651	43.00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	317, 301	610, 643	1, 567, 042	2, 494, 986	2, 087	50. 00
51. 00		RECOVERY ROOM	153	48, 059		119, 576	2, 337	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	_	0	0	52. 00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	2, 854	1, 796 120, 110		82, 314 422, 363	0 6, 400	53. 00 54. 00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	74	51, 062		279, 695	1, 432	54. 01
54. 02		ULTRA SOUND	149	22, 694		28, 999	2, 101	54. 02
54. 03 55. 00	1	MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	153, 794 2, 453	4, 119 119, 250		213, 899 302, 046	3, 197 4, 626	
57. 00		CT SCAN	725	15, 195		248, 407	2, 507	
58. 00	05800		415	13, 580	24, 706	38, 701	1, 133	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	31, 966 22, 144	158, 421 162, 148		662, 469 624, 850	6, 285 15, 235	59. 00 60. 00
60. 00		LABORATORY-PATHOLOGI CAL	6, 474	18, 288		104, 499	1, 622	60. 00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	43	7, 907	16, 425	24, 375	320	62. 00
65. 00 66. 00		RESPIRATORY THERAPY	34, 047	99, 075		323, 180 534, 792	7, 741	65. 00
67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	330, 379 24, 237	3, 425 3, 335		75, 467	13, 703 4, 729	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	56, 871	0		100, 949	2, 812	
69.00		ELECTROCARDI OLOGY	2, 598	21, 095	· ·	97, 313	2, 102	69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	15, 531	0		68, 689 0	2, 687 0	70. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	Ö	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 76. 00		RENAL DIALYSIS ACUPUNCTURE	0	0		0	0	74. 00 76. 00
76. 97	1	CARDI AC REHABI LI TATI ON	565	12, 041	15, 508	28, 114	425	76. 00 76. 97
	OUTPA	TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0 37	0 65, 487		0 99, 517	0 2, 607	89. 00 90. 00
90. 01	09001	DI ABETES CENTER	174	11, 694	7, 809	19, 677	311	90. 01
90. 02		NEUROPSYCH	163	1, 554		3, 588	373	
90. 03 90. 04		WOUND CENTER HYPERBARI C OXYGEN THERAPY	49, 929 276, 165	0	· ·	81, 347 280, 860	1, 454 8	
70.04	10,004	I CONTROL THEIR I	270, 103	0	1 7,073	200, 000	0	70.07

ALLOCATION OF CAPITAL RELATED COSTS	Provi o	der CCN:	150112	Peri	od:	Worksheet B	
				From	01/01/2014	Part II	
				To	12/31/2014	Date/Time Pre	pared:
						5/28/2015 3:3	2 pm
·	CADLTAL	DELATE	D COCTC				

				T	12/31/2014	Date/Time Pre	pared:
						5/28/2015 3:3	2 pm
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
	EMERGENCY	4, 152	146, 606	255, 420	406, 178	20, 286	1
	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	REIMBURSABLE COST CENTERS						
	AMBULANCE SERVICES	49, 269	96, 706	245, 092	391, 067	10, 853	1
99. 10 09910	CORF	0	0	0	0	0	99. 10
	HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	AL PURPOSE COST CENTERS						
109. 00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	2, 043, 569	9, 977, 891	9, 309, 384	21, 330, 844	303, 646	118. 00
NONRE	IMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 970	369	11, 339	0	190. 00
194. 00 07950	WELLNESS COMMUNITY	40, 143	0	22, 794	62, 937	739	194. 00
194. 01 07951	BUILDING RENTALS	30, 307	11, 679	2, 740	44, 726	0	194. 01
194. 02 07952	HOSPI CE	159	0	0	159	0	194. 02
194. 03 07953	OUTREACH CLINICS	0	0	0	0	0	194. 03
194. 04 07954	SPEECH - HEARING AIDS	o	0	0	o	0	194. 04
194. 05 07955	NONALLOWABLE MARKETING	o	0	0	0	0	194. 05
194.06 07956	CRH FOUNDATION	1, 156	12, 298	24, 758	38, 212	0	194. 06
194. 07 07957	HEALTHY COMMUNITIES	0	18, 032		52, 123	631	194. 07
200. 00	Cross Foot Adjustments				0		200. 00
201. 00	Negative Cost Centers		0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	2, 115, 334	10, 030, 870	9, 394, 136	21, 540, 340	305, 016	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150112

Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/28/2015 3:32 pm Cost Center Description NONPATI ENT PURCHASI NG ADMI TTI NG CASHI ERI NG/ACC RECEIVING AND OUNTS TELEPHONES PROCESSI NG **STORES** RECEI VABLE 5. 01 5. 02 5. 04 5.03 5.05 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 NONPATIENT TELEPHONES 202, 145 5.01 00550 DATA PROCESSING 6,516 5.02 740, 580 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 3, 554 364.041 5.03 00570 ADMITTING 5.04 3.406 297 111, 525 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 7,849 84, 352 389 340, 286 5.05 5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 27, 249 64, 282 581 0 0 5.06 00700 OPERATION OF PLANT 5, 627 0 7.00 7.00 69 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 8.00 9.00 00900 HOUSEKEEPING 1, 185 0 5,826 0 0 0 0 9.00 01000 DI ETARY 444 10.00 10.00 104 01100 CAFETERIA 1.037 11.00 11.00 244 0 01300 NURSING ADMINISTRATION 13.00 3, 110 393, 840 139 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1,481 303 0 0 0 14.00 01500 PHARMACY 3,702 9, 628 0 15.00 4.214 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 5, 183 21, 181 684 0 16,00 17.00 01700 SOCIAL SERVICE 444 C 0 17.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 0 0 23.00 02301 XRAY EDUCATION 296 23.01 23.01 C 3 0 02302 PHARMACY RESIDENCY PROG 23.02 296 C 0 0 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 33, 323 12, 294 36, 109 12, 978 39, 570 30.00 31 00 03100 INTENSIVE CARE UNIT 5 183 7, 189 6, 208 31 00 2 036 03200 CORONARY CARE UNIT 32.00 0 C 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 ol 34.00 0 04000 SUBPROVI DER - I PF 40.00 0 C \cap Ω 40.00 04100 SUBPROVIDER - IRF 41.00 3.406 0 2,004 1.165 3, 551 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 0 43 00 04300 NURSERY 148 Ω 37 535 1,632 43 00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 919 62, 853 16, 800 51, 476 50.00 51 00 05100 RECOVERY ROOM Ω 1, 203 1, 135 3, 460 51 00 2.369 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 05300 ANESTHESI OLOGY 592 1, 934 5, 898 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,035 0 1, 181 1, 130 3, 444 54.00 4, 947 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 54 01 1,037 86 1,622 54 01 54.02 05404 ULTRA SOUND 444 475 1,049 3, 197 54.02 54.03 05405 MAMMOGRAPHY 2.073 204 606 1,848 54.03 05500 RADI OLOGY-THERAPEUTI C 55.00 0 102 2.119 55.00 2.221 6.462 05700 CT SCAN 1,037 57 00 Ω 4.324 4.276 13,038 57 00 58.00 05800 MRI 296 C 110 1,631 4, 973 58.00 59 00 05900 CARDIAC CATHETERIZATION 5, 479 3, 582 4, 370 13, 323 59 00 06000 LABORATORY 15, 278 7.492 60.00 9.182 155,003 22,843 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 1,037 C 722 1,031 3, 143 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 592 123 507 1, 547 62.00 06500 RESPIRATORY THERAPY 65.00 4, 147 0 2, 687 2, 247 6, 851 65.00 06600 PHYSI CAL THERAPY 66,00 7.108 C 1.009 2,618 7.983 66,00 67.00 06700 OCCUPATI ONAL THERAPY 2, 369 126 843 2,570 67.00 68.00 06800 SPEECH PATHOLOGY 1,333 52 354 1,079 68.00 06900 ELECTROCARDI OLOGY 2.503 69.00 69.00 3.110 430 7,632 07000 ELECTROENCEPHALOGRAPHY 70.00 3.258 357 1, 206 3, 678 70.00 158, 922 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 4, 456 13, 585 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 5, 952 3, 363 10, 254 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 15, 944 14, 595 44, 500 73.00 74.00 07400 RENAL DIALYSIS 0 0 9 290 883 74.00 76.00 03020 ACUPUNCTURE 76.00 07697 CARDIAC REHABILITATION 1,037 130 202 76. 97 76.97 616 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 C 0 0 89.00 90.00 09000 CLI NI C 3.998 0 3, 435 988 3.012 90.00 09001 DIABETES CENTER 90.01 148 0 11 23 69 90.01 90.02 09002 NEUROPSYCH 296 0 141 90.02 5 46 90.03 09003 WOUND CENTER 889 0 1, 343 1,084 3, 304 90.03 09004 HYPERBARI C OXYGEN THERAPY Ω 201 370 1, 128 90 04 90 04 148 91.00 09100 EMERGENCY 6,220 21,078 12,071 36, 802 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

			То	12/31/2014	Date/Time Pre 5/28/2015 3:3	
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/ACC	
	TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
			STORES		RECEI VABLE	
	5. 01	5. 02	5. 03	5. 04	5. 05	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	1, 037	0	1, 342	1, 773	5, 404	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
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	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	197, 850	740, 580	361, 475	111, 448	340, 051	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	296	0	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	592	0	35	0		194. 00
194.01 07951 BUILDING RENTALS	889	0	0	0		194. 01
194. 02 07952 HOSPI CE	0	0	2, 515	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	77		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 05
194.06 07956 CRH FOUNDATION	1, 185	0	10	0		194. 06
194.07 07957 HEALTHY COMMUNITIES	1, 333	0	6	0		194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	202, 145	740, 580	364, 041	111, 525	340, 286	202. 00

Provi der CCN: 150112

| Period: | Worksheet B | From 01/01/2014 | Part II | Date/Time Prepared: | 5/28/2015 3:32 pm

				'	0 12/31/2014	5/28/2015 3: 3:	
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL			0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 06	7. 00	8.00	9. 00	10. 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. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING			•		ļ	5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 04	00570 ADMITTING			•		ļ	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 086, 040					5. 06
7. 00	00700 OPERATION OF PLANT	71, 068	5, 256, 243			ļ	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	4, 065	12, 224	1			8. 00
9. 00	00900 HOUSEKEEPING	17, 282	89, 840	l	290, 287		9. 00
10. 00	01000 DI ETARY	7, 161	153, 106	1	1, 603	339, 620	10.00
11. 00	01100 CAFETERI A	9, 300	118, 071	0	3, 794	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	58, 771	194, 068		748	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 859	148, 387	1	1, 389	0	14. 00
15. 00	01500 PHARMACY	40, 270	93, 914		4, 756	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	13, 488	77, 128	· · · · · ·	4, 730	0	16.00
17. 00	01700 SOCIAL SERVICE	4, 422	5, 888	1	107	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	4, 422	5, 888	i	107	0	23. 00
23. 00	02301 XRAY EDUCATION	3, 574	14, 115	_	695	0	23. 00
23. 01	02302 PHARMACY RESIDENCY PROG	2, 824	5, 732	1	093	0	23. 01
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2,024	3, 732	. 0	U	U	23.02
30. 00	03000 ADULTS & PEDIATRICS	140, 084	1, 489, 955	10, 034	110, 834	270, 061	30.00
31. 00	03100 I NTENSI VE CARE UNI T	22, 710		l	8, 550	25, 553	31.00
32. 00	03200 CORONARY CARE UNIT	22, 710	213, 662	1, 233	0, 330	25, 555	32.00
33. 00	1 1		0		0	0	•
34. 00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33.00
	03400 SURGICAL INTENSIVE CARE UNIT	١	0		0		34.00
40.00	04000 SUBPROVI DER - I PF	0	217 110	1 457	10 501	0	40.00
41. 00	04100 SUBPROVI DER - I RF	14, 493	216, 118		10, 581	35, 925	41.00
42. 00	04200 SUBPROVI DER	0	11 2//	0	107	0	42.00
43.00	04300 NURSERY	5, 412	11, 366	1	107	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	U	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	102 543	789, 002	5, 209	53, 975	1, 627	50.00
51. 00	05100 RECOVERY ROOM	102, 562 9, 190	62, 096	1		1, 627	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	9, 190	02, 090	000	7,034	0	52.00
53. 00	05300 ANESTHESI OLOGY	1 -1	າລາດ	_	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 566 17, 232	2, 320 155, 192	1	7, 856	198	54.00
54. 00	05402 NUCLEAR MEDICINE-DIAGNOSTIC	9, 927	65, 976	1	6, 306	0	54. 00
54. 01	05404 ULTRA SOUND	5, 250	29, 323		1, 657	0	54. 01
54. 02	05405 MAMMOGRAPHY	8, 887	5, 323	1		0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	13, 106	5, 323 154, 080	1	2, 993 4, 222	694	55. 00
57. 00	1 1	1 ' 1		1	4, 222 695		57.00
58. 00	05700 CT SCAN	9, 916	19, 633	i	695	0	•
59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	4, 074	17, 547	1		673	58. 00 59. 00
	06000 LABORATORY	22, 078	204, 693	1		0/3	
60.00	06001 LABORATORY-PATHOLOGI CAL	69, 740	209, 509		4, 275	0	60.00
60. 01	1	6, 491	23, 630	1	321	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	5, 556	10, 216	1	160	0	62.00
65. 00	06500 RESPIRATORY THERAPY	19, 232	128, 014		3, 260		65. 00
66.00	06600 PHYSI CAL THERAPY	31, 301	4, 426		0	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	10, 602	4, 309	1	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	6, 232	07.054	0	4 400	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 918	27, 256		1, 122	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 541	0	58	10, 474	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 946	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	46, 625	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	81, 354	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	2, 370	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABILITATION	1, 160	15, 558	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 =	0	0	0	89. 00
90.00	09000 CLINIC	7, 234	84, 615	i	3, 474	3, 288	90.00
90. 01	09001 DI ABETES CENTER	1, 203	15, 110	1	160	0	90. 01
90. 02	09002 NEUROPSYCH	795	2, 008	i	0	0	90. 02
90. 03	09003 WOUND CENTER	9, 301	0	145	0	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	2, 058	100 100	22	0	0	90.04
	09100 EMERGENCY	56, 192	189, 428	1, 965	29, 980	1, 601	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 1		I	J	ļ	92. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					5/28/2015 3: 32	
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	23, 612	124, 953	0	0	0	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
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 I NTESTI NAL ACQUI SI TI ON	0	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)	1, 068, 034	5, 187, 791	26, 026	288, 416	339, 620	118. 00
NONREI MBURSABLE COST CENTERS		1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	78		0	0	•	190. 00
194. 00 07950 WELLNESS COMMUNITY	2, 110		0	0	•	194. 00
194. 01 07951 BUI LDI NG RENTALS	454		0	0		194. 01
194. 02 07952 HOSPI CE	443	0	0	0	•	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	•	194. 03
194. 04 07954 SPEECH - HEARING AIDS	1, 372		0	0	•	194. 04
194. 05 07955 NONALLOWABLE MARKETING	11, 683		0	0		194. 05
194.06 07956 CRH FOUNDATION	267			1, 657		194. 06
194. 07 07957 HEALTHY COMMUNITIES	1, 599	23, 298	0	214		194. 07
200.00 Cross Foot Adjustments					:	200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 086, 040	5, 256, 243	26, 026	290, 287	339, 620	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					10	12/31/2014	5/28/2015 3:3	
		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
				ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
			11. 00	13.00	14. 00	15. 00	16. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP						2.00
5. 01		EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES						4. 00 5. 01
5. 02		DATA PROCESSING						5. 02
5. 03	1	PURCHASING RECEIVING AND STORES						5. 03
5.04	1	ADMI TTI NG						5. 04
5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 7. 00		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT						5. 06 7. 00
8.00		LAUNDRY & LINEN SERVICE						8.00
9. 00	1	HOUSEKEEPI NG						9. 00
10.00	01000	DI ETARY						10. 00
11. 00	1	CAFETERI A	361, 652					11. 00
13.00	1	NURSI NG ADMI NI STRATI ON	15, 270		20/ 02/			13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	14, 466	301	386, 026 0	828, 273		14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	11, 653		0	020, 273	320, 420	16. 00
17. 00		SOCIAL SERVICE	2, 813	Ö	0	Ö	0	17. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	О	0	23. 00
23. 01		XRAY EDUCATION	2, 813		0	0	0	23. 01
23. 02		PHARMACY RESIDENCY PROG	2, 009	0	0	0	0	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	102, 065	502, 333	22, 382	596	101, 151	30. 00
31. 00	1	INTENSIVE CARE UNIT	13, 662	66, 228	22, 362	124	9, 216	31. 00
32. 00		CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	О	0	33. 00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40.00	1	SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	1	SUBPROVIDER - IRF	9, 242	44, 760	0	8	23, 225 0	41. 00 42. 00
42.00	1	SUBPROVI DER NURSERY	3, 617	17, 048	890	1	0	42.00
44. 00	1	SKILLED NURSING FACILITY	0,017	1	0	ó	0	44. 00
	ANCI L	LARY SERVICE COST CENTERS						
50.00	1	OPERATI NG ROOM	2, 813	13, 030	337, 736	1, 999	71, 310	50.00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	19	0	25	0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	0	0	3, 848	0	53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	8, 840	Ö	198	135	0	54. 00
54. 01	05402	NUCLEAR MEDICINE-DIAGNOSTIC	1, 607	0	0	8, 775	0	54. 01
54. 02	1	ULTRA SOUND	2, 009		0	71	0	54. 02
54. 03	1	MAMMOGRAPHY	4, 822	24, 099		17	0	54. 03
55. 00 57. 00		RADI OLOGY-THERAPEUTI C CT SCAN	4, 420 3, 215	22, 642 0	0	0 502	2, 799 0	55. 00 57. 00
58. 00	05800		1, 206		0	38	0	
59. 00		CARDI AC CATHETERI ZATI ON	7, 635		3, 362	160	3, 530	
60.00	1	LABORATORY	30, 138		0	18	0	60. 00
60. 01	1	LABORATORY-PATHOLOGI CAL	2, 411		0	3	21, 763	60. 01
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	402	0	0	10	10.454	62.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	11, 653 19, 288		3, 362 5, 801	381 99	18, 456 0	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	4, 822		0	156	3, 567	67. 00
68. 00	06800	SPEECH PATHOLOGY	3, 215		0	О	0	68. 00
69. 00		ELECTROCARDI OLOGY	3, 215		0	177	29, 840	1
70.00	1	ELECTROENCEPHALOGRAPHY	3, 215	0	0	1	16, 747	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS	0	0	0	808, 198	0	73.00
74. 00	1	RENAL DIALYSIS	0	o o	0	271	0	1
76.00		ACUPUNCTURE	0	0	0	О	0	76. 00
76. 97		CARDIAC REHABILITATION	804	3, 597	0	0	0	76. 97
00.00		TIENT SERVICE COST CENTERS	^		ام	<u></u>		00 00
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00		CLINIC	4, 018		0	150	17, 292	•
90. 01		DI ABETES CENTER	402	1, 722	0	0	0	90. 01
90. 02	09002	NEUROPSYCH	402	0	0	o	1, 400	•
90. 03	1	WOUND CENTER	2, 009	0	8, 867	1, 504	0	
90. 04	109004	HYPERBARIC OXYGEN THERAPY	0	1 0	0	0	124	
	1	EMERGENCY	22 NE1	160 OF /	2 724	2001	Λ.	I Q1 NN
91.00	09100	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	32, 951	162, 854	2, 736	380	0	91. 00 92. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150112 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11.00 13.00 15. 00 16.00 14.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 25, 717 607 0 95.00 99. 10 09910 CORF 0 99. 10 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 0 C 113.00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 358, 839 988, 587 386, 026 828, 254 320, 420 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 194. 00 07950 WELLNESS COMMUNITY 1,607 0 0 0 0 194. 00 194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 194. 01 OI 0 19 0 194. 02 194. 02 07952 HOSPI CE 0 194. 03 07953 OUTREACH CLINICS 0 0 0 194. 03 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 0 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 0 194. 05 0 194.06 07956 CRH FOUNDATION 0 194. 06 0 0 194. 07 07957 HEALTHY COMMUNITIES 1, 206 0 194. 07 200.00 Cross Foot Adjustments 200.00

361, 652

988, 587

0 201. 00

320, 420 202. 00

0

828, 273

386, 026

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150112 Peri od:

To

Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014

5/28/2015 3:32 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 00540 NONPATIENT TELEPHONES 5 01 5 01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5. 04 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.05 5.05 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 7.00 00700 OPERATION OF PLANT 7 00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16,00 01700 SOCIAL SERVICE 17 00 90.925 17 00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 23. 01 02301 XRAY EDUCATION 0 43, 942 23.01 02302 PHARMACY RESIDENCY PROG 23.02 0 26, 364 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 41.371 5, 299, 829 30.00 03100 INTENSIVE CARE UNIT 825, 281 31.00 6.001 31.00 32.00 03200 CORONARY CARE UNIT 0 Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 40.00 41.00 28, 732 675, 229 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 43.00 0 71, 267 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 025, 657 50.00 273 51.00 05100 RECOVERY ROOM 0 206, 937 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 Λ 52.00 53.00 05300 ANESTHESI OLOGY 0 99, 472 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 631, 672 54.00 54 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 381, 410 54 01 0 54.02 05404 ULTRA SOUND 74, 575 54.02 05405 MAMMOGRAPHY 0 268, 773 54.03 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 525, 831 6.092 55.00 05700 CT SCAN 307, 550 57 00 0 57 00 58.00 05800 MRI 0 70, 404 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 981, 470 59.00 06000 LABORATORY 60.00 0000000000000 1, 163, 563 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 166, 673 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 43,808 62.00 06500 RESPIRATORY THERAPY 65.00 589, 360 65.00 06600 PHYSI CAL THERAPY 66, 00 628, 682 66,00 67 00 06700 OCCUPATIONAL THERAPY 109, 830 67 00 06800 SPEECH PATHOLOGY 116, 026 68.00 68.00 69 00 06900 ELECTROCARDI OLOGY 195, 816 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 116, 911 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 224, 909 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 66, 194 72.00 07300 DRUGS CHARGED TO PATIENTS 964, 591 73.00 73.00 74.00 07400 RENAL DIALYSIS 3,823 74.00 0 76.00 03020 ACUPUNCTURE 76.00 0 76. 97 07697 CARDIAC REHABILITATION 0 51, 643 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 7, 274 261, 323 90.00 09001 DI ABETES CENTER 90.01 0 38, 836 90.01 90.02 09002 NEUROPSYCH 0 9, 054 90.02 09003 WOUND CENTER 90.03 0 111, 247 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 284, 919 90.04 09100 EMERGENCY 981, 904 91.00 1, 182 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 586, 365 95 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150112

Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared:

5/28/2015 3:32 pm PARAMED ED Cost Center Description SOCIAL SERVICE XRAY EDUCATION PHARMACY Subtotal PRGM RESIDENCY PROG 17.00 23.00 23.02 24.00 23. 01 99. 10 09910 CORF 99. 10 0 n 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 90, 925 0 21, 160, 834 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 25, 887 190. 00 0 0 0 0 0 0 0 194. 00 07950 WELLNESS COMMUNITY 68, 020 194. 00 194. 01 07951 BUILDING RENTALS 61, 159 194. 01 194. 02 07952 HOSPI CE 3, 136 194. 02 194. 03 07953 OUTREACH CLINICS 0 194. 03 194. 04 07954 SPEECH - HEARING AIDS 1, 684 194. 04 11, 683 194. 05 194. 05 07955 NONALLOWABLE MARKETING 57, 221 194. 06 194.06 07956 CRH FOUNDATION 194. 07 07957 HEALTHY COMMUNITIES 80, 410 194. 07 43, 942 70, 306 200. 00 200.00 Cross Foot Adjustments 26, 364 0 201.00 0 0 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118-201) 90, 925 43, 942 26, 364 21, 540, 340 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLUMBUS REGIONAL HOSPITAL Provi der CCN: 150112 Peri od: From 01/01/2014 To 12/31/2014 Intern & Residents Cost Cost Center Description Total

		Residents Cost		
		& Post		
		Stepdown Adjustments		
		25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	23.00	20.00	
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. 01	00540 NONPATIENT TELEPHONES			5. 01
5.02	00550 DATA PROCESSING			5. 02
5.03	00560 PURCHASING RECEIVING AND STORES			5. 03
5.04	00570 ADMITTI NG			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL			5. 06
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 11. 00	01000 DI ETARY 01100 CAFETERI A			10.00
13. 00	01300 NURSING ADMINISTRATION			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
23. 01	02301 XRAY EDUCATION			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG			23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	0	5, 299, 829	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	825, 281	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	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0 475 220	40.00
41. 00 42. 00	04100 SUBPROVI DER		675, 229 0	41. 00 42. 00
43. 00	04300 NURSERY		71, 267	43. 00
44. 00	04400 SKILLED NURSING FACILITY		71, 207	44. 00
	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	1 55
50.00	05000 OPERATING ROOM	0	4, 025, 657	50.00
51. 00	05100 RECOVERY ROOM			
	OS TOO RECOVERT ROOM	0	206, 937	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 99, 472	52. 00 53. 00
53. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	000000000000000000000000000000000000000	0 99, 472 631, 672	52. 00 53. 00 54. 00
53. 00 54. 00 54. 01	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDICINE-DI AGNOSTI C	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410	52. 00 53. 00 54. 00 54. 01
53. 00 54. 00 54. 01 54. 02	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDICINE-DI AGNOSTI C 05404 ULTRA SOUND	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575	52. 00 53. 00 54. 00 54. 01 54. 02
53. 00 54. 00 54. 01 54. 02 54. 03	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDICINE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDICINE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI	0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00 60. 01	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL	0 0 0 0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00 60. 01
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 01 62. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 00 60. 01 62. 00 65. 00 66. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 60. 01 62. 00 65. 00 66. 00 67. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 66. 00 67. 00 68. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 67. 00 68. 00 69. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 67. 00 68. 00 69. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 67. 00 68. 00 69. 00 70. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 59. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS		0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194 964, 591 3, 823	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE		0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194 964, 591 3, 823	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY 06001 LABORATORY PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABILI TATI ON	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194 964, 591 3, 823	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL. DEV. CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABILI TATI ON OUTPATI ENT SERVI CE COST CENTERS	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194 964, 591 3, 823	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 00 76. 00 76. 97
53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL. DEV. CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	000000000000000000000000000000000000000	0 99, 472 631, 672 381, 410 74, 575 268, 773 525, 831 307, 550 70, 404 981, 470 1, 163, 563 166, 673 43, 808 589, 360 628, 682 109, 830 116, 026 195, 816 116, 911 224, 909 66, 194 964, 591 3, 823 0 51, 643	52. 00 53. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00
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Health Financial Systems	COLUMBUS REGION	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014		
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·					
95. 00 09500 AMBULANCE SERVICES	0	586, 365				95. 00
99. 10 09910 CORF	0	0)			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS						1
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 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	21, 160, 834				118. 00
NONREI MBURSABLE COST CENTERS						
100 00 10000 CLET FLOWED COFFEE CHOD & CANTEEN		25 007	1			1100 00

25, 887

68, 020

61, 159

3, 136

1, 684

11, 683

57, 221 80, 410

70, 306

21, 540, 340

190. 00

194. 00

194. 01

194. 02 194. 03 194. 04

194. 05

194. 06

194. 07

200. 00

201. 00

202. 00

200.00

201.00

202.00

190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194. 00 07950 WELLNESS COMMUNITY

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

194. 01 07951 BUILDING RENTALS

194.06 07956 CRH FOUNDATION

194. 02 07952 HOSPI CE 194. 03 07953 OUTREACH CLINICS 194. 04 07954 SPEECH - HEARING AIDS

194. 05 07955 NONALLOWABLE MARKETING

194. 07 07957 HEALTHY COMMUNITIES

	Financial Systems	COLUMBOS REGIO		00N 4F0440 D		U OT FORM CMS-	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2014	Worksheet B-1	
				Т	o 12/31/2014	Date/Time Pre 5/28/2015 3:3	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	NONPATI ENT	DATA	
	Cost Center Beservetton	(SQ FEET)	(DEPR)	BENEFITS	TELEPHONES	PROCESSI NG	
		, ,	, ,	DEPARTMENT	(PHONES)	(DP COST)	
		1.00	2.00	(GROSS SAL)	F 01	F 02	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	4. 00	5. 01	5. 02	
1.00	00100 CAP REL COSTS-BLDG & FIXT	664, 773					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9, 041, 640				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 811	89, 868				4. 00 5. 01
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	2, 484 20, 076	156, 295 356, 377	1	· ·	10, 000	5. 01
5. 03	00560 PURCHASING RECEIVING AND STORES	10, 985	183, 018			0	5. 03
5.04	00570 ADMI TTI NG	2, 403	64, 024			0	5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 321	129, 926			1, 139	5. 05
5. 06 7. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	25, 692 314, 401	402, 238 351, 086			868 0	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	627	0	1		0	8. 00
9.00	00900 HOUSEKEEPI NG	4, 608	91, 696			0	9. 00
10.00	01000 DI ETARY	7, 853	51, 218			0	10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	6, 056 9, 954	120, 081 151, 059			5, 318	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 611	104, 936			0, 0.0	14. 00
	01500 PHARMACY	4, 817	540, 958			130	
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 956	123, 358			286	
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	302	9, 325 0	1		0	17. 00 23. 00
23. 01	02301 XRAY EDUCATION	724	9, 267	1		0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	294	9, 247	319, 085	2	0	23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7/ 400	020 (05	12 1/5 102	225	1//	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	76, 422 10, 959	928, 685 218, 142			166 0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	Ö	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER	11, 085	77, 441	1, 366, 992	0 23	0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	583	17, 008			0	43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00		40, 469	1, 508, 243	456, 452	121	0	50.00
51.00	05100 RECOVERY ROOM	3, 185	68, 686			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	119 7, 960	77, 497 288, 165		34	0	53. 00 54. 00
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 384	219, 983			0	
54. 02	05404 ULTRA SOUND	1, 504	5, 925	459, 570	3	0	
	05405 MAMMOGRAPHY	273	53, 885			0	
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	7, 903 1, 007	173, 576 223, 763			0	55. 00 57. 00
58. 00	05800 MRI	900	23, 779			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 499	454, 368			0	
60.00	06000 LABORATORY	10, 746	424, 027			2, 093	
60. 01 62. 00	06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 212 524	76, 745 15, 809			0	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	6, 566	182, 926			0	65.00
66. 00	06600 PHYSI CAL THERAPY	227	193, 446			0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	221	46, 098			0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 398	42, 424 70, 858	1		0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	51, 163			0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0	73. 00 74. 00
76. 00	03020 ACUPUNCTURE	0	Ö	Ö	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	798	14, 926	92, 900	7	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		^	1 -		^	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	88. 00 89. 00
90.00		4, 340	32, 717		-	0	90.00
90. 01	09001 DI ABETES CENTER	775	7, 516	68, 002	1	0	90. 01
	09002 NEUROPSYCH	103	1, 801			0	
90. 03 90. 04	09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY	0	30, 239 4, 519			0	
			, -, .	, ., ., .,			

Health Financial Customs	COLUMBUS REGION	IAL HOCDITAL		مالعا	u of Form CMC	DEED 10
	COLUMBUS REGION				u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150112	Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 3:3	
	CAPITAL RELA	ATED COSTS				
Cost Center Description	BLDG & FLXT	MVRLE FOLLE	FMPLOYEE	NONPATI ENT	DATA	

			T	0 12/31/2014	Date/Time Pre 5/28/2015 3:3	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DEPR)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATI ENT TELEPHONES (PHONES)	DATA PROCESSING (DP COST)	
	1.00	2. 00	4. 00	5. 01	5. 02	
91. 00 09100 EMERGENCY	9, 716	245, 836	4, 436, 932	42	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	6, 409	235, 895	2, 373, 720	7	0	
99. 10 09910 CORF	0	0	0	0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS		_	_	_1		
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	O	0	O	0	111.00
113. 00 11300 I NTEREST EXPENSE	((4.0(0	0.040.040	// 440 007	4 00/	40.000	113.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	661, 262	8, 960, 068	66, 413, 327	1, 336	10, 000	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	355	0	2		190. 00
194. 00 07950 WELLNESS COMMUNITY	727	21, 939		_		194. 00
194. 01 07951 BUI LDI NG RENTALS	774	2, 637	·	6		194. 00
194. 02 07952 HOSPI CE	774	2,037	0	0		194. 02
194. 03 07953 0UTREACH CLINICS	0	0	0	0		194. 02
194. 04 07954 SPEECH - HEARING ALDS	0	0	o n	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	o o	0		194. 05
194. 06 07956 CRH FOUNDATION	815	23, 829	o o	8		194. 06
194. 07 07957 HEALTHY COMMUNITIES	1, 195			9		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,	10, 030, 870	9, 394, 136	26, 210, 130	921, 058	9, 376, 318	202. 00
Part I) Unit cost multiplier (Wkst. B, Part I)	15. 089166	1. 038986	0. 392879	674. 767766	937. 631800	202 00
204.00 Cost to be allocated (per Wkst. B,	15.009100	1. 030900	305, 016		740, 580	
Part II)			303,010	202, 143	740, 360	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 004572	148. 091575	74. 058000	205. 00

Provi der CCN: 150112

Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm

				'`	12/01/2011	5/28/2015 3:3	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	OTHER	
		RECEIVING AND	(REVENUE)	OUNTS		ADMI NI STRATI VE	
		STORES		RECEI VABLE		AND GENERAL	
		(SUP COST)		(REVENUE)		(ACCUM. COST)	
	DENERAL OFFICE OF SERVICES	5. 03	5. 04	5. 05	5A. 06	5. 06	
4 00	GENERAL SERVI CE COST CENTERS						4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5. 01
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES	7 155 757					5. 02
5. 03	00570 ADMITTING	7, 155, 757 5, 838	496, 362, 785				5. 03 5. 04
5. 05	00570 ADMITTING	7, 641	490, 302, 783				5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL	11, 421	0	470, 302, 703	-22, 777, 900	177, 668, 044	5. 06
7. 00	00700 OPERATION OF PLANT	1, 361	0		-22, 777, 900 N	11, 625, 735	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	136	0	Ö	0	665, 016	8. 00
9. 00	00900 HOUSEKEEPI NG	114, 522	0	0	0	2, 827, 119	9. 00
10. 00	01000 DI ETARY	2,048	0	o o	0	1, 171, 369	10.00
11. 00	01100 CAFETERI A	4, 802	0	o o	0	1, 521, 411	
13. 00	01300 NURSING ADMINISTRATION	2,742	0	o	0	9, 614, 159	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 955	0	o	0	1, 122, 081	14. 00
15. 00	01500 PHARMACY	82, 838	0	О	0	6, 587, 596	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	13, 437	0	0	0	2, 206, 365	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	723, 386	17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	62	0	0	0	584, 639	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	0	0	0	461, 953	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	709, 764	57, 681, 611	57, 681, 611	0	22, 923, 221	30. 00
31.00	03100 NTENSI VE CARE UNIT	141, 319	9, 050, 280	9, 050, 280	0	3, 715, 053	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 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	39, 387	5, 175, 723	5, 175, 723	0	2, 370, 811	41. 00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	733	2, 378, 457		0	885, 344	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1 225 4/5	75 250 0/1	75 250 0/1	0	1/ 777 /50	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	1, 235, 465	75, 358, 061		0	16, 777, 652 1, 503, 415	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	23, 647	5, 044, 223	5, 044, 223	0	1, 503, 415	52.00
53. 00	05300 ANESTHESI OLOGY	0	8, 597, 706	8, 597, 706	0	419, 755	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	23, 211	5, 020, 890		0	2, 818, 940	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 685	7, 210, 671	7, 210, 671	0	1, 623, 902	54. 01
54. 02	05404 ULTRA SOUND	9, 336	4, 660, 058		0	858, 795	54. 02
54. 03	05405 MAMMOGRAPHY	4, 011	2, 693, 821		0	1, 453, 708	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	2,009	9, 419, 299		0	2, 143, 986	55. 00
57. 00	05700 CT SCAN	84, 993	19, 005, 673		0	1, 622, 142	
58. 00	05800 MRI	2, 153	7, 249, 975		0		
59.00	05900 CARDI AC CATHETERI ZATI ON	70, 416	19, 420, 973		0	3, 611, 690	
60.00	06000 LABORATORY	300, 318	33, 298, 342		0	1	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	14, 190	4, 581, 382		0	1, 061, 757	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 413	2, 254, 777		0	908, 923	62. 00
65. 00	06500 RESPIRATORY THERAPY	52, 816	9, 986, 733		0	3, 146, 098	65. 00
66.00	06600 PHYSI CAL THERAPY	19, 825	11, 637, 288	11, 637, 288	0	5, 120, 342	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 473	3, 745, 758	3, 745, 758	0	1, 734, 315	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 021	1, 572, 372	1, 572, 372	0	1, 019, 465	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 445	11, 124, 814	11, 124, 814	0	968, 032	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	7, 010	5, 361, 001	5, 361, 001	0	1, 070, 031	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 123, 863	19, 802, 952		0	7, 843, 248	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	116, 998	14, 947, 614		0	7, 627, 166	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	313, 406	64, 868, 818		0	13, 308, 288	73. 00
74.00	07400 RENAL DI ALYSI S	186	1, 287, 605		0	387, 751	74.00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 555	897, 580	897, 580	0	189, 718	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		_		_		00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	_	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	67 529	U 201 202	4 201 202	0	_	89.00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES CENTER	67, 528 221	4, 391, 302 101, 077	4, 391, 302 101, 077	0	1, 183, 383	90. 00 90. 01
90. 01	09001 DI ABETES CENTER	92	205, 496		0	196, 733 130, 110	90.01
90. 02	09003 WOUND CENTER	26, 391	4, 816, 631	4, 816, 631	0	1, 521, 500	90. 02
90. 03	09004 HYPERBARI C OXYGEN THERAPY	3, 943	1, 644, 848		0	336, 719	90.03
91. 00	09100 EMERGENCY	414, 315	53, 647, 924		0	9, 192, 180	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	717, 313	55, 547, 724	00,047,724	0	,, 1,2, 100	92.00
	1	1				l	

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150112 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm Cost Center Description PURCHASI NG ADMI TTI NG CASHIERING/ACC Reconciliation OTHER RECEIVING AND (REVENUE) OUNTS ADMI NI STRATI VE AND GENERAL **STORES** RECEI VABLE (SUP COST) (REVENUE) (ACCUM. COST) 5.04 5A. 06 5.03 5.05 5.06 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 7, 878, 148 3, 862, 599 95.00 26, 383 7, 878, 148 99. 10 09910 CORF 0 99. 10 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 0 0 109. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 r 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 7, 105, 324 496, 019, 883 496, 019, 883 -22, 777, 900 174, 722, 604 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 689 190. 00 194. 00 07950 WELLNESS COMMUNITY 691 0 0 0 0 345, 177 194. 00 0 74, 280 194. 01 72, 527 194. 02 194. 01 07951 BUI LDING RENTALS 0 194. 02 07952 HOSPI CE 49.441 0 C 194. 03 07953 OUTREACH CLINICS 0 194. 03 194.04 07954 SPEECH - HEARING AIDS 342, 902 342, 902 224, 374 194. 04 0 0 194. 05 07955 NONALLOWABLE MARKETING 1, 911, 110 194. 05 0 0 194.06 07956 CRH FOUNDATION 43, 666 194. 06 190 C 0 194. 07 07957 HEALTHY COMMUNITIES 111 C 0 261, 617 194. 07 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 2, 103, 532 1, 986, 519 6, 276, 266 22, 777, 900 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 293964 0.004002 0.012645 0. 128205 203. 00 1, 086, 040 204. 00

364, 041

0.050874

111, 525

0.000225

340, 286

0.000686

0. 006113 205. 00

204.00

205.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Part II)

11)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 3: 32 pm Provi der CCN: 150112

						5/28/2015 3: 3	2 pm
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING (TIME SPT)	DI ETARY (MEALS)	CAFETERI A (FTES)	
		(SQ FEET)	(LDRY LBS)	, ,			
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 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. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	OO560 PURCHASING RECEIVING AND STORES OO570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT	269, 600					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	627					8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	4,608	l .	5, 432	147 010		9.00
10. 00 11. 00	01100 CAFETERI A	7, 853 6, 056	l .	30 71	147, 818 0	900	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	9, 954	ĺ	14	Ö	38	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 611	0	26	0	0	14.00
15. 00	01500 PHARMACY	4, 817	0	89	0	36	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 956	0	0	0	29	16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	302	0	2	0	7	17. 00 23. 00
23. 00	02301 XRAY EDUCATION	724		13	0	7	23. 00
23. 02	02302 PHARMACY RESIDENCY PROG	294	l .	0	Ö	5	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	76, 422		2, 074	117, 543	254	30. 00
31.00	03100 I NTENSI VE CARE UNI T	10, 959	50, 100	160	11, 122	34	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	Ö	0	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	11, 085	59, 118	198	15, 636	23	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	583		2	0	9	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000 OPERATING ROOM	40, 469	211, 395	1, 010	708	7	50. 00
51. 00	05100 RECOVERY ROOM	3, 185			0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	119	l .	0	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	7, 960 3, 384	100, 150 0	147 118	86	22	54. 00 54. 01
54. 01	05404 ULTRA SOUND	1, 504		31	0	5	54. 01
54. 03	05405 MAMMOGRAPHY	273	7, 276	l	Ö	12	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 903	8, 103	79	302	11	55. 00
57. 00	05700 CT SCAN	1, 007	0	13	0	8	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	900 10, 499	l .	13 123	0 293	3 19	58. 00 59. 00
60.00	06000 LABORATORY	10, 499		80	293	75	
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	l .	6	Ö	6	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	524	l .	3	0	1	62. 00
65. 00	06500 RESPI RATORY THERAPY	6, 566		61	0	29	65.00
66. 00	06600 PHYSI CAL THERAPY	227		0	0	48	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	221	10, 954	0	0	12 8	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 398	_	21	O O	8	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 348			ol	8	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	0	0	0	0	0	74. 00 76. 00
76. 00	07697 CARDI AC REHABI LI TATI ON	798	0	0	0	2	76. 00
. 0. 77	OUTPATIENT SERVICE COST CENTERS	, , , , ,			<u> </u>	2	. 5. 7,
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_	0	o	0	89. 00
90.00	09000 CLINIC	4, 340	l ·	65	1, 431	10	90.00
90. 01 90. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH	775 103	l .	3	0	1 ₁	90. 01 90. 02
	09003 WOUND CENTER	103	5, 867	0	0	5	90. 02
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	877	Ö	ő	0	90. 04
91.00	09100 EMERGENCY	9, 716			697	82	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu o	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150112	Peri od: W From 01/01/2014	/orksheet B-1
			Date/Time Prepared:

COST RELOCATION STATISTICAL BASIS		Trovider		rom 01/01/2014	WOI KSHEEL B I	
			l' _T		Date/Time Pre	nared·
			'		5/28/2015 3:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
	(SQ FEET)	(LDRY LBS)	,	, ,		
	7. 00	8. 00	9. 00	10.00	11. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	6, 409	0	0	0	64	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
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	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	266, 089	1, 056, 223	5, 397	147, 818	893	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	0	0	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	0	4	194. 00
194.01 07951 BUILDING RENTALS	774	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	0	0	0	0	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	815	0	31	0	0	194. 06
194.07 07957 HEALTHY COMMUNITIES	1, 195	0	4	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,	13, 116, 212	780, 778	3, 413, 752	1, 722, 451	2, 055, 711	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	48. 650638	0. 739217	628. 452135	11. 652512	2, 284. 123333	203. 00
204.00 Cost to be allocated (per Wkst. B,	5, 256, 243	26, 026	290, 287	339, 620	361, 652	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	19. 496450	0. 024641	53. 440169	2. 297555	401. 835556	205. 00
)						1

	Financial Systems	COLUMBUS REGION		0011 450440 0		u of Form CMS-	
COST	SLLOCATION - STATISTICAL BASIS		Provi der		eriod: fom 01/01/2014 0 12/31/2014	Worksheet B-1 Date/Time Pre	
						5/28/2015 3:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (DRG COST)	MEDICAL :	SOCIAL SERVICE	
		ADMINISTRATION	SUPPLY	(DRG COST)	LI BRARY	(TIME SPT)	
		(NURS HRS)	(STER SUP)		(TIME SPT)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	OO400				•		4. 00 5. 01
5. 01	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTING						5. 04
5. 05 5. 06	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO590 OTHER ADMINI STRATI VE AND GENERAL						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 040, 312	44 744				13.00
14. 00 15. 00	O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY	317	11, 711 0	12, 115, 803			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	25, 868		16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	1, 000	
23. 00 23. 01	O2300 PARAMED ED PRGM-(SPECIFY) O2301 XRAY EDUCATION	0	0	0	0	0	23. 00 23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	0	0	0	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	528, 616	679	0.710	8. 166	455	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	69, 693	2	8, 719 1, 819	744	455 66	1
32.00	03200 CORONARY CARE UNIT	0	О	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	ol Ol	0	
41.00	04100 SUBPROVI DER - I RF	47, 102	O	119	1, 875	316	41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	17 040	0 27	0 11	0	0	42. 00 43. 00
44. 00	04400 SKI LLED NURSING FACILITY	17, 940 0	0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	10.740	40.04/	00.040	I		
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	13, 712 20	10, 246 0	29, 242 371	5, 757 O	3	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	0	o	0	
53.00	05300 ANESTHESI OLOGY	0	0	56, 284	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0	1, 969 128, 360	0	0	54. 00 54. 01
54. 02	05404 ULTRA SOUND	0	0	1, 042	0	0	54. 02
	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	25, 360 23, 827	19	253	0	0	
57. 00	05700 CT SCAN	23, 827	0	7, 341	226 0	67 0	ı
58. 00	05800 MRI	0	0	550	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	39, 076	102	2, 341 262	285	0	59. 00 60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	o	48	1, 757	0	60.01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	152	0	0	62. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	61, 191	102 176	5, 576 1, 449	1, 490 0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	0	2, 280	288	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	15, 993	0	2, 592 8	2, 409 1, 352	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	ő	Ö	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	11, 822, 141 3, 958	0	0	
76. 00	03020 ACUPUNCTURE	0	O	0	0	0	76. 00
76. 97	O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	3, 785	0	0	0	0	76. 97
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 90. 01	09000 CLI NI C 09001 DI ABETES CENTER	20, 493 1, 812	0	2, 201 0	1, 396 0	80 0	
90. 02	09002 NEUROPSYCH	0	0	0	113	0	1
90. 03	09003 WOUND CENTER	O	269	22, 002	0	0	90. 03
90. 04 91. 00	09004 HYPERBARI C OXYGEN THERAPY 09100 EMERGENCY	171, 375	0 83	0 5, 554	10 0	0 13	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.1,575		3, 334		13	92.00
		·					

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION CTATICTICAL DAGE	D	W

Health Financial Systems	COLUMBUS REGION	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014		
				To 12/31/2014		
C+ C+ D	MUDCLNC	CENTRAL	PHARMACY	MEDI CAL	5/28/2015 3:3	
Cost Center Description	NURSI NG ADMI NI STRATI ON			-	SOCIAL SERVICE	
	ADMINISTRATION	SERVICES & SUPPLY	(DRG COST)	RECORDS & LI BRARY	(TIME CDT)	
	(NURS HRS)	(STER SUP)		(TIME SPT)	(TIME SPT)	
	13.00	14.00	15. 00	16. 00	17. 00	
OTHER REIMBURSABLE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
95. 00 09500 AMBULANCE SERVICES	ام	0	8, 87	8 0	0	95.00
99. 10 09910 CORF		0	0,07		0	
101.00 10100 HOME HEALTH AGENCY		0			_	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u>'</u>	0	0	1101.00
109. 00 10900 PANCREAS ACQUISITION	ام	0		0	0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0				110.00
111. 00 11100 SLET ACQUISITION		0				111.00
113. 00 11300 NTEREST EXPENSE	٩	O	'		O	113.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 040, 312	11, 711	12, 115, 52	2 25, 868	1 000	118. 00
NONREI MBURSABLE COST CENTERS	1,040,312	11, /11	12, 115, 52.	25, 600	1,000	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	Ι	0	0	190. 00
194. 00 07950 WELLNESS COMMUNITY		0				194. 00
194. 01 07951 BUI LDI NG RENTALS		0				194. 01
194. 02 07952 HOSPI CE		0	28	1 0		194. 02
194. 03 07953 OUTREACH CLINICS		0	20	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS		0	l i			194. 04
194. 05 07955 NONALLOWABLE MARKETING		0				194. 05
194. 06 07956 CRH FOUNDATION		0				194. 06
194. 07 07957 HEALTHY COMMUNITIES		0				194. 07
200.00 Cross Foot Adjustments	٩	O	·		O	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	11, 426, 605	1, 656, 039	7, 804, 66	9 2, 747, 934		
Part I)	11, 420, 003	1, 030, 039	7, 804, 80	2, 141, 734	848, 000	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10. 983825	141. 408846	0. 64417	3 106. 229086	848. 066000	203 00
204.00 Cost to be allocated (per Wkst. B,	988, 587	386, 026				204. 00
Part II)	700, 307	300, 020	020, 27	320, 420	70, 723	254.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 950279	32. 962685	0, 06836	3 12. 386733	90. 925000	205 00
II)	0.750277	02. 702000	3.00030	12. 300733	75. 725000	200.00
1 1	1 1		·	1	ı	1

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150112 Peri od:

Peri od: Worksheet B-1 From 01/01/2014 To 12/31/2014 Date/Time Prep

Date/Time Prepared: 5/28/2015 3:32 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 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 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 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 XRAY EDUCATION 0 23 01 100 23 01 23.02 02302 PHARMACY RESIDENCY PROG 100 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 0 n O 30 00 00000000 0 31.00 03100 INTENSIVE CARE UNIT C 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 Ω 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 0 0 41.00 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 0 04300 NURSERY Ω 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0000000000000000000000000000 0 05100 RECOVERY ROOM 51.00 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 53 00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 100 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC r 54.01 54.02 05404 ULTRA SOUND 0 0 54.02 54. 03 05405 MAMMOGRAPHY 0 0 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 06000 LABORATORY 60.00 C 60 00 06001 LABORATORY-PATHOLOGI CAL 60.01 60.01 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 100 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 03020 ACUPUNCTURE 0 0 76.00 0 76.00 0 76.97 07697 CARDIAC REHABILITATION 0 0 76 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 οĺ 09000 CLI NI C 90 00 0 90 00 90.01 09001 DIABETES CENTER 0 0 90.01 09002 NEUROPSYCH 0 90.02 90.02 0 90.03 09003 WOUND CENTER 0 0 90.03 09004 HYPERBARI C OXYGEN THERAPY 0 90 04 0 90.04 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COLUMBUS REGIONAL HOSPITAL

Provider CCN: 150112 | Period: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Provider CCN: 150112 | Provider

PARAMED ED PROM P				To	12/31/2014 Date/Time Pi 5/28/2015 3:	
PRCM	Cost Center Description	PARAMED ED	KRAY EDUCATION	PHARMACY	072072010 0	oz piii
OTHER REIMBURSABLE COST CENTERS						
OTHER REIMBURSABLE COST CENTERS O		(PERCENT)	(PERCENT)			
OTHER REIMBURSABLE COST CENTERS 95.00 09500 0900				(PERCENT)		
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS		23. 00	23. 01	23. 02		
99. 10 09910 CORF 0 0 0 0 0 101.00						
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 1010.00		0	0	0		
SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUI SITI ON 0 0 0 110.00 11755TI NAL ACQUI SITI ON 0 0 0 0 111.00		0	0	0		
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 1100.00 11000 ITESTI NAL ACQUISITION 0 0 0 0 0 1111.00 1110.00 11000 ISLET ACQUISITION 0 0 0 0 0 1111.00 113.00 11300 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 NONRE IMBURSABLE COST CENTERS 118.00 NONRE IMBURSABLE COST CENTERS 119.00 100		0	0	0		101. 00
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 1110. 00 1111. 00 1111. 00 1111. 00 1111. 00 1111. 00 1111. 00 1113. 00 11300 INTEREST EXPENSE						
111. 00		0	0	0		
113. 00		0	0	0		
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 100		0	0	0		
NONRE MBURSABLE COST CENTERS 190. 00 190. 00 190. 00 194. 00 07950 WELLNESS COMMUNITY 0	l l					
190. 00 190. 00 191. 00 192. 00 193. 00 194. 00 195. 00 194. 01 195. 00 194. 01 195. 00 195. 00 196. 00 197. 00 197. 00 197. 00 198. 00 199. 0		0	100	100		118. 00
194. 00				_1		
194. 01 07951 BUILDING RENTALS 0 0 0 194. 01 194. 02 07952 HOSPI CE 0 0 0 194. 03 07953 OUTREACH CLINICS 0 0 0 194. 04 07954 SPECH - HEARING AIDS 0 0 0 194. 05 07955 ONNALLOWABLE MARKETING 0 0 0 194. 06 07956 CRH FOUNDATION 0 0 0 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 200. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 206. 00 Unit cost multiplier (Wkst. B, Part I) 207. 00 Unit cost multiplier (Wkst. B, Part I) 208. 00 Unit cost multiplier (Wkst. B, Part I) 209. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200. 00 Unit cost multiplier (Wkst. B, Part I) 200		0	0	0		
194. 02 07952 HOSPICE 0 0 0 0 194. 02 194. 03 07953 OUTREACH CLINICS 0 0 0 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 194. 04 194. 05 194. 06 07956 OT956 O	l l	0	0	0		
194. 03 07953 OUTREACH CLINICS 0 0 0 194. 03 194. 04 194. 05 19955 NONALLOWABLE MARKETING 0 0 0 194. 05 194. 06 19956 CRH FOUNDATION 0 0 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 194. 07 07957 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 0.000000 77, 189. 750000 57, 469. 020000 203. 00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.000000 439. 420000 263. 640000 205. 00		0	0	0		
194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 194. 04 194. 05 194. 06 194. 06 194. 06 194. 07956 CRH FOUNDATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0		
194. 05 07955 NONALLOWABLE MARKETING 0 0 0 0 194. 05 194. 06 07956 CRH FOUNDATION 0 0 0 0 194. 06 194. 07 07957 HEALTHY COMMUNITIES 0 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, Part I) 0.000000 7, 189. 750000 5, 469. 020000 203. 00 Unit cost multiplier (Wkst. B, Part II) 0.000000 439. 420000 263. 640000 205. 00 Unit cost multiplier (Wkst. B, Part II) 0.000000 439. 420000 263. 640000 205. 00 Unit cost multiplier (Wkst. B, Part III) 0.000000 439. 420000 263. 640000 205. 00 205. 00 205. 00 206. 00 206. 00 206. 00 207. 00 208. 00 209. 00 208. 00 209. 00		0	0	0		
194.06 07956 CRH FOUNDATION 0 0 0 194.07 07957 CRH FOUNDATION 0 0 0 0 194.07 07957 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 7, 189.750000 5, 469.020000 203.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 7, 189.750000 5, 469.020000 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 439.420000 263.640000 205.00 205.00		0	0	0		
194. 07 07957 HEALTHY COMMUNITIES 0 0 0 0 0 194. 07 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 0.000000 7, 189. 750000 5, 469. 020000 203. 00 Unit cost multiplier (Wkst. B, Part II) 0.000000 439. 420000 263. 640000 205. 00 Unit cost multiplier (Wkst. B, Part II) 0.000000 439. 420000 263. 640000 205. 00 205. 00 205. 00 205. 00 205. 00 205. 00 206. 00 205. 00 206. 00 206. 00 205. 00 206.		0	0	0		
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Cross Foot Adjustments 200.00 201.00 718,975 546,902 202.00 7,189.750000 5,469.020000 203.00 203.00 204.00 43,942 26,364 204.00 205.00		0	0	0		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 7,189.750000 5,469.020000 203.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 7,189.750000 5,469.020000 203.		۷	۷	U		
202.00	· · · · · · · · · · · · · · · · · · ·					
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			710 075	E44 000		
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 7,189.750000 5,469.020000 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 43,942 26,364 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 439.420000 263.640000		٩	/18, 9/5	546, 902		202.00
204.00 Cost to be allocated (per Wkst. B, Part 0.000000 43,942 26,364 204.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 439.420000 263.640000 205.00		0.00000	7 189 750000	5 469 020000		203 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 439.420000 263.640000 205.00		0.000000		-		
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 439.420000 263.640000 205.00			43, 742	20, 304		204.00
		0. 000000	439. 420000	263. 640000		205. 00

| Period: | Worksheet C | From 01/01/2014 | Part | Date/Time Prepared: | 5/28/2015 3:32 pm

		5/28/2015 3: 32	2 pm
Title XVIII Hos	pi tal	PPS	
	Costs		
	RCE	Total Costs	
	Howance		
Part I, col.			
26)			
	4. 00	5. 00	
	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS 40, 295, 536 40, 295, 536	137, 518	40, 433, 054	30. 00
31. 00 03100 I NTENSI VE CARE UNI T 5, 971, 306 5, 971, 306 5, 971, 306	6, 440	5, 977, 746	31.00
32.00 03200 CORONARY CARE UNIT 0 0	0	0	32.00
33.00 O3300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	o	0	34.00
40. 00 04000 SUBPROVI DER - I PF 0 0	ol	ol	40.00
41. 00 04100 SUBPROVI DER - 1 RF 4, 601, 528 4, 601, 528	ō	4, 601, 528	41. 00
42. 00 04200 SUBPROVI DER 0 0	0	0	42. 00
	0		
	0	1, 260, 417	43.00
44.00 O4400 SKILLED NURSING FACILITY O O	O	0	44. 00
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 0PERATI NG ROOM 23, 945, 143 23, 945, 143	129, 724	24, 074, 867	50.00
51. 00 05100 RECOVERY ROOM 1, 958, 764 1, 958, 764	0	1, 958, 764	51.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0	O	0	52.00
53. 00 05300 ANESTHESI OLOGY 515, 616 515, 616	14, 955	530, 571	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 506, 360 4, 506, 360	, , , ,	4, 506, 360	54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 4, 300, 300 4, 300, 300 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 2, 162, 707 2, 162, 707	0	2, 162, 707	54. 01
	0		
54. 02 05404 ULTRA SOUND	U	1, 073, 642	54. 02
54. 03 05405 MAMMOGRAPHY 2, 002, 744 2, 002, 744	O	2, 002, 744	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C 3, 230, 164 3, 230, 164 3, 230, 164	107, 558	3, 337, 722	55.00
57. 00 05700 CT SCAN 1, 910, 272 1, 910, 272	0	1, 910, 272	57.00
58. 00 05800 MRI 811, 071 811, 071 811, 071	O	811, 071	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 5, 188, 784 5, 188, 784 5, 188, 784	81, 903	5, 270, 687	59.00
60. 00 06000 LABORATORY 13, 615, 724 13, 615, 724	0	13, 615, 724	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	1, 460, 997	60. 01
	0		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1, 055, 211 1,	10 (01	1, 055, 211	62. 00
65. 00 06500 RESPI RATORY THERAPY	10, 681	4, 832, 548	65. 00
66. 00 06600 PHYSI CAL THERAPY 5, 939, 926 0 5, 939, 926	29, 234	5, 969, 160	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 2, 034, 984 0 2, 034, 984	0	2, 034, 984	67.00
68. 00 06800 SPEECH PATHOLOGY 1, 168, 439 0 1, 168, 439	0	1, 168, 439	68.00
69. 00 06900 ELECTROCARDI OLOGY 1, 624, 863 1, 624, 863	35, 410	1, 660, 273	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 494, 028 1, 494, 028	1, 601	1, 495, 629	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 8, 848, 792 8, 848, 792	., 55.	8, 848, 792	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 605, 007 8, 605, 007	0	8, 605, 007	72.00
	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 23, 176, 877 23, 176, 877	U	23, 176, 877	73.00
74. 00 07400 RENAL DI ALYSI S 440, 013 440, 013 440, 013	O	440, 013	74. 00
76. 00 03020 ACUPUNCTURE 0 0	O	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 299, 006 299, 006	2, 834	301, 840	76. 97
OUTPATIENT SERVICE COST CENTERS			
88. 00 08800 RURAL HEALTH CLINIC 0 0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0	o	0	89.00
90. 00 09000 CLI NI C 2, 097, 672 2, 097, 672	291, 496	2, 389, 168	90.00
90. 01 09001 DI ABETES CENTER 283, 731 283, 731	271, 170	283, 731	90. 01
	0		
90. 02 09002 NEUROPSYCH 166, 090 166, 090 167 168 169 16	1 100	166, 090	90. 02
90. 03 09003 WOUND CENTER 1, 784, 534 1, 784, 534	1, 109	1, 785, 643	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY 381, 598 381, 598	158	381, 756	90. 04
91. 00 09100 EMERGENCY 13, 358, 984 13, 358, 984	60, 081	13, 419, 065	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 4, 858, 293 4, 858, 293		4, 858, 293	92.00
OTHER REIMBURSABLE COST CENTERS			
95. 00	3, 162	4, 824, 671	95.00
99. 10 09910 CORF 0 0	0, .02	0	99. 10
			101. 00
		U	101.00
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		0	111. 00
113. 00 11300 INTEREST EXPENSE			113. 00
200.00 Subtotal (see instructions) 201,772,199 0 201,772,199	913. 864	202, 686, 063	
201. 00 Less Observation Beds 4, 858, 293 4, 858, 293	,	4, 858, 293	
202. 00 Total (see instructions) 196, 913, 906 0 196, 913, 906	913, 864		
292. 50 170.410 (566 11341 4641 613) 170, 713, 700 0 170, 713, 700	713,004	171,021,110	_02.00

Provi der CCN: 150112

					10 12/31/2014	5/28/2015 3:3	
			Titl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
	INDATIENT POUTINE CEDVICE COCT CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	49, 538, 229		49, 538, 22	o		30.00
31. 00	03100 INTENSIVE CARE UNIT	9, 035, 896		9, 035, 89			31. 00
32. 00	03200 CORONARY CARE UNIT	7, 033, 070		7, 033, 03	0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT				0		33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T				0		34. 00
40. 00	04000 SUBPROVI DER - I PF	o			o		40.00
41.00	04100 SUBPROVI DER - I RF	5, 175, 723		5, 175, 72	3		41.00
42.00	04200 SUBPROVI DER	0			0		42.00
43.00	04300 NURSERY	2, 378, 457		2, 378, 45	7		43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44. 00
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATI NG ROOM	21, 802, 394	53, 555, 667				
51.00	05100 RECOVERY ROOM	1, 675, 437	3, 368, 786			l e	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2 504 224	0		0.000000	0.000000	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 504, 324 1, 349, 803	5, 093, 382			0.000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 349, 803	3, 671, 087 5, 850, 475			0. 000000 0. 000000	
54. 01	05404 ULTRA SOUND	915, 549	3, 744, 509			0.000000	1
54. 02	05405 MAMMOGRAPHY	638	2, 693, 183			l	
55. 00	05500 RADI OLOGY-THERAPEUTI C	197, 741	9, 221, 558			0. 000000	
57. 00	05700 CT SCAN	3, 674, 158	15, 331, 515			0. 000000	
58. 00	05800 MRI	1, 360, 880	5, 889, 095			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 617, 575	8, 803, 398			0. 000000	
60.00	06000 LABORATORY	9, 881, 120	23, 417, 222	33, 298, 34	2 0. 408901	0. 000000	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	459, 974	4, 121, 408	4, 581, 38	2 0. 318899	0.000000	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 447, 576	807, 201			0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	7, 791, 915	2, 194, 818			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	3, 117, 661	8, 519, 627			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 930, 372	1, 815, 386			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	603, 244	969, 128			0.000000	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 547, 329 170, 371	6, 577, 485 5, 190, 630			0. 000000 0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 656, 679	9, 146, 273			0.000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 320, 631	4, 626, 983				
73. 00	07300 DRUGS CHARGED TO PATIENTS	29, 616, 841	35, 251, 977			0. 000000	1
74. 00	07400 RENAL DIALYSIS	1, 287, 605	00,201,777			l e	
76.00	03020 ACUPUNCTURE	0	0		0. 000000	l e	1
76. 97	07697 CARDI AC REHABI LI TATI ON	14, 651	882, 929	897, 58	0. 333125	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
90.00	09000 CLI NI C	26, 903	4, 364, 399				1
90. 01	09001 DI ABETES CENTER	768	100, 309			•	1
	09002 NEUROPSYCH	1, 292 81, 517	204, 204 4, 735, 114			l	1
90. 03	O9003 WOUND CENTER O9004 HYPERBARI C OXYGEN THERAPY	39, 044	1, 605, 804				
91.00	09100 EMERGENCY	11, 905, 077	41, 742, 847				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 157, 766				
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0, 107, 700	0, 107, 70	0.070012	0.00000	72.00
95.00	09500 AMBULANCE SERVI CES	0	7, 878, 148	7, 878, 14	8 0. 612010	0.000000	95. 00
99. 10	09910 CORF	0	0		0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	0		0		101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0		0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
	11100 SLET ACQUI SITION	0	0		0		111.00
200.00	11300 INTEREST EXPENSE Subtotal (see instructions)	206, 487, 570	289, 532, 313	496, 019, 88	2		113. 00 200. 00
200.00	1 1	200, 407, 370	207, 332, 313	470, 017, 88	3		200.00
201.00		206, 487, 570	289, 532, 313	496, 019, 88	3		202.00
202.00	1.0101 (300 111311 0011 0113)	200, 407, 570	207, 002, 010	1 175, 517, 60	~	I	1-02.00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150112

Period:
From 01/01/2014
To 12/31/2014

Date/Time Prepared:
5/28/2015 3: 32 pm

		Title XVIII	Uocni tal	5/28/2015 3: 32 PPS	pm
Cost Center Description	PPS Inpatient	THE AVIII	Hospi tal	PP3	
oust center beserver on	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	1				32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - 1 PF					40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 319473				50.00
51.00 05100 RECOVERY ROOM	0. 388318				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 061711				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 897522				54.00
54. O1 O54O2 NUCLEAR MEDICINE-DIAGNOSTIC	0. 299931				54. 01
54. 02 05404 ULTRA SOUND	0. 230392				54. 02
54. 03 05405 MAMMOGRAPHY	0. 743458				54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 354349				55. 00
57. 00 05700 CT SCAN	0. 100511				57. 00
58. 00 05800 MRI	0. 111872				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 271392				59. 00
60. 00 06000 LABORATORY	0. 408901				60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 318899				60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 467989				62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 483897				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 512934				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 543277				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 743106				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 149241				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 278983				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 446842				71. 00 72. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 575678 0. 357288				73. 00
74. 00 07400 RENAL DI ALYSI S	0. 337266				74.00
76. 00 03020 ACUPUNCTURE	0. 000000				76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 336282				76. 97
OUTPATIENT SERVICE COST CENTERS	0. 330202				70. 77
88. 00 08800 RURAL HEALTH CLINIC					88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 09000 CLINIC	0. 544068				90.00
90. 01 09001 DI ABETES CENTER	2. 807078				90. 01
90. 02 09002 NEUROPSYCH	0. 808240				90. 02
90. 03 09003 WOUND CENTER	0. 370724				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 232092				90. 04
91. 00 09100 EMERGENCY	0. 250132				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 595542				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 612412				95.00
99. 10 09910 CORF					99. 10
101.00 10100 HOME HEALTH AGENCY				1	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)				2	202. 00

Health Financial Systems	COLUMBUS REGIC			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150112	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	narod:
				10 12/31/2014	5/28/2015 3:3	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
· ·	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>, </u>					
30. 00 ADULTS & PEDIATRICS	5, 299, 829	[C			178. 73	
31.00 INTENSIVE CARE UNIT	825, 281		825, 28	2, 491	331. 31	
32.00 CORONARY CARE UNIT	0			0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	
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, 229	[C	675, 22	9 3, 500	192. 92	
42. 00 SUBPROVI DER	0	C)	0	0.00	
43. 00 NURSERY	71, 267		71, 26	3, 348	21. 29	
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30-199)	6, 871, 606		6, 871, 60	38, 992		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
LAIDATI FAIT DOUTLAG CEDVI OF COCT CENTEDO	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 ADULTS & PEDI ATRI CS	11, 628	2, 078, 272	,			30.00
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	1					31.00
32. OO CORONARY CARE UNIT	1, 106					32.00
33. 00 BURN INTENSIVE CARE UNIT						33.00
34. 00 SURGI CAL INTENSIVE CARE UNIT						34.00
40. 00 SUBPROVIDER - IPF						40.00
41. 00 SUBPROVIDER - TPF	2, 015	388, 734	<u>'</u>			41. 00
42. 00 SUBPROVI DER	2,013		1			42.00
43. 00 NURSERY			1			43.00
44.00 SKILLED NURSING FACILITY						44. 00
200.00 Total (lines 30-199)	14, 749	2, 833, 435				200.00
200.00 10141 (111103 00 177)	17,747	2,000,400	1			1200.00

Health Financial Systems	COLUMBUS REGIONAL F	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 150112	From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/28/2015 3:32 pm

				From 01/01/2014 To 12/31/2014	Part II Date/Time Prep 5/28/2015 3:3:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLILIADIV CERVILOE COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	4, 025, 657	75, 358, 061	0. 05342	0 9, 377, 575	500, 950	50.00
51. 00 05100 RECOVERY ROOM	206, 937	5, 044, 223	l .		33, 426	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	200, 937		1		33, 420	52.00
53. 00 05200 DELI VERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	99, 472	1	l .		16, 770	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	631, 672	5, 020, 890	1		88, 617	54.00
54. 01 05400 NADI OLOGI - DI AGNOSTI C	381, 410		0. 12380	· ·	36, 710	54. 00
54. 02 05404 ULTRA SOUND	74, 575		1		7, 709	54. 02
54. 03 05405 MAMMOGRAPHY	268, 773				27	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	525, 831	9, 419, 299	1		3, 581	55.00
57. 00 05700 CT SCAN	307, 550		1	· ·	33, 296	57. 00
58. 00 05800 MRI	70, 404	7, 249, 975	1		7, 369	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	981, 470		1		233, 699	59.00
60. 00 06000 LABORATORY	1, 163, 563		1		163, 528	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	166, 673					60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	43, 808				15, 080	62. 00
65. 00 06500 RESPIRATORY THERAPY	589, 360		1	·	223, 138	65. 00
66. 00 06600 PHYSI CAL THERAPY	628, 682	11, 637, 288	1		61, 780	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	109, 830		1		11, 849	67. 00
68.00 06800 SPEECH PATHOLOGY	116, 026			·	8, 418	68. 00
69. 00 06900 ELECTROCARDI OLOGY	195, 816			2, 466, 999	43, 424	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	116, 911	5, 361, 001	0. 02180		2, 074	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	224, 909	19, 802, 952	0. 01135	7 4, 697, 441	53, 349	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	66, 194	14, 947, 614	0.00442	5, 092, 620	22, 550	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	964, 591	64, 868, 818	0. 01487	0 13, 281, 049	197, 489	73. 00
74. 00 07400 RENAL DIALYSIS	3, 823	1, 287, 605	0. 00296	9 766, 722	2, 276	74. 00
76. 00 03020 ACUPUNCTURE	0	0	0.00000	0 0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	51, 643	897, 580	0. 05753	6 4, 698	270	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	0.0000		0	89. 00
90. 00 09000 CLI NI C	261, 323		l .		847	90. 00
90. 01 09001 DI ABETES CENTER	38, 836		1		0	90. 01
90. 02 09002 NEUROPSYCH	9, 054	205, 496			35	90. 02
90. 03 09003 WOUND CENTER	111, 247	4, 816, 631	1		0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	284, 919		1	· ·	4, 017	90. 04
91. 00 09100 EMERGENCY	981, 904				122, 979	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	636, 810	8, 157, 766	0. 07806	2 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVICES	14 220 772	422 012 420		/F 227 027	1 002 001	95. 00
200.00 Total (lines 50-199)	14, 339, 673	422, 013, 430	"	65, 327, 827	1, 903, 991	J∠UU. UU

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provi der	CCN: 150112 P	eri od:	Worksheet D	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre	nared·
					5/28/2015 3:3	2 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		All Other	Swi ng-Bed	Total Costs	
		Cost	Medical Education Cost	Adjustment Amount (see	(sum of cols. 1 through 3,	
			Education Cost	instructions)	minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0			0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	1		0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	1		0	33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
40.00 04000 SUBPROVI DER - PF 41.00 04100 SUBPROVI DER - RF	0	0	0	0	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER 42. 00 04200 SUBPROVI DER	0	0		0	0	
43. 00 04300 NURSERY	0	0		U	0	1
44.00 04400 SKILLED NURSING FACILITY	0	0			0	1
200.00 Total (lines 30-199)	i o	0	Ö			200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpatient	PSA Adj.	
	Days	5 ÷ col. 6)	Program Days		Nursing School	
				Pass-Through		
				Cost (col. 7 x		
	6. 00	7. 00	8. 00	col . 8) 9.00	11. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	0.00	9.00	11.00	
30. 00 03000 ADULTS & PEDIATRICS	29, 653	0.00	11, 628	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 491	0.00			0	
32. 00 03200 CORONARY CARE UNIT	0	0.00			0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0. 00	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0. 00	•	0	0	
40. 00 04000 SUBPROVI DER - I PF	0	0. 00	•	0	0	40. 00
41. 00 04100 SUBPROVI DER - RF	3, 500	0.00	2, 015	0	0	
42. 00 04200 SUBPROVI DER	0	0.00		0	0	
43. 00 04300 NURSERY	3, 348	0.00		0	0	
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	38, 992	0. 00	14, 749	0	0	44. 00 200. 00
Cost Center Description	PSA Adj .	PSA Adj. All	14, 747	U		200.00
oost denter besettptron	Allied Health	Other Medical				
		Education Cost				
	12.00	13. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0				30.00
31. 00 03100 INTENSI VE CARE UNI T	0	0				31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0				32. 00 33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 04000 SUBPROVI DER - PF	0	0	1			40. 00
41. 00 04100 SUBPROVI DER - RF	0	0				41. 00
42. 00 04200 SUBPROVI DER	0	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	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

			1	0 12/31/2014	5/28/2015 3:3	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0		0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	710 075	0	710.075	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	718, 975	0	718, 975	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0	54. 01
54. 02 05404 ULTRA SOUND				0	0	1
54. 03 05405 MAMMOGRAPHY	0			0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
57. 00 05700 CT SCAN	0			0	0	57. 00
58. 00 05800 MRI				0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	0	59.00
60. 00 06000 LABORATORY	0			0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0			0	0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0			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	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY				0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0	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	54/ 000	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		546, 902	0	546, 902	73.00
74. 00 07400 RENAL DIALYSIS	0			0	0	74.00
76. 00 03020 ACUPUNCTURE	0	1	0	0	0	76.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC		1	0	0	0	88. 00
				0		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC				0	0	89. 00 90. 00
				0	· -	
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH				0	0	90. 01
				0	0	90.02
				0	·	90.03
				0	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	91. 00 92. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		' <u> </u>	'I U	1 0	0	92.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	1, 265, 877	0	1, 265, 877	
200.00 10101 (11103 30-177)	1	'1	1,200,011	١	1, 200, 077	1200.00

Health Financial Systems	COLUMBUS REGIONAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

			ΙΤ	o 12/31/2014	Date/Time Prep 5/28/2015 3:32	pared:
		Ti tl	e XVIII	Hospi tal	PPS	2 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.	J	
	4)	ĺ	,	7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	75, 358, 061	0.000000	0. 000000	9, 377, 575	50. 00
51.00 05100 RECOVERY ROOM	0	5, 044, 223	0.000000	0.000000	814, 761	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 000000	0.000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	8, 597, 706	0.000000	0.000000	1, 449, 463	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	718, 975	5, 020, 890	0. 143197	0. 143197	704, 378	54.00
54. O1 O5402 NUCLEAR MEDICINE-DIAGNOSTIC	0	7, 210, 671	0.000000	0. 000000	694, 009	54. 01
54.02 05404 ULTRA SOUND	0	4, 660, 058	0.000000	0. 000000	481, 704	54. 02
54. 03 05405 MAMMOGRAPHY	0	2, 693, 821	0.000000	0. 000000	268	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	9, 419, 299	0. 000000	0. 000000	64, 146	55. 00
57. 00 05700 CT SCAN	0	19, 005, 673	0.000000	0. 000000	2, 057, 619	57.00
58. 00 05800 MRI	0	7, 249, 975	0.000000	0. 000000	758, 859	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	19, 420, 973	0.000000	0. 000000	4, 624, 314	59. 00
60. 00 06000 LABORATORY	0	33, 298, 342	0.000000	0. 000000	4, 679, 718	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	4, 581, 382	0.000000	0. 000000	240, 076	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	2, 254, 777	0.000000	0. 000000	776, 170	62.00
65. 00 06500 RESPIRATORY THERAPY	0	9, 986, 733	0.000000	0. 000000	3, 781, 106	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	11, 637, 288	0.000000	0. 000000	1, 143, 587	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 745, 758	0.000000	0. 000000	404, 103	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1, 572, 372	0.000000	0. 000000	114, 074	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	11, 124, 814	0.000000	0. 000000	2, 466, 999	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	5, 361, 001	0.000000	0. 000000	95, 089	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 802, 952	0.000000	0. 000000	4, 697, 441	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 947, 614	0.000000	0. 000000	5, 092, 620	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	546, 902	64, 868, 818	0. 008431	0. 008431	13, 281, 049	73. 00
74. 00 07400 RENAL DIALYSIS	0	1, 287, 605	0.000000	0. 000000	766, 722	74. 00
76. 00 03020 ACUPUNCTURE	0	0	0.000000	0. 000000	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	897, 580	0.000000	0. 000000	4, 698	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	0.000000	0. 000000	0	89. 00
90. 00 09000 CLI NI C	0	4, 391, 302	0.000000	0. 000000	14, 235	90.00
90. 01 09001 DI ABETES CENTER	0	101, 077	0.000000	0. 000000	0	90. 01
90. 02 09002 NEUROPSYCH	0	205, 496	0.000000	0. 000000	786	90. 02
90. 03 09003 WOUND CENTER	0	4, 816, 631	0.000000	0. 000000	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	1, 644, 848			23, 192	90. 04
91. 00 09100 EMERGENCY	0	53, 647, 924	0.000000	0. 000000	6, 719, 066	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS	•		•	·		1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 265, 877	422, 013, 430			65, 327, 827	200.00
	•	•	•	•	•	

Health Financial Systems	COLUMBUS REGIONAL	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 01/01/2014	Worksheet D Part IV Date/Time Prepared:

			1	0 12/31/2014	5/28/2015 3:3	
		Ti tl	e XVIII	Hospi tal	PPS	<u>_ p</u>
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	16, 277, 138	1	_		
51. 00 05100 RECOVERY ROOM	0	713, 418	i	_	_	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	1, 281, 765	1	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	100, 865	1, 184, 422	1	0	0	54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 223, 202		0	0	54. 01
54. 02 05404 ULTRA SOUND	0	1, 200, 428	1	0	0	54. 02
54. 03 05405 MAMMOGRAPHY	0	238, 295		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	4, 359, 329	1	0	0	55. 00
57. 00 05700 CT SCAN	0	4, 471, 615		0	0	57. 00
58. 00 05800 MRI	0	1, 763, 526	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 524, 804	1	0	0	59. 00
60. 00 06000 LABORATORY	0	2, 961, 704	1	0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	1, 164, 709	1	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	433, 173	1	0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	0	825, 149	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	174, 017		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 281, 969	1	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 334, 418	1	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	3, 068, 707	1	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 874, 738	1	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	111, 973	14, 051, 828	118, 471	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
76. 00 03020 ACUPUNCTURE	0	257 200	0	0	0	76.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	357, 288	0	0	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	_	0	89.00
90. 00 009000 CLINI C	0	1, 964, 269	_	_	0	90.00
90. 00 09000 CETNIC 90. 01 09001 DI ABETES CENTER	0	1, 964, 269	1	0	0	90.00
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	0	126, 623		0	0	90.01
90. 03 09003 WOUND CENTER	0	2, 333, 845		0	0	90.02
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	1, 208, 214		0	0	90.03
91. 00 09100 EMERGENCY		8, 812, 575		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 838, 333		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	1, 050, 555			<u> </u>	1 /2.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	212, 838	82, 051, 406	288, 077	0	n	200.00
	2.2,000	02,00.,100	200,077	ı	·	,_ 50. 00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 150112
Period: From 01/01/2014 To 12/31/2014
Part IV Date/Time Prepared: 5/28/2015 3:32 pm

				5/28/2015 3:32 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description		A Adj. All		
	Allied Health Oth			
		cation Cost		
ANOLILIARY OFRICASE ORDER OFFITERS	23. 00	24. 00		
ANCILLARY SERVICE COST CENTERS				50.00
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	O		52. 00
53. 00 05300 ANESTHESI OLOGY	0	O		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	O		54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54. 01
54. 02 05404 ULTRA SOUND	0	O		54. 02
54. 03 05405 MAMMOGRAPHY	0	0		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		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	0		59. 00
60. 00 06000 LABORATORY	0	0		60.00
60. 01 06001 LABORATORY-PATHOLOGICAL	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	0	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	O		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	O		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	О		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	О		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	o		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	o		73. 00
74.00 07400 RENAL DIALYSIS	o	o		74. 00
76. 00 03020 ACUPUNCTURE	o	О		76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	О		76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>			
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	О		89. 00
90. 00 09000 CLINIC	o	О		90. 00
90. 01 09001 DI ABETES CENTER	l ol	o		90. 01
90. 02 09002 NEUROPSYCH	o	o		90. 02
90. 03 09003 WOUND CENTER	o	ol		90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	o	ol		90. 04
91. 00 09100 EMERGENCY	l ol	ol		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		O		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVI CES				95. 00
200.00 Total (lines 50-199)	0	О		200. 00
	1	91		1230.00

From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 3:32 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 317752 16, 277, 138 5, 172, 093 50.00 51.00 05100 RECOVERY ROOM 0.388318 713, 418 0 0 51.00 277, 033 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.059971 1, 281, 765 76,869 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0.897522 1, 184, 422 0 1, 063, 045 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 299931 2, 223, 202 0 0 54 01 666, 807 54 01 0 54.02 05404 ULTRA SOUND 0.230392 1, 200, 428 276, 569 54.02 54.03 05405 MAMMOGRAPHY 0.743458 238, 295 177, 162 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0.342930 4, 359, 329 0 0 1, 494, 945 55.00 05700 CT SCAN 4.471,615 0 449, 446 57 00 0 100511 57 00 58.00 05800 MRI 0.111872 1, 763, 526 0 197, 289 58.00 05900 CARDIAC CATHETERIZATION 0. 267174 0 941, 736 59.00 59.00 3, 524, 804 0 0 0 06000 LABORATORY 0.408901 2, 961, 704 1, 211, 044 60.00 1.048 60.00 06001 LABORATORY-PATHOLOGI CAL 371, 425 60 01 0.318899 1, 164, 709 0 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.467989 433, 173 0 202, 720 62.00 06500 RESPIRATORY THERAPY 0. 482827 0 65.00 825, 149 0 398, 404 65.00 06600 PHYSI CAL THERAPY 0.510422 0 66.00 0 0 66, 00 06700 OCCUPATIONAL THERAPY 0 67 00 0.543277 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.743106 174, 017 129, 313 68.00 06900 ELECTROCARDI OLOGY 2, 281, 969 0 69.00 0.146058 0 333, 300 69.00 371, 882 70.00 07000 ELECTROENCEPHALOGRAPHY 0.278685 1. 334. 418 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.446842 3,068,707 1, 371, 227 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.575678 1,874,738 0 0 1,079,245 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0. 357288 14, 051, 828 5, 020, 550 73.00 114, 156 07400 RENAL DIALYSIS 74.00 0.341730 0 74.00 0 76.00 03020 ACUPUNCTURE 0.000000 0 Λ 76.00 119, 022 07697 CARDIAC REHABILITATION 0. 333125 76.97 357, 288 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.477688 1, 964, 269 0 938, 308 90.00 09001 DIABETES CENTER 1, 905 0 5, 347 90.01 2.807078 0 90.01 0 90.02 09002 NEUROPSYCH 0.808240 126, 623 102, 342 90.02 0 90.03 09003 WOUND CENTER 0.370494 2, 333, 845 0 864, 676 90.03 09004 HYPERBARI C OXYGEN THERAPY 0. 231996 1, 208, 214 0 280, 301 90.04 90.04 ol 09100 EMERGENCY 0.249012 8, 812, 575 n 2, 194, 437 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.595542 1,838,333 0 1,094,805 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0.612010 09500 AMBULANCE SERVICES 0 95.00 0 26, 881, 342 200. 00 200.00 Subtotal (see instructions) 82, 051, 406 115, 204 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

82, 051, 406

115, 204

0

26, 881, 342 202. 00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

				5/28/2015 3:32 pm
		Title XVIII	Hospi tal	PPS
	Costs			
Cost Center Description	Cost	Cost		
555 551151 55551 P 1 511		ei mbursed		
		rvi ces Not		
		ubject To		
		d. & Coins.		
		see inst.)		
	6.00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	l ol	o		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	ol		52. 00
53. 00 05300 ANESTHESI OLOGY	0	ol		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		o		54.00
· · · · · · · · · · · · · · · · · · ·	١	o _l		
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	١	o		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	o	0		55. 00
57. 00 05700 CT SCAN	l ol	ol		57. 00
58. 00 05800 MRI	l ol	ol		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o o	ol		59.00
	1	٩		
60. 00 06000 LABORATORY	429	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		65. 00
66. 00 06600 PHYSI CAL THERAPY	o	O		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	l ol	ol		67. 00
68. 00 06800 SPEECH PATHOLOGY	ا	ol		68.00
69. 00 06900 ELECTROCARDI OLOGY		ol		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		70.00
· · · · · · · · · · · · · · · · · · ·				
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	40, 787	0		73. 00
74.00 07400 RENAL DIALYSIS	0	0		74. 00
76. 00 03020 ACUPUNCTURE	o	O		76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	l ol	o		76. 97
OUTPATIENT SERVICE COST CENTERS	'			
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		Ö		89. 00
	1 -1	0		
	0	0		90.00
90. 01 09001 DI ABETES CENTER	ا	O		90. 01
90. 02 09002 NEUROPSYCH	0	0		90. 02
90. 03 09003 WOUND CENTER	0	0		90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0		90. 04
91. 00 09100 EMERGENCY	o	o		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	ol		92.00
OTHER REIMBURSABLE COST CENTERS	1 9	~1		72.00
95. 00 09500 AMBULANCE SERVICES	O			95. 00
· · · · · · · · · · · · · · · · · · ·	1	0		200.00
	41, 216	Y		
201.00 Less PBP Clinic Lab. Services-Program	0			201. 00
Only Charges	1 44 64			
202.00 Net Charges (line 200 +/- line 201)	41, 216	0		202. 00

APPORT	Financial Systems IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	COLUMBUS REGIO AL COSTS		CCN: 150112	Peri od:	Worksheet D	
			Component	t CCN: 15T112	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/28/2015 3:3	pared:
				e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	4, 025, 657	75, 358, 061	0. 05342	20 32, 597	1, 741	50.00
51.00	05100 RECOVERY ROOM	206, 937				163	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	200, 737		0.00000		0	1
53. 00	05300 ANESTHESI OLOGY	99, 472				47	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	631, 672		1		2, 452	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	381, 410				712	
54. 02	05404 ULTRA SOUND	74, 575				220	
54. 03	05405 MAMMOGRAPHY	268, 773				0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	525, 831				222	
57. 00	05700 CT SCAN	307, 550				624	
58. 00	05800 MRI	70, 404		1		167	
59.00	05900 CARDI AC CATHETERI ZATI ON	981, 470				0	59.00
60.00	06000 LABORATORY	1, 163, 563	33, 298, 342	0. 03494	14 156, 874	5, 482	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	166, 673	4, 581, 382	0. 03638	4, 580	167	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	43, 808	2, 254, 777	0. 01942		184	62.00
65.00	06500 RESPI RATORY THERAPY	589, 360	9, 986, 733	0.05901	14 107, 149	6, 323	65.00
66.00	06600 PHYSI CAL THERAPY	628, 682				35, 367	
67.00	06700 OCCUPATI ONAL THERAPY	109, 830				18, 453	
68. 00	06800 SPEECH PATHOLOGY	116, 026				16, 495	
69. 00	06900 ELECTROCARDI OLOGY	195, 816				510	
70.00	07000 ELECTROENCEPHALOGRAPHY	116, 911				67	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	224, 909		1		1, 073	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	66, 194				0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	964, 591				10, 587	
76.00	03020 ACUPUNCTURE	3, 823		1		69 0	
76. 97	07697 CARDI AC REHABI LI TATI ON	51, 643		1		0	
70. 97	OUTPATIENT SERVICE COST CENTERS	31,043	097, 360	0.05753	50 0	U	70.97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			1		Ö	
90.00	09000 CLINIC	261, 323				9	
90. 01	09001 DI ABETES CENTER	38, 836				ó	
90. 02	09002 NEUROPSYCH	9, 054				ő	
90. 03	09003 WOUND CENTER	111, 247				Ö	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	284, 919		1		0	
91.00	09100 EMERGENCY	981, 904		1		219	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	13, 702, 863	422, 013, 430		2, 806, 632		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS Cost Center Description ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	Non Physician Ni Anesthetist Cost	Component	CCN: 150112 CCN: 15T112 e XVIII Allied Healt	Subprovi der -	Worksheet D Part IV Date/Time Pre 5/28/2015 3:3 PPS	pared: 2 pm
ANCILLARY SERVICE COST CENTERS	Anesthetist Cost			IRF		
ANCILLARY SERVICE COST CENTERS	Anesthetist Cost	ursing School	Allied Healt			
				th All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
		0		0	0	F0 00
51. 00 05000 0FERATTING ROOM 51. 00 05200 DELIVERY ROOM LABOR ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 0 0	0 0 0 0	718, 9	0 0 0 0 0 0 0 0	0 0 0 0 718, 975	53. 00
54. 01	0 0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	1
57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	57. 00 58. 00 59. 00 60. 00
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0	60. 01 62. 00 65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 0	0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	67. 00 68. 00 69. 00 70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSI S 76. 00 03020 ACUPUNCTURE	0 0	0 0	546, 9	0 0	0 546, 902 0 0	72. 00 73. 00 74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 0 0	0 0 0		0 0 0 0	0 0 0	88. 00 89. 00 90. 00
90. 01	0 0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	90. 01 90. 02 90. 03 90. 04
91. 00	0 0	0		0 0	0	91. 00 92. 00

	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		NAL HOSPITAL S Provider	CCN: 150112	Peri od:	w of Form CMS-2 Worksheet D	
THROUG	SH COSTS		Componen	t CCN: 15T112	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/28/2015 3:3	pared:
			Ti tl	e XVIII	Subprovi der -	PPS	z piii
	Cost Center Description	Total	Total Charges	Datio of Cos	I RF t Outpatient	Inpati ent	
	cost center bescription	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col . 2, 3 and	8)	7)	(col . 6 ÷ col .	onal ges	
		4)		_	7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	C		l			
51. 00	05100 RECOVERY ROOM	C				3, 979	
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	_	0.00000		0	
53.00	05300 ANESTHESI OLOGY	C	-, ,	•		4, 050	
54.00	05400 RADI OLOGY-DI AGNOSTI C	718, 975				19, 487	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	C	.,			13, 458	
54. 02 54. 03	05404 ULTRA SOUND 05405 MAMMOGRAPHY	C				13, 761 0	
55. 00	05500 RADI OLOGY-THERAPEUTI C					3, 976	
57. 00	05700 CT SCAN					38, 570	
58. 00	05800 MRI		,	•		17, 199	
59. 00	05900 CARDI AC CATHETERI ZATI ON					0	1
60.00	06000 LABORATORY					156, 874	
60. 01	06001 LABORATORY-PATHOLOGI CAL					4, 580	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C				9, 478	
65.00	06500 RESPI RATORY THERAPY	C	9, 986, 733	0. 00000	0. 000000	107, 149	65.00
66.00	06600 PHYSI CAL THERAPY		11, 637, 288	0.00000	0. 000000	654, 668	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	C	3, 745, 758			629, 360	67.00
68. 00	06800 SPEECH PATHOLOGY	C	.,			223, 538	
69. 00	06900 ELECTROCARDI OLOGY	C				28, 956	
70. 00	07000 ELECTROENCEPHALOGRAPHY	C				3, 090	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	,,	1		94, 461	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	544 000				99	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	546, 902				711, 959	
76. 00	03020 ACUPUNCTURE					23, 205 0	
76. 97	07697 CARDI AC REHABI LI TATI ON			l		0	1
70. 97	OUTPATIENT SERVICE COST CENTERS		097, 300	ıj 0.0000C	0.00000	U	70.97
88. 00	08800 RURAL HEALTH CLINIC			0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			•		0	
90.00	09000 CLINIC					147	
90. 01	09001 DI ABETES CENTER	Ö		•		0	
90. 02	09002 NEUROPSYCH	i c				0	
90. 03	09003 WOUND CENTER	C				0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	C	1, 644, 848	0. 00000		0	90.04
91. 00	09100 EMERGENCY					11, 991	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	C	8, 157, 766	0.00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1				
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	1, 265, 877	422, 013, 430)		2, 806, 632	1200.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provi der		Peri od: From 01/01/2014	Worksheet D Part IV	
		Component	CCN: 15T112	To 12/31/2014	Date/Time Pre 5/28/2015 3:3	pared: 2 pm
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program	PSA Adj. Non Physician	PSA Adj. Nursing School	
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8 x col. 10)		Costs (col. (Cost		
	11. 00	12. 00	13. 00	21.00	22. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	51. 00

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	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 OPERATI NG ROOM	0	0	0	C	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	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	0	0	C	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 790	0	0	C	0	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	C	0	54. 01
54. 02 05404 ULTRA SOUND	0	0	0	C	0	54. 02
54. 03 05405 MAMMOGRAPHY	o	0	0	C	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	C	0	55. 00
57. 00 05700 CT SCAN	0	0	0	C	Ō	57. 00
58. 00 05800 MRI	0	0	0	Ċ	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	l o		ő	59. 00
60. 00 06000 LABORATORY	0	0	1			60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0	1		Ö	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1			62.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
	0	0			1	
	0	0			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		C	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	C	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	C	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	C	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	C	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	C	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 003	0	0	C	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	C	0	74. 00
76. 00 03020 ACUPUNCTURE	0	0	0	C	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	C	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	C		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	C	0	89. 00
90. 00 09000 CLI NI C	0	0	0	C	0	90. 00
90. 01 09001 DI ABETES CENTER	0	0	0	C	0	90. 01
90. 02 09002 NEUROPSYCH	0	0	0	C	0	90. 02
90. 03 09003 WOUND CENTER	0	0	0	C	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0	0	C	0	90. 04
91. 00 09100 EMERGENCY	O	0	0	C	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	0	C	0	92.00
OTHER REIMBURSABLE COST CENTERS	. '				•	
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	8, 793	0	0	C	0	200. 00

Health Financial Systems	COLUMBUS REGIONAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150112		Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV
		Component CCN: 15T112	To 12/31/2014	Date/Time Prepared:
				5/28/2015 3:32 pm
		Title XVIII	Subprovi der -	PPS

			Titl∈	× XVIII	Subprovi der - I RF	PPS	
Cost Center Description	PSA Adj.	PSA Ad			TIM		
	Allied Health						
			on Cost				
ANGLILLARY CERVICE COCT CENTERS	23. 00	24.	. 00				
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	J	0				50.00
51. 00 05100 RECOVERY ROOM	0	1	0				51.00
52. OO 05200 DELIVERY ROOM & LABOR ROOM	0		0				52.00
53. 00 05300 ANESTHESI OLOGY	0	á	0				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	á	0				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	á	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		0				55. 00
57. 00 05700 CT SCAN	0		O				57. 00
58. 00 05800 MRI	0		O				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		O				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 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)	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
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	1	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
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	J	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l .	0				89.00
90. 00 09000 CLI NI C	0		0				90.00
90. 01 09001 DI ABETES CENTER	0	ál –	0				90.00
90. 02 09002 NEUROPSYCH	0	á	0				90. 02
90. 03 09003 WOUND CENTER	0	á	0				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0		0				90. 04
91. 00 09100 EMERGENCY	0		o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1	o				92. 00
OTHER REIMBURSABLE COST CENTERS							1
95. 00 09500 AMBULANCE SERVI CES							95. 00
200.00 Total (lines 50-199)	0		О				200.00
	•	•					•

Heal th	Financial Systems	COLUMBUS REGIONAL I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 150112	Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 3:3	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room days				29, 653	1. 00
2.00	Inpatient days (including private room days,				29, 653	2. 00
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed days). If you have only pr	ivate room days,	0	3. 00
4 00					0/ 000	4 00

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29, 653	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29, 653	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	26, 090	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		, 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	o	7. 00
7.00	reporting period	٥	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ĭ	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	11, 628	9. 00
	newborn days)	,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	o	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	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)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
47.00	SWING BED ADJUSTMENT	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
10.00	reporting period	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	40, 433, 054	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	40, 433, 054	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	28. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28.00
29. 00 30. 00		0	
31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
33. 00 34. 00	Average per diem private room per diem charge (The 30 ÷ Time 4) Average per diem private room charge differential (Line 32 minus Line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 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 and private room cost differential (line	40, 433, 054	37. 00
37.00	27 minus line 36)	70, 700, 004	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)	1, 363. 54	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	15, 855, 243	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00		15, 855, 243	41.00

/	27: 00 111 vate 1 00m charges (exertaining swing bea charges)	`	0 2 7. 00
30	30.00 Semi-private room charges (excluding swing-bed charges)		30.00
31	31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32	32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33	33.00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34	34.00 Average per diem private room charge differential (line 32 minus line 33	(see instructions) 0.00	34.00
35	35.00 Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36	36.00 Private room cost differential adjustment (line 3 x line 35)		36.00
37	37.00 General inpatient routine service cost net of swing-bed cost and private	e room cost differential (line 40,433,054	4 37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38	38.00 Adjusted general inpatient routine service cost per diem (see instructio	ons) 1, 363. 54	4 38.00
39	39.00 Program general inpatient routine service cost (line 9 x line 38)	15, 855, 243	39.00
40	40.00 Medically necessary private room cost applicable to the Program (line 14	x line 35)	40.00
41	41.00 Total Program general inpatient routine service cost (line 39 + line 40)	15, 855, 243	3 41.00

	Financial Systems	COLUMBUS REGION			In Lie	u of Form CMS-2	
COMPUT	FATION OF INPATIENT OPERATING COST		Provi der	CCN: 150112	Peri od: From 01/01/2014	Worksheet D-1	
					To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Hospi tal	5/28/2015 3: 3 PPS	2 piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	col. 1	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	5, 977, 746	2, 491	2, 399.	74 1, 106	2, 654, 112	43.00
44. 00	CORONARY CARE UNIT	0		1	00	0	44. 00
45. 00		0	0	1		0	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0. (0	0	46. 00 47. 00
	Cost Center Description	'		•			
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	Line 200)			1. 00 23, 125, 181	48. 00
	Total Program inpatient costs (sum of lines			ons)		41, 634, 536	
	PASS THROUGH COST ADJUSTMENTS	y , ,		•			
50. 00	Pass through costs applicable to Program inp	atient routine :	services (from	n Wkst. D, sur	n of Parts I and	2, 444, 701	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	2, 116, 829	51.00
F0 00	and IV)	50 54)				4 5/4 500	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-phy	sician anestl	netist and	4, 561, 530 37, 073, 006	
00.00	medical education costs (line 49 minus line		. a tou, pr.,			0.70.07000]
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	E4 00
	Target amount per discharge						54. 00 55. 00
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00	1	porting period (endi ng 1996, u	updated and co	ompounded by the		59.00
	market basket			•	,		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than					Ü	01.00
42.00	amount (line 56), otherwise enter zero (see	instructions)				0	62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reporting	g period (See	0	65. 00
// 00	instructions) (title XVIII only)	(III	/	E) (+: +1 -)((1)			// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (iine i	64 prus rine 6	ob)(title XVI)	i only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Do	ecember 31 of	the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter b		the cost rep	or tring period	Ü	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N 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		(line 14 v li	ne 35)			72. 00 73. 00
74. 00							74.00
75. 00	'	routine service	costs (from W	Vorksheet 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						77. 00
78. 00		,					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi			(,		81. 00
82.00	Inpatient routine service cost limitation (I		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00			rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					3, 563	87. 00
	, .	•					1
88. 00	Observation bed cost (line 87 x line 88) (se		line 2)			1, 363. 54 4, 858, 293	1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 Fo 12/31/2014		
	_	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	5, 299, 829	40, 433, 054	0. 13107	7 4, 858, 293	636, 810	90.00
91.00 Nursing School cost	0	40, 433, 054	0. 00000	4, 858, 293	0	91.00
92.00 Allied health cost	0	40, 433, 054	0. 00000	4, 858, 293	0	92.00
93.00 All other Medical Education	0	40, 433, 054	0. 00000	4, 858, 293	0	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150112	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15T112	To 12/31/2014	Date/Time Prepared: 5/28/2015 3:32 pm
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 500	
2.00	Inpatient days (including private room days, excluding swing-bed			3, 500	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	. IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 500	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period	daya) after December 3	11 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room (days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 015	9. 00
7. 00	newborn days)	ine i regram (exeracing	oming bod and	2,010	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ento	er 0 on this line)	Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13. 00
14. 00	Medically necessary private room days applicable to the Program	-	, I	0	14. 00
15.00	Total nursery days (title V or XIX only)	. 3 3	,	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	trii ougii beceiibei 31 oi	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	he cost	0.00	18. 00
10.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	inrough December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	21 of the cost respect:	ng poriod (line	4, 601, 528	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	of the cost reporting	period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00	Total swing-bed cost (see instructions)	04 1 11 01		0	
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		4, 601, 528	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		<i>y</i> ,	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 ÷	ine 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	i ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	, ,	·	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	l polyoto ' ''	Forest! - L (L)	4 (01 530	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	i private room cost dif	Terential (line	4, 601, 528	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 314. 72	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3) Medically necessary private room cost applicable to the Program			2, 649, 161 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•		2, 649, 161	
00	1	/	ı	_, 0.7, 101	50

	Financial Systems	COLUMBUS REGIO					eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			der CCN:	Fi	eriod: rom 01/01/2014		
			Compo	nent CCN	I: 15T112 To	o 12/31/2014	Date/Time Pre 5/28/2015 3:3	
				Title XV	111	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient I		erage Per ı (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	(col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0	0.00	4. 00 C		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	I	0	0. 00	C	0	43. 00
44. 00	CORONARY CARE UNIT	0		o	0. 00	C		44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT	0		0	0. 00 0. 00	C	1	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)			<u> </u>	0.00			47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (Wks						1, 322, 669	
49. 00	PASS THROUGH COST ADJUSTMENTS						3, 971, 830	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from Wks	t. D, sum o	of Parts I and	388, 734	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y servi ces	(from W	kst. D, sur	n of Parts II	110, 146	51. 00
52.00	Total Program excludable cost (sum of lines!						498, 880	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		elated, non	-physi ci	an anesthe	tist, and	3, 472, 950	53. 00
54. 00							0	54. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ing cost and ta	arget amoun	t (line	56 minus li	ne 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	parting pariod	anding 100	4 undat	ad and com	acunded by the	0.00	58. 00 59. 00
39.00	market basket	boi triig perrou	enuing 199	o, upuat	eu anu com	bounded by the	0.00	39.00
60. 00 61. 00								60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							62. 00
63. 00	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 cos	ts through Dece	ember 31 of	the cos	t reportino	g period (See	0	64. 00
65. 00	,	ts after Decemb	per 31 of t	he cost	reporting p	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus li	ne 65)(t	itle XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December	31 of th	e cost repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31	of the	cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) 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 facili	ty/ICF/MR rout	ine servic	e cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	,	ine 70 ÷ I	i ne 2)				71. 00 72. 00
73. 00	Medically necessary private room cost applica		n (line 14	x line 3	5)			73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•		,	heet B, Pai	rt II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li							76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus							77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p						79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limita	tion (li	ne 78 minus	s line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	* .					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ıs)					83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructio						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)					86. 00
87. 00	Total observation bed days (see instructions))	line 2)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•					1	88. 00 89. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T112	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	675, 229	4, 601, 528	0. 14674	0 0	0	90. 00
91.00 Nursing School cost	0	4, 601, 528			0	91. 00
92.00 Allied health cost	0	4, 601, 528			0	
93.00 All other Medical Education	0	4, 601, 528	0.00000	0 0	0	93. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPI	I TAL	In Lieu	u of Form CMS-2	552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pro	ovi der CCN: 150112	Period: From 01/01/2014	Worksheet D-3	
				Date/Time Prep 5/28/2015 3:32	
		Title XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Innatient	Innatient	

				Fo 12/31/2014	Date/Time Pre 5/28/2015 3:3	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			18, 920, 659		30.00
31. 00 32. 00	03100 INTENSI VE CARE UNI T 03200 CORONARY CARE UNI T			3, 903, 766		31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T			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
FO 00	ANCILLARY SERVICE COST CENTERS		0.21047	0 277 575	2 005 002	
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM		0. 31947 0. 38831		2, 995, 882 316, 386	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 00000		310, 380	52.00
53. 00	05300 ANESTHESI OLOGY		0. 06171		89, 448	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 89752		632, 195	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 29993		208, 155	54. 01
54.02	05404 ULTRA SOUND		0. 23039	2 481, 704	110, 981	54. 02
54. 03	05405 MAMMOGRAPHY		0. 74345	3 268	199	1
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 35434	-	22, 730	55. 00
57. 00	05700 CT SCAN		0. 10051		206, 813	57. 00
58. 00	05800 MRI		0. 11187		84, 895	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 27139		1, 255, 002	59.00
60. 00 60. 01	06000 LABORATORY 06001 LABORATORY - PATHOLOGI CAL		0. 40890 0. 31889		1, 913, 541 76, 560	60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 31889		363, 239	62.00
65. 00	06500 RESPIRATORY THERAPY		0. 48389		1, 829, 666	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 51293		586, 585	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 54327		219, 540	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 74310	114, 074	84, 769	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 14924		368, 177	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 27898		26, 528	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 44684		2, 099, 014	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 57567		2, 931, 709	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0. 35728 0. 34173		4, 745, 159 262, 012	73. 00 74. 00
76. 00	03020 ACUPUNCTURE		0.00000		202, 012	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 33628		1, 580	ł
	OUTPATIENT SERVICE COST CENTERS			.,	.,,	
88. 00	08800 RURAL HEALTH CLINIC		0.00000	D	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	D	0	89. 00
90. 00	09000 CLI NI C		0. 54406		7, 745	90. 00
90. 01	09001 DI ABETES CENTER		2. 80707		0	90. 01
	09002 NEUROPSYCH		0. 80824		635	
90. 03 90. 04	O9003 WOUND CENTER O9004 HYPERBARI C OXYGEN THERAPY		0. 37072 0. 23209		0 5, 383	1
91.00	09100 EMERGENCY		0. 25013		1, 680, 653	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 59554		1, 660, 653	1
, 00	OTHER REIMBURSABLE COST CENTERS		3. 37334			, 2. 00
95.00	09500 AMBULANCE SERVI CES					95. 00
200.00				65, 327, 827	23, 125, 181	200. 00
201.00		ne 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		1	65, 327, 827		202. 00

Health Financial Systems COLUMBUS RE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	GI ONAL HOSPI TAL	CCN: 150112	Period:	wof Form CMS-2 Worksheet D-3	
INPATIENT ANCIELARY SERVICE COST APPORTIONMENT	Frovider		From 01/01/2014		
	Component	t CCN: 15T112	To 12/31/2014	Date/Time Pre 5/28/2015 3:3	pared:
	Ti tl	e XVIII	Subprovider - IRF	PPS	<u> </u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	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	l	30.00
31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT			0	l	31.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T			0		34.00
40. 00 04000 SUBPROVI DER - PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			2, 982, 339		41. 00
42. 00 04200 SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 O5000 OPERATI NG ROOM		0. 31947	32, 597	10, 414	50.00
51. 00 05100 RECOVERY ROOM		0. 38831			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 06171		250	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 89752	19, 487	17, 490	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 29993			1
54. 02 05404 ULTRA SOUND		0. 23039		3, 170	1
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 74345 0. 35434		0 1, 409	
57. 00 05700 CT SCAN		0. 35454		3, 877	57.00
58. 00 05800 MRI		0. 11187			1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 27139		0	59. 00
60. 00 06000 LABORATORY		0. 40890		64, 146	1
60. 01 06001 LABORATORY-PATHOLOGI CAL		0. 31889		1	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 46798		1	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 48389 0. 51293		1	•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 54327			1
68. 00 06800 SPEECH PATHOLOGY		0. 74310		l	•
69. 00 06900 ELECTROCARDI OLOGY		0. 14924	1 28, 956	4, 321	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 27898		l	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 44684		42, 209	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 57567			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSIS		0. 35728 0. 34173		254, 374 7, 930	1
76. 00 03020 ACUPUNCTURE		0.00000		l	1
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 33628			
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0.00000		0	
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES CENTER		0. 54406 2. 80707		l .	
90. 02 09002 NEUROPSYCH		0. 80824		0	1
90. 03 09003 WOUND CENTER		0. 37072		ő	
90. 04 09004 HYPERBARI C OXYGEN THERAPY		0. 23209		0	90. 04
91. 00 09100 EMERGENCY		0. 25013		2, 999	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 59554	2 0	0	92. 00

92.00 95. 00

201. 00

202. 00

1, 322, 669 200. 00

2, 806, 632

2, 806, 632

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				Т	o 12/31/2014	Date/Time Pre 5/28/2015 3:3	
No. PART A. INPAIT INT HISPITAL SERVICES (MIRRE 1985)			Ti tl	e XVIII	Hospi tal		
No. PART A. INPAIT INT HISPITAL SERVICES (MIRRE 1985)				0	1. 00	2.00	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) personnel for discharges occurring on or						2.00	
1. 10 detable 1 (see instructions) 2. 1. 02 BRG amounts when then ust liver payments for discharges occurring on or after October 1 (see instructions) 3. 1. 02 BRG for Federal (see instructions) 3. 03 desharges occurring prior to October 1 (see instructions) 4. 04 desharges occurring prior to October 1 (see instructions) 5. 05 desharges occurring prior to October 1 (see instructions) 6. 05 desharges occurring prior to October 1 (see instructions) 7. 06 desharges occurring on or after October 1 (see instructions) 8. 07 desharges occurring on or after October 1 (see instructions) 9. 08 desharges occurring on or after October 1 (see instructions) 9. 08 desharges and lated 4 (see instructions) 9. 08 desharges and lated 4 (see instructions) 9. 08 desharges and lated 4 (see instructions) 9. 09 desharges and lated 4 (see instructions) 9. 00 desharges and lated 4 (se		,	a prior		-		1.00
arter (Exchaer I (see Instructions) 1.03 (ORF or federal specific operating payment for Model 4 BPCI for 0 0 1.03 (Oxforage) occurring prior to Dictober I (see Instructions) 1.080 (Oxforage) occurring on or after Oxforage (Oxforage) 0 0 0 0 0 0 0 0 0	1.01		y piroi		21, 144, 703		1.01
1.03 BBC For Federal specific operating payment for World 4 BPCI for discrete specific operating payment for World 4 BPCI for 1.08 Discrete specific operating payment for World 4 BPCI for 1.08 Discrete specific operating payment for World 4 BPCI for 1.08 Discrete specific operating payment for World 4 BPCI for 1.08 Discrete specific operating payment for World 4 BPCI for 1.08 Discrete specific operating payment for disded by nutrient of discrete specific operating payment for disded by nutrient operating payment for disded payment for disperating payment for disded payment for disperating payment for disded payment for disperating payment payment payment for disperating payment payme	1. 02	i j	g on or		6, 677, 275		1. 02
discharges occurring prior to October 1 (see Instructions)	1. 03				0		1. 03
discharges occurring on or 'after October 1 (see instructions) 1,080,249 2,00		discharges occurring prior to October 1 (see instructions)					
2.00 Dutil ein payments for discharges. (see Instructions) 1,080,249 2.00 2.01 Dutil ein processifiation immunt 2.01 3.02 Dutil ein processifiation immunt 3.02 3.03 Managed Carner 1 for discharges for Model 4 IRPCI (see Instructions) 3.02 3.04 Dutil ein payment for discharges for Model 4 IRPCI (see Instructions) 3.02 3.06 Dutil ein payment for discharges for Model 4 IRPCI (see Instructions) 3.02 3.06 Dutil ein payment for discharges for Model 4 IRPCI (see Instructions) 3.02 3.06 Dutil ein for Model 4 IRPCI (see Instructions) 5.00 5.00 FEE count for all opathic and esteopathic programs for the most recent 5.00 6.00 5.00 FEE count for all opathic and esteopathic programs with chimset The 5.00 6.00 5.00 FEE count for all opathic and esteopathic programs in accordance at the 42 6.00 7.00 5.00 FEE count for all opathic and esteopathic programs in accordance at the 42 7.00 7.00 7.00 5.00 FEE count for all opathic and esteopathic programs in accordance at the 42 7.00	1. 04				0		1. 04
2.01 Quttler reconcil lation amount 0 2.01	2.00				1, 080, 249		2.00
Managed Care Simulated Payments					0		2. 01
Bed days available divided by number of days in the cost reporting 140.24 4.00 period (see instructions)		, , ,	ns)		0		2. 02
period Case instructions			i na	-	140 24		
File count for all opathic and osteopathic programs for the most recent constructions 0.00 5.00	1. 00		9		110.21] ". 00
Cost reporting period ending on or before 12/31/1906. (see instructions) 6.00				1			
FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CRR 413, 79(a)	5.00				0.00		5.00
OR 413, 79(e)	6.00	1 31	,		0.00		6.00
7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 cFR \$412.105(Γ(1)(1)(v)(8)(1)(v)(8)(1) 0.00 7.00 7.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 cFR \$421.005(Γ(1)(v)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.01 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and catopathic programs for affiliated programs in accordance with 42 CFR and 67 FR 50069 (August 1, 2002) 0.00 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 0.00 8.02 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 9.00 9.0 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 0.00 9.00 10.00 FTE count for or plasthic and osteopathic programs in the current year 0.00 10.00 11.00 FTE count for all opathic and osteopathic programs. 0.00 11.00 12.00 Local for residents in dental and podiatric programs. 0.00 11.00 10.00 TE count for residents in dental and podiatric programs. 0.00			e with 42				
CRF \$412.105(F)(1)(Iv)(B)(I) CRF \$612.105(F)(1)(Iv)(B)(B)(Z) If the cost report straddles July 1, 2011 then see Instructions. 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and one osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(Iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (May 13, 2006) (August 1, 2002) August 1, 2002) (August 1, 2002) August 1, 2002) (August 1, 2002) August 1, 2002) August 1, 2002) (August 1, 2002) August 1, 2002) August 1, 2002) August 1, 2002) (August 1, 2002) August 1, 2002) August 1, 2002) August 1, 2002) (August 1, 2002) August 1, 2002) (August 1, 2002) August	7 00		dor 12		0.00		7 00
ACA Section 5503 reduction amount to the IME cap as specified under 42	7.00		uei 42		0.00		7.00
then see instructions. 0.0 A justiment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 Instructions. 8.02 Instructions. 8.03 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (See instructions) 9.00 Closed teaching hospital under section 5506 of ACA. (See instructions) 9.01 Closed teaching hospital under section 5506 of ACA. (See instructions) 9.02 The count for allopathic and osteopathic programs in the current year from your records 1.03 FTE count for residents in dental and podiatric programs. 1.04 Closed teaching the path of the programs in the current year from your records 1.05 FTE count for residents in dental and podiatric programs. 1.06 TEC count for residents in dental and podiatric programs. 1.07 TEC count for residents in dental and podiatric programs. 1.08 Current year allowable FTE count for the prior year. 1.09 TEC count for residents in initial years of the program. 1.00 Total allowable FTE count for the prior year. 1.01 The followable FTE count for the prior year. 1.02 Sun of Ilines 12 through 14 divided by 3. 1.03 Sun of Ilines 12 through 14 divided by 3. 1.04 Current year residents displaced by program or hospital closure 1.05 Sun of Ilines 12 through 14 divided by 3. 1.06 Current year resident to bed ratio (line 18 divided by Iline 4). 1.09 Current year resident to bed ratio (see instructions) 1.00 Current year resident to bed ratio (see instructions) 1.00 Current year resident to bed ratio (see instructions) 1.00 Current year resident to bed ratio (see instructions) 1.01 Current year resident to bed ratio (see instructions) 1.02 Current year resident to bed	7. 01	, , , , , , , , , , , , , , , , , , , ,	nder 42		0.00		7. 01
Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01) 10. 00 FTE count for allopathic and osteopathic programs in the current year from your records from your records from your records from your records from your residents in dental and podiatric programs. 11. 00 FTE count for residents in dental and podiatric programs. 12. 00 Current year allowable FTE (see instructions) 13. 00 Total allowable FTE count for the penul timate year if that year ended on your followable for your program or hospital closure 15. 00 Sum of September 30, 1997, otherwise enter zero. 16. 00 Adjustment for residents in initial years of the program 18. 00 Adjustment for residents in initial years of the program 19. 00 Current year residents in initial years of the program 19. 00 Current year residents in initial years of the program 19. 00 Adjustment for residents displaced by program or hospital closure 19. 00 Depart year resident to be deratio (line 18 divided by line 4). 19. 00 Depart year resident to be deratio (line 18 divided by line 4). 20. 00 IMB payment adjustment (see instructions) 21. 00 Depart year resident to be deratio (see instructions) 22. 01 IMB payment adjustment - Managed Care (see instructions) 23. 00 IMB payment adjustment - Managed Care (see instructions) 24. 00 IMB FTE Resident to bed ratio (divide line 25 by line 4) 25. 00 IMB payment adjustment amount (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 0			1, 2011				
osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.76(b), 413.76(c) (2)(iv), 64 FR 20340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	8 00		ic and		0.00		8 00
(August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 o.00 and 8,02) (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records. 11.00 FTE count for residental and podiatric programs. 12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the prior year. 15.00 Sum of lines 12 through 14 divided by 3.00 or after September 30, 1997, otherwise enter zero. 16.00 Adjustment for residents in initial years of the program 17.00 Adjustment for residents in initial years of the program 18.00 Adjustment for residents in initial years of the program 18.00 Adjustment for residents in initial years of the program 18.00 Adjusted rolling average FTE count 18.00 Adjusted rolling average FTE count 18.00 Prior year resident to bed ratio (line 18 divided by line 4). 18.00 Drior year resident to bed ratio (see instructions) 18.00 Prior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to be dratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior year resident to bed ratio (see instructions) 18.00 Drior ye	0.00	,			0.00		0.00
8.01 The amount of Increase If the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions.			FR 50069				
section 5503 of the ACA If the cost report straddles July 1, 2011, see instructions	Q ∩1		s undar		0.00		8 01
Instructions.	0.01	·			0.00		0.01
closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 9.00 and 8.02) (see instructions) 0.00 9.00 and 8.02) (see instructions) 0.00 10		i nstructi ons.					
9.00 Sum of lines 5° plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01)	8. 02				0.00		8. 02
and 8,02) (see instructions) 10.00	9. 00				0.00		9.00
From your records			(=1 =1 = 1				
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 13.00 14.00 12.00 13.00 17.01 14.00 15.00 1	10. 00		t year		0.00		10.00
12.00 Current year allowable FTE (see instructions) 12.00 12.00 13.00 14.00 14.00 14.00 14.00 16.00 17.0	11 00				0.00		11 00
14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00							12. 00
or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Prior year resident to bed ratio (line 18 divided by line 4). 18.00 Prior year resident to bed ratio (see instructions) 18.00 D.000000 20.00 Prior year resident to bed ratio (see instructions) 18.00 D.000000 21.00 Enter the lesser of lines 19 or 20 (see instructions) 18.00 D.000000 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(1)(1)(1)(2) 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment factor. (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.02 Procentage of Ss1 recipient patient days to Medicare Part A patient days 29.02 Sum of lines		. ,					13. 00
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 18.00 17.00 18	14. 00		ended on		0.00		14. 00
16.00	15. 00				0.00		15. 00
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00		Adjustment for residents in initial years of the program					16. 00
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00			е				17. 00
20. 00 Prior year resident to bed ratio (see instructions) 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 22. 00 IME payment adjustment (see instructions) 22. 01 IME payment adjustment - Managed Care (see instructions) 23. 00 IME payment adjustment - Managed Care (see instructions) 24. 00 IME payment adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 01 IME add-on adjustment amount (see instructions) 29. 00 IME payment adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20. 00 Gerchage of Medicaid patient days (see instructions) 21. 00 Gerchage of Medicaid patient days (see instructions) 22. 01 Gerchage of Medicaid patient days (see instructions) 23. 00 Sum of lines 30 and 31 24. 25. 26. 27. 28. 27.							
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 29.00 Total IME payment (sum of lines 22 and 28) 0.00 29.00 29.01		,					
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 29. 00 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 21. 88 31. 00 32. 00 Sum of lines 30 and 31 28. 21 32. 00 33. 00 Allowable disproportionate share percentage (see instructions)		, ,					21.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21.88 31.00 32.00 Sum of lines 30 and 31 28.21 33.00 Allowable disproportionate share percentage (see instructions) 23.00 24.00 25.00 26.00 27.00 28.00 29.00 20.00 2					0		22. 00
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 01 IME add-on adjustment amount (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sem of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 23. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 01 0. 0000000 29. 00 20. 00 20. 00 20. 00 20. 00 21. 88 21. 88 22. 21 23. 00 23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 01 29.	22. 01		n 122 of t	ho MMA	0		22. 01
Slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 29.01 IME payment (sum of lines 22 and 28) 0 29.00 29.01 Total IME payment - Managed Care (see instructions) 0 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 29.01 Disproportionate Share Adjustment 0 29.01 31.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21.88 31.00 32.00 Sum of lines 30 and 31 28.21 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.49 33.00	23. 00			TIE WIWA	0.00		23. 00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 01 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 25. 00 26. 00 27. 00 28. 01 28. 01 29. 00 29. 01 2		slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
Iine 23 or line 24 (see instructions)			-				24. 00
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 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 Disproportionate Share Adjustment 0 30. 00 30. 00 31. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 21. 88 31. 00 32. 00 Sum of lines 30 and 31 28. 21 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 49 33. 00	25.00		wer or		0.00		25.00
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 28. 00 28. 00 29. 00 29. 00 29. 01	26. 00	1			0. 000000		26. 00
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 28. 01 29. 00 29. 00 29. 01					0. 000000		27. 00
29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 29. 00 29. 00 29. 00 29. 01 29. 00 20. 00		1			0		
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 29. 01 30. 00 29. 01 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 34. lowable disproportionate share percentage (see instructions) 35. 00		,			0		
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 21.88 31.00 32.00 33.00 Allowable disproportionate share percentage (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions)		, , ,			ő		29. 01
(see instructions)21.8831.00 Percentage of Medicaid patient days (see instructions)21.8832.00 Sum of lines 30 and 3128.2133.00 Allowable disproportionate share percentage (see instructions)12.49		Di sproporti onate Share Adjustment					
31.00 Percentage of Medicaid patient days (see instructions) 21.88 31.00 32.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 21.88 31.00 32.00 32.00	30. 00		ient days	1	6. 33		30.00
32.00 Sum of lines 30 and 31 28.21 32.00 Allowable disproportionate share percentage (see instructions) 12.49 33.00	31. 00				21 88		31 00
33.00 Allowable disproportionate share percentage (see instructions) 12.49 33.00							32. 00
34.00 Disproportionate share adjustment (see instructions) 868,741 34.00		Allowable disproportionate share percentage (see instructions)			1		33. 00
	34. 00	וען sproportionate share adjustment (see instructions)		I	868, 741		34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/28/2015 3:3	
		Title XVIII	Hospi tal	PPS	2 p
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)			7, 647, 644, 855	35.00
35. 01	Factor 3 (see instructions)		0. 000228110	0. 000225986	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero,		2, 063, 570	1, 728, 258	35. 02
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		1, 543, 437	435, 616	35. 03
	amount (see instructions)				
36.00	Total uncompensated care (sum of columns 1 and 2 on line		1, 979, 053		36.00
	35. 03)				
	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 through	h 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
	682, 683, 684 an 685. (see instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. 00
40.00	qualify for adjustment)		_		40.0-
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
44.00	682, 683, 684 an 685. (see instructions)		0.00000		
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
45 00	divided by line 41 divided by 7 days)		0.00		45 00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
46. 00	instructions) Total additional navment (line 45 times line 44 times line				46. 00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		٩		46.00
47. 00	Subtotal (see instructions)		31, 750, 021		47. 00
48. 00	Hospital specific payments (to be completed by SCH and		31, 730, 021		48.00
46.00	MDH, small rural hospitals only. (see instructions)		٩		40.00
49. 00	Total payment for inpatient operating costs (see		31, 750, 021		49. 00
47.00	instructions)		31, 730, 021		47.00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		2, 579, 592		50.00
30. 00	and Pt. II, as applicable)		2, 377, 372		30.00
51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
31.00	Pt. III, see instructions)		٩		31.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,				52. 00
32.00	line 49 see instructions).		٩		32.00
53. 00	Nursing and Allied Health Managed Care payment		12, 812		53.00
54.00	Special add-on payments for new technologies		16, 946		54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
	line 69)				
56. 00	Cost of physicians' services in a teaching hospital (see		o		56.00
	intructions)				
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		212, 838		58.00
	Pt. IV, col. 11 line 200)				
59.00	Total (sum of amounts on lines 49 through 58)		34, 572, 209		59. 00
60.00	Primary payer payments		50, 017		60.00
61. 00	Total amount payable for program beneficiaries (line 59		34, 522, 192		61. 00
	minus line 60)				
62. 00	Deductibles billed to program beneficiaries		3, 188, 608		62. 00
63. 00	Coinsurance billed to program beneficiaries		41, 952		63. 00
64. 00	Allowable bad debts (see instructions)		164, 350		64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)		106, 828		65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		77, 306		66. 00
	instructions)				
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		31, 398, 460		67. 00
68. 00	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
70 -	96). (For SCH see instructions)				
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
70.5-	instructions)				7
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70.01	instructions)		_		70 0.
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		0		70. 92
70. 93	HVBP payment adjustment amount (see instructions)		18, 827		70. 93
70 04	HRR adjustment amount (see instructions)		-16, 924		70. 94
70. 94	Recovery of accelerated depreciation		اء		70. 95

ealth Financial Systems COLUMBUS REGIONA ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet E Part A Date/Time Pre 5/28/2015 3:3	epared:
	Title XVIII	Hospi tal	PPS	
		Prior to	On/After	
		October 1	October 1	
2 O/ I am und man add und mant. Earl Endamel. El and und man (man)	0	1.00	2. 00	70.0
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0 0		70. 9
0.97 Low volume adjustment for federal fiscal year (yyyy)				70. 9
(Enter in column 0 the corresponding federal year for the				70.7
period ending on or after 10/1)				
D. 98 Low Volume Payment-3		0		70. 9
D. 99 HAC adjustment amount (see instructions)		0		70. 9
1.00 Amount due provider (line 67 minus lines 68 plus/minus		31, 400, 363		71.0
lines 69 & 70)				1
1.01 Sequestration adjustment (see instructions)		628, 007		71.0
2.00 Interim payments		30, 493, 653		72.0
3.00 Tentative settlement (for contractor use only)		070 700		73.0
4.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		278, 703		74. 0
5.00 Protested amounts (nonallowable cost report items) in		1, 963, 011		75. 0
accordance with CMS Pub. 15-2, chapter 1, §115.2		1, 703, 011		/3.0
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
O.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90. 0
1.00 Capital outlier from Wkst. L, Pt. I, line 2		0		91. 0
2.00 Operating outlier reconciliation adjustment amount (see		0		92. 0
instructions)				72.0
3.00 Capital outlier reconciliation adjustment amount (see		0		93.0
instructions)				
4.00 The rate used to calculate the time value of money (see		0.00		94.0
instructions)				
5.00 Time value of money for operating expenses (see		0		95. 0
instructions)		_		1
6.00 Time value of money for capital related expenses (see		0		96. 0
instructions)		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
00.00 HSP bonus amount (see instructions)		0	C	100. 0
HVBP Adjustment for HSP Bonus Payment				
01.00 HVBP adjustment factor (see instructions)		0	-	101. 0
02.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)	0	0	102. 0
HRR Adjustment for HSP Bonus Payment				
03.00 HRR adjustment factor (see instructions)		0. 0000	0.0000	
04.00 HRR adjustment amount for HSP bonus payment (see instructions	5)	0	0	104.

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Preps/28/2015 3:3:	
				e XVIII	Hospi tal	PPS	
		Original .mcrxAdju Values	usted .mcax Values	HFS Look Up	Overri de Val ue	Revised Value	
		1.00	2.00	3.00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6. 33	0. 00	0.0	0.00	0.00	1. 00
2. 00	Percentage of Medicaid patient days to total days (From line 27)	21. 88	0. 00			21. 88	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	28. 21	0. 00			21. 88	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. 24	0. 00			140. 24	5. 00
6. 00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	12. 49	0. 00			7. 27	6. 00
7. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7. 00
8.00	S-2, Line 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, Li ne 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. 33	0. 00	0.0	0.00	0.00	12. 00
13. 00	- Revised from CMS) 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 III, line 2 - Revised from CMS)	2. 49	0. 00	0.0	0.00	0.00	14. 00
	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)	3, 074	0			3, 074	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	755	0			755	16. 00
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	3	0			3	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	O	0			0	18. 00
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24,	0 3, 099	0			0 3, 099	
20. 00	column 5) Other Medicaid days (Worksheet S-2, line 24,	55	0			55	20. 00
21. 00	Total Medicaid patient days for the DSH	6, 986	0			6, 986	21. 00
22. 00	calculation (sum of lines 15-20) Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	31, 929	0			31, 929	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)	0	0			0	24. 00
25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	O	0			0	25. 00
26. 00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	31, 929	0			31, 929	26. 00
27. 00		21. 88	0. 00			21. 88	27. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provi der CCN: 150112	
		From 01/01/2014

			Ti +I	e XVIII	From 01/01/2014 To 12/31/2014 Hospi tal	Date/Time Pre 5/28/2015 3:3	
		0 : : 1					
		Original .m	crx values	Adjusted	. 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. 49		0.00	True	28. 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. 49		0.00		30.00
31. 00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		12. 49		0.00		31. 00
		Original .mcrx/	Adiusted mcax	HES Look Un	Overri de Value	Revised Value	
		Values	Values	I III o Look op	Override varde	nevi sea varae	
		1, 00	2.00	3.00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
	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		Fal se				Fal se	35. 00
36. 00	ls 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 REGIO	NAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provi der CCN: 150	From 01/01/2014	Date/Time Pre	pared:
				5/28/2015 3: 3	2 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. 27				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. 27				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	7. 27				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	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prep 5/28/2015 3:32	
		Title XVIII	Hospi tal	PPS	
				1. 00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00 Medical and other services (see instructions	s)			41, 216	1.00
2.00 Medical and other services reimbursed under	OPPS (see instructi	ons)		26, 593, 265	2.00

		Title XVIII	Hospi tal	PPS	2 piii
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			41, 216	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		26, 593, 265	2. 00
3.00	PPS payments			22, 196, 519	3.00
4.00	Outlier payment (see instructions)			140, 261	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8. 00 9. 00	Transitional corridor payment (see instructions)	ani 12 lina 200		0	8.00
10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, Cor. 13, 11 ne 200		288, 077 0	9. 00 10. 00
11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			41, 216	11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			71,210	11.00
	Reasonable charges				İ
12.00	Ancillary service charges			115, 204	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			115, 204	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for page 1			0	15.00
16. 00	Amounts that would have been realized from patients liable for	payment for services or	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 (115, 204	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ne 11) (see	73, 988	19.00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 exceeds lin	no 10) (soo	0	20.00
20.00	instructions)	TI TITLE TI EXCEEDS TIT	16 10) (366	J	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		41, 216	21.00
22. 00	Interns and residents (see instructions)	,		0	22.00
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)	ŕ		22, 624, 857	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			4, 723, 040	25.00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			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} (for	17, 943, 033	27. 00
20.00	CAH, see instructions)	2 50)			20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	9 50)		0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)			17, 943, 033	
31. 00	Primary payer payments			10, 925	
32. 00	Subtotal (line 30 minus line 31)			17, 932, 108	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)		,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			356, 937	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			232, 009	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		273, 152	
37. 00	Subtotal (see instructions)			18, 164, 117	
	MSP-LCC reconciliation amount from PS&R			0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruct	(i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			18, 164, 117	40.00
40. 01	Sequestration adjustment (see instructions)			363, 282	40. 01
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			17, 317, 084 0	41. 00 42. 00
43.00	Balance due provider/program (see instructions)			483, 751	
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15_2 (chanter 1	406, 000	
44.00	§115. 2	e with cms rub. 13-2, t	лартег т,	400, 000	44.00
	TO BE COMPLETED BY CONTRACTOR				ĺ
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			Ō	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions)			0	93.00
94.00				0	94.00
				Overri des	
				1. 00	
440.5	WORKSHEET OVERRIDE VALUES				146
112.00	Override of Ancillary service charges (line 12)			J 0	112. 00

Health Financial Systems COLUMNALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150112 | Period: | Worksheet E-1 | Part | Part | |

					5/28/2015 3: 3	2 pm
			e XVIII	Hospi tal	PPS	
		·	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		30, 493, 653		17, 317, 084	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 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
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		0			3. 50
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		30, 493, 653		17, 317, 084	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program		1			
5. 50 5. 51	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 51			0		0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
3. 77	5. 50-5. 98)					3. 77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		278, 703		483, 751	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		30, 772, 356		17, 800, 835	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00					'	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	Total interim payments paid to provider		3, 189, 540		0	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3.04			C		0	3. 04
3. 05	Durani dana da Duranana		C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		C	1	0	3. 50
3. 50	ADJUSTIMENTS TO FROGRAM		0			3. 51
3. 52			O			3. 52
3. 53			Ö		l o	3. 53
3. 54			Ö		l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 189, 540)	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			C		0	5. 02
5.03			C		0	5. 03
	Provi der to Program			ı		
5.50	TENTATI VE TO PROGRAM		O		0	5. 50 5. 51
5. 51 5. 52			0			5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
5. 77	5. 50-5. 98)				o o	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		5, 985		0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 183, 555		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	()	1.00	2.00	8. 00
5. 50	name s. santi dotoi			1	1	0.00

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Heal th Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of For						
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150112 Period: Worksheet E-						
				To 12/31/2014		oared:
					5/28/2015 3: 3:	
		Title XV	Ш	Hospi tal	PPS	
					1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COS						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND						
1.00 Total hospital discharges as defined in AARA §4102		Pt. I col.	15 line	14	8, 416	1. 00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of					12, 734	2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. I					2, 593	3. 00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of					28, 581	4. 00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8					496, 019, 883	5. 00
6.00 Total hospital charity care charges from Wkst. S-1					45, 859, 459	6. 00
7.00 CAH only - The reasonable cost incurred for the pu	rchase of certifie	ed HIT tecl	nnol ogy	Wkst. S-2, Pt. I	0	7. 00
8.00 Calculation of the HIT incentive payment (see inst	ructions)				1, 530, 461	8. 00
9.00 Sequestration adjustment amount (see instructions)	ŕ				30, 609	9. 00
10.00 Calculation of the HIT incentive payment after seq	uestration (see in	nstructi on:	s)		1, 499, 852	10.00
I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH	,					
30.00 Initial/interim HIT payment adjustment (see instru	ctions)				1, 594, 212	30.00
31.00 Other Adjustment (specify)	,				0	31. 00
32.00 Balance due provider (line 8 (or line 10) minus li	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) -94,360					
					Overri des	
					1. 00	
CONTRACTOR OVERRIDES						
108.00 Override of HIT payment					0	108. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150112	Peri od: From 01/01/2014	Worksheet E-3
	Component CCN: 15T112		
	Title XVIII	Subprovi der -	PPS
		LRF	

			I RF		
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1.00	Net Federal PPS Payment (see instructions)			2, 804, 040	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0249	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			85, 804	3. 00
4.00	Outlier Payments			396, 798	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost	reporting period end	ling on or prior	0.00	5. 00
5.00	to November 15, 2004 (see instructions)	reporting perrod end	ing on or prior	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for	or residents that were	displaced by	0.00	5. 01
0.0.	program or hospital closure, that would not be counted without a		'	0.00	0.0.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)				
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 pe	eriod of a "new	0. 00	7. 00
	teaching program" (see instructions)	р9 9 р.			
8.00	Current year's unweighted I&R FTE count for residents within the	new program growth pe	eriod of a "new	0. 00	8. 00
	teaching program" (see instructions)	1 13 1 3 1 1			
9.00	Intern and resident count for IRF PPS medical education adjustmen	nt (see instructions)		0. 00	9. 00
10.00	Average Daily Census (see instructions)	,		9. 589041	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)			3, 286, 642	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction))		0	14. 00
	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instruc-	tions)		0	16. 00
17. 00	Subtotal (see instructions)	,		3, 286, 642	
	Primary payer payments			10, 611	
19. 00	Subtotal (line 17 less line 18).			3, 276, 031	
20. 00	Deducti bl es			32, 832	
	Subtotal (line 19 minus line 20)			3, 243, 199	
22. 00	Coinsurance			4, 256	
	Subtotal (line 21 minus line 22)			3, 238, 943	
	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		1, 216	
	Adjusted reimbursable bad debts (see instructions)	, (,		790	
	Allowable bad debts for dual eligible beneficiaries (see instruc-	tions)		1, 216	
	Subtotal (sum of lines 23 and 25)	11 0113)		3, 239, 733	
	Direct graduate medical education payments (from Wkst. E-4, line	49)		0	
	Other pass through costs (see instructions)	,		8, 793	
	Outlier payments reconciliation			0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31. 50				0	
31. 99	Recovery of Accelerated Depreciation			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			3, 248, 526	-
	Sequestration adjustment (see instructions)			64, 971	
33. 00	Interim payments			3, 189, 540	
34. 00	Tentative settlement (for contractor use only)			0, 107, 010	34.00
35. 00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	1		-5, 985	
36. 00	Protested amounts (nonallowable cost report items) in accordance		hanter 1	23, 706	
00.00	§115. 2	WI TIT OMO T GD. 10 2, C	mapter 1,	20, 700	00.00
	TO BE COMPLETED BY CONTRACTOR				
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			396, 798	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)			0,70,770	51.00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
50.00	1		ļ	٥١	30.00

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

Provider CCN: 150112 Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			'	0 12/31/2014	5/28/2015 3:3	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	lauppeur, Accesso	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	2/ 150 727		0	0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	26, 159, 737 0	1		0	1. 00 2. 00
3.00	Notes receivable				0	3.00
4. 00	Accounts receivable	54, 058, 136			0	4. 00
5. 00	Other receivable	28, 381, 035		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-25, 818, 318	0	0	0	6. 00
7.00	Inventory	3, 102, 713	0	0	0	7. 00
8.00	Prepai d expenses	3, 911, 525	l .	0	0	8. 00
9.00	Other current assets	1, 800, 456	l .	0	0	9. 00
10.00	Due from other funds	04 505 004	1 ~		0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	91, 595, 284	0	0	0	11. 00
12. 00	Land	1, 786, 052	0	0	0	12. 00
13. 00	Land improvements	17, 419, 747	1		0	13. 00
14. 00	Accumulated depreciation	-10, 687, 316	1		0	14. 00
15. 00	Bui I di ngs	184, 503, 106	1	0	0	15. 00
16.00	Accumulated depreciation	-108, 936, 125	1	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0		0	18. 00
19. 00	Fi xed equipment	7, 932, 198			0	19. 00
20.00	Accumulated depreciation	-4, 700, 708	1		0	20.00
21. 00	Automobiles and trucks	1, 641, 079	l .		0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	-1, 308, 801 122, 777, 433	l .	_	0	22. 00 23. 00
24. 00	Accumul ated depreciation	-90, 619, 595	l .	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	70,017,379		0	0	25. 00
26. 00	Accumulated depreciation	0	Ö	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	119, 807, 070	0	0	0	30. 00
24 00	OTHER ASSETS	14 701 407			0	21 00
31. 00 32. 00	Investments Deposits on Leases	14, 701, 406	1		0	31. 00 32. 00
33. 00	Due from owners/officers			0	0	33.00
34. 00	Other assets	173, 380, 608	Ö	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	188, 082, 014	1		0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	399, 484, 368	1		0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	11, 069, 121		0	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 015, 298	1	0	0	38. 00
39. 00	Payroll taxes payable	911, 688	1	0	0	39. 00
40.00	Notes and Loans payable (short term)	5, 070, 000		0	0	40.00
41. 00 42. 00	Deferred income Accel erated payments	0	0	U	0	41. 00 42. 00
43. 00	Due to other funds	0	o	0	0	
44. 00	Other current liabilities	10, 298, 072	1		0	
45.00	Total current liabilities (sum of lines 37 thru 44)	35, 364, 179		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	73, 228, 673	0		0	
47. 00	Notes payable	0	0		0	
48. 00	Unsecured Loans	0	· ·		0	48. 00
49.00	Other long term liabilities	8, 000, 030 81, 228, 703	l .		0	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49 Total liabilites (sum of lines 45 and 50)	116, 592, 882	l .		0	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	110, 392, 662	.	U U	0	31.00
52. 00	General fund balance	282, 891, 486				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	282, 891, 486	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	399, 484, 368	l .	0	0	
	59)					
				•		

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150112 Peri od: Worksheet G-1 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 3:32 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period 1.00 255, 696, 652 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 27, 194, 834 2.00 Total (sum of line 1 and line 2) 282, 891, 486 3.00 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 0 0 0 0 0 0 5.00 0 5.00 6.00 6.00 7.00 0 0 0 0 7.00 8.00 0 8.00 9.00 9. 00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 282, 891, 486 11.00 11.00 Deductions (debit adjustments) (specify) 12.00 0 0 0 0 0 12.00 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 282, 891, 486 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

		6. 00	7. 00	8. 00		
1.00	Fund balances at beginning of period	0		0	·	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2. 00
3.00	Total (sum of line 1 and line 2)	0		0		3. 00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5. 00
6.00			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			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	0		0		19.00

sheet (line 11 minus line 18)

Health Financial Systems C STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150112 Cost Center Description

	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
	Hospi tal	49, 477, 843		49, 477, 843	1. 00
	SUBPROVI DER - I PF	0		0	2. 00
	SUBPROVI DER - I RF	5, 175, 723		5, 175, 723	3. 00
	SUBPROVI DER	0		0	4. 00
5. 00	Swing bed - SNF	0		0	5. 00
6. 00	Swing bed - NF	0		0	6. 00
7. 00	SKILLED NURSING FACILITY	0		0	7. 00
	NURSING FACILITY				8. 00
	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	54, 653, 566		54, 653, 566	10. 00
	Intensive Care Type Inpatient Hospital Services				
	INTENSIVE CARE UNIT	9, 035, 896		9, 035, 896	
	CORONARY CARE UNIT	0		0	12.00
	BURN INTENSIVE CARE UNIT	0		0	13.00
	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
	OTHER SPECIAL CARE (SPECIFY)	0.005.007		0.005.007	15.00
	Total intensive care type inpatient hospital services (sum of lines	9, 035, 896		9, 035, 896	16. 00
	11-15)	(2 (00 4(2		(2 (00 4(2	17. 00
	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	63, 689, 462 128, 480, 763	241, 366, 552	63, 689, 462 369, 847, 315	
	Outpatient services	11, 905, 077	41, 742, 847	53, 647, 924	
	RURAL HEALTH CLINIC	11, 903, 077	41, 742, 047	03, 047, 924	20.00
	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
	HOME HEALTH AGENCY	١	0	0	22.00
	AMBULANCE SERVICES	0	7, 878, 478	7, 878, 478	
	CMHC		7, 070, 470	7, 070, 470	24.00
	CORF	0	0	0	24. 10
	AMBULATORY SURGICAL CENTER (D. P.)		Ĭ.	o .	25. 00
	HOSPI CE				26. 00
	LEVEL 11 NURSERY	2, 378, 457	0	2, 378, 457	
	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	206, 453, 759	290, 987, 877	497, 441, 636	
	G-3, line 1)			,,	
	PART II - OPERATING EXPENSES				
	Operating expenses (per Wkst. A, column 3, line 200)		221, 764, 602		29. 00
30. 00	ADD (SPECIFY)	0			30. 00
31. 00	PROVISION FOR BAD DEBT	12, 455, 438			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)		12, 455, 438		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41. 00		0			41. 00
	Total deductions (sum of lines 37-41)		0		42. 00
	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		234, 220, 040		43. 00
	to Wkst. G-3, line 4)	I I	I		

Heal	h Financial Systems COLUMBUS REGIONAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	EMENT OF REVENUES AND EXPENSES	Provi der CCN: 150112	Peri od:	Worksheet G-3	
			From 01/01/2014		
			To 12/31/2014		
				5/28/2015 3: 3	2 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		497, 441, 636	1. 00
2. 00	Less contractual allowances and discounts on patients' accounts			243, 149, 832	
3.00	Net patient revenues (line 1 minus line 2)	5		254, 291, 804	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 4)	3)		234, 220, 040	
5. 00	Net income from service to patients (line 3 minus line 4)	,		20, 071, 764	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			408, 582	6. 00
7.00	Income from investments			5, 264, 154	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		37, 508	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. C	Purchase di scounts			135, 152	10.00
11. 0	Rebates and refunds of expenses			1, 081	11. 00
12.0	Parking lot receipts			95	12.00
13.0	Revenue from Laundry and Linen service			0	13.00
14.0	Revenue from meals sold to employees and guests			981, 399	14. 00
15. C	Revenue from rental of living quarters			0	15. 00
16.0	Revenue from sale of medical and surgical supplies to other that	an patients		54, 875	16. 00
17. C				0	
18. 0				20, 391	
19. 0				21, 109	
20.0				3, 395	
21. 0	, i i i i i i i i i i i i i i i i i i i			142	
22. 0				90, 051	22. 00
23.0				350, 000	
24.0				-199, 061	
24. 0				271, 175	
24.0				43, 418	
24. 0				1, 781, 013	
24. 0				1, 610, 909	
24. 0				2, 369, 801	
24. 0				257, 151	
25. 0	,			13, 502, 340	•
26.0				33, 574, 104	
27. 0				46, 489	
27.0				6, 332, 781	
28. 0) Total other expenses (sum of line 27 and subscripts)			6. 379. 270	1 28.00

33, 574, 104 26, 00 46, 489 27, 00 6, 332, 781 27, 01 6, 379, 270 28, 00 27, 194, 834 29, 00

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

CALOU	Financial Systems COLUMBUS REGIO			u of Form CMS-2	2552-10
CALCU	LATION OF CAPITAL PAYMENT	Provi der CCN: 150112	Peri od: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/28/2015 3:3	
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 224, 039	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			224, 780	2. 0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 0
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructi ons)	78. 30	3. 0
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)	the cum of lines 1 and 1 01	`	0.00	5. 00 6. 00
6. 00 7. 00	Indirect medical education adjustment (multiply line 5 by the Percentage of SSI recipient patient days to Medicare Part A			6. 33	7.0
7.00	30) (see instructions)	Patrent days (worksheet L	, part A Title	0. 33	7.00
8. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		21. 88	8. 00
9. 00	Sum of lines 7 and 8	•		28. 21	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ons)		5. 88	10.00
11. 00	, , , , , , , , , , , , , , , , , , ,			130, 773	
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2	2, 2.01, 6 and 11)		2, 579, 592	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)	1		0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4. 00 5. 00	Capital cost payment factor (see instructions)			0	4. 00 5. 00
3.00	Total inpatient program capital cost (line 3 x line 4)			U	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	2. 0
	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0. 00	3. 00 4. 00
				0.00	5. 00
4. 00	ICanital cost for comparison to payments (line 3 v line 1)				J. 0
4. 00 5. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6.00
4. 00 5. 00 6. 00	Percentage adjustment for extraordinary circumstances (see		line 6)	0.00	
4. 00 5. 00 6. 00 7. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina		line 6)	0. 00 0 0	7. 00
4. 00 5. 00 6. 00 7. 00 8. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	ary circumstances (line 2 x	line 6)	0	7. 00 8. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 x olicable)	ŕ	0 0	7. 00 8. 00 9. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	ary circumstances (line 2 x blicable) b capital payments (line 8	less line 9)	0 0 0	7. 00 8. 00 9. 00 10. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	ary circumstances (line 2 x blicable) b capital payments (line 8 capital payment (from pri	less line 9) or year	0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	ary circumstances (line 2 x olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus lin	less line 9) or year e 11)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	ary circumstances (line 2 x olicable) o capital payments (line 8 o capital payment (from pri payments (line 10 plus line ter the amount on this line	less line 9) or year e 11)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app. Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	ary circumstances (line 2 x olicable) o capital payments (line 8 o capital payment (from pri payments (line 10 plus line ter the amount on this line	less line 9) or year e 11)	0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app. Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus line ter the amount on this line capital payment for the f	less line 9) or year e 11)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see i	olicable) o capital payments (line 8 capital payment (from pri payments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00