	required by law (42 USC 139					\
payments made	since the beginning of the co	ost reporting period being	g deemed overpayments	s (42 USC 1395g).	OMB NO. 0938-00 EXPIRES 05-31-2	
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 15-011	From 01/01/2017	Worksheet S Parts I-III Date/Time Prepa 10/29/2019 2:12	
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 10/29/2	019 Time: 2:1	12 pm
use only	2. [] Manually submitted c	ost report				
	3. [1] If this is an amende 4. [F] Medicare Utilization	d report enter the number . Enter "F" for full or "l	of times the provide _" for low.	er resubmitted this o	cost report	
Contractor use only	5. [5]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened	7. Contractor No.	or this Provider CCN		or Code: olumn 1 is 4: Ent nes reopened = 0-	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (15-0112) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)
Officer or Administrator of Provider(s)
Ti tl e
Title
Date

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	212, 287	193, 248	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	99, 709	0		0	3.00
4.00	SUBPROVI DER I						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	311, 996	193, 248	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

COLUMBUS REGIONAL HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 10/29/2019 2:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2400 EAST 17TH STREET 1.00 1.00 PO Box: City: COLUMBUS State: IN Zi p Code: 47201-County: BARTHOLOMEW 2.00 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Number Number Certi fi ed Type V 1.00 2.00 3.00 4.00 5.00 6. 00 | 7. 00 | 8. 00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COLUMBUS REGIONAL 150112 18020 1 07/01/1966 N Р 0 3.00 HOSPI TAL 4.00 Subprovi der - IPF 4.00 5.00 Subprovi der - IRF COLUMBUS REGIONAL REHAB 15T112 18020 01/01/1984 Ρ Ν 5.00 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital - Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17.10

	nospi tai -basea (com) i									17.10
18. 00	Renal Dialysis							1 1		18.00
19.00	Other							1 1		19.00
						From:		To:		
						1. 00		2. 00)	1
20. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	17	12/31/2		20.00
	Type of Control (see instructions)					8				21.00
21.00	Type or control (see that detrons)					J				21.00
					1. 00	2. 00		3.00)	
	Inpatient PPS Information				1.00	2.00		0.00	<u>, </u>	
22 00	Does this facility qualify and is it	currently receiving pa	vments for	-	Υ	N				22. 00
22.00	di sproporti onate share hospi tal adju				,					22.00
	§412.106? In column 1, enter "Y" for			`						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" for		cridilicire							
22. 01	1 ' '		ts for thi	e	Υ	Υ	ŀ			22. 01
22.01	cost reporting period? Enter in colu					•				22.01
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft			.031						
22 02	Is this a newly merged hospital that				N	N	ŀ			22. 02
22. 02	payments to be determined at cost re				14	IV				22.02
	Enter in column 1, "Y" for yes or "N			13)						
	cost reporting period prior to Octob			V06						
	or "N" for no, for the portion of the									
	October 1.	le cost reporting perrou	on or arr	.61						
22 02	Did this hospital receive a geograph	ic roclassification from	m urban to	,	N	N	ŀ	N		22. 03
22. 03	rural as a result of the OMB standar				IN	IN		IN		22.03
	adopted by CMS in FY2015? Enter in a									
	for the portion of the cost reportir									
	in column 2, "Y" for yes or "N" for			=1						
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	2. 105)? Enter in column	3, Y 10	or.						
00.00	yes or "N" for no.	Part I I am a litera 04		_	0		ŀ			00.00
23.00	Which method is used to determine Me				3	N				23. 00
	below? In column 1, enter 1 if date									
	if date of discharge. Is the method			COST						
	reporting period different from the									
	reporting period? In column 2, ente	er "Y" for yes or "N" fo	r no.							

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 10/29/2019 2:12 pm In-State In-State Out-of Out-of Medi cai d 0ther 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 pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 524 6,533 98 24.00 676 12 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 67 399 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47 00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1

is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Ν

58.00

59.00

	Financial Systems COLUMBUS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider C	F	In Lie	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 10/29/2019 2:	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2. 00	3.00	_
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? If line 60 is yes, complete columns 2 and 3 for each	(see ins	tructions)	Y	23. 01	1	60. 00 60. 01
60. 02	instructions) If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 02	1	60. 02
	i nati deti ona)	Y/N	I ME	Direct GME	I ME	Direct 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) Enter the average number of unweighted primary care	N			0.00		61.00
61. 01	FITES from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
51. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Prog	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4.00	(4.40
	Of the FTEs in line 61.05, specify each new program 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. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
	Of the FTEs in line 61.05, specify each expanded 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. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20

	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)		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	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	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		

Health Financial Systems	COLUMBU	S REGIONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION D	ATA Provi der (eriod: rom 01/01/2017 o 12/31/2017	Worksheet S-2 Part I Date/Time Pre 10/29/2019 2:	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	12 piii
Cooting FEOA of the ACA Dane Versus	- FTF D: : N		1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju			inis base year	'is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numbers ident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facili per of unweighted no cations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00		64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1 00	2.00	Si te	4.00	5.00	-
65.00 Enter in column 1, if line 63	1. 00	2. 00	3.00	4.00	5. 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)			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
Soction EEOA of the ACA Comment	/oor ETE Doo! dont- !	n Nonnrovi dan Catti	1.00	2.00	3. 00	
Section 5504 of the ACA Current Neginning on or after July 1, 201		n Nonprovider Settir	igsEffective i	or cost report	ing periods	
66.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Pry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
(column 1 divided by (column 1 +	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program 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)			0.00	0.00	O. 00000C	67.00

			From 01/01, To 12/31,		Part I Date/Ti 10/29/2		
				1.00	2. 00	3. 00	
70. 00 I	npatient Psychiatric Facility PPS s this facility an Inpatient Psychiatric Facility (IPF), or do	es it contain an IPF s	ubprovi der?	N			70.00
71.00 I r 4 p	Enter "Y" for yes or "N" for no. fline 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 12 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began of (see instructions)	"Y" for yes or "N" fo residents in a new te "Y" for yes or "N" fo	r no. (see achi ng r no.	N		0	71.00
Ī	npatient Rehabilitation Facility PPS s this facility an Inpatient Rehabilitation Facility (IRF), or	does it contain an IR	F	Y			75.00
76. 00 I	subprovider? Enter "Y" for yes and "N" for no. f line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co ndicate which program year began during this cost reporting pe	GME teaching program i 004? Enter "Y" for yes ng program in accordan lumn 3: If column 2 is	n the most or "N" for ce with 42 Y,	N		0	76. 00
					1. (00	
80. 00 I 81. 00 I	1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period "Y" for yes and "N" for no.						80. 00 81. 00
85. 00 I 86. 00 D							85. 00 86. 00
87. 00 I	s this hospital an extended neoplastic disease care hospital class(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	lassified under sectio	n		N		87.00
			V 1. 00		XI 2. 0		
90.00	Fitle V and XIX Services Ooes this facility have title V and/or XIX inpatient hospital s	ervices? Enter "Y" for	N		Y		90.00
91. 00 Ĭ	/es or "N" for no in the applicable column. s 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 applica		N		N		91.00
92.00 A	Are title XIX NF patients occupying title XVIII SNF beds (dual nstructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see			N		92.00
93. 00 D	Does this facility operate an ICF/IID facility for purposes of Y" for yes or "N" for no in the applicable column.	title V and XIX? Enter	N		N		93.00
a	Ooes title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.		N		N		94.00
96.00 D	f line 94 is "Y", enter the reduction percentage in the applic Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N	'	O. 0 N		95. 00 96. 00
97. 00 I 98. 00 D	appricable column. I line 96 is "Y", enter the reduction percentage in the applic Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 Y)	0. (Y		97. 00 98. 00
98. 01 D	Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title				Υ		98. 01
98. 02 D	ritle XIX. Does title V or XIX follow Medicare (title XVIII) for the calcu Ded costs on Wkst. D–1, Pt. IV, line 89? Enter "Y" for yes or " For title V, and in column 2 for title XIX.		Y		Υ		98. 02
98. 03 D	Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes c for title V, and in column 2 for title XIX.				N		98. 03
98. 04 D	on the V, and in column 2 for title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co n column 2 for title XIX.		d N		N		98. 04
98. 05 D	Oces title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colucolumn 2 for title XIX.				Υ		98. 05
98. 06 D	Ordining 2 for title XIX. Obes title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers		Y		Y		98. 06
105. 00 D 106. 00 I	Does this hospital qualify as a CAH? f this facility qualifies as a CAH, has it elected the all-inc	lusive method of payme	nt N				105. 00 106. 00
107. 00 l t	For outpatient services? (see instructions) f this facility qualifies as a CAH, is it eligible for cost recraining programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimbursed. If yes complete Wkst. D-2, Pt. II.	(see instructions) If					107. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		eriod: com 01/01/	2017 2017	Workshe Part I Date/Ti	et S-2 me Pre	epared:
		·	V				
108.00 s this a rural hospital qualifying for an exception to the	e CRNA fee sche	edul e? See 42	1. 00 N		D17 Date/Time Prepar 10/29/2019 2: 12 XIX 2.00 108	108.00	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							1
	Physi cal 1.00	0ccupati onal 2.00	Speecl 3. 00				1
109.00 olf this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N				109.00
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	,			110.00
			1.00		2. (00	1
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled and that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.	N				111.00
				1. 00	2.00	3. 00	1
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of 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 provided Pub. 15-1, chapter 22, \$2208.1.	2. If column 2 ent for long te	is "E", enter erm care (inclu	in column des	N		0	115. 00
116.00 s this facility classified as a referral center? Enter "Y' 117.00 s this facility legally-required to carry malpractice insu			"N" for				116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence polarim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	if the policy	is	1			118. 00
		Premi ums	Losses	6	Insur	ance	
		1. 00	2. 00		3. (
118.01 List amounts of malpractice premiums and paid losses:		819, 040		0			118. 01
			1.00		2. (00	
118. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N				118. 02
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	in column 1, "Y qualifies for t	" for yes or he Outpatient	N		N		120.00
121.00 Did this facility incur and report costs for high cost impl	lantable device	es charged to	Υ				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information	1 is "Y", ente		N				122. 00
125.00 Does this facility operate a transplant center? Enter "Y" 1	for yes and "N"	for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e		fication date					126. 00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en	nter the certif	cation date					127. 00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column	nter the certif	ication date					128. 00
129.00 f this is a Medicarre certified lung transplant center, enterpolicy column 1 and termination date, if applicable, in column 2.		cation date in					129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co		ti fi cati on					130.00
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in co	er, enter the d	erti fi cati on					131. 00
		~	1	İ			132.00
132.00 If this is a Medicare certified islet transplant center, er in column 1 and termination date, if applicable, in column 133.00 If this is a Medicare certified other transplant center, er	2.						133. 00

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	NAL HOSPITAL Provider CCN	: 15-0112	Peri od:	worksheet S-	
		. 10 0112	From 01/01/2017 To 12/31/2017	Part I	epared:
				1072772017	12 0111
			1. 00	2. 00	
34.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2. All Providers	he OPO number i	n column 1			134. 0
40.00 Are there any related organization or home office costs as o	defined in CMS	Pub 15-1	Υ		140.0
chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.	yes, and home	office cost			
1.00 2.00			3. 00		
If this facility is part of a chain organization, enter on loffice and enter the home office contractor name and contract		gh 143 the	name and address	s of the home	
41. 00 Name: Contractor's Name:	ctor number.	Contract	tor's Number:		141. (
42.00 Street: P0 Box:					142. (
43. 00 Ci ty: State:		Zi p Code	e:		143. (
				1.00	4
44.00 Are provider based physicians' costs included in Worksheet A	Λ2			1. 00 Y	144. C
14. OUNT & provider based physicians costs included in worksheet A	n:			· ·	144.0
			1.00	2. 00	
45.00 If costs for renal services are claimed on Wkst. A, line 74,			Y		145.0
inpatient services only? Enter "Y" for yes or "N" for no in					
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	for this cost	reporting			
46.00 Has the cost allocation methodology changed from the previou	usly filed cost	report?	N		146.0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1					1 10.
yes, enter the approval date (mm/dd/yyyy) in column 2.	, , , , , , , , , , , , , , , , , , , ,				
					_
47.00 Was there a change in the statistical basis? Enter "Y" for y	vos or "N" for	20		1. 00 N	147. (
48.00Was there a change in the statistical basis? Enter if for §				N N	148. (
49.00 Was there a change to the simplified cost finding method? Er			or no.	N	149. (
	Part A	Part B	Ti tle V	Title XIX	
	1. 00	2. 00	3. 00	4. 00	
Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each component					
55. 00 Hospi tal	N N	N N	N (366 42 CIK 94	N N	155. (
56. 00 Subprovi der - IPF	N	N	N	N	156. (
57.00 Subprovi der - IRF	N	N	N	N	157. (
58. 00 SUBPROVI DER					158. (
59. 00 SNF	N	N	N	N	159. 0
60. OO HOME HEALTH AGENCY 61. OO CMHC	N	N N	N N	N N	160. 0
61. 10 CORF		N	N N	N N	161.
01. Toponti		14	IV.	10	101.
				1.00	
Mul ti campus			Control OPCA O	T N	⊣ ₄,,,
65.00 Is this hospital part of a Multicampus hospital that has one	e or more campu	ses in diff	erent CBSAs?	N	165. C
	e or more campu County		Ferent CBSAs?	N FTE/Campus	165. (
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no.	<u> </u>				165.0
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County	State Zi	p Code CBSA	FTE/Campus 5.00	
65.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name	County	State Zi	p Code CBSA	FTE/Campus 5.00	
55.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name	County	State Zi	p Code CBSA	FTE/Campus 5.00	
65.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County	State Zi	p Code CBSA	FTE/Campus 5.00	
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name O	County	State Zi	p Code CBSA	FTE/Campus 5.00	
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name O	County	State Zi	p Code CBSA	FTE/Campus 5.00 0.0	
65.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County 1.00	State Zi 2.00	p Code CBSA 3.00 4.00	FTE/Campus 5.00	
65.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County 1.00 an Recovery and	State Zi 2.00	p Code CBSA 3.00 4.00	FTE/Campus 5.00 0.0	00166.0
65.00 s this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County 1.00 an Recovery and Y" for yes or "	Rei nvestme	p Code CBSA 3.00 4.00	FTE/Campus 5.00 0.0	167.0
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County 1.00 an Recovery and Y" for yes or " gful user (line	Rei nvestme	p Code CBSA 3.00 4.00	FTE/Campus 5.00 0.0	165. C
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name 0	County 1.00 an Recovery and Y" for yes or "I gful user (line ns) s this provider	Reinvestme N" for no. 167 is "Y" qualify for	p Code CBSA 3.00 4.00 ent Act), enter the or a hardship	FTE/Campus 5.00 0.0	00 166. C
65.00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no. Name	an Recovery and Y" for yes or " gful user (line ns) s this provider for no. (see i	Reinvestme N" for no. 167 is "Y" qualify for	p Code CBSA 3.00 4.00 ent Act), enter the or a hardship s)	FTE/Campus 5.00 0.0	167. C

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Peri od: From 01/01/2017	Worksheet S-2	
			To 12/31/2017		pared:
				10/29/2019 2:	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			02/01/2017	05/01/2017	170. 00
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider hav			N	0	171. 00
section 1876 Medicare cost plans reported					
"Y" for yes and "N" for no in column 1. If		nter the number of section	on		
1876 Medicare days in column 2. (see instr	ructions)			ł	

	Financial Systems COLUMBUS REGIO		ON. 4E 0410		eu of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2017 To 12/31/2017		
					10/29/2019 2:	
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses. Ent			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation				1	٠
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
	proporting period. It yes, enter the date of the change in the	301 diiii 2. (300	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home condition or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	rerationships: (see Thati detroils)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports				1	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
. 00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reconstructions are the cost reports to the cost reports and total revenues and total revenues and total revenues and total revenues are the cost reports and total revenues and total revenues are the cost reports and total revenues and total revenues are the cost reports and total revenues and total revenues and total revenues are the cost reports and total revenues and total revenues and total revenues are the cost reports and total revenues and total revenues are the cost reports and total revenues and total revenues are the cost reports and total revenues and total revenues are the cost reports are the cost reports are the cost reports and total revenues are the cost reports are the cost reports are the cost reports and total revenues are the cost reports are the cost reports are the cost reports and the cost reports are the c		Y			5. 00
				Y/N	Legal Oper.	-
	Approved Educational Activities			1. 00	2. 00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is t	he provider i	s N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9.00
0.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& K In an Ap	provea	N		11.00
	Treads in the French in the Fr				Y/N	
					1. 00	
	Bad Debts				1	1.0.0
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12.00
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see in	structions.	N	14.00
5. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see ins		Υ	15.00
			t A		rt B	
		Y/N 1.00	2. 00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
. 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	Υ	04/18/2018	Y	04/18/2018	16.00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/18/2018	Y	04/18/2018	17.00
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.00

Heal th	Financial Systems COLUMBUS REGIO	ONAL HOSPITAL		In Lie	u of Form CM	S-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0112	Period: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time P 10/29/2019	5-2 Prepared:	
		Desc	ription	Y/N	Y/N	1	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	MCD CADE DAD	_0 ΓA DISCH & P1	1. 00 Γ Υ	3. 00 N	20.00	
20.00	Report data for Other? Describe the other adjustments:	DAYS	I A DISCH & PI	T T	IN	20.00	
		Y/N	Date	Y/N	Date		
04.00	In the second se	1.00	2. 00	3. 00	4. 00	24.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			uning the cost	N N	22. 00 23. 00	
23.00	reporting period? If yes, see instructions.	irrig the cost	IN	23.00			
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	eporting period?	N	24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	? If yes, see	N	25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost repor	ting period?	If yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost report	ing period? I	f yes, submit	N	27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credite	N	28. 00				
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)	Y	29. 00			
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	N	30.00				
31. 00	instructions. Has debt been recalled before scheduled maturity without i	es, see	N	31.00			
	instructions. Purchased Services						
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		hed through c	ontractual	N	32.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ing to compet	itive bidding? If		33.00	
	Provi der-Based Physi ci ans						
34. 00	,	arrangement wi	th provider-b	ased physicians?	Υ	34.00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	Υ	35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?			N		36.00	
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	orepared by th	ne home office	9?		37.00	
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en	nd of the home	e office.			38.00	
39. 00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain comp	onents? If ye	es,		39.00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	'If yes, see			40. 00	
			1. 00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CATHERI NE		SIMMONS		41.00	
42. 00	respectively. Enter the employer/company name of the cost report	COLUMBUS REGI	ONAL HOSPITAL	-		42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	812-376-5248		CSI MMONS@CRH. O	RG	43. 00	
	report preparer in columns 1 and 2, respectively.	I		I		II	

Health Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Li	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	REIMBURSEMENT QUE	STI ONNAI RE	Provi der (Peri od:	Worksheet S-2)
					From 01/01/201 To 12/31/201	7 Part 7 Date/Time Pre	nared:
						10/29/2019 2:	
			3	. 00			
Cost Report Preparer Contact	Information						
41.00 Enter the first name, last r	name and the titl	e/position	MANAGER ACCOU	NTI NG			41.00
held by the cost report prep	parer in columns	1, 2, and 3,					
respecti vel y.							
42.00 Enter the employer/company r	name of the cost	report					42.00
preparer.							
43.00 Enter the telephone number a							43.00
report preparer in columns 1	I and 2, respecti	vel y.					

					' '	12/31/2017	10/29/2019 2:	
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number		0.00	Available			
1 00	Tu	1. 00		2.00	3.00	4. 00	5. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		197	71, 905	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	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			197	71, 905	0. 00	0	
7.00	beds) (see instructions)			177	71, 703	0.00	O	7.00
8. 00	INTENSIVE CARE UNIT	31.00		17	6, 205	0. 00	0	8.00
9. 00	CORONARY CARE UNIT	32.00		.,		0. 00	0	
10.00	BURN INTENSIVE CARE UNIT	33.00		Ö	l ĭ	0. 00	0	
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	o o	0. 00	0	
12. 00	OTHER SPECIAL CARE (SPECIFY)			_	_		_	12.00
13. 00	NURSERY	43.00					0	
14. 00	Total (see instructions)			214	78, 110	0. 00	0	
15. 00	CAH visits				,		0	
16.00	SUBPROVIDER - IPF	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	
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			232				27. 00
28. 00	Observation Bed Days						0	
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
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days							33.00
33. U l	LTCH site neutral days and discharges		I		l l			33. 01

Provider CCN: 15-0112

						10/29/2019 2:	12 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11, 848	5, 646	26, 577			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)	3, 337	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	204	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	11, 848	5, 646	26, 577			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 321	470	3, 361			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1, 727	3, 269			13.00
14.00	Total (see instructions)	13, 169	7, 843	33, 207	0.00	1, 292. 00	14.00
15.00	CAH visits	0	0	0			15. 00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	2, 196	466	3, 676	0.00	23. 00	17.00
18.00	SUBPROVI DER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	O	0	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00		
28.00	Observation Bed Days		766	3, 127			28. 00
29.00	Ambul ance Trips	4, 303		·			29. 00
30.00	Employee discount days (see instruction)	.,		0			30.00
31.00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	0	Ō			32.00
32. 01	Total ancillary labor & delivery room	-		Ō			32. 01
	outpatient days (see instructions)]			-
33.00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	o					33. 01
				•	•	•	•

Health Financial SystemsCOLUMBUSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Period: Worksheet S-3 From 01/01/2017 Part I Provider CCN: 15-0112

				F T	rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre	nared:
					12/31/201/	10/29/2019 2:	
		Full Time		Di sch	arges		
		Equi val ents		T =			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1. 00	Hearital Adulta & Dada (columns E / 7 and	11. 00	12. 00	13.00	14. 00 1, 672	15. 00 8, 865	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		(3, 121	1,0/2	8, 800	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			852	0		2.00
3. 00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	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
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00							13.00
14.00	Total (see instructions)	0. 00	C	3, 727	1, 672	8, 865	•
15. 00	1		_	_	_	_	15.00
16. 00	•	0.00	(0	0	
17.00	•	0.00	(40	300	•
18.00		0.00	(7	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20. 00 21. 00	•						20. 00 21. 00
22. 00	1	0.00					22.00
23. 00	•	0.00					23.00
24. 00	` ′						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00							25.00
25. 10	CMHC - CORF	0.00					25. 10
26. 00		0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	,			0			33.00
33. 01	LTCH site neutral days and discharges			0	ı l		33. 01

| Period: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0112

					T	12/31/2017	Date/Time Pre 10/29/2019 2:	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	12 pili
		Number	Reported	ion of Salaries	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2.00	A-6) 3.00	4.00	F 00	4 00	
	PART II - WAGE DATA	1.00	2. 00	3.00	4.00	5. 00	6. 00	
4 00	SALARI ES	202 00	00 010 170	407.540	70 700 047	0.744.040.00	20.20	1
1. 00	Total salaries (see instructions)	200. 00	80, 218, 479	-487, 563	79, 730, 916	2, 714, 048. 00	29. 38	1.00
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
	В							
4. 00	Physician-Part A - Administrative		Ü	0	0	0. 00	0. 00	4.00
4. 01	Physicians - Part A - Teaching		0	0	-	0.00	0.00	
5. 00	Physician and Non Physician-Part B		1, 093, 676	0	1, 093, 676	5, 999. 00	182. 31	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		186, 771	0	186, 771	4, 067. 00	45. 92	6. 00
7. 00	Interns & residents (in an	21. 00	0	О	0	0. 00	0.00	7.00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
7.01	residents (in an approved programs)		O		0	0.00	0.00	7.01
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 4, 858, 539	0 813, 604	0 5, 672, 143	0. 00 230, 643. 00	0. 00 24. 59	
10.00	instructions)		4, 858, 539	813, 604	5, 6/2, 143	230, 643. 00	24. 59	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		13, 151, 674	0	13, 151, 674	256, 975. 00	51 18	11.00
	Care							
12. 00	Contract Labor: Top Level management and other		1, 724, 209	0	1, 724, 209	34, 783. 00	49. 57	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		5, 663, 823	0	5, 663, 823	41, 968. 00	134. 96	13.00
14.00	A - Administrative					0. 00	0.00	14.00
14. 00	Home office and/or related organization salaries and		0	0	U	0.00	0.00	14.00
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0.00	14. 01
14. 01	Related organization salaries		5, 441, 602		_	54, 976. 00		14.01
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15.00
16. 00	Home office and Contract		0	О	0	0. 00	0. 00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							i
17. 00	Wage-related costs (core) (see		23, 794, 215	0	23, 794, 215			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)		O					
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 842, 313 0	0	1, 842, 313			19.00 20.00
	Α		-					
21. 00	Non-physician anesthetist Part B		0	0	0			21.00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	О	0			22. 01
23. 00	Physician Part B		415, 889	0	415, 889			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
	(core)		0					
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							

Period: Worksheet S-3 From 01/01/2017 Part II Provider CCN: 15-0112

18.00

					F	rom 01/01/201/	Part II	
					T	o 12/31/2017	Date/Time Pre	
							10/29/2019 2:	12 pm
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	1, 216, 829	-1, 092, 250	124, 579	3, 343. 00	37. 27	26. 00
27.00	Administrative & General	5. 00	14, 056, 808	532, 402	14, 589, 210	465, 638. 00	31. 33	27. 00
28.00	Administrative & General under		5, 618, 881	0	5, 618, 881	63, 213. 00	88. 89	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6.00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7.00	2, 396, 996	29, 968	2, 426, 964	80, 934. 00	29. 99	30.00
31.00	Laundry & Linen Service	8. 00	24, 885	-2, 388	22, 497	1, 607. 00	14. 00	31.00
32.00	Housekeepi ng	9. 00	1, 666, 203	18, 783	1, 684, 986	112, 289. 00	15. 01	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10.00	1, 997, 300	-1, 364, 577	632, 723	37, 321. 00	16. 95	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 385, 525	1, 385, 525	81, 724. 00	16. 95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	3, 473, 540	71, 375	3, 544, 915	80, 475. 00	44. 05	38. 00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0. 00	39. 00
40.00	Pharmacy	15. 00	3, 629, 873	-172, 991	3, 456, 882	75, 871. 00	45. 56	40.00
41.00	Medical Records & Medical	16. 00	1, 549, 353	-647, 044	902, 309	35, 770. 00	25. 23	41.00
	Records Library							
42.00	Social Service	17. 00	525, 626	8, 126	533, 752	15, 820. 00	33. 74	42.00
42 00	Other Coneral Comitee	10 00	0		1 ^	0.00	0.00	1 12 00

533, 752 0

15, 820. 00 0. 00

33. 74 42. 00 0. 00 43. 00

43.00 Other General Service

HOSPITAL WA	GE INDEX INFORMATION			Provi der Co	CN: 15-0112	Peri od:	Worksheet S-3	
						From 01/01/2017	Part III	
						To 12/31/2017	Date/Time Pre	pared:
							10/29/2019 2:	12 pm
		Worksheet A	Δmount	Reclassificat	Adiusted	Paid Hours	Average	

					''	0 12/31/2017	10/29/2019 2:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	•
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		84, 556, 913	-487, 563	84, 069, 350	2, 767, 195. 00	30. 38	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 858, 539	813, 604	5, 672, 143	230, 643. 00	24. 59	2.00
	instructions)							
3.00	Subtotal salaries (line 1		79, 698, 374	-1, 301, 167	78, 397, 207	2, 536, 552. 00	30. 91	3.00
	minus line 2)							
4.00	Subtotal other wages & related		25, 981, 308	0	25, 981, 308	388, 702. 00	66. 84	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		23, 794, 215	0	23, 794, 215	0. 00	30. 35	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		129, 473, 897	-1, 301, 167	128, 172, 730	2, 925, 254. 00	43. 82	6.00
7.00	Total overhead cost (see		36, 156, 294	-1, 233, 071	34, 923, 223	1, 054, 005. 00	33. 13	7.00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	Peri od:	Worksheet S-3
		From 01/01/2017	
			D-+- /T: D

PART I V - WAGE RELATED COSTS Part A - Core List		To 12/31/201	7 Date/Time Pre 10/29/2019 2:	
PART IV - WAGE RELATED COSTS Part A - Core List				
PART I V - WAGE RELATED COSTS			Reported	
Part A - Core List RETREMENT COST			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST	_	
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 276,708 4.00 201 ified Defined Benefit Plan Cost (see instructions) 276,708 4.00 276,708	1.00	401K Empl oyer Contributions	3, 543, 253	1.00
A . 00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA PI an Administration fees 0 5.00 6.00 Legal/Accounting/Management Fees-Pension PI an 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 8.00 Real th Insurance (Purchased or Self Funded without a Third Party Administrator) 0 8.01 Real th Insurance (Self Funded without a Third Party Administrator) 13,895,633 8.02 Real th Insurance (Self Funded with a Third Party Administrator) 13,895,633 8.02 Real th Insurance (Purchased) 0 8.03 Real th Insurance (Purchased) 0 8.03 Real th Insurance (Purchased) 0 9.00 Real th Insurance (If employee is owner or beneficiary) 0 9.00 Real th Insurance (If employee is owner or beneficiary) 0 14,00 15,00 1	3.00		0	3.00
5.00 401K/TSA Plan Administration fees 0.5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0.6.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0.6.00 6.00 1.00	4.00	Qualified Defined Benefit Plan Cost (see instructions)	276, 708	4. 00
Column C				
The color of the	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
Real th Insurance (Purchased or Self Funded) Real th Insurance (Self Funded without a Third Party Administrator) 0	7.00		0	7.00
Heal th Insurance (Self Funded without a Third Party Administrator) 13,895,633 8.02 Heal th Insurance (Self Funded with a Third Party Administrator) 13,895,633 8.02 Real th Insurance (Purchased) 0 8.03 Real th Insurance (Purchased) 0 9.00 Prescription Drug Plan 0 9.00 Dental, Hearing and Vision Plan 414,083 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 64,201 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance (If employee is owner or beneficiary) 0 14.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 5,678,936 17.00 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 18.00 19.00 Unemployment Insurance 44,593 19.00 19.00 Unemployment Insurance 44,593 19.00 19.00 Unemployment Insurance 44,593 19.00 19.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 65,203 22.00 23.00 Tuition Reimbursement 279,612 23.00 24.00 Part B - Other than Core Related Cost				
Heal th Insurance (Self Funded with a Third Party Administrator) 13,895,633 8.02	8.00			
8.03 Heal th Insurance (Purchased) 0 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 414,083 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 64,201 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 1,144,634 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 645,561 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 17AXES 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 44,593 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 65,203 22.00 23.00 Tuit ion Reimbursement 279,612 23.00 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Cost 44,000 Part B - Other than Core Related Co	8. 01		_	
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 414,083 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 64,201 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 1,144,634 13.00 14.00 Cong-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 645,561 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 5,678,936 17.00 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 44,593 19.00 20.00 State or Federal Unemployment Taxes 0 0 0 0THER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. 65,203 22.00 22.00			13, 895, 633	
10.00 Dental, Hearing and Vision Plan			0	
11.00			_	
12.00	10.00		414, 083	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 13.00 14.00 15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 3.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			64, 201	
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00		-	
15. 00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuit ion Reimbursement 24. 00 Part B - Other than Core Related Cost			1	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES				
Non cumulative portion TAXES To A Employers Portion Only T			645, 561	
TAXES 17.00 FI CA-Employers Portion Only 5,678,936 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 44,593 19.00 20.00	16.00		0	16. 00
17. 00 FI CA-Employers Portion Only 5, 678, 936 17. 00 18. 00 19. 00 1				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 44,593 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 65,203 22.00 23.00 Tuition Reimbursement 279,612 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 26,052,417 24.00 Part B - Other than Core Related Cost		·		
19.00 Unemployment Insurance 44,593 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 65,203 22.00 23.00 Tuit ion Reimbursement 279,612 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 26,052,417 24.00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 65, 203 22.00 23.00 Tuit ion Reimbursement 279, 612 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 26,052,417 24.00 Part B - Other than Core Related Cost				
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21. 00 21. 00 22. 00 22. 00 22. 00 24. 00 25. 00 26, 052, 417 26, 052, 417 27. 00 28. 00 29. 00 20. 00 2				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost Instructions				
22. 00 Day Care Cost and Allowances 65, 203 22. 00 23. 00 Tuition Reimbursement 279, 612 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 26, 052, 417 24. 00 Part B - Other than Core Related Cost 20. 00 24. 00	21. 00		· e 0	21. 00
23. 00 Tuition Reimbursement 279, 612 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 26, 052, 417 Part B - Other than Core Related Cost (24. 00)				
24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 26,052,417				
Part B - Other than Core Related Cost				
	24. 00		26, 052, 417	24.00
25. 00 O HER WAGE RELATED COSTS (SPECIFY) 0 25. 00			1	
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	Peri od:	Worksheet S-3

		From 01/01 To 12/31		Part V Date/Time Pre 10/29/2019 2:	
	Cost Center Description	Contra Labor		Benefit Cost	
		1. 00		2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		1, 674		1.00
2. 00	Hospi tal	13, 15	1, 674	26, 052, 417	2.00
3.00	Subprovi der - I PF		0	0	3.00
4.00	Subprovi der - I RF		0	0	4.00
5. 00	Subprovi der - (0ther)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
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
	Hospi tal -Based HHA		0	0	11.00
12. 00	Separately Certified ASC				12.00
					13.00
	Hospital-Based Health Clinic RHC		0	0	14.00
	Hospital-Based Health Clinic FQHC		0	0	15. 00
	Hospi tal -Based-CMHC				16.00
	Hospi tal -Based-CMHC 10		0	0	16. 10
			0	0	17.00
18. 00	Other		0	0	18. 00

	Financial Systems COLUMBUS REGIONAL HOSE			u of Form CMS-2	
1103111	TAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	vider CCN: 15-0112	Peri od: From 01/01/2017	Worksheet S-1	U
			To 12/31/2017	Date/Time Pre 10/29/2019 2:	
					12 0111
	Uncomponented and indigent care cost computation			1.00	
1. 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 col	ımn 8)	0. 356321	1.00
1.00	Medicaid (see instructions for each line)	cu by Time 202 con	anni O)	0.330321	1.00
2. 00	Net revenue from Medicaid			13, 120, 773	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		cai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d		10, 726, 659	
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)			97, 954, 977 34, 903, 415	6. 00 7. 00
8. 00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus sum of	ines 2 and 5 if	11, 055, 983	
0.00	< zero then enter zero)	io / iii rido odiii or		11,000,700	0.00
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)			
9. 00	Net revenue from stand-alone CHIP			0	
10.00	Stand-alone CHIP charges			0	
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (lin	na 11 minus lina 0	if / zero then	0	11. 00 12. 00
12.00	enter zero)	ie ii iiiiilius iiile 7	TI < Zel O tileli	U	12.00
	Other state or local government indigent care program (see instruc	tions for each li	ne)		
13. 00	Net revenue from state or local indigent care program (Not include	ed on lines 2, 5 o	9)	0	13.00
14. 00	Charges for patients covered under state or local indigent care pr	ogram (Not includ	ed in lines 6 or	0	14.00
15 00	10)				15 00
15. 00 16. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indige	ant care program (ling 15 minus ling	0	15. 00 16. 00
10.00	13; if < zero then enter zero)	ant care program (THE IS III III III STITIE		10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line)	nd state/local in	digent care progra	ams (see	
17. 00	Private grants, donations, or endowment income restricted to fundi	ng charity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hosp			0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	ndigent care progr	ams (sum of lines	11, 055, 983	19. 00
	1	Uni nsure	d Insured	Total (col. 1	
		patients		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for the entire facili	ty 10, 723,	918 0	10, 723, 918	20 00
20.00	(see instructions)	10,720,	710	10,720,710	20.00
	Cost of patients approved for charity care and uninsured discounts	s (see 3,821,	157 0	3, 821, 157	
21. 00					21. 00
21. 00	instructions)	_	_	_	
21. 00 22. 00	Payments received from patients for amounts previously written off	as	0 0	0	
22. 00	Payments received from patients for amounts previously written off charity care				22. 00
22. 00	Payments received from patients for amounts previously written off	3, 821,			22. 00
22. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	3, 821,	157 0		22. 00
22. 00 23. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d	3, 821,	157 0	3, 821, 157	22. 00 23. 00
22. 00 23. 00 24. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i	3, 821, days beyond a Leng	157 0	3, 821, 157	22. 00 23. 00 24. 00
22. 00 23. 00 24. 00 25. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit	3,821, days beyond a lengogram? ndigent care prog	157 0	3, 821, 157 1. 00 N	22. 00 23. 00 24. 00 25. 00
22. 00 23. 00 24. 00 25. 00 26. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instru	3,821, days beyond a lengogram? ndigent care prog	157 0	3, 821, 157 1. 00 N 0 11, 744, 168	22. 00 23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit	days beyond a leng ogram? ndigent care proguctions) see instructions)	157 0	3, 821, 157 1. 00 N	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instru Medicare reimbursable bad debts for the entire hospital complex (s	days beyond a leng ogram? ndigent care proguctions) see instructions)	157 0	3, 821, 157 1. 00 N 0 11, 744, 168 782, 173	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instru Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	days beyond a leng ogram? ndigent care prog uctions) see instructions) instructions)	th of stay limit	3, 821, 157 1. 00 N 0 11, 744, 168 782, 173 1, 203, 342 10, 540, 826 4, 177, 087	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyond a leng ogram? ndigent care proguctions) see instructions) instructions) see (see instructions)	th of stay limit	3, 821, 157 1. 00 N 0 11, 744, 168 782, 173 1, 203, 342 10, 540, 826	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00

	Financial Systems	COLUMBUS REGIONA		ON 45 0440		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0112	Period: From 01/01/2017	Worksheet A	
				-	Γο 12/31/2017	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	10/29/2019 2: Recl assi fi ed	12 pm
	oost denter bescriptron	Sararres	o their	+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3.00	4.00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		19, 081, 837	19, 081, 83	-8, 386, 335	10, 695, 502	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		10, 916, 247	10, 916, 247	
3. 00	00300 OTHER CAP REL COSTS		0	(0	0	
4. 00 5. 00	OO400	1, 216, 829 14, 056, 808	31, 406, 429 40, 448, 741			28, 502, 351 48, 796, 932	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 396, 996	6, 626, 866			6, 665, 428	1
8. 00	00800 LAUNDRY & LINEN SERVICE	24, 885	648, 964				1
9.00	00900 HOUSEKEEPI NG	1, 666, 203	806, 421	2, 472, 62	18, 783	2, 491, 407	
10.00	01000 DI ETARY	1, 997, 300	1, 013, 903	1		950, 582	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	3, 473, 540	669, 630	1	2, 081, 569 74, 718		
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 473, 540	803, 920			1, 098, 187	
15. 00	01500 PHARMACY	3, 629, 873	1, 978, 509				1
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 549, 353	1, 521, 183				
17.00	01700 SOCIAL SERVICE	525, 626	2, 809	1			
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 XRAY EDUCATION	0 145, 823	0 3, 219		0 2 327, 579	0 476, 621	
23. 01	02302 PHARMACY RESIDENCY PROG	205, 721	4, 579				
	INPATIENT ROUTINE SERVICE COST CENTERS		.,, ., .				1
30.00	03000 ADULTS & PEDIATRICS	13, 410, 486	1, 936, 912				1
31.00	03100 INTENSIVE CARE UNIT	2, 142, 144	1, 360, 375	3, 502, 51	-115, 388		•
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0			0	34.00
40.00	04000 SUBPROVI DER - I PF	o	0		0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	1, 259, 727	118, 742	1, 378, 469	209, 794	1, 588, 263	•
42.00	04200 SUBPROVI DER	0	0	(00.00)	0	0	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	661, 451	22, 458 0	1	-4, 176 0 0		1
44.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		1	<u>, </u>	<u> </u>	1 44.00
50.00	05000 OPERATING ROOM	661, 879	26, 005, 914			21, 247, 061	
51.00	05100 RECOVERY ROOM	148	980, 339	1			
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0	0 227, 291	1	0 1 76, 004	0 303, 295	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 767, 323	492, 287			2, 170, 074	1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	370, 878	1, 401, 535		-368, 754	1, 403, 659	54. 01
54. 02	05404 ULTRA SOUND	462, 134	278, 053				1
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	739, 447 1, 636, 917	309, 829 223, 640				
57.00	05700 CT SCAN	596, 823	837, 988				
	05800 MRI	284, 632	155, 591				
	05900 CARDI AC CATHETERI ZATI ON	1, 584, 939	4, 070, 862	1		, . ,	1
	06000 LABORATORY	3, 974, 179	3, 766, 896				
60. 01 62. 00	O6001 LABORATORY-PATHOLOGI CAL O6200 WHOLE BLOOD & PACKED RED BLOOD CELL	318, 871	245, 943 600, 236			792, 089 646, 289	
65. 00	06500 RESPIRATORY THERAPY	1, 599, 518	361, 639				1
66.00	06600 PHYSI CAL THERAPY	4, 155, 376	631, 860			4, 143, 062	66.00
67.00	06700 OCCUPATI ONAL THERAPY	489, 466	7, 447				
68.00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	734, 196	346, 208				
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	559, 617 625, 154	398, 455 295, 623			942, 022	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	6, 729, 620		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0		8, 395, 290		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	17, 460, 581			17, 460, 581	1
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	337	568, 091 0	1	0 0	568, 428 0	1
	07697 CARDI AC REHABI LI TATI ON	215, 247	166, 502		-		
	OUTPATIENT SERVICE COST CENTERS		,		.,	331, 131	1
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 947 400	254 907	1	0	1 120 201	89.00
90. 00 90. 01	O9000 CLI NI C O9001 DI ABETES CENTER	867, 490 86, 459	256, 897 123, 790			1, 130, 201 235, 676	
90. 02	09002 NEUROPSYCH	306, 953	8, 736	1			1
90. 03	09003 WOUND CENTER	449, 279	1, 097, 107	1	-85, 136	1, 461, 250	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0		202, 193		
90. 05 90. 06	O9005 VIMCARE CLINIC O9006 MEDICATION MGMT CLINIC	488, 385	80, 209	1			1
90.06	09100 EMERGENCY	248, 642 5, 384, 157	3, 293 1, 524, 083			253, 722 8, 975, 799	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,00.,107	., 32 ., 300	2,733,21	_, 55., 567	=, ,, ,, ,,	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0.070 (0-1	074 065	0.440.55	50.055	0.404.0:5	05 22
95.00	09500 AMBULANCE SERVICES	3, 072, 607	371, 302	3, 443, 90	53, 059	3, 496, 968	<u> 95.00</u>

	COLUMBUS REGION.				u of Form CMS-	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CO		eri od:	Worksheet A	
				rom 01/01/2017 o 12/31/2017	Date/Time Pre	narod:
			'	0 12/31/2017	10/29/2019 2:	12 pm
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		, <u>, , , , , , , , , , , , , , , , , , </u>
			+ col . 2)	ions (See	Trial Balance	
			ŕ	A-6)	(col. 3 +-	
				·	col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
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						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0		111.00
113.00 11300 INTEREST EXPENSE		1, 707, 033		· · ·		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	80, 043, 818	173, 460, 757	253, 504, 575	-2, 132, 613	251, 371, 962	118. 00
NONRE 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	270, 435	· ·	1
194. 01 07951 BUILDING RENTALS	0	185, 232		·	127, 961	1
194. 02 07952 HOSPI CE	0	97, 336	97, 336	0	97, 336	
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	302, 784	· ·	1
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	1, 620, 965	1, 620, 965	1
194. 06 07956 CRH FOUNDATION	13, 254	0	13, 254		13, 254	1
194. 07 07957 HEALTHY COMMUNITIES	161, 407	41, 850	203, 257	·	179, 057	
194. 08 07958 CRHP	0	0	0	19, 900	19, 900	
194. 09 07959 NEUROPSYCH PART B	0	0	0	0		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	80, 218, 479	173, 785, 175	254, 003, 654	0	254, 003, 654	200.00

Provi der CCN: 15-0112

Period: Worksheet A From 01/01/2017 Date/Time Prepared: 10/29/2019 2:12 pm

			10/29/2019 2:1	12 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	/ 00	Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7.00		
1. 00 00100 CAP REL COSTS-BLDG & FLXT	-487, 094	10, 208, 408		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-396, 187	10, 520, 460		2.00
3. 00 00300 OTHER CAP REL COSTS	0	1	•	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-39, 124	· -		4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-17, 030, 501	31, 766, 431		5. 00
7. 00 00700 OPERATION OF PLANT	-98, 995			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	671, 461		8.00
9. 00 00900 HOUSEKEEPI NG	-100	l .		9.00
10. 00 01000 DI ETARY	-135, 948			10.00
11. 00 01100 CAFETERI A	-1, 105, 677	975, 892		11.00
13.00 01300 NURSING ADMINISTRATION	0	4, 217, 888		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 098, 187		14.00
15. 00 01500 PHARMACY	-54, 795	5, 426, 518		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-27, 136			16.00
17. 00 01700 SOCIAL SERVICE	0	537, 721		17. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	1	23. 00
23. 01 02301 XRAY EDUCATION	-20, 480	1	1	23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	0	388, 666		23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	-1, 098, 928	1E 220 E70		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	-1,098,928	1	·	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0	3, 387, 131 0	1	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	1	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0		34.00
40. 00 04000 SUBPROVI DER - PF	0	0		40.00
41. 00 04100 SUBPROVI DER - I RF	o o	1, 588, 263		41.00
42. 00 04200 SUBPROVI DER	0	0	1	42.00
43. 00 04300 NURSERY	0	679, 733		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	-169, 617	21, 077, 444		50.00
51.00 05100 RECOVERY ROOM	0	1, 283, 075		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	52.00
53. 00 05300 ANESTHESI OLOGY	-8, 040	l .		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-45, 153	1		54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0			54. 01
54. 02 05404 ULTRA SOUND	0			54.02
54. 03 05405 MAMMOGRAPHY	-648			54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	-59, 937	2, 523, 165	1	55.00
57. 00 05700 CT SCAN	0	938, 779	1	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	-50, 046	427, 246 2, 271, 055	1	58. 00 59. 00
60. 00 06000 LABORATORY	-9, 758	1	1	60.00
60. 01 06001 LABORATORY - PATHOLOGI CAL	-9, 584	7, 833, 843		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	646, 289	1	62.00
65. 00 06500 RESPIRATORY THERAPY	-3, 865	l .	·	65.00
66. 00 06600 PHYSI CAL THERAPY	-12, 105			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 288, 843		67.00
68. 00 06800 SPEECH PATHOLOGY	-2, 107	879, 988	•	68.00
69. 00 06900 ELECTROCARDI OLOGY	-36, 414	659, 685	•	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	942, 022		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 729, 620		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 395, 290		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 460, 581		73.00
74. 00 07400 RENAL DI ALYSI S	0	568, 428		74.00
76. 00 03020 ACUPUNCTURE	0	0		76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	-3, 268	386, 221		76. 97
OUTPATIENT SERVICE COST CENTERS		_		
88. 00 08800 RURAL HEALTH CLINIC	0			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l		89.00
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES CENTER	-600	1, 130, 201 235, 076		90. 00 90. 01
90. 01 09001 DTABETES CENTER 90. 02 09002 NEUROPSYCH	-600 -186, 771	132, 880		90.01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	-186, 771	1	1	90.02
90. 04 09004 HYPERBARI C OXYGEN THERAPY	-23, 509	1, 437, 741	1	90.03
90. 05 09005 VI MCARE CLINI C	-2, 620	1	1	90.04
90. 06 09006 MEDICATION MGMT CLINIC	0	253, 722	1	90.06
91. 00 09100 EMERGENCY	-673, 761	8, 302, 038	1	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,3,701	3, 302, 030		92.00
OTHER REIMBURSABLE COST CENTERS				, 00
95. 00 09500 AMBULANCE SERVI CES	-410, 098	3, 086, 870		95.00
99. 10 09910 CORF	0	1	1	99. 10
			•	

Health FinancialSystemsCOLUMBUS RERECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0112

			10/29/2019 2: 12 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
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	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113. 00 11300 I NTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-22, 202, 866	229, 169, 096	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00 07950 WELLNESS COMMUNITY	0	270, 435	l
194. 01 07951 BUI LDI NG RENTALS	0	127, 961	194. 01
194. 02 07952 HOSPI CE	0	97, 336	l
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	302, 784	l
194. 05 07955 NONALLOWABLE MARKETING	0	1, 620, 965	194. 05
194. 06 07956 CRH FOUNDATION	0	13, 254	·
194. 07 07957 HEALTHY COMMUNITIES	0	179, 057	·
194. 08 07958 CRHP	0	19, 900	·
194. 09 07959 NEUROPSYCH PART B	0	0	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-22, 202, 866	231, 800, 788	200.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 01/01/2017
To 12/31/2017 Date/Time Prepared: Provi der CCN: 15-0112

					10 12/3	10/29/2019 2: 12 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
4 00	B - RECLASS DEPREC BLDG/EQUIP			4 004 470		1.00
1. 00 2. 00	CAP REL COSTS BLDG & FLXT	1. 00	0	1, 221, 479		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	48 <u>5, 5</u> 54 1, 707, 033		2.00
	C - RECLASS INSURANCE		<u> </u>	1, 707, 033		
1. 00	OCCUPATI ONAL THERAPY	67. 00	O	1, 541		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	1. 00	o	822, 879		2.00
3.00	AMBULANCE SERVICES	95. 00	O	36, 236		3.00
4.00	LABORATORY	60. 00	0	3, 798		4.00
	0		0	864, 454		
	D - RECLASS BILLING COST					
1. 00	ADMI NI STRATI VE & GENERAL		665, 318	<u>1, 008, 889</u>		1.00
	0 E DEGLACO INDERDADIO THERAD	V EVDENCE	665, 318	1, 008, 889		
1 00	E - RECLASS HYPERBARI C THERAP	90. 04	/1 07E	07.474		1 00
1. 00	HYPERBARI C OXYGEN THERAPY		6 <u>1, 8</u> 75 61, 875	9 <u>7, 4</u> 74 97, 474		1.00
	F - RECLASS CAFETERIA EXPENSE		01, 675	77,474		
1. 00	CAFETERI A	11. 00	1, 371, 144	696, 044		1.00
00	0		1, 371, 144	696, 044		
	G - RECLASS WELLNESS					
1.00	WELLNESS COMMUNITY	194. 00	171, 303	108, 743		1.00
	0		171, 303	108, 743		
	H - RECLASS PHYSICIAN FEES					
1.00		0. 00	0	0		1.00
2. 00	ADULTS & PEDIATRICS	30. 00	0	1, 396, 552		2.00
3. 00	INTENSIVE CARE UNIT	31. 00	0	26, 300		3.00
4. 00	SUBPROVI DER – I RF	41. 00	0	117, 479		4.00
5.00	OPERATI NG ROOM	50.00	0	826, 558		5.00
6.00	ANESTHESI OLOGY	53. 00	0	45, 000		6.00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	103, 126		7.00
8. 00 9. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	100, 786		8.00
9. 00 10. 00	LABORATORY-PATHOLOGI CAL RESPI RATORY THERAPY	60. 01 65. 00	0	225, 000		9. 00 10. 00
11. 00	PHYSICAL THERAPY	66.00	0	12, 000 23, 750		11.00
12. 00	ELECTROCARDI OLOGY	69. 00	0	106, 372		12.00
13. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	9, 575		13.00
14. 00	CARDI AC REHABI LI TATI ON	76. 97	0	6, 623		14.00
15. 00	EMERGENCY	91. 00	0	2, 099, 089		15.00
16. 00	AMBULANCE SERVICES	95. 00	0	13, 125		16.00
17. 00	WOUND CENTER	90. 03	o	36, 931		17. 00
18.00	HYPERBARIC OXYGEN THERAPY	90. 04	0	4, 044		18. 00
				5, 152, 310		
	I - RECLASS REHAB SERVICES					
1. 00	OCCUPATI ONAL THERAPY	67. 00	24, 221	24, 256		1.00
2.00	PHYSI CAL THERAPY	66. 00	46, 221	40, 559		2.00
3. 00	SPEECH PATHOLOGY	68. 00	18, 879	78, 132		3.00
4.00	SUBPROVI DER – I RF	41.00	140, 715	2, 319		4.00
5.00	ELECTROENCEPHALOGRAPHY	70.00	5, 591	1, 546		5.00
6.00	SOCIAL SERVICE	17. 00	4, 193	1, 160		6.00
7. 00 8. 00	ADULTS & PEDI ATRI CS NEUROPSYCH	30. 00 90. 02	37, 738 6, 184	10, 437 1, 546		7. 00 8. 00
9. 00	WOUND CENTER	90. 02	6, 184 8, 999	85, 305		9.00
10.00	HYPERBARI C OXYGEN THERAPY	90. 03	574	37, 786		10.00
11. 00	DI ABETES CENTER	90. 04	19, 568	5, 412		11.00
00	0		312, 883	288, 458		60
	J - RECLASS PHARMACY RES PROG	RAM	- ,	,		
1.00	PHARMACY RESIDENCY PROG	23. 02	173, 456	760		1.00
2.00	PHARMACY RESIDENCY PROG	23. 02	0	1, 832		2.00
3.00	PHARMACY RESIDENCY PROG	23. 02	0	<u>1, 4</u> 25		3.00
	0		173, 456	4, 017		
	L - RECLASS MARKETING EXPENSE					
1. 00	NONALLOWABLE MARKETING	1 <u>94.</u> 05	0_	14 <u>0, 000</u>		1.00
	U DECLACE DEPOSE AT ON THE	NCE	0	140, 000		
1 00	M - RECLASS DEPRECIATION EXPE		ما	10 420 (02		1.00
1. 00	CAP REL COSTS-MVBLE EQUIP		0	10, 430, 693		1.00
	N DECLASS MAINTENANCE EVEN	SE	O	10, 430, 693		
1 00	N - RECLASS MAINTENANCE EXPEN	65. 00	ol	2 202		1 00
1. 00 2. 00	ANESTHESI OLOGY	53.00	0	3, 292 2, 750		1.00
3. 00	CARDI AC CATHETERI ZATI ON	59. 00	ol Ol	288, 305		3.00
4. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	91, 155		4.00
5. 00	OPERATING ROOM	50.00	o	231, 652		5.00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	593, 851		6.00
7. 00	LABORATORY	60.00	o	135, 018		7. 00
	,	50.00	<u> </u>	.55,510		7.00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0112

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared:

					10 12/31/2017 bate/11iile Pr 10/29/2019 2	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
8.00	LABORATORY-PATHOLOGI CAL	60. 01	0	518		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	830		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	244, 942		10.00
11. 00	MAMMOGRAPHY	54. 03	0	153, 860		11.00
12.00	ULTRA SOUND	54. 02	0	48, 348		12.00
13. 00	CT SCAN	57. 00	0	194, 839		13.00
14. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	193, 350		14.00
15. 00	MRI	58. 00	0	133, 600		15. 00
16.00	PHARMACY	15. 00	0	46, 682		16.00
17. 00	EMERGENCY	91.00	0	3, 569		17.00
18.00	ADMINISTRATIVE & GENERAL	5. 00	0	18, 498		18.00
19. 00	NURSING ADMINISTRATION	13.00	0	3, 343		19. 00
	P - RECLASS CRHP EXPENSES		0	2, 388, 402		-
1. 00	CRHP	194. 08	0	19, 900		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	28, 637		2.00
2.00	O GENERAL		<u>0</u>	48, 537		2.00
	Q - RECLASS XRAY EDUCATION E	I I I I I I I I I I I I I I I I I I I	U	40, 557		-
1. 00	XRAY EDUCATION	23. 01	52	0		1.00
2. 00	XRAY EDUCATION	23. 01	314, 151	546		2.00
3. 00	XRAY EDUCATION	23. 01	0,.0	2, 971		3.00
4. 00	XRAY EDUCATION	23. 01	0	8, 734		4. 00
5. 00	XRAY EDUCATION	23. 01	232	0		5. 00
0.00	0		314, 435	12, 251		0.00
	R - RECLASS ADMIN HEALTHY CO	MMUNI TI ES	21.7.120	.=,=;		
1.00	ADMINISTRATIVE & GENERAL	5. 00	24, 870	0		1.00
	0 — — — — — —		24, 870	₀		
	S - RECLASS NON ALLOW ADVERT	ISING COSTS				
1.00	NONALLOWABLE MARKETING	194. 05	0	1, 480, 965		1. 00
	0		0	1, 480, 965		
	T - RECL EQUIP RENTAL TO CHA	RGEABLE SUPP				
1.00		0.00	0	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	235, 044		2. 00
	PATI ENT					
3. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	10, 739		3. 00
4 00	PATI ENT	74 00		47 000		4 00
4. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	46, 932		4. 00
5. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	46, 819		5. 00
5.00	PATIENT	71.00	U	40, 619		3.00
	0		— — ₀	339, 534		
	U - RECLASS CHARGEABLE SUPPL	Y COST	<u> </u>	007,001		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	208, 982		1.00
	PATI ENT					
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	141, 131		2.00
	PATI ENT					
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	5, 738		3. 00
	PATI ENT					
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 895		4. 00
F 00	PATIENT		_	0 4/0 077		
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 462, 077		5. 00
6 00	PATIENT	72.00	0	6, 239, 366		4 00
6. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	U	0, 239, 300		6. 00
8. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	30, 262		8.00
0.00	PATIENT	,1.00	U	30, 202		0.00
9. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	559, 573		9. 00
50	PATI ENT	, 1. 30	J	337, 373		/. 00
10.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 139		10.00
	PATI ENT			,		
11.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	12, 089		11.00
	PATI ENT					
13.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	689, 028		13. 00
	PATI ENT					
14.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	144, 779		14. 00
	PATIENT					
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 567, 018		15. 00
4	PATI ENT		_	0 455 55		4
16. 00	I MPL. DEV. CHARGED TO	72. 00	0	2, 155, 924		16. 00
17 00	PATIENTS	71 00	_	40 50/		17 00
17. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	49, 536		17.00
18. 00	MEDICAL SUPPLIES CHARGED TO	71 00	0	22 450		18.00
10.00	PATIENT	71.00	U	22, 450		10.00
19. 00	SPEECH - HEARING AIDS	194. 04	0	302, 784		19.00
. 7. 00	In Termino Albo	174.04	O	302, 704		

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: | 10/29/2019 2: 12 pm Provider CCN: 15-0112

					10/29/2019 2	2:12 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
20.00	2.00	3.00	4. 00	5. 00		20.00
20. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	371, 027		20.00
21. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	63, 941		21.00
21.00	PATI ENT	71.00		03, 741		21.00
22.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	30, 938		22. 00
	PATI ENT					
23.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	25, 745		23.00
	PATI ENT					
24. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 738		24.00
	PAT I ENT	+	+			
	V - RECL PTO COST FOR STD ELI	MINATION DD	U _I	15, 088, 160		
1. 00	V - RECL PIO COST FOR STD ELI	0. 00	0	0		1.00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	2, 230		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9, 426		3.00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 598		4. 00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	6, 646		5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	48, 166		6. 00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	7, 876		7. 00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	О	2, 835		8. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	О	7, 745		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 601		10.00
11.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 885		11. 00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	17, 087		12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	44, 727		13.00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 146		14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	122, 092		15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 632		16.00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 876		17.00
18.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 971		18.00
19.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 124		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 541		20.00
21. 00 22. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	17, 825 476		21. 00 22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 778		23.00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 193		24.00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 129		25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	14, 741		26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	20, 009		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 609		28. 00
29.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	О	38, 651		29. 00
30.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	О	6, 576		30.00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	668		32.00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39, 003		33.00
34.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 215		34.00
35.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 046		35.00
36. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	•	440		36. 00
	O DECLACE DEDT 0003 FMD DEN	JEEL TO	0	487, 563		
1 00	W - RECLASS DEPT 9902 EMP BEN		<u></u>	EOF 07/		1 00
1.00	ADMINISTRATIVE & GENERAL CENTRAL SERVICES & SUPPLY	5.00	0	585, 976		1.00
2. 00 3. 00	OPERATING ROOM	14. 00 50. 00	0	203, 112 2, 262, 500		2. 00 3. 00
4. 00	RECOVERY ROOM	51. 00	0	302, 588		4.00
5. 00	ANESTHESI OLOGY	53. 00	o	28, 254		5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	425, 723		6.00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	20, 651		7. 00
8. 00	ADMINISTRATIVE & GENERAL	5. 00	203, 263	0		8. 00
9.00	OPERATION OF PLANT	7. 00	37, 844	0		9. 00
10.00	LAUNDRY & LINEN SERVICE	8. 00	447	0		10.00
11.00	HOUSEKEEPI NG	9. 00	26, 528	0		11. 00
12.00	DI ETARY	10.00	10, 168	0		12.00
13.00	CAFETERI A	11. 00	22, 266	0		13.00
14.00	NURSING ADMINISTRATION	13. 00	88, 462	0		14. 00
15. 00	PHARMACY	15. 00	45, 192	0		15. 00
16. 00	MEDICAL RECORDS & LIBRARY	16. 00	29, 420	0		16.00
17.00	SOCI AL SERVI CE	17. 00	8, 531	0		17.00
18.00	XRAY EDUCATION	23. 01	893	0		18.00
19.00	PHARMACY RESIDENCY PROG	23. 02	893	0		19.00
20.00	ADULTS & PEDIATRICS	30.00	111, 670	0		20.00
21. 00	INTENSIVE CARE UNIT	31.00	16, 814	0		21.00
22. 00	SUBPROVIDER - IRF	41. 00 43. 00	9, 827	0		22. 00 23. 00
23. 00 24. 00	NURSERY OPERATING ROOM	50. 00	4, 690 7, 125	0		23.00
24. 00 25. 00	RADI OLOGY-DI AGNOSTI C	54. 00	28, 306	0		25.00
	p. 2. 5. 5. 5. 5. 7. 6. 65. 11 6	37.00	20, 300	O _I		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

| Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: | 10/29/2019 2: 12 pm

						10/29/2019 2	: 12 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
26.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	2, 010	0			26. 00
27.00	ULTRA SOUND	54. 02	3, 127	0			27. 00
28.00	MAMMOGRAPHY	54. 03	10, 048	0			28. 00
29.00	RADI OLOGY-THERAPEUTI C	55.00	7, 147	0			29.00
30.00	CT SCAN	57.00	3, 350	0			30.00
31.00	MRI	58.00	1, 563	0			31.00
32.00	CARDI AC CATHETERI ZATI ON	59.00	13, 892	0			32.00
33.00	LABORATORY	60.00	49, 824	0			33.00
34.00	LABORATORY-PATHOLOGI CAL	60. 01	2, 233	0			34.00
35.00	RESPI RATORY THERAPY	65. 00	18, 845	0			35.00
36.00	PHYSI CAL THERAPY	66.00	32, 970	0			36.00
37.00	OCCUPATI ONAL THERAPY	67. 00	7, 589	0			37.00
38.00	SPEECH PATHOLOGY	68. 00	9, 202	0			38.00
39. 00	ELECTROCARDI OLOGY	69. 00	3, 350	0			39.00
40.00	ELECTROENCEPHALOGRAPHY	70.00	5, 579	0			40.00
41.00	CLINIC	90.00	6, 254	0			41.00
42.00	DI ABETES CENTER	90. 01	447	0			42.00
43.00	NEUROPSYCH	90. 02	2, 010	0			43.00
44. 00	WOUND CENTER	90. 03	6, 919	0			44.00
45. 00	HYPERBARI C OXYGEN THERAPY	90. 04	440	0			45. 00
46. 00	EMERGENCY	91. 00	34, 842	0			46. 00
47. 00	AMBULANCE SERVICES	95. 00	34, 658	0			47.00
48. 00	CARDI AC REHABI LI TATI ON	76. 97	1, 117	0			48. 00
49. 00	HEALTHY COMMUNITIES	194. 07	670	0			49. 00
50.00	VIMCARE CLINIC	90. 05	4, 020	0			50.00
51. 00	MEDICATION MGMT CLINIC	90. 06	1, 787	Ö			51.00
52. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	271	Ö			52. 00
53. 00	WELLNESS COMMUNITY	194. 00	4, 715	0			53. 00
33. 00	0		921, 218	3, 828, 804			33.00
	X - RECLASS OT SALARIES AND O	THER EXP	721, 210	3,020,004			+
1. 00	OCCUPATIONAL THERAPY	67.00	568, 863	169, 615			1.00
1.00	O THE		568, 863	169, 615			1.00
	Y - RECL MILLRACE FOR WELLNES	TQ/Q0/23	300, 003	107, 013			+
1. 00	PHYSI CAL THERAPY	66, 00	O	7, 178			1.00
2. 00	OCCUPATIONAL THERAPY	67. 00	0	1, 460			2. 00
3.00	PHYSI CAL THERAPY	66. 00		4, 727			3. 00
		67. 00	0	4, 727 961			1
4. 00	OCCUPATI ONAL THERAPY		— — 	<u>961</u> 14, 326			4. 00
	Z - RECLASS LAB BLOOD SUPERVI	SOD	· υ	14, 320	 		-
1 00	WHOLE BLOOD & PACKED RED	62. 00	44 OE3	0			1 00
1. 00	BLOOD CELL	62.00	46, 053	U			1.00
	DLUUD CELL	+	— — [
E00 00	Crand Total: Increases		46, 053	44, 356, 272			E00.00
500. OC	Grand Total: Increases		4, 631, 418	44, 330, 272			500.00

RECLASSI FI CATIONS

Provider CCN: 15-0112

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

10/29/2019 2:12 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - RECLASS DEPREC BLDG/EQUIP 1.00 INTEREST EXPENSE 113. 00 1, 221, 479 11 1.00 2.00 INTEREST EXPENSE 485, 554 2.00 113.00 0 11 ō 1, 707, 033 - RECLASS INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5. 00 0 1, 541 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 ol 822.879 12 2.00 ADMINISTRATIVE & GENERAL 5.00 0 0 3.00 36, 236 3.00 4.00 ADMINISTRATIVE & GENERAL 5.00 3,798 0 4.00 864, 454 D - RECLASS BILLING COST 1.00 MEDICAL RECORDS & LIBRARY 16.00 665, 318 1,008,889 0 1.00 665, 318 1, 008, 889 RECLASS HYPERBARIC THERAPY EXPENSE 97 474 1 00 WOUND CENTER 61, 875 90.03 0 1.00 97, 474 61, 875 RECLASS CAFETERIA EXPENS DI ETARY 1, 371, 144 1.00 10.00 696, 044 1.00 0 1, 371, 144 696, 044 RECLASS WELLNESS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 171, 303 108, 743 0 1.00 171, 303 108, 743 RECLASS PHYSICIAN FEES 1.00 0.00 0 1.00 ADMINISTRATIVE & GENERAL 5.00 0 1, 396, 552 0 2.00 2.00 ladministrative & GENERAL 3 00 5.00 0 26, 300 0 3 00 4.00 ADMINISTRATIVE & GENERAL 5.00 0 117, 479 0 4.00 ADMINISTRATIVE & GENERAL o 0 5.00 5.00 826, 558 5.00 0 0 OPERATING ROOM 6.00 50.00 45,000 6.00 ADMINISTRATIVE & GENERAL 7 00 5 00 103, 126 7 00 8.00 ADMINISTRATIVE & GENERAL 5.00 0 100, 786 0 8.00 9.00 ADMINISTRATIVE & GENERAL 5.00 o 225,000 0 9.00 0 ADMINISTRATIVE & GENERAL 0 10.00 5.00 12,000 10.00 11.00 ADMINISTRATIVE & GENERAL 5.00 0 23, 750 11.00 ADMINISTRATIVE & GENERAL 5.00 106, 372 0 0 12.00 12.00 0 13.00 ADMINISTRATIVE & GENERAL 5.00 o 9,575 13.00 0 0 14.00 ADMINISTRATIVE & GENERAL 5.00 6,623 14.00 2,099,089 0 15.00 ADMINISTRATIVE & GENERAL 5.00 0 15.00 16.00 ADMINISTRATIVE & GENERAL 5.00 0 13, 125 0 16.00 17.00 ADMINISTRATIVE & GENERAL 5.00 0 36, 931 0 17.00 <u>4, 0</u>44 ADMINISTRATIVE & GENERAL 0 18.00 5.00 18.00 5, 152, 310 - RECLASS REHAB SERVICES 1.00 ADMINISTRATIVE & GENERAL 5. 00 24, 221 24, 256 0 1.00 ADMINISTRATIVE & GENERAL 0 2.00 5.00 46, 221 40, 559 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 18, 879 78, 132 0 3.00 4.00 ADMINISTRATIVE & GENERAL 5.00 140, 715 2, 319 0 4.00 ADMINISTRATIVE & GENERAL 0 5.00 5.00 5, 591 1.546 5.00 6.00 ADMINISTRATIVE & GENERAL 5.00 4, 193 1, 160 0 6.00 7.00 ADMINISTRATIVE & GENERAL 5.00 37, 738 10, 437 0 7.00 ADMINISTRATIVE & GENERAL 0 8 00 5 00 6 184 1 546 8 00 ADMINISTRATIVE & GENERAL 8, 999 0 9.00 5.00 85, 305 9.00 10.00 ADMINISTRATIVE & GENERAL 5.00 574 37, 786 0 10.00 5. 00 11.00 ADMINISTRATIVE & GENERAL 19,568 5, 412 0 11.00 312, 883 288, 458 RECLASS PHARMACY RES PROGRAM 1.00 15. 00 173, 456 760 0 1.00 PHARMACY 2.00 ADMINISTRATIVE & GENERAL 5.00 1,832 0 0 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1 425 0 3.00 173, 456 4, 017 RECLASS MARKETING EXPENSE 5. 00 140, 000 1.00 ADMINISTRATIVE & GENERAL 0 1.00 0 140, 000 RECLASS DEPRECIATION EXPENSE 0 1.00 CAP REL COSTS-BLDG & FIXT 1.00 10, 430, 693 1.00 10, 430, 693 - RECLASS MAINTENANCE EXPENSE 1.00 OPERATION OF PLANT 7. 00 3, 292 0 1.00 OPERATION OF PLANT 0 2.00 7. 00 0 2, 750 2.00 OPERATION OF PLANT 0 3.00 7.00 288.305 0 3.00 0 4.00 OPERATION OF PLANT 7.00 0 91, 155 4.00 OPERATION OF PLANT 0 5.00 7.00 0 231, 652 5.00 OPERATION OF PLANT 7.00 0 0 6.00 593, 851 6.00 OPERATION OF PLANT 7.00 7.00 135, 018 0 7.00

Heal th	Financial Systems	(COLUMBUS REGION	AL HOSPITAL		In Lieu	of Form CMS-2552-	-10
RECLASS	SI FI CATI ONS			Provi der CCN:			Vorksheet A-6	
					To	om 01/01/2017 12/31/2017 [Date/Time Prepared	ed:
		Decreases				1	10/29/2019 2:12 pn	m
	Cost Center	Li ne #	Sal ary	Other Wks	t. A-7 Ref.			
	6. 00	7.00	8. 00	9. 00	10. 00			
8. 00	OPERATION OF PLANT	7. 00	0	518	0			00
9. 00	OPERATION OF PLANT	7.00	0	830	0			00
10. 00 11. 00	OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	244, 942 153, 860	0		10.0	
12. 00	OPERATION OF PLANT	7.00	o	48, 348	o		12.0	
13. 00	OPERATION OF PLANT	7. 00	o	194, 839	o		13. (
14.00	OPERATION OF PLANT	7. 00	0	193, 350	o		14.0	00
15.00	OPERATION OF PLANT	7. 00	0	133, 600	0		15. (
16. 00	OPERATION OF PLANT	7. 00	0	46, 682	0		16. (
17.00	OPERATION OF PLANT	7.00	0	3, 569	0		17. (
18. 00 19. 00	OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	18, 498 3, 343	0		18. (19. (
17.00	0	7.00		2, 388, 402	· — — 🏺		17. (00
	P - RECLASS CRHP EXPENSES							
1.00	BUILDING RENTALS	194. 01	0	19, 900	0			00
2. 00	BUILDING RENTALS	194.01		28, 637			2.0	00
	Q - RECLASS XRAY EDUCATION EX	VDENCEC	0	48, 537				
1. 00	RESPIRATORY THERAPY	65. 00	52	0	0		1 (00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	314, 151	546	Ö			00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 971	O			00
4.00	BUILDING RENTALS	194. 01	0	8, 734	o		4.0	00
5.00	MRI	58. 00	232	0	0		5. 0	00
	O DECLACE ARMIN HEALTHY CON	MAUNITIES	314, 435	12, 251				
1. 00	R - RECLASS ADMIN HEALTHY COMMENT TIES	MMUNI ITES 194, 07	24, 870	0	0		1 (00
1.00	0	194.07	24,870		· — — Ч		1.0	00
	S - RECLASS NON ALLOW ADVERT	ISING COSTS	21,070					
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 480, 965	0		1. (00
	0		0	1, 480, 965				
4 00	T - RECL EQUIP RENTAL TO CHAI		ما					
1. 00 2. 00	ADULTS & PEDIATRICS	0.00	0	0 235, 044	0			00
3. 00	INTENSIVE CARE UNIT	30.00	0	10, 739	0		•	00
4. 00	SUBPROVI DER - I RF	41. 00	o	46, 932	o		•	00
5. 00	RESPIRATORY THERAPY	65. 00	o	46, 819	ō			00
	0		0	339, 534				
4 00	U - RECLASS CHARGEABLE SUPPLY		ما	200 000				00
1. 00 2. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	208, 982 141, 131	0			00
3. 00	SUBPROVIDER - IRF	41.00	o	5, 738	o			00
4. 00	NURSERY	43. 00	Ö	1, 895	o			00
5.00	OPERATING ROOM	50.00	0	2, 462, 077	o			00
6.00	OPERATI NG ROOM	50.00	0	6, 239, 366	0			00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	30, 262	0			00
9. 00	NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	54. 01 54. 02	0	559, 573	0			00
10. 00 11. 00	MAMMOGRAPHY	54. 02	0	2, 139 12, 089	0		10.0	
13. 00	CT SCAN	57. 00	o	689, 028	o		13.0	
14. 00	MRI	58. 00	Ö	144, 779	ō		14. (
15.00	CARDIAC CATHETERIZATION	59. 00	O	1, 567, 018	0		15.0	00
16.00	CARDI AC CATHETERI ZATI ON	59. 00	0	2, 155, 924	0		16.0	
17.00	RESPIRATORY THERAPY	65.00	0	49, 536	0		17. (
18. 00 19. 00	PHYSI CAL THERAPY SPEECH PATHOLOGY	66. 00 68. 00	0	22, 450 302, 784	0		18. (19. (
20. 00	ELECTROCARDI OLOGY	69.00	0	371, 027	o		20.0	
21. 00	WOUND CENTER	90. 03	Ö	63, 941	Ö		21. (
22. 00	EMERGENCY	91. 00	o	30, 938	ō		22. (
23.00	AMBULANCE SERVICES	95. 00	O	25, 745	0		23.0	00
24.00	SPEECH PATHOLOGY	68.00	0	1, 738	0		24.0	00
	V DECLIDIO COST FOR STR. FL	I MI NATI ON DD	0	15, 088, 160				
1. 00	V - RECL PTO COST FOR STD ELI	0.00	0	0	0		1 (00
2. 00	RADI OLOGY-THERAPEUTI C	55. 00	2, 230	0	0			00
3. 00	MAMMOGRAPHY	54. 03	9, 426	Ö	ő			00
4. 00	SOCIAL SERVICE	17. 00	4, 598	0	o			00
5. 00	ULTRA SOUND	54. 02	6, 646	0	О			00
6. 00	ADMI NI STRATI VE & GENERAL	5. 00	48, 166	0	0			00
7.00	OPERATION OF PLANT	7.00	7, 876	0	0			00
8. 00 9. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	2, 835 7, 745	0	0			00
10. 00	DI ETARY	10. 00	3, 601	0	0		10.0	
11. 00	CAFETERI A	11. 00	7, 885	0	ő		11. (
12. 00	NURSING ADMINISTRATION	13. 00	17, 087	0	O		12. (
	·						<u> </u>	

COLUMBUS REGIONAL HOSPITAL

Provider CCN: 15-0112 | Period: Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm

		Dooroooo				10/29/2019 2	: 12 piii
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
13. 00	PHARMACY	15. 00	44, 727	7.00	0	,	13.00
14. 00	MEDICAL RECORDS & LIBRARY	16. 00	11, 146	0	0		14. 00
15. 00	ADULTS & PEDIATRICS	30.00	122, 092	0	0		15.00
16. 00	INTENSIVE CARE UNIT	31.00	6, 632	0	0		16.00
17. 00	SUBPROVI DER - I RF	41.00	7, 876	0	0	l l	17. 00
18. 00	NURSERY	43. 00	6, 971	0	0	l I	18.00
19.00	OPERATING ROOM	50.00	2, 124	0	0		19.00
20.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	4, 541	0	0		20.00
21.00	RADI OLOGY-DI AGNOSTI C	54.00	17, 825	0	0		21.00
22.00	LABORATORY-PATHOLOGI CAL	60. 01	476	0	0		22. 00
23.00	NEUROPSYCH	90. 02	5, 778	0	0		23.00
24.00	CT SCAN	57.00	5, 193	0	0		24.00
25.00	MRI	58. 00	3, 129	0	0		25.00
26.00	CARDI AC CATHETERI ZATI ON	59.00	14, 741	0	0		26. 00
27.00	LABORATORY	60.00	20, 009	0	0		27. 00
28.00	RESPI RATORY THERAPY	65. 00	4, 609	0	0		28. 00
29.00	PHYSI CAL THERAPY	66. 00	38, 651	0	0		29. 00
30.00	OCCUPATI ONAL THERAPY	67. 00	6, 576	0	0		30.00
32.00	ELECTROCARDI OLOGY	69. 00	668	0	0		32.00
33. 00	EMERGENCY	91. 00	39, 003	0	0		33. 00
34.00	AMBULANCE SERVICES	95. 00	5, 215	0	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70. 00	1, 046	0	0		35.00
36. 00	CLINIC	90.00	440	0	0		36. 00
	0		487, 563	0			
	W - RECLASS DEPT 9902 EMP BEI		-1				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	585, 976	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	203, 112	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 262, 500	0		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	302, 588	0	l l	4.00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28, 254	0	l I	5.00
6.00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	425, 723	0		6.00
7. 00 8. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	202 242	20, 651	0		7. 00 8. 00
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	203, 263 37, 844	0	0		9.00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	447	0	0	l l	10.00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	26, 528	0	0		11.00
12. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	10, 168	0	0		12.00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	22, 266	0	0		13.00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	88, 462	0	0		14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	45, 192	0	0		15.00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	29, 420	0	0		16.00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8, 531	0	0		17. 00
18.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	893	0	0		18.00
19.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	893	0	0		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	111, 670	0	0		20.00
21.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	16, 814	0	0		21.00
22.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	9, 827	0	0		22. 00
23.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	4, 690	0	0		23. 00
24.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 125	0	0		24.00
25.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28, 306	0	0		25.00
26.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 010	0	0		26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	3, 127	0	0		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	10, 048	0	0		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 147	0	0		29.00
30.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 350	0	0	l l	30.00
31.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 563	0	0		31.00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13, 892	0	0	l l	32.00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	49, 824	0	0		33.00
34.00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	2, 233	0	0	l l	34. 00 35. 00
35.00		1	18, 845 32, 970		0		1
36. 00 37. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	7, 589	0	0		36. 00 37. 00
38. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9, 202	0	0		38.00
39.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 350	0	0	l I	39.00
40.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	5, 579	0	0	l l	40.00
41.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	6, 254	0	0		41.00
42. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	447	0	0	l e	42.00
43. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 010	0	0		43.00
44. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	6, 919	0	0	l e	44.00
45. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	440	0	0		45.00
46. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	34, 842	0	0		46. 00
47.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	34, 658	0	0		47.00
48. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 117	0	0		48. 00
49.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	670	0	0	l e e e e e e e e e e e e e e e e e e e	49.00
			,				

Health Financial Systems RECLASSIFICATIONS COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: Provider CCN: 15-0112

					'	10/29/2019	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
50.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	4, 020	0	0		50.00
51.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 787	0	0		51.00
52.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	271	0	0		52.00
53.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	<u>4, 7</u> 15	0	0		53.00
	0		921, 218	3, 828, 804			
	X - RECLASS OT SALARIES AND O	OTHER EXP					
1.00	PHYSICAL THERAPY	<u>66.</u> 00	<u>568, 8</u> 63	16 <u>9, 6</u> 15	0		1.00
	0		568, 863	169, 615			
	Y - RECL MILLRACE FOR WELLNES						
1. 00	WELLNESS COMMUNITY	194. 00	0	7, 178	0		1.00
2. 00	WELLNESS COMMUNITY	194. 00	0	1, 460			2. 00
3. 00	WELLNESS COMMUNITY	194. 00	0	4, 727	0		3.00
4. 00	WELLNESS COMMUNITY	19400	0_	<u> </u>	0		4.00
	0		0	14, 326			
	Z - RECLASS LAB BLOOD SUPERVI						
1. 00	LABORATORY	6000	4 <u>6, 0</u> 53	0	0		1.00
	0		46, 053	0			
500.00	Grand Total: Decreases		5, 118, 981	43, 868, 709			500.00

Provi der CCN: 15-0112

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

			T	o 12/31/2017	Date/Time Pre	pared:
		Acqui si ti ons			10/29/2019 2:	12 piii
	Beginning	Purchases	Donati on	Total	Disposals and	
	Bal ances	i di chases	Donation	Total	Retirements	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00 Land	2, 373, 066	48, 000	C	48, 000	0	1.00
2.00 Land Improvements	21, 508, 963	26, 780	C	26, 780	1, 460, 275	2.00
3.00 Buildings and Fixtures	98, 145, 144	1, 996, 455		1, 996, 455	3, 171, 402	3.00
4.00 Building Improvements	108, 196, 083	1, 228, 534	C	1, 228, 534	3, 796, 109	4.00
5.00 Fi xed Equi pment	9, 241, 835	213, 550	C	213, 550	19, 829	5.00
6.00 Movable Equipment	137, 769, 045	18, 597, 090	C	18, 597, 090	3, 697, 512	6.00
7.00 HIT designated Assets	0	0	C	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	377, 234, 136	22, 110, 409	C	22, 110, 409	12, 145, 127	8.00
9.00 Reconciling Items	0	0	C	0	0	9. 00
10.00 Total (line 8 minus line 9)	377, 234, 136	22, 110, 409	C	22, 110, 409	12, 145, 127	10.00
	Endi ng	Ful I y				
	Bal ance	Depreci ated				
		Assets				
	6. 00	7. 00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00 Land	2, 421, 066	0			ļ	1.00
2.00 Land Improvements	20, 075, 468	0			ļ	2.00
3.00 Buildings and Fixtures	96, 970, 197	0			l	3.00
4.00 Building Improvements	105, 628, 508	0			l	4.00
5.00 Fixed Equipment	9, 435, 556	0			ļ	5.00
6.00 Movable Equipment	152, 668, 623	0			ļ	6. 00
7.00 HIT designated Assets	0	0			l	7. 00
8.00 Subtotal (sum of lines 1-7)	387, 199, 418	0			ļ	8. 00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	387, 199, 418	0			ļ	10.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0112	Peri od: From 01/01/2017 To 12/31/2017			
				10 12/31/2017	10/29/2019 2:		
	SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
				(see instructions)	instructions)		
	9. 00	10. 00	11. 00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1.00 CAP REL COSTS-BLDG & FLXT	19, 081, 837	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)	19, 081, 837			0 0	0	3.00	
SUMMARY OF CAPITAL							
Cost Center Description	Other	Total (1)					
	Capi tal -Rel at						
	ed Costs (see	9 through 14)					
	instructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU						
1.00 CAP REL COSTS-BLDG & FLXT	0	19, 081, 837				1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00 Total (sum of lines 1-2)	0	19, 081, 837				3.00	

Health Financial Systems		COLUMBUS REGIO	COLUMBUS REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C		Period: From 01/01/2017 Fo 12/31/2017		pared:	
		COM	DUTATION OF DAT	FLOC	ALLOCATION OF	10/29/2019 2:	12 pm	
		COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITA						
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 -				
				col . 2)				
	DART III DECONOLILATION OF CARLEY COOTS	1.00	2. 00	3. 00	4. 00	5. 00		
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C			004 500 70	0 (05744	0	1 00	
1.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	234, 530, 794				0	1.00	
2. 00 3. 00	Total (sum of lines 1-2)	152, 668, 624 387, 199, 418		152, 668, 62, 387, 199, 418			2. 00 3. 00	
3.00	Total (Sum of Times 1-2)						3.00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
	· ·		Capi tal -Rel at	cols. 5				
			ed Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0		8, 673, 172		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		10, 378, 830		2.00	
3.00	Total (sum of lines 1-2)	0	0		19, 052, 002	0	3.00	
		SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
	·		(see	instructions)	Capi tal -Rel at	(sum of cols.		
			instructions)		ed Costs (see	9 through 14)		
					instructions)			
		11. 00	12. 00	13.00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C				- 1			
1.00	CAP REL COSTS-BLDG & FIXT	712, 357		•	0		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	141, 230			0	10, 520, 060	2.00	
3. 00	Total (sum of lines 1-2)	853, 587	822, 879		0	20, 728, 468	3. 00	

From 01/01/2017 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -509, 122 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В -84, 953 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) -84, 665 ADMI NI STRATI VE & GENERAL 4.00 Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -80, 318 ADMINISTRATIVE & GENERAL 5.00 B 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7 00 -105, 214 ADMINISTRATIVE & GENERAL 5 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -10, 916 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) -205 OPERATION OF PLANT 9.00 В 7.00 -6, 960, 595 Provi der-based physici an 10.00 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 -582, 756 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -733, 967 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 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 Sale of medical records and -24, 436 MEDICAL RECORDS & LIBRARY 18.00 В 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines В -100HOUSEKEEPING 9.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22 00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0112 Peri od: Worksheet A-8 From 01/01/2017 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 32.00 CAH HIT Adjustment for 0 0.00 Depreciation and Interest TELEPHONE SERVICES -3, 900 ADMINISTRATIVE & GENERAL 33.00 В 5.00 33.00 34.00 DEPR PAT PHONES NEW EQUIP -23, 263 CAP REL COSTS-MVBLE EQUIP 2.00 34.00 Α -28,600 CAP REL COSTS-MVBLE EQUIP 35.00 TV DEPR NEW EQUIP Α 2.00 35.00 36.00 CAFETERIA VISITORS Α -371, 710 CAFETERI A 11.00 36.00 -87, 757 DI ETARY 37.00 MEALS TO GO Α 10.00 37.00 OTHER ADJUSTMENTS (SPECIFY) 37 01 37 01 B 0.00(3) 38.00 OTHER ADJUSTMENTS (SPECIFY) В 0 0.00 38.00 (3)-455 PHYSI CAL THERAPY 39.00 INPATIENT PT В 66.00 39.00 EAP REVENUE -14,870 EMPLOYEE BENEFITS DEPARTMENT 40.00 40.00 В 4.00 41.00 BOND AMORTIZATION 82, 092 CAP REL COSTS-BLDG & FIXT 1.00 41.00 Α LAND RENT MOB -2, 000 ADMINISTRATIVE & GENERAL 42.00 42.00 В 5.00 43.00 RENT FOXPOINTE LAND SWAP В -5, 348 ADMINISTRATIVE & GENERAL 5.00 43.00 -9, 758 LABORATORY LABORATORY OTHER REVENUE 60.00 44.00 44 00 R 44.01 EMPLOY BENEFITS OTHER REVENUE В -23, 609 EMPLOYEE BENEFITS DEPARTMENT 4.00 44.01 -20, 480 XRAY EDUCATION 45.00 XRAY EDUCATION В 23.01 45.00 MEDICAL STAFF INCOME -4, 400 ADMINISTRATIVE & GENERAL 45.01 В 5.00 45.01 -12, 778 RADI OLOGY-DI AGNOSTI C RADIOLOGY OTHER REVENUE 45.02 В 54.00 45.02 45.03 BREAST FILM COPIES В -648 MAMMOGRAPHY 54.03 45.03 45.04 MEDICAL RECORDS OTHER REVENUE В -2, 700 MEDICAL RECORDS & LIBRARY 16.00 45.04 45 05 FACILITIES OTHER REVENUE -79, 474 OPERATION OF PLANT 45 05 B 7 00 -135 ADULTS & PEDIATRICS 45.06 SICK BAY В 30.00 45.06 45.07 RADIATION ONCOLOGY OTHER В -59, 937 RADI OLOGY-THERAPEUTI C 55.00 45.07 REVENUE ADMIN OTHER REVENUE В -5, 034 ADMI NI STRATI VE & GENERAL 45.08 5.00 0 45.08 COPY CENTER OTHER REVENUE -5. 129 ADMINISTRATIVE & GENERAL 45 09 B 5.00 45.09 45. 10 INFO SERV OTHER REVENUE -13, 020 ADMINISTRATIVE & GENERAL 5.00 45.10 В FOOD OTHER REVENUE -48, 191 DI ETARY 45. 11 B 10.00 45.11 -2, 107 SPEECH PATHOLOGY SPEECH THERAPY OTHER REVENUE 45.12 45.12 В 68.00 45 13 PROTECTIVE SERV OTHER REVENUE R -8, 400 OPERATION OF PLANT 7.00 45.13 PHARMACY OTHER REVENUE -54, 795 PHARMACY 45.14 45.14 В 15.00 HUMAN RESOURCES OTHER REVENUE -645 EMPLOYEE BENEFITS DEPARTMENT 45. 15 В 45.15 4.00 LACTATION AND PREPARE OTHER -5, 117 ADULTS & PEDIATRICS 30.00 0 45.16 45. 16 В REVENUE 45.17 VOLUNTEER OTHER REVENUE В -79, 997 ADMINISTRATIVE & GENERAL 5.00 0 45.17 RENTAL PROPERTIES DEPRECIATION -111, 344 CAP REL COSTS-BLDG & FIXT 45.18 Α 1.00 45.18 45 19 OTHER ADJUSTMENTS (SPECIFY) 0.0045 19 B 45. 20 EMERGENCY ROOM OTHER REV В -40, 360 EMERGENCY 91.00 0 45.20 LOSS ON DISPOSAL DEMOLITION 11, 218 CAP REL COSTS-BLDG & FIXT 45.21 Α 1.00 45.21 45, 22 UNALLOWABLE PHYS RECRUITMENT -154, 929 ADMI NI STRATI VE & GENERAL 5.00 0 45, 22 Α 33, 351 CAP REL COSTS-BLDG & FIXT DEPRECIATION RELIFED 45 23 Α 1.00 45 23 CRHP OTHER REVENUE -980, 828 ADMINISTRATIVE & GENERAL 45.24 45.24 В 5.00 45, 25 DIABETES CLINIC В -600 DI ABETES CENTER 90.01 0 45.25 PRIOR YEAR AUDIT ADJUSTMENT 6,711 CAP REL COSTS-BLDG & FLXT 45 27 45 27 Α 1.00 45. 28 NONALLOWABLE INT EXP 1993 -73, 201 CAP REL COSTS-MVBLE EQUIP 2.00 11 45.28 Α BONDS 45. 29 NONALLOWABLE INT EXP 2003/2009 -186, 170 CAP REL COSTS-MVBLE EQUIP 2.00 11 45. 29 Α BONDS UNALLOWABLE AHA MEMBERSHIP -12, 834 ADMI NI STRATI VE & GENERAL 45 30 5 00 ol 45 30 Α DUES 45.31 AMBULANCE SERVICES В -407, 751 AMBULANCE SERVICES 95.00 45.31 OTHER ADJUSTMENTS (SPECIFY) 45.32 В 0.00 45.32 OTHER ADJUSTMENTS (SPECIFY) 45.33 В 0.00 45.33 (3) 45.34 HAF ADJUSTMENT Α -10, 216, 717 ADMINISTRATIVE & GENERAL 5.00 45.34 50.00 TOTAL (sum of lines 1 thru 49) -22, 202, 866 50.00 (Transfer to Worksheet A, column 6, line 200.)

Health Financial Systems		COLUMBUS REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0112	Peri od:	Worksheet A-8	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
					10/29/2019 2:	12 pm
			Expense Classification of	on Worksheet A		
			To/From Which the Amount i	s to be Adjusted		
				_		
Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	(2)				Ref.	
	1. 00	2. 00	3.00	4. 00	5. 00	

- (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.

			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 RELATE	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	Е	J BICKEL	O.OOSI HEALTH MANAGEMENT	0.00	6.00
7.00	E	D TRAPP	O. OO SI HEALTH MANAGEMENT	0.00	7.00
8.00	E	Z ELLISON	O.OOSI HEALTH MANAGMENT	0.00	8.00
9.00	E	R SHEDD	O.OOSI HEALTH MANAGEMENT	0.00	9.00
10.00	E	S STARK	O.OOSI HEALTH MANAGEMENT	0. 00	10.00
10. 01	E	D DOUP	O.OOSI HEALTH MANAGMENT	0. 00	10.01
10.02	E	D MI CHAEL	O.OOSI HEALTH MANAGMENT	0. 00	10.02
100.00	G. Other (financial or	NONE		-	100.00
	non-financial) specify:				

(1) 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.

		SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der	CCN: 15-0112	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2017 To 12/31/2017	Date/Time Pro 10/29/2019 2:	epared: 12 pm
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:							
1.00	-582, 756	0						1.00
2.00	0	0						2.00
3.00	0	0						3.00
4.00	0	0						4.00
5.00	-582, 756							5.00
* The	amounts on lin	es 1-4 (and sub	bscripts as appropriate) are tra	nsferred i	n detail to Wo	rksheet A. column	6. lines as	
			se cost and negative amounts dec					t which
			columns 1 and/or 2, the amount					
	Related Orga	ani zati on(s)						
	and/or Ho	ome Office						
	Type of	Busi ness						
	•							

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

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.

i ei iiibui	Schieff under title Aviii.	
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:

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

- 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

6.00

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm

	Wkst. A Line #	Cost Center/Physician I dentifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	4, 837, 191	4, 555, 742	281, 449	211, 500	1, 414	1.00
2. 00	30. 00	ADULTS & PEDIATRICS	1, 396, 552	1, 093, 676	302, 876	211, 500	3, 203	2.00
3. 00	31. 00	INTENSIVE CARE UNIT	26, 300	0	26, 300	211, 500	263	3.00
4. 00	41. 00	SUBPROVIDER - IRF	117, 479	0	117, 479	211, 500	4, 324	4.00
5. 00	50.00	OPERATING ROOM	1, 766, 952	0	1, 766, 952	246, 400	13, 484	5. 00
6. 00	53. 00	ANESTHESI OLOGY	45, 000	0	45, 000	246, 400	312	6. 00
7. 00	54. 00	RADI OLOGY-DI AGNOSTI C	67, 800	0	67, 800	271, 900	271	7. 00
8. 00		RADI OLOGY-THERAPEUTI C	103, 126	0		271, 900	836	
9. 00		CARDIAC CATHETERIZATION	100, 786		100, 786	211, 500	499	
10.00		LABORATORY-PATHOLOGI CAL	225, 000			260, 200	1, 722	
11. 00		RESPI RATORY THERAPY	12, 000			211, 500	80	
12. 00		PHYSI CAL THERAPY	23, 750			211, 500	119	
13. 00		ELECTROCARDI OLOGY	106, 372	0		211, 500	688	
14. 00		ELECTROENCEPHALOGRAPHY	9, 575	0		211, 500	96	
15. 00		NEUROPSYCH	186, 771	186, 771		211, 500	0	15. 00
16. 00		WOUND CENTER	36, 931	0		211, 500	132	16. 00
17. 00		HYPERBARIC OXYGEN THERAPY	4, 044	0	· ·	211, 500	14	17. 00
18. 00		EMERGENCY	2, 545, 239	0	2, 545, 239	211, 500	18, 802	18. 00
19. 00		AMBULANCE SERVICES	13, 125	0		211, 500	106	
20. 00		CARDIAC REHABILITATION	6, 623	0		211, 500	33	
200.00			11, 630, 616	5, 836, 189		,	46, 398	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	143, 779	7, 189		0	0	
2.00		ADULTS & PEDIATRICS	325, 690			0	0	
3.00		INTENSIVE CARE UNIT	26, 742	1, 337		0	0	3.00
4.00		SUBPROVI DER - I RF	439, 676			0	0	4.00
5. 00		OPERATING ROOM	1, 597, 335		_	0	0	5. 00
6.00		ANESTHESI OLOGY	36, 960		_	0	0	
7. 00 8. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	35, 425		-	0	0	
9. 00		CARDI AC CATHETERI ZATI ON	109, 283 50, 740	5, 464 2, 537		0	0	i
10.00		LABORATORY-PATHOLOGI CAL	215, 416		-	0	0	10.00
11. 00		RESPIRATORY THERAPY	8, 135	407		0	0	11.00
12. 00		PHYSI CAL THERAPY	12, 100	605		0	0	12.00
13. 00		ELECTROCARDI OLOGY	69, 958			0	0	13. 00
14. 00		ELECTROENCEPHALOGRAPHY	9, 762	488		0	0	14. 00
15. 00		NEUROPSYCH	0	0	_	0	0	15. 00
16. 00		WOUND CENTER	13, 422	671	0	0	0	16. 00
17. 00		HYPERBARIC OXYGEN THERAPY	1, 424	71	0	0	0	17. 00
18. 00	91. 00	EMERGENCY	1, 911, 838	95, 592	0	0	0	18.00
19. 00	95. 00	AMBULANCE SERVICES	10, 778	539		0	0	19.00
20. 00		CARDIAC REHABILITATION	3, 355	168	0	0	0	20.00
200. 00			5, 021, 818		0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1 00	2.00	14	14 00	17.00	10.00		
1. 00	1.00	2. 00 ADMI NI STRATI VE & GENERAL	15. 00 0	16. 00 143, 779	17. 00 137, 670	18. 00 4, 693, 412		1. 00
2. 00		ADULTS & PEDIATRICS				1, 093, 412		2.00
3. 00		INTENSIVE CARE UNIT		1		0		3.00
4. 00		SUBPROVI DER - I RF				0		4.00
5. 00		OPERATING ROOM		1, 597, 335		169, 617		5. 00
6. 00		ANESTHESI OLOGY	0	36, 960		8, 040		6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	0	35, 425		32, 375		7. 00
8. 00		RADI OLOGY-THERAPEUTI C	0	109, 283		0		8. 00
9. 00		CARDIAC CATHETERIZATION	0	50, 740		50, 046		9. 00
10. 00		LABORATORY-PATHOLOGI CAL	0	215, 416	9, 584	9, 584		10.00
11. 00		RESPI RATORY THERAPY	0			3, 865		11.00
12. 00		PHYSI CAL THERAPY	0	12, 100		11, 650		12.00
13.00	69. 00	ELECTROCARDI OLOGY	0	69, 958	36, 414	36, 414		13.00
14. 00	70. 00	ELECTROENCEPHALOGRAPHY	0	9, 762	0	0		14. 00
15. 00	90. 02	NEUROPSYCH	0	0	0	186, 771		15.00
16. 00		WOUND CENTER	0	13, 422	23, 509	23, 509		16. 00
17. 00		HYPERBARIC OXYGEN THERAPY	0	1, 424		2, 620		17. 00
18. 00		EMERGENCY	0			633, 401		18. 00
19. 00		AMBULANCE SERVICES	0	10, 778		2, 347		19. 00
20.00	76. 97	CARDIAC REHABILITATION	0			3, 268		20.00
200. 00	<u> </u>		0	5, 021, 818	1, 124, 406	6, 960, 595	<u> </u>	200. 00

| Period: | Worksheet B | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0112

COST Center Description					o 12/31/2017	Date/Time Pre		
Process Proc				CAPI TAL REI	LATED COSTS		10/29/2019 2:	12 piii
Process Proc		Coot Conton Dogoni ati on	Not Evpopos	DIDC 0 FLVT	MANDLE FOLLID	EMBL OVEE	Cub+a+al	
Chernel Service COST CENTERS 1.00 0.00, 408 1.00 2.00 4.00 4.00 1.00		cost center bescription		BLDG & FIXI	MARTE EGGLA		Subtotai	
CHARGE SERVICE CIDST CENTERS 0 1.00 2.00 4.00 4.00 4.00 1.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.00 0.000 4.			Allocation					
DEBERAL SERVICE COST CENTERS 10 1.00 2.00 6.90 4A								
1.00 100100 CAP REL CUSIS'-BLOB & FIRTY 10, 208, 408 10, 200, 400 20, 407, 40 40,				1. 00	2. 00	4. 00	4A	
2.00					ı			
4.00 0.000 DOBO PRINCY IT SIMPLIFIES DEPARTMENT 31,643, 297 1711,000 6,127 281,647,749 4,104,749 5.00 0.000 DOPO DOP					1			
7.00 COZOGO DEPERTION OF PLANT 8.00 CURRENI LABRIEY & LIMB SERVICE 9.07 (1.401 1) 1.077 9.00 DOSCO HURBRY & LIMB SERVICE 9.07 (1.401 1) 1.077 9.00 DOSCO HURBRY & LIMB SERVICE 9.07 (1.401 1) 1.077 9.00 DOSCO HURBRY & LIMB SERVICE 9.00 LIMB SERVICE 1.077 9.00 DOSCO HURBRY & LIMB SERVICE 9.00 LIMB SERVICE 1.077 9.00 DOSCO HURBRY & LIMB SERVICE 9.00 LIMB SERVICE 1.077					1	1		
8.00 0.0800 JAUNDRY & LINEN SERVICE 671, 461 11,077 0 0 0.0800 JAUNDRY & LINEN SERVICE 874, 13,07 72, 172 44, 671 616, 167 3,274, 464 9.00 10.00 0.000 ETARY 110,00 1								
9.00 0.0900 0.0900 0.0900 0.0900 0.0900 0.0900 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000								
11.00 01100 CAFETERIA 975.892 80,445 34,795 501.741 1.598.873 11.00 1030 01300 CAFETERIA 4.217.888 136.275 67.05 1.326.971 5.707.331 13.00 13.00 01300 CANTRAL SERVICES & SURPLY 1.098.187 106,444 99.386 91.304.071 11.00 1050					1		·	
13.00 01300 NIRESTING AMMINISTRATION 4, 217, 888 136, 725 67, 053 6, 053 0, 013, 00 13.00 15.00 01500 PARAMACY 5, 426, 618 66, 222 267, 447 1, 261, 529 7, 021, 716 15.00 10500 PARAMACY 1, 367, 467 5, 426, 618 66, 222 267, 447 1, 261, 529 7, 021, 716 15.00 10500 PARAMACY 1, 367, 467 5, 426, 618 66, 222 27, 447 1, 261, 529 7, 021, 716 15.00 10500 PARAMACY 1, 367, 467 1,								
14.00 01400 CENTRAL SERVICES & SUPPLY 1.098.187 106.444 97.386 0 1.304,017 14.00 10.00 10.00 10.00 MEDICAL RECORDS & LIBRARY 1.387.407 56.300 38.607 328.408 1.810,790 16.00 17.00 1								
16.00 01-60 MEDICAL RECORDS & LIBRARY 1.387, 467 56, 306 38, 600 328, 408 1.810, 700 16.00 0.0								•
17.00 17.0								
23.00 02300 PARAMED ED PROM. (SPECIFY)								
12.0 20.00 PIANBARCY RESIDENCY PROG 388, 666 5, 259 0 139,071 532,996 20.00					l .			
INPATI ENT ROUTINE SERVICE COST CENTERS 15,239,579 1,072,496 373,334 4,917,407 21,002,876 30 00 310 00 30100 AURITS & PEDIATRICS 3,387,131 153,266 144,522 787,632 4,472,553 31 00 32 00 320 00					l .			
10.00 03000 ADULTS & PEDIATRICS 15,299,579 1,7074,496 373,334 4,171,407 21,602,876 30.00 30.00 3000 0300 03000 0700 0 0 0 0 0 0 0	23. 02		388, 666	5, 259	' <u> </u>	139, 071	532, 996	23.02
32 00 30200 CORROMARY CARE UNIT 0 0 0 0 0 0 32 00	30. 00		15, 239, 579	1, 072, 496	373, 334	4, 917, 467	21, 602, 876	30. 00
33 00			3, 387, 131					
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0				
1.00 0.4100 SUBPROVI DER 1.1 1.588, 263 155, 030 17, 829 513, 096 2, 274, 218 41, 00			0	Ö				
42 00 04200 SUPROVI DER 0 0 0 0 0 0 0 0 0			0	0	1	-		
43.00 04300 NURSERY 679,733 8, 154 16,785 241,171 945,843 44,00			1, 588, 263	155, 030	1			
ANCILLARY SERVICE COST CENTERS			679, 733	8, 154	1	_		
50.00 05000 0FEATH ING ROOM 21, 077, 444 546, 486 1, 114, 317 247, 893 22, 986, 140 50.00 51.00 05100 060 07.00 07.00 07.00 07.00 08.00 05.20 05.200 0	44. 00		0	0	0	0	0	44. 00
1.	50.00		21, 077, 444	546, 486	1. 114. 317	247, 893	22. 986. 140	50.00
53.00 05300 AMESTHESI OLOGY 295, 255 1, 664 7, 034 0 303, 953 53.00		05100 RECOVERY ROOM						
54.00 05400 RADIOLOGY-DI AGNOSTIC 2,124,921 121,045 127,039 534,497 2,907,502 54.00		05200 DELIVERY ROOM & LABOR ROOM	0	_	1	_		
54.02 OS402 NUCLEAR MEDI CI NE-DI AGNOSTIC 1, 403, 659 47, 327 6, 701 134, 762 1, 592, 449 54. 01 54.02 OS404 ULTRA SQUIND 782, 877 21, 034 72, 067 167, 795 1, 043, 773 54. 02 54.03 OS500 CABDI AGNOGRAPHY 1, 191, 021 3, 818 81, 544 270, 489 1, 546, 872 54. 03 55.00 OS5000 CT SCAN 938, 779 25, 146 292, 333 217, 693 1, 473, 951 57. 00 58.00 OS5000 CT SCAN 938, 779 25, 146 292, 333 217, 693 1, 473, 951 57. 00 58.00 OS5000 CARDI AC CATHETERI ZATI ON 2, 271, 055 149, 142 43, 238 579, 250 3, 042, 685 59. 00 60.00 OS000 LABORATORY 7, 853, 895 145, 576 131, 757 1, 447, 509 9, 578, 737 60. 00 60.01 OSC00 MHOLE BLOOD & PACKED RED BLOOD CELL 646, 289 7, 328 4, 323 16, 852 674, 792 62. 00 65.00 OSC00 WHOLE BLOOD & PACKED RED BLOOD CELL 646, 289 7, 328 4, 323 16, 852 674, 792 62. 00 66.00 OSC00 OSC00 OSC00 CABDIAC LHERAPY 1, 899, 413 92, 640 122, 778 589, 958 2, 695, 789 65. 00 67.00 OSC00 OSC00 PATISICAL HERAPY 1, 288, 843 3, 091 5, 124 396, 225 1, 693, 283 67. 00 68.00 OSG00 OSECOL PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 69.00 OSG00 OSECOL PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 69.00 OSG00 OSECOL PATHOLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 6, 729, 620 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
54.03 05405 MAMMOGRAPHY	54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 403, 659	47, 327	6, 701	134, 762	1, 592, 449	54. 01
55.00 05500 RADI OLOGY-THERAPEUTI C 2, 523, 165 103, 941 744, 091 602, 082 3, 973, 279 55.00 57.00 05700 CT SCAN 938, 779 25, 146 292, 333 217, 693 1, 473, 951 57.00 58.00 05800 MRI 427, 246 12, 587 7, 059 103, 484 550, 376 58.00 05900 CARDI AC CATHETER IZATI ON 2, 271, 055 149, 142 43, 238 579, 250 3, 042, 685 59.00 05900 CARDI AC CATHETER IZATI ON 2, 271, 055 149, 142 43, 238 579, 250 3, 042, 685 59.00 05900 CARDI AC CATHETER IZATI ON 2, 271, 055 149, 142 43, 238 579, 250 3, 042, 685 59.00 05900 CARDIA CORPATORY 7, 853, 895 145, 576 131, 757 1, 447, 509 9, 578, 737 60.00 06000 LABORATORY - PATHOLOGI CAL 782, 505 16, 950 12, 695 117, 309 929, 459 60.01 60.00 06500 RESPI RATORY THERAPY 1, 890, 413 92, 640 122, 778 589, 958 2, 695, 799 65.00 06500 RESPI RATORY THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66.00 660, 00 6								
57.00 05700 CT SCAN 938, 779 25, 146 292, 333 217, 693 1, 473, 951 57.00 58.00 05800 MRI 427, 246 12, 587 7, 059 103, 484 550, 376 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 271, 055 149, 142 43, 238 579, 250 3, 042, 685 59.00 60.01 06000 LABORATORY 7, 853, 895 145, 576 131, 757 1, 447, 509 9, 578, 737 60.00 60.01 06000 LABORATORY 60.001 12, 695 117, 309 992, 459 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 646, 289 7, 328 4, 323 16, 852 674, 792 62.00 65.00 06500 RESPI RATORY THERAPY 1, 890, 413 92, 640 122, 778 589, 958 2, 695, 789 65.00 66.00 06600 PHYSI CAL THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66.00 06600 PHYSI CAL THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66.00 06600 DECLIPATIONAL THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 67.00 06700 OCCUPATI ONAL THERAPY 1, 288, 843 3, 091 5, 124 396, 225 1, 693, 283 67.00 68.00 06800 SPEECH PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68.00 69.00 06900 ELECTROCARDI OLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68.00 69.00 06900 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 6, 729, 620 0 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 17, 460, 581 0 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74.00 75.07 76797 CARDI ACR EMBILLI TATI ON 386, 221 22, 111 13, 815 79, 165 501, 312 76.07 07907 CARDI ACR EMBILLI TATI ON 386, 221 22, 111 13, 815 79, 165 501, 312 76.00 09000 NURAL HEALTH CLINIC 0 0 0 0 0 76.00 09000 NURAL HEALTH CLINIC 0 0 0 0 76.00 09000 NURAL HEALTH CLINIC 1, 437, 741 0 1, 731 147, 502 1, 586, 749 76.00 0900								
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60. 00 06000 LABORATORY 7, 853, 895 145, 576 131, 757 1, 447, 509 9, 578, 737 60. 00 06001 LABORATORY-PATHOLOGI CAL 782, 505 16, 950 12, 695 117, 309 929, 459 60. 01 06001 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 646, 289 7, 328 4, 323 16, 852 674, 792 62. 00 06500 RESPI RATORY THERAPY 1, 890, 413 92, 640 122, 778 589, 958 2, 695, 789 65. 00 06500 RESPI RATORY THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66. 00 06700 0CCUPATI ONAL THERAPY 1, 288, 843 3, 091 5, 124 396, 225 1, 693, 283 67. 00 680 09000 ELECTROCARDI OLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 06800 SPECCH PATHOLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 642, 022 0 12, 079 232, 851 1, 186, 952 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 6, 729, 620 0 0 0 0 6, 729, 620 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 8, 395, 290 0 0 0 0 0 8, 395, 290 72. 00 73. 00 07400 RENAL DI ALYSIS 568, 428 0 63 123 568, 614 74. 00 7								
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65. 00 06500 RESPIRATORY THERAPY 1, 890, 413 92, 640 122, 778 589, 958 2, 695, 789 65. 00 66. 00 06600 PHYSI CAL THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66. 00 06700 DCUPATI ONAL THERAPY 1, 288, 843 3, 091 5, 124 396, 225 1, 693, 283 67. 00 68. 00 06800 SPEECH PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 06900 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 07000 ELECTROCARDI OLOGY 649, 00 0 0 0 0, 00								
66. 00 06600 PHYSICAL THERAPY 4, 130, 957 3, 175 24, 170 1, 326, 671 5, 484, 973 66. 00 6700 0CCUPATI ONAL THERAPY 1, 288, 843 3, 991 5, 124 396, 225 1, 693, 283 67. 00 68. 00 06800 SPECCH PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 06900 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 942, 022 0 12, 079 232, 851 1, 186, 952 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 6, 729, 620 0 0 0 0 6, 729, 620 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 8, 395, 290 0 0 0 0 8, 395, 290 72. 00 73. 00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74. 00 76. 00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74. 00 76. 00 07697 CARDI AC REHABI LI TATI ON 386, 221 22, 111 13, 815 79, 165 501, 312 76. 97 0017PATI ENT SERVI CE COST CENTERS 88. 00 08900 FOBERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 0 0							·	•
67. 00 06700 OCCUPATI ONAL THERAPY 1, 288, 843 3, 091 5, 124 396, 225 1, 693, 283 67. 00 68. 00 06800 SPEECH PATHOLOGY 879, 988 0 23, 335 278, 609 1, 181, 932 68. 00 70. 00 06900 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 70. 00 07000 ELECTROCARDI OLOGY 942, 022 0 12, 079 232, 851 1, 186, 952 70. 00 71. 00 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 6, 729, 620 0 0 0 0 0 6, 729, 620 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 8, 395, 290 0 0 0 0 0 8, 395, 290 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 17, 460, 581 0 0 0 0 17, 460, 581 73. 00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 76. 00 76. 00 77. 00 07400 RENAL DI ALYSI S 568, 428 0 0 63 123 568, 614 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 0 0 0 76. 00 76. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1		•
69. 00 06900 ELECTROCARDI OLOGY 659, 685 19, 552 35, 178 205, 734 920, 149 69. 00 70. 00 07000 ELECTROREPHALOGRAPHY 942, 022 0 12, 079 232, 851 1, 186, 952 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 6, 729, 620 0 0 0 0 0 8, 395, 290 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 8, 395, 290 0 0 0 0 8, 395, 290 72. 00 07300 DRUGS CHARGED TO PATI ENTS 17, 460, 581 0 0 0 0 17, 460, 581 73. 00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 0 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 76. 00 76. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								•
70.00 07000 ELECTROENCEPHALOGRAPHY 942,022 0 12,079 232,851 1,186,952 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 6,729,620 0 0 0 6,729,620 71.00 72.00 70.00 MPU. DEV. CHARGED TO PATIENTS 8,395,290 0 0 0 0 8,395,290 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 17,460,581 0 0 0 0 0 17,460,581 73.00 74.00 07400 RENAL DI ALYSIS 568,428 0 63 123 568,614 74.00 76.00 76.00 70.697 CARDI AC REHABI LI TATI ON 386,221 22,111 13,815 79,165 501,312 76.97 79,165 79,					1			•
71. 00								•
73.00 07300 DRUGS CHARGED TO PATIENTS 17, 460, 581 0 0 0 17, 460, 581 73.00 74.00 07400 RENAL DI ALYSIS 568, 428 0 63 123 568, 614 74.00 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 76.00 76.97 OT697 CARDI AC REHABI LI TATI ON 386, 221 22, 111 13, 815 79, 165 501, 312 76.97 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 0 89.00 90.01 09001 DI ABETES CENTER 235,076 10,839 887 38,958 285,760 90.01 90.02 O9002 NEUROPSYCH 132,880 1,650 321 44,846 179,697 90.02 90.04 O9004 HYPERBARIC OXYGEN THERAPY 199,573 0 <t< td=""><td></td><td></td><td></td><td>_</td><td></td><td></td><td></td><td></td></t<>				_				
74. 00 07400 RENAL DI ALYSI S 568, 428 0 63 123 568, 614 74. 00 76. 00 0 0 0 0 0 0 76. 00 76.			1 ' ' '	0	1	1		
76. 00				0	-	1		
SECTION SERVICE COST CENTERS SECTION S					o c	0		
88. 00	76. 97		386, 221	22, 111	13, 815	79, 165	501, 312	76. 97
89. 00	88 00		0	0		ol	0	88 00
90. 01 09001 DI ABETES CENTER 235, 076 10, 839 887 38, 958 285, 760 90. 01 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 03 90. 04 90. 04 90. 04 90. 04 90. 05 90. 05 90. 05 90. 05 90. 06		08900 FEDERALLY QUALIFIED HEALTH CENTER	O		o c	O		
90. 02 09002 NEUROPSYCH 132, 880 1, 650 321 44, 846 179, 697 90. 02 90. 03 90. 04 90. 03 90. 04 90. 04 90. 05 90. 05 90. 06								•
90. 03 09003 WOUND CENTER 1,437,741 0 1,731 147,502 1,586,974 90. 03 90. 04 90. 04 90. 05 09005 VI MCARE CLINIC 572,614 59,509 5,598 180, 152 817,873 90. 05 90. 06 09006 MEDICATION MGMT CLINIC 253,722 951 0 91,625 346,298 90. 06 91. 00 09100 EMERGENCY 8,302,038 254,677 384,526 1,969,760 10,911,001 91. 00								
90. 05 09005 VI MCARE CLINI C 572, 614 59, 509 5, 598 180, 152 817, 873 90. 05 90. 06 09006 MEDICATION MGMT CLINI C 253, 722 951 0 91, 625 346, 298 90. 06 91. 00 09100 EMERGENCY 8, 302, 038 254, 677 384, 526 1, 969, 760 10, 911, 001 91. 00					1	1		
90.06 09006 MEDICATION MGMT CLINIC 253, 722 951 0 91, 625 346, 298 90.06 91.00 09100 EMERGENCY 8, 302, 038 254, 677 384, 526 1, 969, 760 10, 911, 001 91.00				Ĭ	1			
91. 00 09100 EMERGENCY 8, 302, 038 254, 677 384, 526 1, 969, 760 10, 911, 001 91. 00								
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 92. 00	91.00	09100 EMERGENCY				, , ,	10, 911, 001	91.00
	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

Health Financial Systems	COLUMBUS REGIO	NAI HOSPITAI		Inlie	u of Form CMS-2	2552_10
COST ALLOCATION - GENERAL SERVICE COSTS	COLUMBOS REGIO	Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 10/29/2019 2:	pared:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2. 00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 086, 870	112, 332	336, 02	0 1, 134, 647	4, 669, 869	
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 0					
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111. 00 11100 SLET ACQUISITION	0	Ü		0	U	111.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	220 140 004	10, 111, 362	0 712 40	5 28, 526, 994	228, 144, 720	113.00
NONREIMBURSABLE COST CENTERS	229, 169, 096	10, 111, 302	9, 713, 48	5 20, 320, 994	220, 144, 720	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		10, 167	35	8 0	10, 525	190 00
194. 00 07950 WELLNESS COMMUNITY	270, 435	10, 107	8, 76			
194. 01 07951 BUILDING RENTALS	127, 961	0	0,70	0 02,000	127, 961	
194. 02 07952 HOSPI CE	97, 336	0		0	97, 336	
194. 03 07953 OUTREACH CLINICS	0	0		o o		194. 03
194. 04 07954 SPEECH - HEARING AIDS	302, 784	0		ol o	302. 784	
194. 05 07955 NONALLOWABLE MARKETING	1, 620, 965	0		ol ol	1, 620, 965	
104 OCOTOF CODU FOUNDATION	10,054	44 000	٦.,	0 4 050	20,001	

179, 057

19, 900

11, 398

16, 713

51, 705

10, 208, 408

7, 063

719

795, 358

10, 520, 060

1, 374

0

0

4, 850

0

53, 220

28, 647, 749

1, 620, 965 13, 254

231, 800, 788

1, 620, 965 194. 05 30, 221 194. 06 248, 990 194. 07

248, 990 194. 07 866, 963 194. 08 8, 437 194. 09 0 200. 00 0 201. 00 231, 800, 788 202. 00

194. 06 07956 CRH FOUNDATION 194. 07 07957 HEALTHY COMMUNITIES

194.09 07959 NEUROPSYCH PART B
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers

TOTAL (sum lines 118 through 201)

194. 08 07958 CRHP

202.00

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				72/31/2017	10/29/2019 2:	
Cost Center Description	ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT 7.00	LINEN SERVICE	0.00	10.00	
GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTM						4.00
5.00 00500 ADMINISTRATIVE & GENERAL	42, 104, 749					5.00
7.00 00700 OPERATION OF PLANT	2, 866, 593	15, 781, 561				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	153, 322	42, 956	887, 045			8. 00
9. 00 00900 HOUSEKEEPI NG	715, 654		0	4, 219, 620		9. 00
10. 00 01000 DI ETARY	261, 202		0	29, 803	1, 894, 330	10.00
11. 00 01100 CAFETERI A	354, 884		0	65, 401	0	11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	1, 266, 749		0	11, 590	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	289, 438 1, 558, 533		0	40, 565 33, 942	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY		218, 360	0	33, 742	0	16.00
17. 00 01700 SOCI AL SERVI CE	163, 587	16, 380	0	0	0	17.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	100,007		0	Ö	0	23.00
23. 01 02301 XRAY EDUCATION	139, 420	1	0	Ö	0	23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	118, 303		0	2, 484	0	23. 02
INPATIENT ROUTINE SERVICE COST						
30. 00 03000 ADULTS & PEDIATRICS	4, 794, 953	4, 159, 249	387, 308	1, 367, 631	1, 452, 076	30.00
31.00 03100 INTENSIVE CARE UNIT	992, 723	594, 388	47, 132	129, 975	182, 635	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	33.00
34. 00 03400 SURGICAL INTENSIVE CARE U		1	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		0	0	0	40.00
41. 00 04100 SUBPROVI DER - RF	504, 783	1	46, 334	144, 876	199, 803	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	200, 020	1	12 772	0	0	42.00
43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	209, 938		13, 772 0	828 0	0	43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS		0	U	U	0	44.00
50. 00 05000 OPERATING ROOM	5, 101, 989	2, 119, 326	138, 974	713, 618	3, 952	50.00
51. 00 05100 RECOVERY ROOM	301, 905		32, 114	49, 672	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROO			0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	67, 465	6, 454	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	645, 346	469, 425	72, 629	145, 704	1, 039	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOST			0	62, 090	0	54. 01
54.02 05404 ULTRA SOUND	231, 675	81, 573	0	29, 803	0	54.02
54.03 05405 MAMMOGRAPHY	343, 342		7, 383	39, 737	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	881, 905		11, 065	81, 958	8, 393	55.00
57. 00 05700 CT SCAN	327, 157		0	16, 557	0	57.00
58. 00 05800 MRI	122, 161	48, 814	0	9, 934	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	675, 351	578, 387	1, 918	110, 934	4, 453	59.00
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL	2, 126, 087 206, 302		0	60, 434 3, 311	0	60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED			0	2, 484	0	62.00
65. 00 06500 RESPIRATORY THERAPY	598, 355		0	119, 212	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 217, 439		13, 181	117, 212	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	375, 839			0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	262, 340		0	Ö	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	204, 235		0	24, 836	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	263, 455		1, 275	152, 327	2, 113	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED			0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PAT		0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 875, 533	0	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	126, 209		0	0	0	74.00
76. 00 03020 ACUPUNCTURE	0	1	0	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	111, 271	85, 749	0	2, 484	0	76. 97
OUTPATIENT SERVICE COST CENTERS	_					00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALT	U CENTED 0	0	0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALT 90. 00 09000 CLINIC	353, 881	386, 550	37, 984	81, 131	28, 786	89. 00 90. 00
90. 01 09001 DI ABETES CENTER	63, 427	42, 034	37, 7 04	1, 656	28, 780	90.00
90. 02 09002 NEUROPSYCH	39, 885		0	1, 030	0	90.02
90. 03 09003 WOUND CENTER	352, 243		3, 010	0	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY			192	ol	0	90.04
90. 05 09005 VI MCARE CLINIC	181, 534		3, 035	163, 917	0	90.05
90.06 09006 MEDICATION MGMT CLINIC	76, 864		0	10, 762	0	90.06
91. 00 09100 EMERGENCY	2, 421, 795	987, 663	0	464, 431	11, 080	91.00
92.00 O9200 OBSERVATION BEDS (NON-DIS						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	1, 036, 519		60, 073	0	0	95.00
99. 10 09910 CORF	0		0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

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Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	E & GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10. 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 through 117)	41, 293, 250	15, 405, 207	887, 045	4, 174, 087	1, 894, 330 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 336	•	0	0	0 190.00
194. 00 07950 WELLNESS COMMUNITY	75, 885		0	0	0 194.00
194. 01 07951 BUI LDI NG RENTALS	28, 402		0	0	0 194. 01
194. 02 07952 HOSPI CE	21, 605	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	67, 206		0	0	0 194.04
194. 05 07955 NONALLOWABLE MARKETING	359, 788		0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	6, 708	•	0	43, 877	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	55, 266		0	1, 656	0 194. 07
194. 08 07958 CRHP	192, 430			0	0 194. 08
194.09 07959 NEUROPSYCH PART B	1, 873	27, 390	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	42, 104, 749	15, 781, 561	887, 045	4, 219, 620	1, 894, 330 202. 00

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CAFETERIA NURSING CENTRAL PHARMACY MEDICAL RECORDS & SERVICES & SERVICES & LI BRARY	1.00
11. 00 13. 00 14. 00 15. 00 16. 00 GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FIXT	
1. 00 00100 CAP REL COSTS-BLDG & FIXT	
2 00 00200 CAR REL COSTS MARIE FOLLID	
Z. OU	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	5.00
7. 00 00700 OPERATION OF PLANT	7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	8. 00
9. 00 00900 HOUSEKEEPI NG	9. 00
10. 00 01000 DI ETARY	10.00
11. 00 01100 CAFETERI A 2, 354, 399	11. 00
13.00 01300 NURSI NG ADMI NI STRATI ON 84, 472 7, 598, 430	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 25, 992 0 2, 072, 813	14.00
15. 00 01500 PHARMACY 80, 141 519, 153 0 9, 470, 299	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 67, 145 0 0 0 2, 498, 2	
17. 00 01700 SOCI AL SERVI CE 17, 328 0 0 0	17.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0	23.00
23. 01 02301 XRAY EDUCATI ON 15, 162 0 0 0	23. 01
23. 02 02302 PHARMACY RESI DENCY PROG 8, 664 57, 570 0 0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	- 20 00
30. 00 03000 ADULTS & PEDIATRICS 534, 989 3, 492, 630 93, 226 7, 552 574, 2-31. 00 03100 INTENSIVE CARE UNIT 71, 477 468, 768 3, 884 4, 435 55, 2-4 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,	
31. 00 03100 I NTENSI VE CARE UNI T 71, 477 468, 768 3, 884 4, 435 55, 2' 32. 00 03200 CORONARY CARE UNI T 0 0 0 0	3 31.00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0	32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	34.00
40. 00 04000 SUBPROVI DER - PF	40.00
41. 00 04100 SUBPROVI DER - RF 49, 817 323, 077 0 184 73, 9	
42. 00 04200 SUBPROVI DER	42.00
43. 00 04300 NURSERY	43.00
44.00 04400 SKILLED NURSING FACILITY 0 0 0	44.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 253, 417 0 1, 856, 419 35, 516 747, 7	50.00
51. 00 05100 RECOVERY ROOM 28, 157 0 0 215	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0	52.00
53. 00 05300 ANESTHESI OLOGY 2, 166 0 57, 722	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 45, 485 0 2, 266 2, 904	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 10, 830 0 148, 336	54.01
54. 02 05404 ULTRA SOUND 12, 996 0 0 260	54.02
54. 03 05405 MAMMOGRAPHY 25, 992 0 2, 266 372	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C 36, 821 0 0 69, 7	•
57. 00 05700 CT SCAN 19, 494 0 0 9, 518	57.00
58. 00 05800 MRI	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 43, 319 0 17, 965 5, 588 225, 18	•
60. 00 06000 LABORATORY 177, 609 0 280	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 2, 166 0 0 0 65. 00 06500 RESPIRATORY THERAPY 56, 315 368, 059 4, 208 6, 620 43, 75	
65. 00 06500 RESPI RATORY THERAPY 56, 315 368, 059 4, 208 6, 620 43, 79 66. 00 06600 PHYSI CAL THERAPY 110, 464 0 31, 561 1, 525 13, 29 10, 20	
67. 00 06700 OCCUPATI ONAL THERAPY 28, 157 0 0 128 2, 79	
68. 00 06800 SPEECH PATHOLOGY 21, 660 0 0 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 17, 328 0 0 3, 415	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 9, 138, 638	73.00
74. 00 07400 RENAL DI ALYSI S 0 6, 070	74.00
76. 00 03020 ACUPUNCTURE 0 0 0 0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 6, 498 0 0 89	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 0 0	89.00
90. 00 09000 CLI NI C 32, 489 0 7, 445 77 350, 13	
90. 01 09001 DI ABETES CENTER 4, 332 0 0 0	90.01
90. 02 09002 NEUROPSYCH	90.02
90. 03 09003 WOUND CENTER 15, 162 0 45, 480 16, 721 3, 177	90.03
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 2, 166 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90.04
90. 05 09005 VI MCARE CLI NI C 19, 494 134, 076 0 8, 256 4, 232 34, 457 0 4, 232 1, 24, 457 1, 24, 467 1, 24,	90.05
90. 06 09006 MEDI CATI ON MGMT CLI NI C 4, 332 34, 657 0 403 104 034 1 005 327 5 237 6 005	90.06
91. 00 09100 EMERGENCY 194, 936 1, 095, 387 5, 827 6, 905	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	92.00
95. 00 09500 AMBULANCE SERVI CES 151, 617 974, 144 0 7, 553	95.00
99. 10 09910 CORF 0 0 0 0 0 0 0 0 0	99.10
101. 00 10100 HOME HEALTH AGENCY 0 0 0	0 101.00

			10	12/31/2017	10/29/2019 2:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 1	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	110.00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 1	111. 00
113.00 11300 INTEREST EXPENSE					1	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 339, 237	7, 598, 430	2, 072, 813	9, 469, 754	2, 498, 216 1	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	8, 664	0	0	0		194.00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	I	194. 01
194. 02 07952 HOSPI CE	0	0	0	545	I	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0	I	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 1	194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0	0 1	194.06
194. 07 07957 HEALTHY COMMUNITIES	4, 332	0	0	0	0 1	194. 07
194. 08 07958 CRHP	0	0	0	0	0 1	194. 08
194. 09 07959 NEUROPSYCH PART B	2, 166	0	0	0	0 1	194. 09
200.00 Cross Foot Adjustments					2	200.00
201.00 Negative Cost Centers	0	0	0	0	0 2	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 354, 399	7, 598, 430	2, 072, 813	9, 470, 299	2, 498, 216 2	202.00

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				12/31/2017	10/29/2019 2:	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY	Subtotal	
	17. 00	23. 00	23. 01	PROG 23. 02	24. 00	
GENERAL SERVICE COST CENTERS	17.00	23.00	23.01	25.02	24.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY						15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	934, 310					17. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	934, 310	0				23. 00
23. 01 02300 FARAWED ED FROM (GFECTIT)	0	U	791, 502			23. 00
23. 02 02302 PHARMACY RESI DENCY PROG	0		771, 302	740, 410		23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			740, 410		23.02
30. 00 03000 ADULTS & PEDIATRICS	270, 951	0	0	ol	38, 737, 686	30. 00
31. 00 03100 INTENSIVE CARE UNIT	66, 336	0	Ö	ol	7, 089, 599	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	o	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	o	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	o	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	O	o	0	40.00
41. 00 04100 SUBPROVI DER - I RF	148, 555	0	0	0	4, 366, 843	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	0	0	0	0	1, 354, 588	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS	-1					
50. 00 05000 OPERATI NG ROOM	0	0	0	0	33, 957, 124	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	1, 944, 994	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	701 500	0	437, 760	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	791, 502	U	5, 083, 802	54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0	0	U	2, 350, 702	54.01
54. 02 05404 ULTRA SOUND 54. 03 05405 MAMMOGRAPHY	0	0	0	0	1, 400, 080 1, 980, 771	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	55, 124	0	0	0	5, 521, 349	55. 00
57. 00 05700 CT SCAN	33, 124	0	0	0	1, 944, 196	57.00
58. 00 05800 MRI	0	0	0	0	740, 403	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	Ö	4, 705, 784	59. 00
60. 00 06000 LABORATORY	0	0	0	o	12, 507, 704	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0	Ö	ol	1, 446, 480	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	O	o	857, 638	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	o	4, 251, 584	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	o	6, 884, 745	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	o	2, 121, 817	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	1, 465, 932	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	1, 245, 787	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 736, 831	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8, 223, 320	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10, 258, 700	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	740, 410	31, 215, 162	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	700, 975	74.00
76. 00 03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	55, 124	0	0	U	762, 527	76. 97
OUTPATIENT SERVICE COST CENTERS	٥	0		ما	0	00 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	O O	0	88. 00 89. 00
90. 00 09000 CLINIC	109, 314	0	0	0	2, 982, 200	90.00
90. 01 09001 DI ABETES CENTER	109, 314	0	0	0	397, 209	90.00
90. 02 09002 NEUROPSYCH	0	0	0	0	228, 148	90.01
90. 03 09003 WOUND CENTER	0	0		Ö	2, 019, 590	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	n	0	ا	n	274, 287	90. 04
90. 05 09005 VI MCARE CLI NI C	0	0		o N	1, 558, 965	90. 05
90. 06 09006 MEDICATION MGMT CLINIC	n	0	ا	n n	477, 004	90.06
91. 00 09100 EMERGENCY	228, 906	0	l o	ol O	16, 327, 931	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, ,30	· ·		Ĭ	-,, , , , ,	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	7, 335, 410	95.00
99. 10 09910 CORF	0	0	0	o	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
			<u> </u>			

			To	o 12/31/2017	Date/Time Prepared: 10/29/2019 2:12 pm
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal
, , , , , , , , , , , , , , , , , , ,	SERVI CE	PRGM	EDUCATI ON	RESI DENCY	
				PROG	
	17. 00	23. 00	23. 01	23. 02	24. 00
SPECIAL PURPOSE COST CENTERS				<u>.</u>	
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 through 117)	934, 310	0	791, 502	740, 410	<u>226, 895, 627</u> 118. 00
NONREI MBURSABLE COST CENTERS	_				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	52, 292 190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	0	426, 435 194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	156, 363 194. 01
194. 02 07952 H0SPI CE	0	0	0	0	119, 486 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194. 04 07954 SPEECH - HEARING ALDS	0	0	0	0	369, 990 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	1, 980, 753 194. 05
194. 06 07956 CRH FOUNDATI ON	0	0	0	0	125, 009 194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	375, 058 194. 07
194. 08 07958 CRHP	0	0	0	0	1, 259, 909 194. 08
194.09 07959 NEUROPSYCH PART B	0	0	0	0	39, 866 194. 09
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 through 201)	934, 310	0	791, 502	740, 410	231, 800, 788 202. 00

Company				To 12/31/2017 Date/Time P 10/29/2019	
1.00	Cost Center Description	Residents Cost & Post Stepdown	Total	10,27,2017	2. 12 pm
COLOR SERVICE COST CENT HIST 1 00 00100 CAP REL COSTS-LANDE FOURTH 1 0 0 0000 CAP REL COSTS-LANDE FOURTH 1 0 0 0 0000 CAP REL COSTS CAP REL COST			26.00		
1.00	GENERAL SERVICE COST CENTERS	25.00	20.00		
4.00 0.0400 DIPLICYCE BEWEIT TS DEPARTWENT					1.00
D. DIG DOSED ADMINISTRATIVE & GENERAL					
0.00700 0.00	· ·				
8 00 08000 JAURORY & LINEN SERVICE 9.00 08000 JAURORY & LINEN SERVICE 9.00 08000 JAURORY & LINEN SERVICE 9.00 10.00 JAURORY & LINEN SERVICES 8.19PLY 1.10.00 11.00 JAURORY & LINEN SERVICES 9.19PLY 1.10.00 11.00 JAURORY & LINEN SERVICES 9.10 JAU	· ·				
9.00 00900 0015KEPEP INS 9.00 11.00 01000 015KEPEP INS 11.00 015KEP INS 11.00 015KEP INS 11.00 015KEP INS 015KEP IN					1
10.00 1000 DETARY 10.00 10.00 DETARY 11.00 11.00 11.00 CAFFERT A 11.00 1	· ·				1
11.00 01100 CAPETERIA 11.00 13.00	· · · · · · · · · · · · · · · · · · ·				1
13.00 01300 MIRSH NG ABM IN STRATION 11.00					1
15.00					
16. 00 10-000 MEDICAL, RECORDS & LIBRARY	14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
17.00 1700 SOCIAL SERVICE					
23.00					
23.01 0220 PHANNECY RESIDENCY PROG					
23. 02	, , ,				
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30					
31.00 03100 INTENSI VE CARE UNIT			'		
32.00 03200C CORDMARY CARE UNIT	30. 00 03000 ADULTS & PEDIATRICS	0	38, 737, 686		30.00
33 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 40 00 104000 SURGICAL INTENSIVE CARE UNIT 0 0 0 4.00 40 00 104000 SURGICAL INTENSIVE CARE UNIT 0 0 0 4.00 41 00 104000 SURGICAL INTENSIVE CARE UNIT 0 0 0 4.36.843 41.10 42 00 104200 SUBPROVIDER - INF 0 4.366.843 41.10 42 00 104200 SUBPROVIDER - INF 0 0 4.366.843 41.00 43 00 104200 SUBPROVIDER - INF 0 0 1.354.58B 43.00 44 00 10400 SINJECED UNISHING FACILITY 0 0 0 0 42.00 AMOUNT LIARTY SERVICE COST CENTERS 50 00 105000 DEEDATING ROOM 0 1.944.994 51.00 51 00 105000 DEEDATING ROOM 0 1.944.994 51.00 52 00 105200 DELIVERY ROOM LABOR ROOM 0 1.944.994 51.00 52 00 105200 DELIVERY ROOM LABOR ROOM 0 1.944.994 51.00 52 00 105200 DELIVERY ROOM ALABOR ROOM 0 1.944.994 51.00 52 00 105200 DELIVERY ROOM ALABOR ROOM 0 1.944.994 51.00 52 00 105400 RESTRIES 10.00 INFO CONTROL CONT			7, 089, 599		
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 44. 00 0400 04000 SUBPROVIDER - I PF 0 0 0 04. 00 0400 04100 SUBPROVIDER - I PF 0 0 0 04. 00 0420 04200 04		i i			
40. 00 04000 SUBPROVI DER - 1 PF 0 0 4, 366, 843 41, 00 410 0		0	0		
14. 00 04100 SUBPROVI DER - 1 RF 0 4. 366, B43 4.1 0.0	l l	0	O O		
42.00 04200 SUBROVI DER 0	· · · · · · · · · · · · · · · · · · ·	- I	4 366 843		
43.00 04300 NURSERY 0 1, 354, 588 43.00 44.00 AMCULARY SERVICE COST CENTERS 50.00 50.00 0500 0PERATIN ROOM 0 33, 957, 124 55.00 55.00 05100 0PERATIN ROOM 0 1, 944, 994 55.00 55.00 05100 0PERATIN ROOM 0 1, 944, 994 55.00 55.00 05100 0ELI VERY ROOM & LABOR ROOM 0 52.00 05200 0ELI VERY ROOM & LABOR ROOM 0 437, 760 53.00 05300 ANESTHESI OLOGY 0 437, 760 53.00 05400 ROOM 0 00 054.00 05400 ROOM 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		
ANCILLARY SERVICE COST CENTERS 50.00	· · · · · · · · · · · · · · · · · · ·	O	1, 354, 588		
SOLID 05000 0FEATTING ROOM 0 33, 957, 124 51.00 52.00 05200 05200 DELLYERY ROOM 0 0 0 0 52.00 05300 05400 RADI DI CINETA SOLUBO 0 1,400,090 54.01 05400 05500 RADI DI CIOETT HERAPEUTI C 0 5,521,349 35.00 05500 RADI DI CIOETT HERAPEUTI C 0 5,521,349 35.00 05500 RADI DI CIOETT HERAPEUTI C 0 1,944,196 57.00 05700 05900 0	44.00 04400 SKILLED NURSING FACILITY	0	0		44. 00
51.00 05100 RECOVERY ROOM ALBOOR ROOM 0 0 0 0 0 52.00 052.00					
S2. 00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0					1
S3. 00 05300 AMESTHESI OLOGY 0 437, 760 53. 00	· · · · · · · · · · · · · · · · · · ·	- 1	1, 944, 994		1
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 5. 083, 802 54. 00	· · · · · · · · · · · · · · · · · · ·		437 760		1
54. Q2 05404 UITRA SOUND	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		1
54. 03 05405 MAMMOGRAPHY 0 1,980,771 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 5,521,349 55. 00 05700 CT SCAN 0 1,944,196 57. 00 58. 00 05800 MRI 0 740,403 58. 00 69.00 05900 CARDI AC CATHETERI ZATI ON 0 4,705,784 59. 00 06. 00 06000 LABORATORY 0 12,507,704 60. 00 06. 00		o			
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 5. 521, 349 55. 00 05700 CT SCAN 0 1, 944, 196 57. 00 05800 MRI 0 744, 403 58. 00 05800 MRI 0 744, 403 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 4, 705, 784 59. 00 60. 00 60000 LABORATORY 0 12, 5807, 704 60. 00 60. 00 60000 LABORATORY 0 12, 5807, 704 60. 00		0			1
57. 00 05700 CT SCAN 0 1. 944, 196 57. 00		1			
58. 00 05800 MR 58. 00 05900 CARDI AC CATHETERI ZATI ON		-			
59, 00 05900 CARDIAC CATHETERIZATION 0 4,705,784 60.00		0			
60. 00 0000 LABORATORY 0 12, 507, 704 60. 01 06001 LABORATORY PATHOLOGI CAL 0 1, 446, 480 60. 01 06001 LABORATORY PATHOLOGI CAL 0 1, 446, 480 60. 01 06001 LABORATORY PATHOLOGI CAL 0 0 4, 251, 584 62. 00 06500 RESPIRATORY THERAPY 0 4, 251, 584 65. 00 0600 06000 PHYSI CAL THERAPY 0 6, 884, 745 65. 00 06700 0CCUPATI ONAL THERAPY 0 6, 884, 745 67. 00 06700 0CCUPATI ONAL THERAPY 0 2, 121, 817 67. 00 06700 0CCUPATI ONAL THERAPY 0 1, 465, 932 68. 00 0800 SPEECH PATHOLOGY 0 1, 465, 932 68. 00 0800 SPEECH PATHOLOGY 0 1, 465, 932 68. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 736, 831 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8, 223, 320 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8, 223, 320 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 10, 258, 700 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 31, 215, 162 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 10, 258, 700 72. 00 07400 RENAL DIALYSIS 0 700, 975 74. 00 07400 RENAL DIALYSIS 0 700, 975 74. 00 07400 RENAL DIALYSIS 0 700, 975 74. 00 07697 CARDI AC REHABILI TATI ON 0 762, 527 76. 97 00000 CLI NIC COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 09000 CLI NIC 0 0 2, 982, 200 90. 00					
60. 01 06001 LABORATORY-PATHOLOGI CAL 0 1, 446, 480 66. 01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 857, 638 66. 00 65. 00 06500 RESPIRATORY THERAPY 0 4, 251, 584 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 6, 884, 745 66. 00 67. 00 06700 OCUPATI ONAL THERAPY 0 6, 884, 745 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1, 465, 932 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 245, 787 69. 00 71. 00 07000 ELECTROCARDI OLOGY 0 1, 736, 831 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 8, 223, 320 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 10, 258, 700 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 31, 215, 162 73. 00 74. 00 07400 RENAL DI ALYSI S 0 700, 975 74. 00 76. 00 03020 ACUPUNCUTRE 0 0 0 76. 97 07697 CARDI AC REHABILITATI ON 0 762, 527 76. 97 007787 00000 DRUGS CHARGED TO PATI ENTS 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 09900 EDERARLY QUALIFIED HEALTH CENTER 0 2, 982, 200 90. 01 09001 DI ABETES CENTER 0 274, 287 90. 04 90. 02 09002 NUMBO CENTER 0 274, 287 90. 04 90. 03 09003 WOUND CENTER 0 274, 287 90. 05 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 274, 287 90. 05 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 477, 004 90. 05 90. 05 09005 MICARE CLI NIC 0 477, 004 90. 05 90. 06 09006 MEDI CALTION MGMT CLI NIC 0 477, 004 90. 05 90. 07 07100		1			
65.00 06500 RESPIRATORY THERAPY 0 4, 251, 584 66.00 66.00 06600 PHYSI CAL THERAPY 0 6, 884, 745 67.00 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 2, 121, 817 67.00 68.00 SPEECH PATHOLOGY 0 1, 465, 932 68.00 69.00 06900 ELECTROCARDI OLOGY 0 1, 245, 787 69.00 70.00 07000 ELECTROCARDI OLOGY 0 1, 736, 831 70.00 71.00 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8, 223, 320 71.00 72.00 73		o			60. 01
66. 00 06600 PHYSI CAL THERAPY 0 6,884,745 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 2,121,817 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 1,465,932 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1,245,787 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 1,245,787 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8,223,320 71. 00 72. 00 07200 IMPL DEV CHARGED TO PATIENTS 0 10,258,700 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 31,215,162 73. 00 74. 00 07400 RENAL DI ALYSI S 0 700,975 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 00 07697 CARDI AC REHABILITATION 0 762,527 76. 90 76. 97 07697 CARDI AC REHABILITATION 0 762,527 76. 90 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 89. 00 09000 CLINI C 0 2,982,200 99. 00 99. 01 09001 DI ABETES CENTER 0 397,209 99. 01 99. 02 09002 NEUROPSYCH 0 228,148 99. 02 99. 03 09003 WOUND CENTER 0 274,287 99. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 274,287 99. 04 99. 05 09005 VI MCARE CLINI C 0 477,004 99. 05 99. 06 09006 MEDI CATION MGMT CLINI C 0 477,004 99. 05 99. 07 09100 EMERGENCY 0 16,327,931 91. 00 90. 08 09ECHALTH ONLY OF A PATIENT 0 0 0 90. 01 09ECHALTH ONLY OF A PATIENT 0 0 90. 01 09ECHALTH ONLY OF A PATIENT 0 0 0 90. 02 09005 VI MCARE CLINI C 0 477,004 99. 05 90. 05 09006 MEDI CATION MGMT CLINI C 0 477,004 99. 05 90. 06 09006 MEDI CATION MGMT CLINI C 0 16,327,931 91. 00 90. 07 07 07 07 07 07 07 07		0	857, 638		62.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 2, 121, 817 68. 00 68. 00 SPECCH PATHOLOGY 0 1, 465, 932 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 245, 787 69. 00 07000 ELECTROCARDI OLOGY 0 1, 736, 831 70. 00 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 1, 736, 831 70. 00 70.		l l			
68. 00 06800 SPEECH PATHOLOGY 0 1, 465, 932 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 1, 245, 787 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 1, 245, 787 70. 00 71. 00 07000 ELECTROCENCEPHALOGRAPHY 0 1, 736, 831 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8, 223, 320 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 258, 700 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 31, 215, 162 73. 00 74. 00 07400 RENAL DI ALYSIS 0 70. 09 76. 00 07400 RENAL DI ALYSIS 0 70. 09 76. 00 03020 ACUPUNCTURE 0 0 70. 975 76. 90 03020 ACUPUNCTURE 0 0 7697 CARDIA CREHABILITATION 0 762, 527 76. 97 001794TIENT SERVICE COST CENTERS 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 889. 00 99. 00 09900 CLINIC 0 0, 98900 FEDERALLY QUALIFIED HEALTH CENTER 0 90. 01 90. 01 09001 DI ABETES CENTER 0 397, 209 90. 01 90. 02 09002 NEUROPSYCH 0 228, 148 90. 02 90. 03 09003 WOUND CENTER 0 2, 982, 200 90. 04 90. 05 09005 VI MCARE CLINIC 0 0 1, 558, 965 90. 06 09006 MEDI CATION MGMT CLINIC 0 16, 327, 931 90. 06 90. 00 09000 EMERGENCY 0 16, 327, 931 90. 00 09000 EMERGENCY 0 90. 00 0THER REIMBURSABLE COST CENTERS		0			
69. 00 06900 ELECTROCARDI OLOGY 0 1, 245, 787 70. 00 7000 DELECTROCARDI OLOGY 0 0 1, 245, 787 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 8, 223, 320 71. 00 72. 00 7200 I MPL. DEV. CHARGED TO PATIENTS 0 10, 258, 700 72. 00 7300 DRUGS CHARGED TO PATIENTS 0 31, 215, 162 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 70, 00 70, 00 7400 RENAL DI ALYSI S 0 70, 00 70, 975 74. 00 70, 00 70, 00 RENAL DI ALYSI S 0 70, 00 70, 975 74. 00 70, 00 76. 97 76. 9					
70. 00 07000 ELECTROENCEPHALOGRAPHY 0					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 258, 700 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 31, 215, 162 73. 00 74. 00 77400 RENAL DI ALYSI S 0 700, 975 74. 00 03020 ACUPUNCTURE 0 0 0 76. 00		O			
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8, 223, 320		71.00
74. 00 07400 RENAL DI ALYSI S 0 700, 975 76. 00 76.		1			
76. 00 76. 97 76		1 1			
76. 97 O7697 CARDI AC REHABI LI TATI ON O 762, 527 OUTPATI ENT SERVI CE COST CENTERS		1	· •		
SECTION SERVICE COST CENTERS SECTION		- I	71		
88. 00			702,027		— , o. , ,
90. 00 09000 CLI NI C 0 2, 982, 200 90. 01 09001 DI ABETES CENTER 0 397, 209 90. 01 09002 09002 NEUROPSYCH 0 228, 148 90. 02 09003 NOUND CENTER 0 2, 019, 590 90. 03 09004 HYPERBARI C OXYGEN THERAPY 0 274, 287 90. 04 09005 VI MCARE CLI NI C 0 1, 558, 965 90. 05 09005 VI MCARE CLI NI C 0 477, 004 90. 06 09100 EMERGENCY 0 16, 327, 931 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00. 00 00		0	0		88. 00
90. 01 09001 DI ABETES CENTER 0 397, 209 90. 01 90. 02 09002 NEUROPSYCH 0 228, 148 90. 02 90. 03 09003 WOUND CENTER 0 2,019, 590 90. 03 90. 04 HYPERBARI C OXYGEN THERAPY 0 274, 287 90. 04 90. 05 09005 VI MCARE CLINI C 0 1,558, 965 90. 05 90. 06 09006 MEDI CATI ON MGMT CLINI C 0 477, 004 90. 06 91. 00 09100 EMERGENCY 0 16,327, 931 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 071HER REI MBURSABLE COST CENTERS	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 02 09002 NEUROPSYCH 0 228, 148 90. 02 90. 03 90. 03 90. 04 90. 04 90. 04 90. 04 90. 05 90. 05 90. 05 90. 06 90.		1			
90. 03 09003 WOUND CENTER 0 2, 019, 590 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 274, 287 90. 04 90. 05 09005 VI MCARE CLI NI C 0 1,558, 965 90. 05 09006 MEDI CATI ON MGMT CLI NI C 0 477, 004 90. 06 91. 00 09100 EMERGENCY 0 16, 327, 931 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 071HER REI MBURSABLE COST CENTERS 90. 03 09. 04 09. 05 09. 06		0			
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 274, 287 90. 04 90. 05 90. 05 90. 06 90. 0		0			
90. 05 09005 VI MCARE CLI NI C 0 1,558,965 90. 06 90. 06 90. 06 90. 06 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 071HER REI MBURSABLE COST CENTERS 90. 05 90. 05 90. 05 90. 06 90. 0					
90. 06 09006 MEDI CATI ON MGMT CLINIC 0 477, 004 91. 00 09100 EMERGENCY 0 16, 327, 931 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 071HER REI MBURSABLE COST CENTERS 92. 00 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000		0			
91. 00 09100 EMERGENCY 0 16, 327, 931 91. 00 92. 00 OTHER REI MBURSABLE COST CENTERS 91. 00 92. 00 OTHER REI MBURSABLE COST CENTERS 91. 00 92. 00 OTHER REI MBURSABLE COST CENTERS 91. 00 92. 00 OTHER REI MBURSABLE COST CENTERS 92. 00 OTHER REI MBURSABLE COST CENTERS 93. 00 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		0			
OTHER REI MBURSABLE COST CENTERS	91. 00 09100 EMERGENCY	- 1	16, 327, 931		
		0			92. 00
45. 00 U450U0 ANNOULANCE SERVICES U 1, 335, 410 95. 00			7 225 410		OF 00
	73. 00 07300 AWIDULAINGE SERVI GES	ı U	1, 330, 410		J 90.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0112	Period: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Pre	pared:

			From 01/01/2017 Part To 12/31/2017 Date/Ti	me Prepared: 2019 2:12 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	107297.	2019 2. 12 piii
	25. 00	26. 00		
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	0	0		99. 10 101. 00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0		109. 00 110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	226, 895, 627		118. 00
NONREI MBURSABLE COST CENTERS	,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	52, 292		190. 00
194.00 07950 WELLNESS COMMUNITY	0	426, 435		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	156, 363		194. 01
194. 02 07952 HOSPI CE	0	119, 486		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	369, 990		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	1, 980, 753		194. 05
194. 06 07956 CRH FOUNDATION	0	125, 009		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	375, 058		194. 07
194. 08 07958 CRHP	0	1, 259, 909		194. 08
194.09 07959 NEUROPSYCH PART B	0	39, 866		194. 09
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	231, 800, 788		202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

					To	12/31/2017	Date/Time Pre 10/29/2019 2:	
				CAPI TAL REI	LATED COSTS		10/24/2014 2.	12 piii
		Cook Cooks Doors at a	D:+1	DIDC & FLVT	MVDLE FOULD	Culatatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	4.00	0.00	0.4	4.00	
	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. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	16, 890 1, 060, 816	178, 400 962, 248		201, 412 6, 457, 816	201, 412 34, 724	4. 00 5. 00
7. 00		OPERATION OF PLANT	62, 355	4, 998, 352		5, 524, 526	6, 232	7. 00
8. 00		LAUNDRY & LINEN SERVICE	0	11, 077		11, 077	58	8. 00
9. 00		HOUSEKEEPI NG	5, 232	72, 124		122, 027	4, 332	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	1, 894 4, 148			127, 766 125, 388	1, 661 3, 528	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	12, 004	136, 275		215, 331	9, 042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	427	106, 444		206, 257	0	14.00
15.00		PHARMACY	13, 401	66, 222		347, 070	8, 870	15.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 140 595	56, 306 4, 224		96, 055 4, 898	2, 309 1, 371	16. 00 17. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	1	0	0	23. 00
23. 01	02301	XRAY EDUCATION	8, 735	2, 266		11, 987	1, 186	
23. 02		PHARMACY RESIDENCY PROG	0	5, 259	0	5, 259	978	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	251, 057	1, 072, 496	373, 334	1, 696, 887	34, 577	30. 00
31. 00	1	INTENSIVE CARE UNIT	14, 317	153, 268		312, 107	5, 538	31.00
32.00		CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	1	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0) 0	0	0	0	34. 00 40. 00
41. 00		SUBPROVI DER – I RF	46, 466	155, 030	17, 829	219, 325	3, 608	41. 00
42.00	1	SUBPROVI DER	0	0	-	o	0	42.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	264	8, 154 0		25, 203 0	1, 696 0	43.00
44.00		LARY SERVICE COST CENTERS	U	0	0	<u>U</u>	U	44. 00
50.00	05000	OPERATING ROOM	527, 941	546, 486	1, 114, 317	2, 188, 744	1, 743	50.00
51.00		RECOVERY ROOM	1, 185			78, 241	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0 1, 664	-	0 8, 698	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	1, 262	121, 045		249, 346	3, 758	54.00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	26, 175	47, 327		80, 203	948	54. 01
54. 02		ULTRA SOUND	214	21, 034		93, 315	1, 180	
54. 03 55. 00		MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	152, 586 21, 845	3, 818 103, 941		237, 948 869, 877	1, 902 4, 233	54. 03 55. 00
57. 00		CT SCAN	94	25, 146		317, 573	1, 531	57.00
58.00	05800	i e e e e e e e e e e e e e e e e e e e	47	12, 587	7, 059	19, 693	728	58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	20, 574	149, 142		212, 954	4, 073	59.00
60. 00 60. 01		LABORATORY LABORATORY-PATHOLOGI CAL	29, 196 1, 491	145, 576 16, 950		306, 529 31, 136	10, 178 825	60. 00 60. 01
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	271	7, 328		11, 922	118	
65. 00	1	RESPI RATORY THERAPY	50, 383			265, 801	4, 148	
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	374, 738 9, 471	3, 175 3, 091		402, 083 17, 686	9, 328 2, 786	
68. 00	1	SPEECH PATHOLOGY	19, 629			42, 964	1, 959	
69. 00	1	ELECTROCARDI OLOGY	5, 189			59, 919	1, 447	
70.00	1	ELECTROENCEPHALOGRAPHY	145, 648			157, 727	1, 637	
71. 00 72. 00		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		o	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	63	63	1	74.00
76.00		ACUPUNCTURE	0	0	-	0	0	76.00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	1, 827	22, 111	13, 815	37, 753	557	76. 97
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	О	0	89. 00
90.00		CLINIC	37	99, 675		144, 674	2, 247	
90. 01 90. 02		DI ABETES CENTER NEUROPSYCH	212 55	10, 839 1, 650	1	11, 938 2, 026	274 315	
90. 02		WOUND CENTER	1, 823	0 0		3, 554	1, 037	90.03
90. 04	09004	HYPERBARI C OXYGEN THERAPY	84, 035		110	84, 145	161	90. 04
90. 05 90. 06	1	VIMCARE CLINIC MEDICATION MGMT CLINIC	2, 639	59, 509 951		67, 746 951	1, 267	90. 05 90. 06
90.06		EMERGENCY	9, 656		1	648, 859	644 13, 850	90.06
		OBSERVATION BEDS (NON-DISTINCT PART				0	2, 230	92.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Period: Worksheet B

ALLUCATION OF CAPITAL RELATED COSTS		Provider Co		From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	
		CAPI TAL REI	ATED COSTS			•
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	32, 848	112, 332	336, 020	481, 200	7, 978	
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	(이	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 020, 812	10, 111, 362	9, 713, 485	22, 845, 659	200, 563	1118.00
NONREI MBURSABLE COST CENTERS		40.4/3		10 505		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 167	358			190.00
194. 00 07950 WELLNESS COMMUNITY	56, 776	0	8, 76			194.00
194. 01 07951 BUI LDI NG RENTALS	44, 320	0	9	44, 320		194. 01
194. 02 07952 HOSPI CE	0	0	9			194. 02
194. 03 07953 OUTREACH CLINICS	0	0	9			194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	9			194.04
194. 05 07955 NONALLOWABLE MARKETING	0	11 200	71/	10 117		194. 05
194. 06 07956 CRH FOUNDATION	0	11, 398				194.06
194.07 07957 HEALTHY COMMUNITIES 194.08 07958 CRHP	0	16, 713		16, 713		194. 07 194. 08
	0	51, 705				
194. 09 07959 NEUROPSYCH PART B	U	7, 063	1, 374	8, 437	Ü	194. 09 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		_			0	200.00
202.00 Regative cost centers 202.00 TOTAL (sum lines 118 through 201)	3, 121, 908	10 200 400	10 520 044	23, 850, 376		
202.00 TOTAL (Suil Titles 118 through 201)	3, 121, 908	10, 208, 408	10, 520, 060	23, 850, 376	201, 412	J2U2. UU

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2017 | Part II |
| To | 12/31/2017 | Date/Time Prepared: | 10/29/2019 2:12 pm

SENERAL SERVICE COST CENTERS					1	0 12/31/201/	10/29/2019 2:	
CENERAL SERVICE COST CENTERS		Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
1.00						9. 00	10.00	
2.00 002000 CAP PETC COSTS-AWBLE FOULP								
4.00								1.00
5.00 00500 ADM IN STRATIVE & GENERAL 6,492,540 7.70 00700 OPERATION OF PLANT 442,028 5,972,766 7.70 0.310 0.10								2. 00 4. 00
2.00 000000 DEPARTION OF PLANT			6, 492, 540					5.00
9.00 009900 00SEKEEPI NG			1	5, 972, 786				7. 00
10.00 010000 01ETARY	1			16, 257	51, 034			8. 00
11.00 01100 CAFETERIA					_			9. 00
13.0 01300 O1300 O1300 O1300 O1500 O150 O150 O150								
14. 0 01400 CAUTRAL SERVI CES & SUPPLY 44. 631 156. 231 0 3. 293 0 14.	1	· ·	1		_			13.00
16.00 01600 MEDICAL RECORDS & LIBRARY 61.976 82.642 0 0 0 0 0 16.	1		1		_	l I		14.00
17.00 01700 01700 01700 011 01 0	15. 00	D1500 PHARMACY	1		0		0	15. 00
23.00 02300 PARMED ED PREMI-(SPECIFY)					Ĭ	0		16.00
23. 01 02301 XRAY EDUCATION 21, 499 3, 325 0 0 0 0 23.	1			6, 199	Ĭ	0		17.00
23.02 02302 PHARMACY RESIDENCY PROB 18, 242 7, 718 0 202 0 23.			-	3 325	_		-	23.00
IMPATIENT ROUTINE SERVICE COST CENTERS	1	· ·				202		23. 02
33.00 03100 INTENSI WE CARE UNIT 1 153,078 224,956 2,712 10,552 32,158 31. 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 3. 33.00 03300 BURN INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 3. 34.00 03400 SUBROLL INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 3. 34.00 03400 SUBROLUDER - I PF 7 0 0 0 0 0 0 0 0 0 40. 41.00 04100 SUBPROVIDER - I RF 77,837 227,542 2.666 11,762 35,181 41. 42.00 04200 SUBPROVIDER - I RF 77,837 227,542 2.666 11,762 35,181 41. 43.00 04300 SUBRSERY 0 0 0 0 0 0 0 0 0 0 42. 44.00 04400 SUBPROVIDER - I RF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				·				
32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 32. 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 33. 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 34. 40.00 04000 SUBRROVIDER - IPF 0 0 0 0 0 0 0 0 34. 40.00 04000 SUBRROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 40. 41.00 04100 SUBRROVIDER - IRF 77,837 227,542 2.666 11,762 35,181 41. 42.00 04200 SUBRROVIDER 3 0 0 0 0 0 0 0 0 0 44. 44.00 04400 SUBRROVIDER 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 3.34. 40.00 3400 SURGICAL INTENSIVE CARE UNIT 1 0 0 0 0 0 0 0 3.4. 40.00 04000 SUBPROVIDER - IPF 7 0 0 0 0 0 0 0 0 0 0 40. 41.00 04100 SUBPROVIDER - IRF 77,837 227,542 2,666 11,762 35,181 41. 42.00 04200 SUBPROVIDER 1 RF 77,837 227,542 2,666 11,762 35,181 41. 43.00 04300 SUBPROVIDER 0 0 0 0 0 0 0 0 0 42. 43.00 04300 INDESERY 32,372 11,967 792 67 0 43. 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 44. **NORTHING SERVICE COST CENTERS** 50.00 05000 OPERATING ROOM 786,731 802,093 7,996 57,935 696 50. 51.00 05100 RECOVERY ROOM 46,554 65,379 1,848 4,033 0 51. 52.00 05200 DELIVERY ROOM & 1.4BOR ROOM 0 0 0 0 0 0 5. 53.00 05300 ANESTHESIOLOGY 10,403 2,443 0 0 0 0 5. 54.00 05400 RADIOLOGY-DIAGNOSTIC 99,512 177,661 4,179 11,829 183 54. 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54,503 69,463 0 5,041 0 54. 54.02 05402 NUCLEAR MEDICINE-DIAGNOSTIC 135,989 152,557 637 6,654 1,478 55. 57.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 57.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 57.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 57.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 58.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 58.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 59.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 59.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 1,478 55. 59.00 05500 RADIOLOGY-THERAPEUTIC 135,989 152,557 637 6,654 0,490 6 0. 60.00 60000 LABORATORY 327,842 213,666 0 0 0,490 6 0. 60.00 60000 LABORATORY 7400 7400 7400 740 7594 74,660 758 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	224, 956		10, 552	· ·	1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		32. 00 33. 00
40. 00 04000 SUBPROVI DER - IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	Ö	l ol		34.00
42.00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	40.00
43.00 04300 NURSERY 32, 372 11, 967 792 67	1		77, 837	227, 542	2, 666	11, 762	35, 181	41.00
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44.			0	0	0	١		42.00
ANCI LLARY SERVICE COST CENTERS	1		1			l .		1
50. 00 050000 OPERATI NG ROOM 786, 731 802, 093 7, 996 57, 935 696 50. 51. 00 05100 RECOVERY ROOM 46, 554 65, 379 1, 848 4, 033 0 51. 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 51. 53. 00 05200 DELI VERY ROOM & LABOR ROOM 0 53. 34. 0 0 0 0 53. 34. 0 0 0 0 53. 34. 0 2. 420 0 54. 45. 42. 0 54. 45. 54. 50. 50. 50. 44. 425 3. 2.26 0 54. 54. 54.			l ol	U	0	l U	0	44.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52. 53. 00 05300 ANESTHESI OLOGY 10, 403 2, 443 0 0 0 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 99, 512 177, 661 4, 179 11, 829 183 54. 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 54, 503 69, 463 0 5, 041 0 54. 54. 02 05404 ULTRA SOUND 35, 724 30, 873 0 2, 420 0 54. 54. 03 05405 MANMOGRAPHY 52, 943 5, 604 425 3, 226 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 135, 989 152, 557 637 6, 654 1, 478 55. 57. 00 05700 CT SCAN 50, 447 36, 908 0 1, 344 0 57. 58. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 <t< td=""><td></td><td></td><td>786, 731</td><td>802, 093</td><td>7, 996</td><td>57, 935</td><td>696</td><td>50.00</td></t<>			786, 731	802, 093	7, 996	57, 935	696	50.00
53. 00 05300 ANESTHESI OLOGY 10, 403 2, 443 0 0 0 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 99, 512 177, 661 4, 179 11, 829 183 54. 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 54, 503 69, 463 0 5, 041 0 54. 54. 02 05404 ULTRA SOUND 35, 724 30, 873 0 2, 420 0 54. 54. 03 05405 MAMMOGRAPHY 52, 943 5, 604 425 3, 226 0 54. 57. 00 05700 CT SCAN 135, 989 152, 557 637 6, 654 1, 478 55. 59. 00 05800 MRI 18, 837 18, 474 0 807 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 60. 00 06000 LABORATORY 327, 842 213, 666 0 <t< td=""><td></td><td></td><td>46, 554</td><td>65, 379</td><td>1, 848</td><td>4, 033</td><td></td><td>51.00</td></t<>			46, 554	65, 379	1, 848	4, 033		51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 99, 512 177, 661 4, 179 11, 829 183 54. 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 54, 503 69, 463 0 5, 041 0 54. 54. 02 05404 ULTRA SOUND 35, 724 30, 873 0 2, 420 0 54. 54. 03 05405 MAMMOGRAPHY 52, 943 5, 604 425 3, 226 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 135, 989 152, 557 637 6, 654 1, 478 55. 57. 00 05700 CT SCAN 50, 447 36, 908 0 1, 344 0 57. 57. 50. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 4, 906 0 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 0			·	0	_	0		52.00
54. 01 05402 05404 ULTRA SOUND NUCLEAR MEDI CI NE-DI AGNOSTI C 54, 503 35, 724 52, 943 69, 463 30, 873 0 5, 041 2, 420 0 54. 54. 02 05404 MAMMOGRAPHY 52, 943 55, 00 5604 425 425 3, 226 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 135, 989 152, 557 637 66, 654 6, 654 1, 478 55. 1, 478 55. 57. 6037 66, 654 6, 654 1, 478 55. 1, 478 55. 57. 6037 66, 654 6, 654 1, 478 57. 1, 478 57. 55. 637 66, 654 6, 654 1, 478 57. 1, 478 57. 55. 637 66, 654 1, 478 57. 55. 637 67. 6, 654 67. 1, 478 67. 55. 637 67. 6, 654 67. 1, 478 67. 55. 57. 637 67. 6, 654 67. 1, 478 67. 55. 57. 637 67. 6, 654 67. 1, 478 67. 57. 64. 66. 67. 66. 67. 66. 67. 66. 67. 67.			1 ' 1		_	11 920		53.00
54. 02 05404 ULTRA SOUND 35, 724 30, 873 0 2, 420 0 54. 54. 03 05405 MAMMOGRAPHY 52, 943 5, 604 425 3, 226 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 135, 989 152, 557 637 6, 654 1, 478 55. 57. 00 05700 CT SCAN 50, 447 36, 908 0 1, 344 0 55. 58. 00 05800 MRI 18, 837 18, 474 0 807 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 60. 01 06000 LABORATORY 327, 842 213, 666 0 4, 906 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23, 095 10, 756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 187, 729 4, 660 758 0			1		· ·			54.00
54. 03 05405 MAMMOGRAPHY 52, 943 5, 604 425 3, 226 0 54. 55. 00 05500 RADI OLOGY-THERAPEUTI C 135, 989 152, 557 637 6, 654 1, 478 55. 57. 00 05700 CT SCAN 50, 447 36, 908 0 1, 344 0 55. 58. 00 05800 MRI 18, 837 18, 474 0 807 0 55. 59. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 60. 00 06000 LABORATORY 327, 842 213, 666 0 4, 906 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 31, 812 24, 879 0 269 0 60. 65. 00 06500 RESPI RATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 </td <td>1</td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td>	1		1					
57. 00 05700 CT SCAN 50, 447 36, 908 0 1, 344 0 57. 58. 00 05800 MRI 18, 837 18, 474 0 807 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 60. 00 06000 LABORATORY 327, 842 213, 666 0 4, 906 0 60. 60. 01 06001 LABORATORY-PATHOLOGI CAL 31, 812 24, 879 0 269 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23, 095 10, 756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 66. 67. 00 06700 OCCUPATI ONAL THERAPY 57, 954 4, 536 556	54. 03	D5405 MAMMOGRAPHY	52, 943	5, 604	425		0	54.03
58. 00 05800 MRI 18,837 18,474 0 807 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 104,139 218,900 110 9,006 784 59. 60. 00 06000 LABORATORY 327,842 213,666 0 4,906 0 60. 60. 01 06001 LABORATORY -PATHOLOGI CAL 31,812 24,879 0 269 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23,095 10,756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 92,266 135,971 0 9,678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187,729 4,660 758 0 0 66. 67. 00 06700 OCCUPATI ONAL THERAPY 57,954 4,536 556 0 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40,453 0 0 0 0 0 68. 69. 00 0900 ELECTROCARDI OLOGY <td></td> <td></td> <td>1</td> <td></td> <td></td> <td>l ' '</td> <td></td> <td></td>			1			l ' '		
59. 00 05900 CARDI AC CATHETERI ZATI ON 104, 139 218, 900 110 9, 006 784 59. 60. 00 06000 LABORATORY 327, 842 213, 666 0 4, 906 0 60. 60. 01 06001 LABORATORY-PATHOLOGI CAL 31, 812 24, 879 0 269 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23, 095 10, 756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 66. 67. 00 06700 OCCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493					_	,		57.00
60. 00 06000 LABORATORY 327, 842 213, 666 0 4, 906 0 60. 60. 01 06001 LABORATORY - PATHOLOGI CAL 31, 812 24, 879 0 269 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23, 095 10, 756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 74.					_	l .		1
60. 01 06001 LABORATORY-PATHOLOGI CAL 31, 812 24, 879 0 269 0 60. 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 23, 095 10, 756 0 202 0 62. 65. 00 06500 RESPI RATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 71. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 74.						, , , , ,		60.00
65. 00 06500 RESPIRATORY THERAPY 92, 266 135, 971 0 9, 678 0 65. 66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 67. 68. 00 06800 SPECH PATHOLOGY 40, 453 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 230, 328 0 0 0 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 74. 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 74.			1		0		0	60. 01
66. 00 06600 PHYSI CAL THERAPY 187, 729 4, 660 758 0 0 66. 67. 00 06700 0CCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 72. 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 0 74.			1		_	l		62.00
67. 00 06700 0CCUPATI ONAL THERAPY 57, 954 4, 536 556 0 0 67. 68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 0 74.			1		_		-	65.00
68. 00 06800 SPEECH PATHOLOGY 40, 453 0 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 0 74.	1		1					66. 00 67. 00
69. 00 06900 ELECTROCARDI OLOGY 31, 493 28, 697 0 2, 016 0 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 40, 625 0 73 12, 367 372 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 73. 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 74.			1	4, 550	0	0	-	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 230, 328 0 0 0 0 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 597, 606 0 0 0 0 0 73. 74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 0 0 74.				28, 697	0	2, 016		69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 287, 337 0 0 0 0 0 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 597, 606 0 0 0 0 73. 74. 00 07400 RENAL DI ALYSIS 19, 461 0 0 0 0 0 74.				0	73	12, 367	372	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 597,606 0 0 0 0 73. 74.00 07400 RENAL DI ALYSIS 19,461 0 0 0 0 74.				0	0	0		71.00
74. 00 07400 RENAL DI ALYSI S 19, 461 0 0 0 74.	1		1	0	0	0		72. 00 73. 00
	1			0	0			74.00
70. UU U3UZU ACUPUNCTUKE U U U U U O O /6.		03020 ACUPUNCTURE	0	Ö	Ö	o	0	76.00
			17, 158	32, 453	0	202	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1					
	1	· ·	0	0	0	0		88.00
	1	· ·	54 568	146 296) 0 2 185	6 587		89. 00 90. 00
			1		2, 109			90.01
			1	2, 422	0	l l	0	90. 02
				0		l l		90.03
				07.000				90.04
					175		-	90. 05 90. 06
			1		0	l .		91.00
	1	·	3.5, 170	3.5,777		27,733	1, 751	92.00
OTHER REIMBURSABLE COST CENTERS	C	OTHER REIMBURSABLE COST CENTERS	,					
			1	164, 873	3, 456	l I		
			1	0	0	l .		99. 10 101. 00
.555 _{1.555} 1.5mile Herietti Nochot	131.00	10.00 NOME TENETH MOLITOT	١	0	0	ı Yı	0	1,01.00

Peri od: Worksheet B From 01/01/2017 Part II Date/Time Prepared:

					10/29/2019 2:12 pm
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	E & GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10. 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 through 117)	6, 367, 408	5, 830, 349	51, 034	338, 875	333, 548 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	360	14, 923	0	0	0 190.00
194. 00 07950 WELLNESS COMMUNITY	11, 701	0	0	0	0 194.00
194.01 07951 BUILDING RENTALS	4, 380	0	0	0	0 194. 01
194. 02 07952 H0SPI CE	3, 331	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	10, 363	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	55, 479	0	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	1, 034	16, 730	0	3, 562	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	8, 522	24, 530	0	134	0 194. 07
194. 08 07958 CRHP	29, 673	75, 888	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	289	10, 366	0	0	0 194. 09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	6, 492, 540	5, 972, 786	51, 034	342, 571	333, 548 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm

) 12/31/2017	10/29/2019 2:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11. 00	13. 00	14.00	15. 00	16.00	
	GENERAL SERVICE COST CENTERS	I					
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
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	315, 826					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	11, 331	631, 992				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 487	0	413, 899			14.00
15.00	01500 PHARMACY	10, 750	43, 180	0	750, 146		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 007	0	0	0	251, 989	16. 00
17. 00	01700 SOCIAL SERVICE	2, 324	0	0	0	0	17.00
23. 00 23. 01	O2300 PARAMED ED PRGM-(SPECIFY) O2301 XRAY EDUCATION	0 2, 034	0		0	0	23. 00 23. 01
23. 01	02302 PHARMACY RESIDENCY PROG	1, 162	4, 788	0	0	0	23. 01
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	., ., .,	.,	<u> </u>			20.02
30.00	03000 ADULTS & PEDIATRICS	71, 765	290, 495	18, 615	598	57, 923	30.00
31.00	03100 NTENSI VE CARE UNI T	9, 588	38, 989	776	351	5, 577	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	6, 683	26, 872	Ö	15	7, 462	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	2, 615	10, 881	452	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	33, 994	0	370, 692	2, 813	75, 424	50.00
51. 00	05100 RECOVERY ROOM	3,777	0	370, 072	2, 013	73, 424	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	Ö	0	0	52.00
53.00	05300 ANESTHESI OLOGY	291	0	0	4, 572	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 102	0	452	230	0	54.00
54. 01	05402 NUCLEAR MEDICINE-DI AGNOSTI C	1, 453	0	0	11, 750	0	54. 01
54. 02 54. 03	O5404 ULTRA SOUND O5405 MAMMOGRAPHY	1, 743 3, 487	0	0 452	21 29	0	54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	4, 939	0	432	0	7, 032	1
57. 00	05700 CT SCAN	2, 615	0	Ö	754	0	57.00
58.00	05800 MRI	1, 162	0	0	36	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 811	0	3, 587	443	22, 714	59.00
60.00	06000 LABORATORY	23, 825	0	0	22	0	60.00
60. 01 62. 00	O6001 LABORATORY-PATHOLOGICAL O6200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 453 291	0	0	0	23, 283 0	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	7, 554	30, 613	840	524	4, 414	1
66. 00	06600 PHYSI CAL THERAPY	14, 818	0		121		66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 777	0	0	10	278	67.00
68. 00	06800 SPEECH PATHOLOGY	2, 905	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 324	0	0	270	11 210	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 615 0	0	0	0	11, 218 0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	723, 876	0	73.00
74.00	07400 RENAL DIALYSIS	0	7	0	481	0	74.00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	872	0	0	7	0	76. 97
88 00	08800 RURAL HEALTH CLINIC	0	0	O	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	0	89.00
	09000 CLI NI C	4, 358	0	1, 487	6	35, 323	90.00
90. 01	09001 DI ABETES CENTER	581	0	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	291	0	0	0	0	90.02
90. 03	09003 WOUND CENTER	2, 034	0	9, 081	1, 325	0	90.03
90. 04 90. 05	O9004 HYPERBARI C OXYGEN THERAPY O9005 VI MCARE CLINI C	291 2, 615	0 11, 152		654	0	90. 04 90. 05
90. 06	09006 MEDICATION MGMT CLINIC	581	2, 883	Ö	32	0	90.06
91. 00	09100 EMERGENCY	26, 149	91, 108	1, 163	547	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
o=	OTHER REIMBURSABLE COST CENTERS	0.5.5%	0	- 1			05.5-
	09500 AMBULANCE SERVI CES 09910 CORF	20, 338	81, 024 0	0	598	0	95. 00 99. 10
	10100 HOME HEALTH AGENCY	0	0	_	0		101.00
.51.50			0		0		1.000

			10	12/31/2017	Date/lime Prepared:
01. 01 D	OAFFTED! A	NUDGLNG	OFNEDAL	DUADMAOV	10/29/2019 2: 12 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI O	SERVICES &		RECORDS &
		N	SUPPLY		LI BRARY
	11. 00	13. 00	14. 00	15. 00	16. 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 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 through 117)	313, 792	631, 992	413, 899	750, 103	251, 989 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	1, 162	0	0	0	0 194. 00
194. 01 07951 BUILDING RENTALS	0	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	0	0	0	43	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	ol	0	0	0 194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	ol	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	ol	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	0	l ol	0	o	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	581	ol	O	o	0 194. 07
194. 08 07958 CRHP	0	ol	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	291	اً ا	0	0	0 194. 09
200.00 Cross Foot Adjustments]	-		200.00
201.00 Negative Cost Centers	0	٥	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	315, 826	631, 992	413, 899	750, 146	251, 989 202. 00
202.00 10 me (3am 171e3 110 till ough 201)	313, 020	001, 772	113, 077	, 50, 140	201, 707 202.00

					10/29/2019 2:	12 pm
Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY PROG	Subtotal	
	17. 00	23. 00	23. 01	23. 02	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10. 00 11. 00
13. 00 O1300 NURSING ADMINISTRATION						13.00
14. 00 O1400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 01700 SOCIAL SERVICE	40, 017					17.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	40, 017	0				23.00
23. 01 02301 XRAY EDUCATION	o	J	40, 031			23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	o		,	38, 349		23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			,		
30. 00 03000 ADULTS & PEDIATRICS	11, 605				4, 884, 969	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 841				799, 223	31.00
32.00 03200 CORONARY CARE UNIT	0				0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	o				0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0				0	34.00
40. 00 04000 SUBPROVI DER - I PF	0				0	40.00
41. 00 04100 SUBPROVI DER - I RF	6, 363				625, 316	41.00
42. 00 04200 SUBPROVI DER	0				0	42.00
43. 00 04300 NURSERY	0				86, 045	43.00
44. 00 04400 SKILLED NURSING FACILITY	0				0	44.00
ANCILLARY SERVICE COST CENTERS	٥				4 200 0/4	F0 00
50. 00 05000 OPERATI NG ROOM	0				4, 328, 861	50.00
51. 00 05100 RECOVERY ROOM	0				199, 849	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0 27 407	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				26, 407	53. 00 54. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0				553, 252 223, 361	54.00
54. 02 05404 ULTRA SOUND	0				165, 276	54.01
54. 03 05405 MAMMOGRAPHY	0				306, 016	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 361				1, 185, 757	55.00
57. 00 05700 CT SCAN	2, 001				411, 172	57.00
58. 00 05800 MRI	o				59, 737	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o				582, 521	59.00
60. 00 06000 LABORATORY	o				886, 968	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	o				113, 658	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o				46, 384	62.00
65. 00 06500 RESPIRATORY THERAPY	0				551, 809	65.00
66. 00 06600 PHYSI CAL THERAPY	0				627, 140	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0				87, 583	67.00
68.00 06800 SPEECH PATHOLOGY	0				88, 281	
69. 00 06900 ELECTROCARDI OLOGY	0				126, 166	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				226, 634	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0				230, 328	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				287, 337	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 74. 00 07400 RENAL DLALYSES	0				1, 321, 482 20, 013	73. 00 74. 00
76. 00 03020 ACUPUNCTURE	0				20, 013	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 361				91, 363	76.00
OUTPATIENT SERVICE COST CENTERS	2, 301				71, 303	70. 77
88. 00 08800 RURAL HEALTH CLINIC	0				0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o				0	89.00
90. 00 09000 CLI NI C	4, 682				407, 481	90.00
90. 01 09001 DI ABETES CENTER	0				38, 615	90. 01
90. 02 09002 NEUROPSYCH	0				11, 204	90. 02
90. 03 09003 WOUND CENTER	o				71, 520	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	o				92, 224	90. 04
90. 05 09005 VI MCARE CLI NI C	o				212, 252	90.05
90.06 09006 MEDICATION MGMT CLINIC	0				19, 213	90.06
91. 00 09100 EMERGENCY	9, 804				1, 578, 373	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0				919, 298	95.00
99. 10 09910 CORF	0				0	99. 10
101.00 10100 HOME HEALTH AGENCY	0				0	101. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Peri od:	Worksheet B

				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 10/29/2019 2:	pared:
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	12 piii
Coot Conton Bood (ptron	SERVI CE	PRGM	EDUCATI ON	RESI DENCY	oub to tu.	
				PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
SPECIAL PURPOSE COST CENTERS	•					
109. 00 10900 PANCREAS ACQUISITION	0				0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0				0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0				0	111.00
113. 00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	40, 017	0		0 0	22, 493, 088	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				25, 808	
194. 00 07950 WELLNESS COMMUNITY	0				,	194. 00
194. 01 07951 BUI LDI NG RENTALS	0				48, 700	
194. 02 07952 HOSPI CE	0					194. 02
194. 03 07953 OUTREACH CLINICS	0					194. 03
194. 04 07954 SPEECH - HEARING AIDS	0					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
194. 08 07958 CRHP	0				952, 624	
194. 09 07959 NEUROPSYCH PART B	0				19, 383	
200.00 Cross Foot Adjustments		0	40, 03	1 38, 349		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	40, 017	0	40, 03	1 38, 349	23, 850, 376	202.00

Table				10 12/31/2017	Date/lime Prepared: 10/29/2019 2:12 pm
STEPROSON Adj Suthernis 29.00 26.00	Cost Center Description		Total		1.072772017 2.12 p
CARLESSAN SERVICE COST CRITERS 25.00		Cost & Post			
CHERNEL SERVICE DOST CENTERS 1.0 00 0000 CAP REL COSTS-EARCH E SOUTH 2.0 00 0000 CAP REL COSTS-EARCH 2.0 00 0000 CAP REL COSTS EARCH 2.0 0000 CAP REL		Adjustments			
1.00	CENEDAL SEDVICE COST CENTEDS	25. 00	26. 00		
0.00 0.00 DEPLOYEE BRIEFITS DEPARTWENT					1.00
0.000 0.0000 DOSON INSTRATIVE & CENERAL	· · · · · · · · · · · · · · · · · · ·				
1.00 100	· · · · · · · · · · · · · · · · · · ·				
8 00 00000 LAURDRY & LINEN SERVICE 9.00 00000 HOUSE SERVINES 9.00 00000 HOUSE SERVINES 9.00 10.00 010000 (I FLARY 1.00 0100000 (I FLARY 1.00 010000 (I FLARY 1.00 010000 (I FLARY 1.00 010000 (I FLARY	1 I				
10.00 01000 DETARY					
11.00 01100 CAPTERIA 11.00 13.00	· · · · · · · · · · · · · · · · · · ·				
13 00 0300 MURSING ADMINISTRATION 13 00					
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 1					
16. 00	· · · · · · · · · · · · · · · · · · ·				
17.00 1700 SOCIAL SERVICE					
23.00	· · · · · · · · · · · · · · · · · · ·				
23.01 0320 PARAMECU PATRON 22.01 22.01 23.01 23.02 0320 PARAMECY RESIDENCY PROG 23.00 23.00 03.00 03.00 03.00 03.00 03.10 00.11 05.00 03.10 00.11 05.00 03.00 03.00 03.1					
INPATI ENT ROUTINE SERVICE COST CENTERS 3					
30.00 3000 ADULTS & PEDIATRICS 0 4,884,969 30.00 32.00 32.00 33.00					23. 02
31.00		0	4 884 969		30.00
33.0 03300 BURN INTENSIVE CARE UNIT	· · · · · · · · · · · · · · · · · · ·	1			
34 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 40.00	+ · · · · · · · · · · · · · · · · · · ·	0	0		
40, 00 04000 04000 04000 04000 0400 041, 00 041, 00 041, 00 042, 00 0420	· · · · · · · · · · · · · · · · · · ·	0	0		
11. 00 04100 SUBPROVI DER 1 1 0 0 0 0 0 0 0 0	• • • • • • • • • • • • • • • • • • •	0	0		
43.00 04300 NURSERY 0 86.045 44.00		o o	625, 316		
A4. 00 O4400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0	42. 00 04200 SUBPROVI DER	1	-1		42.00
ANCILLARY SERVICE COST CENTERS 50.00	· · · · · · · · · · · · · · · · · · ·	1			
SOLID SOLI		0	O		44.00
S2 00 05200 05200 05200 05200 05200 0530		0	4, 328, 861		50.00
S3. 00 03.00 AMESTHESI OLOGY 0 26, 407 53. 00			199, 849		
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 553, 252 54. 00	· · · · · · · · · · · · · · · · · · ·	1 1	26 407		
54.01 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0 223, 361 54, 02 54.02 54.03 05405 MAMMOGRAPHY 0 306, 016 54.02 54.03 05405 MAMMOGRAPHY 0 306, 016 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 1, 185, 757 55.00 05500 RADI OLOGY-THERAPEUTI C 0 1, 185, 757 55.00 05500 RADI OLOGY-THERAPEUTI C 0 1, 185, 757 55.00 05800 MRI 0 59, 737 58.00 05800 MRI 0 590, 737 58.00 05800 MRI 0 582, 521 59, 00 05900 CARDIA C CATHETERI ZATI ON 0 582, 521 59, 00 0500 05000 CARDIA C CATHETERI ZATI ON 0 582, 521 59, 00 0500 06000 LABORATORY 0 886, 968 60, 001 06010 LABORATORY-PATHOLOGI CAL 0 113, 658 60, 001 06010 LABORATORY-PATHOLOGI CAL 0 113, 658 60, 001 06000 HASDRATORY HERAPY 0 551, 809 65.00 06000 PHYSI CAL THERAPY 0 551, 809 65.00 06000 PHYSI CAL THERAPY 0 627, 140 66.00 06000 PHYSI CAL THERAPY 0 627, 140 66.00 06000 PHYSI CAL THERAPY 0 87, 583 67, 00 06000 PHYSI CAL THERAPY 0 87, 583 67, 00 06000 PHYSI CAL THERAPY 0 87, 583 67, 00 06000 06000 SPECEN PATHOLOGY 0 88, 281 68, 80 06, 90 00 06000 ELECTROCARDI OLOGY 0 126, 166 69, 90 00 00000 ELECTROCERCEPHALOGRAPHY 0 226, 634 70, 00 07, 00 07, 000 ELECTROCERCEPHALOGRAPHY 0 267, 337 72, 00 07, 00 ELECTROCERCEPHALOGRAPHY 0 267, 337 72, 00 07, 00 07, 00 ELECTROCERCEPHALOGRAPHY 0 267, 337 72, 00 07		1			
S4 03 05500 RADIOLOGY-THERAPEUTIC 0 1.18.7.577 55.00		O	1		
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 1,185,757 55. 00 05700 CT SCAN 0 05700 CT SCAN 0 05700 CT SCAN 0 05700 CT SCAN 0 05900 CARDI AC CATHETERI ZATI ON 0 582, 521 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 582, 521 59. 00 06000 LABORATORY 0 886, 968 60. 010 06000 LABORATORY 0 886, 968 60. 010 06000 CABORATORY 0 0886, 968 60. 010 06000 CABORATORY 0 06000 06000 CABORATORY 0 060000 060000 060000 060000 060000 0600000 0600000 060000000 0600000000					
57.00 05700 CT SCAN 05800 MRI 0 059737 58.00					
59.00 05900 05900 05900 05800 05900 05800 059000 059					
60. 00 06000 LABORATORY 0 886, 968 60. 00 60. 01 06001 LABORATORY APACKED RED BLOOD CELL 0 113, 658 60. 01 60. 01 60. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 46, 384 62. 00 66. 00	58. 00 05800 MRI	O			
60. 01 06001 LABORATORY-PATHOLOGICAL 0 113,658 60. 01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 46,384 62. 00 65. 00 06500 RESPIRATORY THERAPY 0 551,809 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 627,140 66. 00 67. 00 06700 OCUPATI ONAL THERAPY 0 87,583 67,00 68. 00 06800 SPECH PATHOLOGY 0 88,281 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 126, 166 69,00 70. 00 07000 ELECTROCARDI OLOGY 0 126, 166 69,00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 230,328 71,00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 287,337 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 287,337 73. 00 74. 00 07400 RENAL DI ALYSIS 0 20,013 74,00 76. 00 30202 AUPUNICTURE 0 0 0 76. 97 07697 CARDI AC REHABILITATION 0 91,363 76,97 0UTPATI ENT SERVICE COST CENTERS 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 407,481 99.00 99. 00 09000 DI ABETES CENTER 0 11,204 99.01 99. 01 09001 DI ABETES CENTER 0 71,520 99.01 99. 02 09002 NUROPSYCH 0 11,204 99.02 99. 03 09003 WUNDO CENTER 0 71,520 99.03 99. 04 09004 HYPERBARI C OXYGEN THERAPY 0 212,252 99.05 99. 05 09005 VI MCARE CLI NI C 0 12,578,373 99.00 99. 00 09000 MERGEROCY 0 1,578,373 99.00 99. 01 09100 EMERGEROCY 0 1,578,373 99.00 99. 02 09000 MERGEROCY 0 1,578,373 99.00 99. 00 09100 EMERGEROCY 0 1,578,373 99.00		1			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 46, 384 62, 00 65. 00 06500 RESPIRATORY THERAPY 0 551, 809 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 627, 140 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 87, 583 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 87, 583 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 126, 166 69. 00 70. 00 07000 CLECTROENCEPHALLOGRAPHY 0 226, 634 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 230, 328 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 287, 337 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 287, 337 73. 00 74. 00 07400 RENAL DI ALYSIS 0 1, 321, 482 73. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 97 07697 CARDI AC REHABILITATI ON 0 91, 363 74. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 91, 363 74. 00 90. 00 90000 CLUR SEPPLATE COST CENTERS 90. 00 90. 00 90000 CLUR SEPPLATE COST CENTER 90. 00 90. 01 09001 DI ABETES CENTER 0 407, 481 90. 00 90. 01 09001 DI ABETES CENTER 0 71, 520 90. 03 90. 04 09004 HYPERBARI COXYGEN THERAPY 0 92, 224 90. 04 90. 05 09005 VIMCARE CLINIC 0 71, 520 90. 03 90. 06 09006 MEDI CATION MGMT CLINIC 0 19, 213 90. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 19, 213 90. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 19, 213 90. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 19, 213 90. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 11, 578, 373 91. 00 90. 00 09000 MEDICATION MGMT CLINIC 0 11, 578, 373 99. 00 90. 00 09000 MEDICATION MGMT CLINIC 0 17, 578, 373 91. 00 90. 00 09000 MEDICATION MGMT CLINIC 0 17, 578, 373 99. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 17, 578, 373 99. 06 90. 00 09000 MEDICATION MGMT CLINIC 0 17, 578, 373 99. 06	1 I				
65.00 06500 RESPI RATORY THERAPY 0 551, 809 66.00 66.00 06600 PHYSI CAL THERAPY 0 627, 140 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 87, 583 67.00 68.00 06800 SPEECH PATHOLOGY 0 88, 281 68.00 69.00 06900 ELECTROCARDI OLOGY 0 126, 166 67.00 70.00 07000 ELECTROCARDI OLOGY 0 226, 634 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 230, 328 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 287, 337 72.00 73.00 07300 RUSS CHARGED TO PATIENTS 0 287, 337 72.00 74.00 07400 RENAL DI ALYSIS 0 1, 321, 482 73.00 75.00 07300 RUSS CHARGED TO PATIENTS 0 20, 013 74.00 76.00 03020 ACUPUNCTURE 0 0 0 76.97 07597 CARDI AC REHABILITATION 0 91, 363 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FURBALLY QUALIFIED HEALTH CENTER 0 0 0 90.00 09000 CLINIC 0 407, 481 99.00 90.01 09001 DI ABETES CENTER 0 38, 615 99.01 90.02 09002 NEUROPSYCH 0 11, 204 90.02 90.03 09003 WOUND CENTER 0 71, 520 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 92, 224 90.04 90.05 09005 VIMCARE CLINIC 0 19, 213 90.06 90.06 09006 MEDICATION MIGHT CLINIC 0 19, 213 90.06 91.00 09000 EMERGENCY 0 1, 578, 373 91.00 91.00 09100 EMERGENCY 0 1, 578, 373 91.00 91.00 07HER REIMBURSABLE COST CENTERS		1			
67. 00	1 I	0			65. 00
68. 00 06800 SPEECH PATHOLOGY 0 88, 281 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 126, 166 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 126, 166 70. 00 70. 00 07000 ELECTROCARDI OLOGY 0 226, 634 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 230, 328 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 287, 337 72. 00 73. 00 07400 RENAL DI ALYSI S 0 20. 013 74. 00 74. 00 74. 00 74. 00 74. 00 76. 7		0			
69. 00 06900 ELECTROCARDI OLOGY 0 126, 166 70. 00 700. 00 7000 ELECTROCARDI OLOGY 0 226, 634 70. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 230, 328 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 287, 337 72. 00 71. 00	+ · · · · · · · · · · · · · · · · · · ·				
71. 00	+ · · · · · · · · · · · · · · · · · · ·	Ö			
72. 00		0			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1,321,482 73. 00 74. 00 07400 RENAL DI ALYSIS 0 20,013 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 76. 07 76. 07 76. 07 76. 07 76. 08 76. 09 76. 07 76. 00 77. 07697 CARDI AC REHABILITATION 0 91,363 76. 97 76. 97 76. 97 78. 00 79. 00		0			
74. 00		1			
76. 97 07697 CARDIAC REHABILITATION 0 91, 363 76. 97 0UTPATIENT SERVICE COST CENTERS 88. 00 0 0 0 0 0 0 0 0 0	+ · · · · · · · · · · · · · · · · · · ·	O			
SECTION SERVICE COST CENTERS SECTION		-1	-1		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89. 00 09900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	91, 363		/6. 9/
89. 00		Ol	0		88.00
90. 01 09001 DI ABETES CENTER 0 38, 615 90. 01 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 04 90. 04 90. 05 90. 05 90. 06		0	-1		
90. 02 09002 NEUROPSYCH 0 11, 204 90. 02 90. 03 09003 WOUND CENTER 0 71, 520 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 92, 224 90. 05 90. 05 90. 06 MEDI CATI ON MGMT CLI NI C 0 212, 252 90. 05 91. 00 9100 EMERGENCY 0 1, 578, 373 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 00000 0000 0000 0000 0000 0000 0000 0000 0000 00		0			
90. 03 09003 WOUND CENTER 0 71, 520 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 92, 224 90. 04 90. 05 09005 VI MCARE CLI NI C 0 212, 252 90. 05 90. 06 09006 MEDICATION MGMT CLI NI C 0 19, 213 90. 06 91. 00 09100 EMERGENCY 0 1,578,373 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0710 OTHER REIMBURSABLE COST CENTERS					
90. 05 09005 VI MCARE CLINI C 0 212, 252 90. 06 09006 MEDI CATI ON MGMT CLINI C 0 19, 213 90. 06 91. 00 09100 EMERGENCY 0 1, 578, 373 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 071HER REI MBURSABLE COST CENTERS 92. 00 09000		Ö			
90. 06 09006 MEDI CATI ON MGMT CLINIC 0 19, 213 90. 06 91. 00 09100 EMERGENCY 0 1,578,373 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 071HER REIMBURSABLE COST CENTERS 92. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 0 09200 09200 OSSERVATION BEDS (NON-DISTINCT PART 0 0920		0			
91. 00 09100 EMERGENCY 0 1,578,373 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 OTHER REIMBURSABLE COST CENTERS 92. 00 OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	0			
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
	1	1	., ., ., ., .,		
95. UU U95UU AMBULANCE 0 919, 298 95. 00			040 000		05.55
	90. UU U90UU AMBULANCE SERVI CES	l Ol	919, 298		95.00

Health Financial Systems	COLUMBUS REGIONAL	L HOSPITAL		In Lieu	u of Form CMS-2552-	-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0112	From 01/01/2017	Worksheet B Part II Date/Time Prepared 10/29/2019 2:12 pm	d: m
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				

			10/29/2019 2: 12 pm
Cost Center Description	Intern & Residents	Total	
	Cost & Post		
	Stepdown		
	Adjustments		
	25. 00	26. 00	
99. 10 09910 CORF	0	0	99. 10
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	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	111.00
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	22, 493, 088	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 808	190. 00
194. 00 07950 WELLNESS COMMUNITY	0	78, 846	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	48, 700	194. 01
194. 02 07952 HOSPI CE	0	3, 374	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	10, 363	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	55, 479	194. 05
194. 06 07956 CRH FOUNDATION	0	33, 477	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	50, 854	194. 07
194. 08 07958 CRHP	0	952, 624	194. 08
194.09 07959 NEUROPSYCH PART B	0	19, 383	194. 09
200.00 Cross Foot Adjustments	0	78, 380	200. 00
201.00 Negative Cost Centers	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	23, 850, 376	202.00

| Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0112

						o 12/31/2017		
			CAPITAL REL	_ATED COSTS			10/29/2019 2:	12 piii
		Cook Cooks Donnel at long	DIDC 0 FLVT	MVDLE FOLLID	EMDL OVEE	D!!!-#!-	ADMINI CTDATIV	
		Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DEPR)	EMPLOYEE BENEFITS	Reconciliatio n	E & GENERAL	
			(52 : 22 :)	(==:)	DEPARTMENT		(ACCUM. COST)	
			1. 00	2.00	(GROSS SAL) 4.00	5A	5. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	4.00) DA	5.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT	729, 925	l				1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	12, 756	10, 430, 694 6, 070				2.00 4.00
5. 00	1	ADMINISTRATIVE & GENERAL	68, 803				189, 696, 039	5.00
7.00	00700	OPERATION OF PLANT	357, 394	459, 879			12, 914, 968	7. 00
8.00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	792	l e			690, 767	8.00
9. 00 10. 00		DI ETARY	5, 157 7, 864	44, 292 15, 755			3, 224, 264 1, 176, 802	9. 00 10. 00
11.00	01100	CAFETERI A	6, 181	34, 499	1, 371, 144	0	1, 598, 873	11. 00
13.00		NURSING ADMINISTRATION	9, 744	l .			5, 707, 130	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	7, 611 4, 735	98, 542 265, 175		_	1, 304, 017 7, 021, 716	14. 00 15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	4, 026	38, 281			1, 810, 790	
17. 00		SOCIAL SERVICE	302	i e			737, 015	
23. 00 23. 01		PARAMED ED PRGM-(SPECIFY) XRAY EDUCATION	0 162			0	0 628, 134	23. 00 23. 01
23. 02	02302	PHARMACY RESIDENCY PROG	376	ŀ		0	532, 996	23. 02
20.00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	7/ /0/	270 1/2	12 420 200		21 (02 07(20.00
30. 00 31. 00		INTENSIVE CARE UNIT	76, 686 10, 959				21, 602, 876 4, 472, 553	30. 00 31. 00
32.00	03200	CORONARY CARE UNIT	0	0			0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41.00	04100	SUBPROVI DER - I RF	11, 085	17, 678	1, 402, 173	0	2, 274, 218	41.00
42.00		SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	583 0	16, 642 0			945, 843	43. 00 44. 00
	ANCI L	LARY SERVICE COST CENTERS	_	-	-	-	-	
50.00	1	OPERATING ROOM	39, 075	1				
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	3, 185	1	1		1, 360, 185 0	51. 00 52. 00
53.00		ANESTHESI OLOGY	119	· -			303, 953	
54.00		RADI OLOGY-DI AGNOSTI C	8, 655	l .			2, 907, 502	54.00
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	3, 384 1, 504	6, 644 71, 455			1, 592, 449 1, 043, 773	54. 01 54. 02
54. 03	1	MAMMOGRAPHY	273				1, 546, 872	
55.00		RADI OLOGY-THERAPEUTI C	7, 432				3, 973, 279	55.00
57. 00 58. 00	05800	CT SCAN	1, 798 900				1, 473, 951 550, 376	57. 00 58. 00
59.00		CARDI AC CATHETERI ZATI ON	10, 664				3, 042, 685	
60.00		LABORATORY	10, 409					
60. 01 62. 00		LABORATORY-PATHOLOGICAL WHOLE BLOOD & PACKED RED BLOOD CELL	1, 212 524				929, 459 674, 792	
65.00	1	RESPIRATORY THERAPY	6, 624				2, 695, 789	65.00
66.00		PHYSI CAL THERAPY	227	23, 965			5, 484, 973	•
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	221	5, 080 23, 137			1, 693, 283 1, 181, 932	
69. 00	06900	ELECTROCARDI OLOGY	1, 398	l .			920, 149	
70.00	1	ELECTROENCEPHALOGRAPHY	0	11, 976	636, 328	0	1, 186, 952	
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6, 729, 620 8, 395, 290	
73. 00	1	DRUGS CHARGED TO PATIENTS	0	ő	Ö	0	17, 460, 581	
74.00		RENAL DI ALYSI S	0	62	337		568, 614	
76. 00 76. 97		ACUPUNCTURE CARDI AC REHABI LI TATI ON	0 1, 581	0 13, 698			0 501, 312	76. 00 76. 97
, 5. , 1		TIENT SERVICE COST CENTERS	1,301	13, 370	210, 337		301,312	, 5. ,,
88.00	1	RURAL HEALTH CLINIC	0				0	
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0 7, 127	0 44, 580	1		0 1, 594, 354	89. 00 90. 00
90. 01		DI ABETES CENTER	7, 127	l .		0	285, 760	90. 01
90. 02	09002	NEUROPSYCH	118	l e			179, 697	90.02
90. 03 90. 04	1	WOUND CENTER HYPERBARIC OXYGEN THERAPY	0	1, 716 109			1, 586, 974 222, 535	
90. 05	09005	VIMCARE CLINIC	4, 255	ŀ			817, 873	
90.06		MEDICATION MGMT CLINIC	68	ŀ			346, 298	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	18, 210	381, 259	5, 382, 901	0	10, 911, 001	91. 00 92. 00
. 2. 00	, - , 200	1	1	1	1	1	1	

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0112	Peri od:	Worksheet B-1

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description MVBLE EQUIP (SQ FEET) (DEPR) BENEFITS E & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SAL) 1. 00 2.00 4. 00 5A 5.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 8, 032 333, 165 3, 100, 729 4, 669, 869 95.00 0 99. 10 09910 CORF 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 0 109. 00 0 Ω 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 o 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 722, 986 77, 957, 796 186, 039, 971 118. 00 118.00 9, 630, 971 -42, 104, 749 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 355 10, 525 190. 00 727 0 0 194. 00 07950 WELLNESS COMMUNITY 0 341, 886 194. 00 171, 303 0 8, 692 194. 01 07951 BUI LDI NG RENTALS 0 0 0 127, 961 194. 01 194. 02 07952 HOSPI CE 0 0 97, 336 194. 02 0 0 0 0 0 194. 03 07953 OUTREACH CLINICS 0 0 0 194.03 Ω 302, 784 194. 04 194. 04 07954 SPEECH - HEARING AIDS C 0 194. 05 07955 NONALLOWABLE MARKETING 0 0 1, 620, 965 194. 05 194.06 07956 CRH FOUNDATION 30, 221 194. 06 815 713 13, 254 248, 990 194. 07 194. 07 07957 HEALTHY COMMUNITIES 145, 439 1, 195 194. 08 07958 CRHP 3,697 788, 601 0 866, 963 194. 08 194. 09 07959 NEUROPSYCH PART B 505 0 8, 437 194. 09 1, 362 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 10, 208, 408 10, 520, 060 28, 647, 749 42, 104, 749 202. 00 Part I) 0. 221959 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 13. 985557 1.008568 0.365929 Cost to be allocated (per Wkst. B, 6, 492, 540 204. 00 204.00 201, 412 Part II) 0. 034226 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.002573 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 10/29/2019 2: 12 pm

	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	10/29/2019 2: CAFETERI A	
	cost center bescription	PLANT	LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
		(SQ FEET) 7.00	(LDRY LBS) 8.00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS	T					1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	290, 972					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	792	1, 137, 944				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG	5, 157	0	5, 097	150 774		9.00
11. 00	01000 DI ETARY 01100 CAFETERI A	7, 864 6, 181	0	36 79	158, 664 0	1, 087	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	9, 744	0	14	Ö	39	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 611	0	49	0	12	14.00
	01500 PHARMACY	4, 735	0	41	0	37	15.00
	01600 MEDI CAL RECORDS & LI BRARY	4, 026	0	0	0	31	16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	302	0	0	0	8	17. 00 23. 00
23. 00	02301 XRAY EDUCATION	162	0	0	0	7	23. 00
	02302 PHARMACY RESIDENCY PROG	376	0	3	0	4	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	76, 686	496, 859	1, 652	121, 622	247	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	10, 959	60, 463 0	157 0	15, 297 0	33	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	Ö	ő	0	1
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	11, 085	59, 439	175	16, 735	23	1
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	583	17, 667	1	0	0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	Ö	ő	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	39, 075	178, 282	862	331	117	50.00
51.00	05100 RECOVERY ROOM	3, 185	41, 197	60	0	13	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 119	0	0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 655	93, 172	176	87	21	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 384	0	75	0	5	54.01
54. 02	05404 ULTRA SOUND	1, 504	0	36	0	6	54.02
54. 03	05405 MAMMOGRAPHY	273	9, 471	48 99	703	12 17	54.03
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	7, 432 1, 798	14, 195 0	20	703 0	9	55. 00 57. 00
58. 00	05800 MRI	900	0	12	0	4	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 664	2, 460	134	373	20	59. 00
60.00	06000 LABORATORY	10, 409	0	73	0	82	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	0	4	0	5	60.01
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	524 6, 624	0	144	0	26	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	227	16, 909		Ö	51	1
67.00	06700 OCCUPATI ONAL THERAPY	221	12, 400	0	0	13	1
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	10	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 398	1 425	30 184	0 177	8	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 635 0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ō	Ö	Ö	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	1, 581	0	0	0	0	76. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	1, 301	0	J 3	<u> </u>		70. 77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	7, 127	48, 728	98	2, 411	15	90.00
90. 01 90. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH	775 118	0	2	0	2	90. 01 90. 02
	09003 WOUND CENTER	0	3, 862		Ö	7	90. 03
90.04	09004 HYPERBARIC OXYGEN THERAPY	0	246	0	0	1	90. 04
	09005 VI MCARE CLI NI C	4, 255	3, 894	198	0	9	90.05
90. 06 91. 00	O9006 MEDICATION MGMT CLINIC O9100 EMERGENCY	19 210	0	13 561	0 928	2 90	90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	18, 210		301	928	90	91.00
, 00	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	8, 032	77, 065		0	70	
	09910 CORF	0	0	0	0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (TIME SPT) (MEALS) (FTES) (SQ FEET) (LDRY LBS) 9.00 10.00 11.00 7 00 8 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 ol 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 Ω 0 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 284, 033 1, 137, 944 5,042 158, 664 1, 080 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 727 0 0 194. 00 07950 WELLNESS COMMUNITY 0 0 4 194.00 194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 0 194. 01 0 194. 02 07952 HOSPI CE 0 0 194. 02 0 0 0 0 194.03 194. 03 07953 OUTREACH CLINICS 0 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 194.04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 0 194.05 0 194.06 07956 CRH FOUNDATION 0 194.06 815 0 53 194. 07 07957 HEALTHY COMMUNITIES 1, 195 0 2 0 2 194. 07 194. 08 07958 CRHP 3, 697 0 0 0 194. 08 194. 09 07959 NEUROPSYCH PART B 1 194. 09 505 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 4, 219, 620 2, 354, 399 202. 00 Cost to be allocated (per Wkst. B, 15, 781, 561 887, 045 1, 894, 330 Part I) 11. 939255 2, 165. 960442 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 54. 237387 0.779516 827.863449 204.00 Cost to be allocated (per Wkst. B, 5, 972, 786 51,034 342, 571 333, 548 315, 826 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 20. 527013 0.044848 67. 210320 2. 102229 290. 548298 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 COLUMBUS REGIONAL HOSPITAL Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 10/29/2019 2: 12 pm Provider CCN: 15-0112

					10/29/2019 2:	12 pm_
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY (DRG COST)	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPT)	
	(NURS HRS)	(STER SUP)		(TIME SPT)		
GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 23. 00 02300 PARAMED ED PRGM- (SPECI FY) 23. 01 02301 XRAY EDUCATI ON 23. 02 DARAMACY RESI DENCY PROG	1, 117, 927 0 76, 381 0 0 0 0 0 8, 470	12, 807 0 0 0 0 0 0 0	18, 811, 151 0 0 0 0 0 0	19, 925 0 0 0 0 0	1, 000 0 0 0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 23. 00 23. 01 23. 02
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	513 857	576	15 001	4, 580	290	30. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	513, 857 68, 968 0 0 0 47, 533 0 19, 248	576 24 0 0 0 0 0 0 0 0 14	15, 001 8, 809 0 0 0 0 365 0 0	4,580 441 0 0 0 0 590 0	290 71 0 0 0 0 159 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
50. 00 05000 OPERATING ROOM	o	11, 470	70, 546	5, 964	0	50. 00
51. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11, 470 0 0 0 14 0 0 14 0 0 0 1111 0 0 26 195 0 0 0 0	70, 546 427 0 114, 654 5, 768 294, 644 516 739 0 18, 906 902 11, 100 556 32 0 13, 149 3, 030 255 0 6, 783 3 0 0 18, 152, 365 12, 057 0 176	5, 964 0 0 0 0 0 0 0 0 556 0 0 1, 796 0 1, 841 0 349 106 22 0 0 887 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 59 0 0 0 0 0 0 0 0 0	51. 00 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 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 97
88. 00	0 0 0 0 0 0 0 19, 726 5, 099 161, 160	0 0 46 0 0 281 0 0 0 36	0 0 152 0 0 33, 214 0 16, 400 801 13, 715	0 0 2, 793 0 0 0 0 0 0	0 0 117 0 0 0 0 0 0 245	88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	143, 322	0	15, 003	0	0	95.00
99. 10 09910 CORF	0	0	0	0	0	99. 10

Health Financial Systems	COLUMBUS REGION	NAL HOSPITAL		In Lie	u of Form CMS-2552-10)
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	-
				From 01/01/2017 To 12/31/2017	Date/Time Prepared:	
				10 12/31/2017	10/29/2019 2:12 pm	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	Ī
	ADMI NI STRATI O	SERVICES &	(DRG COST)	RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY	(TIME SPT)	
	(NURS HRS)	(STER SUP)		(TIME SPT)		
	13. 00	14. 00	15. 00	16.00	17. 00	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 101.00	-
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	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 INTEREST EXPENSE					113.00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 117, 927	12, 807	18, 810, 06	19, 925	1, 000 118. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0 190.00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112

				'	o 12/31/2017 Date/lime Pr 10/29/2019 2	
	Cost Center Description	PARAMED ED	XRAY	PHARMACY		
		PRGM (PERCENT)	EDUCATION (PERCENT)	RESI DENCY PROG		
		(= =)	(* = *** = ***)	(PERCENT)		
	GENERAL SERVICE COST CENTERS	23. 00	23. 01	23. 02		
1. 00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY					14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE					17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0				23. 00
23. 01	02301 XRAY EDUCATION		100			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG INPATIENT ROUTINE SERVICE COST CENTERS			100	J	23. 02
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	C		30.00
	03100 INTENSIVE CARE UNIT	0	0			31.00
	03200 CORONARY CARE UNIT	0	0	C		32.00
	03300 BURN INTENSIVE CARE UNIT	0	0	C		33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0			34. 00 40. 00
	04100 SUBPROVI DER – I RF		0			41.00
42.00	04200 SUBPROVI DER	0	0	d		42.00
43.00	04300 NURSERY	0	0	C		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0)	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	C		50.00
	05100 RECOVERY ROOM		Ö			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C		52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	D	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	100			54.00
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND		0			54. 01 54. 02
54. 03	05405 MAMMOGRAPHY		o			54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C		55.00
57.00	05700 CT SCAN	0	0	C		57.00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0			58. 00 59. 00
60.00	06000 LABORATORY		0			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	l o	Ö	d		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	c		62.00
	06500 RESPIRATORY THERAPY	0	0	C		65.00
	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0			66. 00 67. 00
	06800 SPEECH PATHOLOGY		0			68.00
	06900 ELECTROCARDI OLOGY	0	0	ď		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	100		72. 00 73. 00
	07400 RENAL DIALYSIS	l o	Ö	100		74.00
	03020 ACUPUNCTURE	0	0	C		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	D	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS		٥			- 00 00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00 89. 00
	09000 CLINIC		o			90.00
90. 01	09001 DI ABETES CENTER		o			90. 01
	09002 NEUROPSYCH	0	0		2	90. 02
	09003 WOUND CENTER	0	0			90.03
	O9004 HYPERBARI C OXYGEN THERAPY O9005 VI MCARE CLINI C		O O			90. 04 90. 05
	09006 MEDICATION MGMT CLINIC		ol			90.06
91.00	09100 EMERGENCY	0	o	C		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0	O			95.00
	09910 CORF	0	0			99. 10
	1				ı	

| Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

				10	12/31/2017 Date/11me Pr 10/29/2019 2	
	Cost Center Description	PARAMED ED	XRAY	PHARMACY		
		PRGM	EDUCATI ON	RESI DENCY		
		(PERCENT)	(PERCENT)	PROG		
				(PERCENT)		
		23. 00	23. 01	23. 02	<u> </u>	
	HOME HEALTH AGENCY	0	0	0		101.00
	AL PURPOSE COST CENTERS		_			
	PANCREAS ACQUISITION	0	0	0		109.00
	INTESTINAL ACQUISITION	0	0	0		110.00
	I SLET ACQUI SITI ON	0	0	0		111.00
4	INTEREST EXPENSE		100	100		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	U ₁	100	100		118. 00
	I MBURSABLE COST CENTERS	٥	0			190. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	U O	0	0		194.00
	WELLNESS COMMUNITY BUILDING RENTALS	U O	0	0		194.00
194. 01 07951		0	0	0		194.01
	OUTREACH CLINICS	0	0	0		194. 02
	SPEECH - HEARING AIDS	0	0	0		194.03
	NONALLOWABLE MARKETING	0	0	0		194.05
	CRH FOUNDATION	0	0	0		194.06
	HEALTHY COMMUNITIES	0	0	0		194. 07
194. 08 07958		0	0			194. 08
	NEUROPSYCH PART B	0	0	0		194. 09
200.00	Cross Foot Adjustments	Ĭ.	J	J		200.00
201. 00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	o	791, 502	740, 410		202.00
	Part I)		·			
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	7, 915. 020000	7, 404. 100000		203.00
204. 00	Cost to be allocated (per Wkst. B,	0	40, 031	38, 349		204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	400. 310000	383. 490000		205.00
	11)					
206. 00	NAHE adjustment amount to be allocated	0	0	0		206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000		207. 00
	Parts III and IV)					1

Provider CCN: 15-0112 Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

						0 12/31/201/	Date/IIme Pre 10/29/2019 2:	
				Title	XVIII	Hospi tal	PPS	
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst.	Adj .		Di sal I owance		
			B, Part I,					
			col . 26) 1.00	2.00	3.00	4. 00	5. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	1. 00	0.00	
30.00		ADULTS & PEDIATRICS	38, 737, 686		38, 737, 686	0	38, 737, 686	30.00
31.00	03100	INTENSIVE CARE UNIT	7, 089, 599		7, 089, 599	o	7, 089, 599	31.00
		CORONARY CARE UNIT	0		0	0	0	
33.00	1	BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00		SUBPROVUER - I PF	4 244 042		4 244 042	0	0	40.00
41. 00 42. 00		SUBPROVI DER - I RF SUBPROVI DER	4, 366, 843		4, 366, 843		4, 366, 843 0	1
43. 00		NURSERY	1, 354, 588		1, 354, 588	ا ۱	1, 354, 588	
		SKILLED NURSING FACILITY	0	l e	0	I I	0	
	ANCI L	LARY SERVICE COST CENTERS				'		
		OPERATING ROOM	33, 957, 124		33, 957, 124	169, 617	34, 126, 741	50.00
		RECOVERY ROOM	1, 944, 994		1, 944, 994	I I	1, 944, 994	
52.00		DELIVERY ROOM & LABOR ROOM	0		407.70	0	0	52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	437, 760	l e	437, 760		445, 800	
54. 00		NUCLEAR MEDICINE-DIAGNOSTIC	5, 083, 802 2, 350, 702		5, 083, 802 2, 350, 702		5, 116, 177 2, 350, 702	
54. 02	1	ULTRA SOUND	1, 400, 080		1, 400, 080		1, 400, 080	
54. 03	1	MAMMOGRAPHY	1, 980, 771		1, 980, 771	I I	1, 980, 771	
55.00		RADI OLOGY-THERAPEUTI C	5, 521, 349		5, 521, 349	I I	5, 521, 349	
57.00	1	CT SCAN	1, 944, 196		1, 944, 196	0	1, 944, 196	57.00
58. 00	05800		740, 403	l e	740, 403	I I	740, 403	
59.00		CARDI AC CATHETERI ZATI ON	4, 705, 784	l	4, 705, 784		4, 755, 830	
60. 00 60. 01		LABORATORY LABORATORY-PATHOLOGI CAL	12, 507, 704 1, 446, 480	l	12, 507, 704 1, 446, 480	I I	12, 507, 704 1, 456, 064	1
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	857, 638	l	857, 638		857, 638	1
65. 00		RESPIRATORY THERAPY	4, 251, 584	l		I I	4, 255, 449	1
66. 00	1	PHYSI CAL THERAPY	6, 884, 745				6, 896, 395	1
67.00	06700	OCCUPATI ONAL THERAPY	2, 121, 817	0	2, 121, 817	0	2, 121, 817	67.00
68. 00		SPEECH PATHOLOGY	1, 465, 932	0	1, 465, 932		1, 465, 932	
69. 00		ELECTROCARDI OLOGY	1, 245, 787		1, 245, 787		1, 282, 201	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 736, 831		1, 736, 831	I I	1, 736, 831	
		IMPL. DEV. CHARGED TO PATIENTS	8, 223, 320 10, 258, 700		8, 223, 320 10, 258, 700		8, 223, 320 10, 258, 700	
		DRUGS CHARGED TO PATIENTS	31, 215, 162	ł	31, 215, 162	I I	31, 215, 162	
		RENAL DIALYSIS	700, 975	ł	700, 975	I I	700, 975	
76.00	03020	ACUPUNCTURE	0		0		0	76. 00
76. 97		CARDI AC REHABI LI TATI ON	762, 527		762, 527	3, 268	765, 795	76. 97
00.00		TIENT SERVICE COST CENTERS	0	I		ا	0	00 00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0		0	I I	0	1
		CLINIC	2, 982, 200		2, 982, 200		2, 982, 200	
		DI ABETES CENTER	397, 209		397, 209		397, 209	
		NEUROPSYCH	228, 148		228, 148		228, 148	
		WOUND CENTER	2, 019, 590		2, 019, 590		2, 043, 099	
	1	HYPERBARI C OXYGEN THERAPY	274, 287	l	274, 287		276, 907	
90.05		VIMCARE CLINIC	1, 558, 965 477, 004		1, 558, 965	I I	1, 558, 965 477, 004	
		MEDICATION MGMT CLINIC EMERGENCY	477, 004 16, 327, 931		477, 004 16, 327, 931	I I	16, 961, 332	
	1	OBSERVATION BEDS (NON-DISTINCT PART	4, 077, 983		4, 077, 983		4, 077, 983	
		REIMBURSABLE COST CENTERS	.,,		.,,	'	.,,	
95.00	09500	AMBULANCE SERVICES	7, 335, 410		7, 335, 410	2, 347	7, 337, 757	95.00
99. 10			0	l .	0		0	
101. 00		HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00								
	1	INTESTINAL ACQUISITION	0			1		1109.00
	1	ISLET ACQUISITION	0			I .		111.00
		INTEREST EXPENSE]		Ü	113.00
200.00		Subtotal (see instructions)	230, 973, 610	О	230, 973, 610	986, 736	231, 960, 346	200.00
201.00		Less Observation Beds	4, 077, 983		4, 077, 983	I I	4, 077, 983	
202.00)	Total (see instructions)	226, 895, 627	0	226, 895, 627	986, 736	227, 882, 363	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 10/29/2019 2:12 pm Provider CCN: 15-0112

					'	0 12/31/2017	10/29/2019 2:	
				Title	XVIII	Hospi tal	PPS	
				Charges		·		
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Ratio	I npati ent	
							Rati o	
			6. 00	7. 00	8. 00	9. 00	10.00	
		I ENT ROUTINE SERVICE COST CENTERS				T T		
30.00		ADULTS & PEDIATRICS	57, 727, 209		57, 727, 209			30.00
31.00		INTENSIVE CARE UNIT	13, 969, 629		13, 969, 629			31.00
32. 00 33. 00		CORONARY CARE UNIT	0		0			32.00
34.00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT			0			33. 00 34. 00
40.00	4	SUBPROVIDER - IPF	0					40.00
41. 00		SUBPROVI DER - I RF	6, 374, 194		6, 374, 194			41.00
42.00		SUBPROVI DER	0, 374, 174		0, 374, 174			42.00
43. 00		NURSERY	2, 466, 553		2, 466, 553			43.00
44. 00		SKILLED NURSING FACILITY	2, 100, 000		0			44.00
11.00		LARY SERVICE COST CENTERS	<u> </u>					11.00
50.00		OPERATING ROOM	25, 135, 023	64, 014, 876	89, 149, 899	0. 380899	0. 000000	50.00
51.00		RECOVERY ROOM	2, 444, 321	4, 387, 916			0. 000000	1
52.00		DELIVERY ROOM & LABOR ROOM	0	0	1		0. 000000	
53.00		ANESTHESI OLOGY	4, 517, 274	7, 419, 719	11, 936, 993		0.000000	
54.00	05400	RADI OLOGY-DI AGNOSTI C	1, 346, 900	3, 939, 653			0.000000	
54.01	05402	NUCLEAR MEDICINE-DIAGNOSTIC	1, 356, 054	9, 266, 572	10, 622, 626	0. 221292	0.000000	54. 01
54.02	05404	ULTRA SOUND	1, 175, 008	4, 488, 579	5, 663, 587	0. 247207	0.000000	54.02
54.03	05405	MAMMOGRAPHY	185	4, 020, 041	4, 020, 226	0. 492701	0.000000	54.03
55.00	05500	RADI OLOGY-THERAPEUTI C	265, 614	21, 400, 200	21, 665, 814	0. 254842	0.000000	55.00
57.00	05700	CT SCAN	6, 217, 083	21, 599, 141	27, 816, 224	0. 069894	0.000000	57.00
58.00	05800	•	1, 494, 873	6, 561, 579			0. 000000	1
59.00		CARDI AC CATHETERI ZATI ON	14, 875, 455	10, 406, 214			0. 000000	
60.00		LABORATORY	13, 506, 386	30, 680, 664			0. 000000	
60. 01		LABORATORY-PATHOLOGI CAL	522, 466	4, 766, 795		0. 273475	0. 000000	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	1, 410, 957	822, 918			0. 000000	62.00
65.00		RESPI RATORY THERAPY	8, 041, 431	2, 632, 947			0.000000	1
66.00		PHYSI CAL THERAPY	4, 025, 202	10, 344, 127			0.000000	
67.00		OCCUPATIONAL THERAPY	2, 495, 110	2, 166, 846			0.000000	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	1, 156, 341	904, 240		0. 711417 0. 079177	0. 000000 0. 000000	1
70.00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	5, 951, 728 150, 582	9, 782, 413 6, 585, 361			0. 000000	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	10, 837, 508	9, 069, 272			0. 000000	
71.00		IMPL. DEV. CHARGED TO PATIENTS	10, 837, 508	7, 231, 240			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	30, 909, 707	54, 883, 434		0. 363842	0. 000000	
74.00		RENAL DIALYSIS	1, 891, 579	0 000	1		0. 000000	
76. 00	4	ACUPUNCTURE	0	0			0. 000000	1
76. 97		CARDI AC REHABI LI TATI ON	33, 226	2, 156, 938	1		0. 000000	
		TIENT SERVICE COST CENTERS		,,				
88.00		RURAL HEALTH CLINIC	0	0	0			88. 00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
90.00		CLINIC	40, 431	5, 900, 838			0. 000000	1
90. 01		DI ABETES CENTER	178	203, 657			0. 000000	1
		NEUROPSYCH	4, 485	256, 542			0. 000000	
	1	WOUND CENTER	49, 367	5, 770, 455			0. 000000	1
90. 04		HYPERBARI C OXYGEN THERAPY	6, 096	794, 006	1		0. 000000	
90. 05		VI MCARE CLINIC	1, 163	561, 206			0. 000000	
90.06		MEDICATION MGMT CLINIC	1, 200	416, 867			0. 000000	
91.00		EMERGENCY	15, 460, 824	54, 909, 011			0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	0	10, 006, 377	10, 006, 377	0. 407538	0. 000000	92.00
95. 00		AMBULANCE SERVICES	0	11, 659, 077	11, 659, 077	0. 629159	0. 000000	95.00
99. 10			o	11, 039, 077		1	0.000000	99. 10
	4	HOME HEALTH AGENCY	o	0	1			101.00
		AL PURPOSE COST CENTERS	<u> </u>					
109.00		PANCREAS ACQUISITION	0	0	0			109. 00
110.00	11000	INTESTINAL ACQUISITION	o	0	0			110.00
		ISLET ACQUISITION	0	0	0			111. 00
	1	INTEREST EXPENSE						113. 00
200.00	1	Subtotal (see instructions)	246, 763, 910	390, 009, 721	636, 773, 631			200. 00
201.00	1	Less Observation Beds						201.00
202.00)	Total (see instructions)	246, 763, 910	390, 009, 721	636, 773, 631			202. 00

Heal th Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0112

Period:
From 01/01/2017
To 12/31/2017

Date/Time Prepared:
10/29/2019 2:12 pm

		Title XVIII	Hospi tal	10/29/2019 2: PPS	12 pm
Cost Center Description	PPS Inpatient	THE XVIII	поэрг саг	113	
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - PF					40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY					43. 00 44. 00
ANCILLARY SERVICE COST CENTERS					1 44.00
50. 00 05000 OPERATING ROOM	0. 382802				50.00
51. 00 05100 RECOVERY ROOM	0. 284679				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 037346				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 967772				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 221292				54.01
54. 02 05404 ULTRA SOUND	0. 247207				54.02
54. 03 05405 MAMMOGRAPHY	0. 492701				54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 254842				55.00
57. 00 05700 CT SCAN	0. 069894				57.00
58. 00 05800 MRI	0. 091902				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 188114				59.00
60. 00 06000 LABORATORY	0. 283063				60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 275287 0. 383924				60. 01 62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 398660				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 479939				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 455134				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 711417				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 081492				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 257845				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 413091				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 565722				72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 363842				73. 00
74. 00 07400 RENAL DI ALYSI S	0. 370577				74.00
76. 00 03020 ACUPUNCTURE	0. 000000				76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 349652				76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC					88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLINIC	0. 501947				90.00
90. 01 09001 DI ABETES CENTER	1. 948679				90. 01
90. 02 09002 NEUROPSYCH	0. 874040				90. 02
90. 03 09003 WOUND CENTER	0. 351059				90.03
90.04 09004 HYPERBARIC OXYGEN THERAPY	0. 346090				90.04
90. 05 09005 VI MCARE CLINI C	2. 772139				90.05
90.06 09006 MEDICATION MGMT CLINIC	1. 140975				90.06
91. 00 09100 EMERGENCY	0. 241031				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 407538				92.00
OTHER REIMBURSABLE COST CENTERS	0 (000(0				05.00
95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF	0. 629360				95.00
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY					99. 10 101. 00
SPECIAL PURPOSE COST CENTERS					1101.00
109. 00 10900 PANCREAS ACQUISITION					109. 00
110. 00 11000 NTESTINAL ACQUISITION					110.00
111. 00 11100 SLET ACQUISITION					111.00
113. 00 11300 NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Peri od: Worksheet C From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 10/29/2019 2:12 pm Provider CCN: 15-0112

					'	0 12/31/201/	10/29/2019 2:	
				Ti tl	e XIX	Hospi tal	Cost	
				<u> </u>		Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst.	Adj .		Di sal I owance		
			B, Part I,					
			col. 26)					
			1. 00	2. 00	3. 00	4. 00	5. 00	
		IENT ROUTINE SERVICE COST CENTERS						
	1	ADULTS & PEDIATRICS	38, 737, 686		38, 737, 686		38, 737, 686	1
		INTENSIVE CARE UNIT	7, 089, 599		7, 089, 599		7, 089, 599	1
		CORONARY CARE UNIT	0		0	0	0	32.00
		BURN INTENSIVE CARE UNIT	0		0	0	0	
		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		SUBPROVIDER - I PF	4 244 042		4 244 042	0	0	
		SUBPROVI DER – I RF SUBPROVI DER	4, 366, 843		4, 366, 843	0	4, 366, 843 0	41. 00 42. 00
		NURSERY	1, 354, 588		1, 354, 588	0	1, 354, 588	•
		SKILLED NURSING FACILITY	1, 354, 566	ľ	1, 354, 566		1, 354, 566	•
		LARY SERVICE COST CENTERS	0			U U	U	44.00
		OPERATING ROOM	33, 957, 124		33, 957, 124	169, 617	34, 126, 741	50.00
	1	RECOVERY ROOM	1, 944, 994	ł .	1, 944, 994		1, 944, 994	1
	1	DELIVERY ROOM & LABOR ROOM	0	l	1, 7, 1, 7, 7, 1		0	52.00
		ANESTHESI OLOGY	437, 760		437, 760		445, 800	1
		RADI OLOGY-DI AGNOSTI C	5, 083, 802		5, 083, 802	-,	5, 116, 177	54.00
		NUCLEAR MEDICINE-DIAGNOSTIC	2, 350, 702		2, 350, 702		2, 350, 702	1
54.02	05404	ULTRA SOUND	1, 400, 080		1, 400, 080		1, 400, 080	
54.03	05405	MAMMOGRAPHY	1, 980, 771		1, 980, 771	o	1, 980, 771	54.03
55.00	05500	RADI OLOGY-THERAPEUTI C	5, 521, 349		5, 521, 349	0	5, 521, 349	55.00
57.00	05700	CT SCAN	1, 944, 196		1, 944, 196	0	1, 944, 196	57.00
	05800		740, 403		740, 403		740, 403	58. 00
		CARDI AC CATHETERI ZATI ON	4, 705, 784		4, 705, 784	50, 046	4, 755, 830	
60.00	06000	LABORATORY	12, 507, 704		12, 507, 704	0	12, 507, 704	60.00
60. 01		LABORATORY-PATHOLOGI CAL	1, 446, 480		1, 446, 480		1, 456, 064	60. 01
		WHOLE BLOOD & PACKED RED BLOOD CELL	857, 638	l	857, 638		857, 638	1
65.00		RESPI RATORY THERAPY	4, 251, 584	0			4, 255, 449	1
		PHYSI CAL THERAPY	6, 884, 745	l			6, 896, 395	1
67.00		OCCUPATI ONAL THERAPY	2, 121, 817	0	_,,		2, 121, 817	1
68.00	1	SPEECH PATHOLOGY	1, 465, 932	0	1, 465, 932		1, 465, 932	1
		ELECTROCARDI OLOGY	1, 245, 787		1, 245, 787		1, 282, 201	69.00
		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 736, 831 8, 223, 320		1, 736, 831 8, 223, 320		1, 736, 831 8, 223, 320	70. 00 71. 00
		IMPL. DEV. CHARGED TO PATIENTS	10, 258, 700		10, 258, 700		10, 258, 700	
		DRUGS CHARGED TO PATIENTS	31, 215, 162	ł	31, 215, 162		31, 215, 162	
		RENAL DI ALYSI S	700, 975	ł	700, 975		700, 975	1
		ACUPUNCTURE	0	i e	, , , , , ,		0	76.00
		CARDIAC REHABILITATION	762, 527		762, 527	3, 268	765, 795	•
		TIENT SERVICE COST CENTERS	,	ļ.				
88.00		RURAL HEALTH CLINIC	0		C	0	0	88. 00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	o	0	89. 00
		CLI NI C	2, 982, 200		2, 982, 200	0	2, 982, 200	
90. 01	09001	DI ABETES CENTER	397, 209		397, 209	0	397, 209	90. 01
	1	NEUROPSYCH	228, 148	l	228, 148		228, 148	1
		WOUND CENTER	2, 019, 590	l	2, 019, 590		2, 043, 099	1
		HYPERBARIC OXYGEN THERAPY	274, 287	l	274, 287		276, 907	90. 04
		VI MCARE CLI NI C	1, 558, 965		1, 558, 965		1, 558, 965	•
		MEDICATION MGMT CLINIC	477, 004		477, 004		477, 004	
	1	EMERGENCY	16, 327, 931		16, 327, 931		16, 961, 332	•
		OBSERVATION BEDS (NON-DISTINCT PART	4, 077, 983		4, 077, 983		4, 077, 983	92.00
		REIMBURSABLE COST CENTERS	7 225 410		7 225 410	2 247	7 227 757	05 00
	09500	AMBULANCE SERVICES	7, 335, 410	l	7, 335, 410		7, 337, 757 0	
	1	HOME HEALTH AGENCY	0	l .				101.00
		AL PURPOSE COST CENTERS	U				U	101.00
		PANCREAS ACQUISITION	0		С		0	109. 00
	1	INTESTINAL ACQUISITION	0					110.00
		ISLET ACQUISITION	0					111.00
		INTEREST EXPENSE			Ĭ			113.00
200.00		Subtotal (see instructions)	230, 973, 610	0	230, 973, 610	986, 736	231, 960, 346	
201.00		Less Observation Beds	4, 077, 983		4, 077, 983		4, 077, 983	
202.00	1	Total (see instructions)	226, 895, 627					
				-		· '		•

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 10/29/2019 2:12 pm Provider CCN: 15-0112

						10/29/2019 2:	12 pm
				e XIX	Hospi tal	Cost	
			Charges	1			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
		6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00	03000 ADULTS & PEDIATRICS	57, 727, 209		57, 727, 209)		30.00
31.00	03100 INTENSIVE CARE UNIT	13, 969, 629		13, 969, 629			31.00
32.00	03200 CORONARY CARE UNIT	0		(32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		()		34.00
40. 00	04000 SUBPROVI DER - I PF	0		(40.00
41.00	04100 SUBPROVI DER – I RF	6, 374, 194		6, 374, 194			41.00
42.00	04200 SUBPROVI DER	0		0 4// 55			42.00
43.00	04300 NURSERY	2, 466, 553		2, 466, 553			43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0)		44.00
50. 00	05000 OPERATING ROOM	25, 135, 023	64, 014, 876	89, 149, 899	0. 380899	0. 000000	50.00
51.00	05100 RECOVERY ROOM	2, 444, 321	4, 387, 916			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 557, 710	0,002,20		0. 000000	
53. 00	05300 ANESTHESI OLOGY	4, 517, 274	7, 419, 719	11, 936, 993		0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 346, 900	3, 939, 653			0. 000000	
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 356, 054	9, 266, 572	10, 622, 626	0. 221292	0. 000000	54.01
54. 02	05404 ULTRA SOUND	1, 175, 008	4, 488, 579	5, 663, 587	0. 247207	0. 000000	54.02
54.03	05405 MAMMOGRAPHY	185	4, 020, 041			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	265, 614	21, 400, 200			0. 000000	
57.00	05700 CT SCAN	6, 217, 083	21, 599, 141			0.000000	
58.00	05800 MRI	1, 494, 873	6, 561, 579			0.000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	14, 875, 455	10, 406, 214			0.000000	
60. 00 60. 01	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL	13, 506, 386 522, 466	30, 680, 664 4, 766, 795			0. 000000 0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 410, 957	822, 918			0. 000000	
65. 00	06500 RESPIRATORY THERAPY	8, 041, 431	2, 632, 947			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	4, 025, 202	10, 344, 127			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	2, 495, 110	2, 166, 846			0. 000000	
68.00	06800 SPEECH PATHOLOGY	1, 156, 341	904, 240		0. 711417	0. 000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	5, 951, 728	9, 782, 413	15, 734, 141	0. 079177	0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	150, 582	6, 585, 361			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 837, 508	9, 069, 272			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 902, 568	7, 231, 240			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 909, 707	54, 883, 434			0.000000	
74.00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	1, 891, 579	0	1, 891, 579		0.000000	1
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	33, 226	2, 156, 938			0. 000000 0. 000000	
70. 77	OUTPATIENT SERVICE COST CENTERS	33, 220	2, 130, 730	2, 170, 10-	0. 340100	0.00000	70.77
88. 00	08800 RURAL HEALTH CLINIC	O	0	(0. 000000	0. 000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
90.00	09000 CLI NI C	40, 431	5, 900, 838	5, 941, 269	0. 501947	0. 000000	90.00
90. 01	09001 DI ABETES CENTER	178	203, 657	203, 835		0. 000000	1
	09002 NEUROPSYCH	4, 485	256, 542			0. 000000	1
	09003 WOUND CENTER	49, 367	5, 770, 455				
90.04	09004 HYPERBARI C OXYGEN THERAPY	6, 096	794, 006			0.000000	
90.05	09005 VI MCARE CLINI C	1, 163	561, 206			0.000000	1
90. 06 91. 00	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY	1, 200 15, 460, 824	416, 867 54, 909, 011			0. 000000 0. 000000	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 460, 624	10, 006, 377			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	٩	10,000,377	10,000,37	0.407330	0.00000	72.00
95.00	09500 AMBULANCE SERVICES	0	11, 659, 077	11, 659, 07	0. 629159	0. 000000	95. 00
	09910 CORF	o	0				99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	(101.00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	()		109. 00
	11000 INTESTINAL ACQUISITION	0	0				110.00
	11100 SLET ACQUI SITION	0	0	(ן		111.00
	11300 INTEREST EXPENSE	244 742 010	200 000 701	424 772 /2			113.00
200. 00 201. 00		246, 763, 910	390, 009, 721	636, 773, 63			200. 00 201. 00
201.00		246, 763, 910	390, 009, 721	636, 773, 63			201.00
202.00	p Total (See Thati detrons)	240, 703, 710	370,007,721	1 030,773,03	1	l	1202. UU

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

Provider CCN: 15-0112 Period: Worksheet C From 01/01/2017 To 12/31/2017 Date/Time Prepared: 10/29/2019 2: 12 pm

			12, 01, 201,	10/29/2019 2: 12 pm
Cost Contar Description	DDC Innationt	Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
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 O4400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0.000000			54. 01
54. 02 05404 ULTRA SOUND	0.000000			54. 02
54. 03 05405 MAMMOGRAPHY	0. 000000			54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	0. 000000 0. 000000			55.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0. 000000			57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06000 LABORATORY PATHOLOGI CAL	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
76. 00 03020 ACUPUNCTURE	0. 000000			76.00
76. 97 07697 CARDI AC REHABILI TATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 DI ABETES CENTER	0. 000000			90. 01
90. 02 09002 NEUROPSYCH	0. 000000			90.02
90. 03 09003 WOUND CENTER	0. 000000			90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000			90.04
90. 05 09005 VI MCARE CLI NI C	0. 000000			90.05
90. 06 09006 MEDICATION MGMT CLINIC	0. 000000			90.06
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			05.00
95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF	0. 000000			95.00
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY				99. 10 101. 00
SPECIAL PURPOSE COST CENTERS				101.00
109. 00 10900 PANCREAS ACQUISITION				109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100 I SLET ACQUISITION				111.00
113. 00 11300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
1	1			===: 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0112	Peri od:	Worksheet D	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre 10/29/2019 2:	pared: 12 nm
		Title	xVIII	Hospi tal	PPS	12 piii
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4, 884, 969	0			164. 45	
31.00 INTENSIVE CARE UNIT	799, 223		799, 22	3, 361	237. 79	31.00
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	0		0	0. 00	
41. 00 SUBPROVI DER - I RF	625, 316	0	625, 31	6 3, 676	170. 11	
42. 00 SUBPROVI DER	0	0	1	0	0. 00	
43. 00 NURSERY	86, 045		86, 04	15 3, 269	26. 32	
44.00 SKILLED NURSING FACILITY	0			0	0. 00	44. 00
200.00 Total (lines 30 through 199)	6, 395, 553		6, 395, 55	40, 010		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
LANDATI ENT. DOUTLAND OFFICE COOT OFFITEDO	6. 00	7. 00				
30.00 ADULTS & PEDIATRICS	11 040	1, 948, 404				30.00
	11, 848		1			
31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT	1, 321	314, 121	1			31. 00 32. 00
	0	0				
33. 00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVIDER - IPF	2 10(0				40.00
41. 00 SUBPROVI DER - I RF	2, 196		1			41.00
42. 00 SUBPROVI DER	0	0	1			42.00
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	0	0	•			43. 00 44. 00
	15 245	0 424 007	1			
200.00 Total (lines 30 through 199)	15, 365	2, 636, 087	I			200. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SER	RVICE CAPITAL COSTS	Provi der CCN: 15-0112	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0112	Peri od:	Worksheet D	
				From 01/01/2017	Part II	narad.
				To 12/31/2017	Date/Time Pre 10/29/2019 2:	12 nm
		Title	xVIII	Hospi tal	PPS	12 piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
, , , , , , , , , , , , , , , , , , ,	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)	Ŭ	ŕ	
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 328, 861	89, 149, 899	1		536, 374	
51. 00 05100 RECOVERY ROOM	199, 849				33, 483	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	ļ	0.00000		ı	
53. 00 05300 ANESTHESI OLOGY	26, 407	,	1	· · · · · ·		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	553, 252			· ·	80, 048	1
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	223, 361					
54. 02 05404 ULTRA SOUND	165, 276					
54. 03 05405 MAMMOGRAPHY	306, 016				0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 185, 757					
57. 00 05700 CT SCAN	411, 172			· · · · · ·	43, 795	1
58. 00 05800 MRI	59, 737					1
59. 00 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	582, 521 886, 968				139, 746 121, 123	
						1
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	113, 658		0. 02148 0. 02076			1
65. 00 06500 RESPI RATORY THERAPY	46, 384 551, 809					65.00
66. 00 06600 PHYSI CAL THERAPY	627, 140				64, 185	1
67. 00 06700 OCCUPATI ONAL THERAPY	87, 583		1		11, 059	1
68. 00 06800 SPEECH PATHOLOGY	88, 281		1	·		1
69. 00 06900 ELECTROCARDI OLOGY	126, 166				23, 273	
70. 00 07000 ELECTROENCEPHALOGRAPHY	226, 634					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	230, 328				58, 832	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	287, 337					
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 321, 482				214, 132	1
74. 00 07400 RENAL DI ALYSI S	20, 013		1		10, 069	
76. 00 03020 ACUPUNCTURE	0	0	0.00000		0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	91, 363	2, 190, 164	1		503	76. 97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
90. 00 09000 CLI NI C	407, 481	5, 941, 269	0. 06858	5 31, 228	2, 142	90.00
90. 01 09001 DI ABETES CENTER	38, 615	203, 835	0. 18944	2 178	34	90. 01
90. 02 09002 NEUROPSYCH	11, 204	261, 027			103	90. 02
90. 03 09003 WOUND CENTER	71, 520				0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	92, 224	800, 102	0. 11526	5 6, 096	703	90.04
90. 05 09005 VI MCARE CLINI C	212, 252				0	90.05
90.06 09006 MEDICATION MGMT CLINIC	19, 213				0	90.06
91. 00 09100 EMERGENCY	1, 578, 373				184, 494	1
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	514, 250	10, 006, 377	0. 05139	2 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES				7		95.00
200.00 Total (lines 50 through 199)	15, 692, 487	544, 576, 969	Ί	75, 920, 698	1, 902, 686	1200.00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lieu	of Form CMS-2552-10
ADDODEL ONMENT OF LAIDATIENT	DOLLTINE CERVILOE OTHER DACC TUROUGH COCTO	D	D	We deleted D

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	STS Provider C	F	Period: From 01/01/2017 To 12/31/2017		pared:
		Ti +Lo	xVIII	Hospi tal	PPS	12 piii
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
cost center bescriptron	School	School	Post-Stepdown	Cost	Medical	
		301001		COST		
	Post-Stepdown		Adjustments		Educati on	
	Adj ustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	l c	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	Ö	1		l	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	ĺ			Ö	34.00
40. 00 04000 SUBPROVI DER - PF		1			0	
	0	0				40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	C		0	41.00
42. 00 04200 SUBPROVI DER	0	0	(42.00
43. 00 04300 NURSERY	0	0	(0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	0	l c	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpati ent	
μ	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Jajo	col . 6)	l og. a bajo	
	instructions)	minus col. 4)		(01. 0)		
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	_
	0		20.70	0.00	11 040	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	29, 704			
31.00 03100 INTENSIVE CARE UNIT		0				
32. 00 03200 CORONARY CARE UNIT		0	(l	
33.00 03300 BURN INTENSIVE CARE UNIT		0	(0.00	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0.00	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 676	0.00	2, 196	41.00
42. 00 04200 SUBPROVI DER	0	0		0.00		42.00
43. 00 04300 NURSERY		Ö	3, 269		•	43.00
44.00 04400 SKILLED NURSING FACILITY		Ö			•	44. 00
200.00 Total (lines 30 through 199)					15, 365	
	Innotiont	U	40,010	<u>'</u>	10, 300	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	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 - PF						40.00
41. 00 04100 SUBPROVI DER - 1 FF						41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43.00
44.00 O4400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199)	0					200.00

Peri od: Worksheet D From 01/01/2017 Part IV To 12/31/2017 Date/Time Prepared: THROUGH COSTS

				12,01,201,	10/29/2019 2:	12 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
ANOLILIARY OFFICE COOT OFFITERS	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	_	_		_	_	
50. 00 05000 OPERATI NG ROOM	0	-	1	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	-	1	0	· ·	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		2	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		2	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		2	0	791, 502	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			0	0	54.01
54. 02 05404 ULTRA SOUND	0		2	0	0	54.02
54. 03 05405 MAMMOGRAPHY	0		2	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	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		2	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0		2	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0		2	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		2	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0		2	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		2	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		2	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		2	0	740, 410	73.00
74. 00 07400 RENAL DI ALYSI S	0	1	2	0	0	74.00
76. 00 03020 ACUPUNCTURE	0		1	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	C)	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			J			00 00
88. 00 08800 RURAL HEALTH CLINIC	0		•	0	-	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	1	0		89.00
90. 00 09000 CLI NI C	0			0	0	90.00
90. 01 09001 DI ABETES CENTER	0			0	0	90. 01
90. 02 09002 NEUROPSYCH	0			0	0	90.02
90. 03 09003 WOUND CENTER	0			0	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0			0	0	90.04
90. 05 09005 VI MCARE CLI NI C	0]	0	0	90.05
90. 06 09006 MEDICATION MGMT CLINIC	0	1	1	0	0	90.06
91. 00 09100 EMERGENCY	0)	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART] 0			U	0	92.00
OTHER REIMBURSABLE COST CENTERS					I	05 00
95. 00 09500 AMBULANCE SERVI CES			,		1 501 040	95.00
200.00 Total (lines 50 through 199)	0	[C	ין	0 0	1, 531, 912	1200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time Prepared: | 12/31/2017 | Date/Time Pre THROUGH COSTS

				'	0 12/31/2017	10/29/2019 2:	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	0	89, 149, 899	0.000000	1
51. 00	05100 RECOVERY ROOM	0	0	0	6, 832, 237	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	_	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0	0	,	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	791, 502	791, 502		0. 149720	1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	,	0.000000	1
54. 02	05404 ULTRA SOUND	0	0	0	5, 663, 587	0.000000	54.02
54. 03	05405 MAMMOGRAPHY	0	0	0	4, 020, 226	0.000000	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	21, 665, 814	0.000000	55.00
57.00	05700 CT SCAN	0	0	0	27, 816, 224	0.000000	57.00
58. 00	05800 MRI	0	0	0	8, 056, 452	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	25, 281, 669	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	44, 187, 050	0. 000000	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	0	5, 289, 261	0.000000	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2, 233, 875	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	10, 674, 378	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	14, 369, 329	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	4, 661, 956	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2, 060, 581	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	15, 734, 141	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	6, 735, 943	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19, 906, 780	0.000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18, 133, 808	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	740, 410	740, 410	85, 793, 141	0. 008630	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1, 891, 579	0.000000	74.00
	03020 ACUPUNCTURE	0	0	0	0	0.000000	76.00
76. 97	07697 CARDIAC REHABILITATION	0	0	C	2, 190, 164	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	•			0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0.000000	1
90.00	09000 CLI NI C	0	0	0	-, ,	0.000000	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	203, 835	0.000000	90. 01
90. 02	09002 NEUROPSYCH	0	0	0	261, 027	0.000000	90. 02
90. 03	09003 WOUND CENTER	0	0	0	5, 819, 822	0.000000	90. 03
90.04	09004 HYPERBARIC OXYGEN THERAPY	0	0	0	800, 102	0.000000	90. 04
90. 05	09005 VIMCARE CLINIC	0	0	C	562, 369	0. 000000	90. 05
90.06	09006 MEDICATION MGMT CLINIC	0	0	O	418, 067	0. 000000	90.06
91.00	09100 EMERGENCY	0	0	0	70, 369, 835	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10, 006, 377	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	1, 531, 912	1, 531, 912	544, 576, 969		200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	From 01/01/2017	Worksheet D Part IV Date/Time Prepared:

111100011 00313			To	12/31/2017	Date/Time Pre 10/29/2019 2:	pared: 12 nm
		Title	XVIII	Hospi tal	PPS	12 piii
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	-	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	11, 046, 277	0	18, 477, 906	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 144, 685	0	947, 759	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 960, 299	0	1, 926, 602	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 149720	764, 885	114, 519	1, 339, 093	200, 489	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	798, 986	0	3, 959, 353	0	54.01
54.02 05404 ULTRA SOUND	0. 000000	594, 828	0	1, 277, 429	0	54.02
54. 03 05405 MAMMOGRAPHY	0. 000000	0	0	394, 957	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	187, 620	0	8, 517, 085	0	55.00
57.00 05700 CT SCAN	0. 000000	2, 962, 697	0	6, 332, 259	0	57.00
58. 00 05800 MRI	0. 000000	714, 460	0	2, 064, 158	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 065, 087	0	4, 488, 028	0	59.00
60. 00 06000 LABORATORY	0. 000000	6, 034, 146	0	3, 589, 768	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	277, 794	0	1, 298, 144	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	661, 726	o	418, 826	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	4, 116, 656	o	1, 087, 787	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 470, 638	o o	73, 621	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	588, 627	o o	39, 949	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	172, 128		228, 970	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 902, 227	o o	3, 315, 956	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	89, 163	o o	1, 806, 002	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 084, 873		3, 314, 934	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 152, 022	0	3, 380, 940	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 008630	13, 901, 961	119, 974	22, 969, 526	198, 227	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	951, 660	0	22, 707, 020	0	74.00
76. 00 03020 ACUPUNCTURE	0. 000000	751, 000 N	ĺ	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	12, 058	0	1, 040, 246	0	76. 97
OUTPATIENT SERVICE COST CENTERS	0.00000	12,000	۷	1,010,210		70.77
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	O	Ol	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	Ö	ol	0	89. 00
90. 00 09000 CLI NI C	0. 000000	31, 228		2, 934, 874	0	90.00
90. 01 09001 DI ABETES CENTER	0. 000000	178		10, 329	0	90. 01
90. 02 09002 NEUROPSYCH	0. 000000	2, 392	0	150, 098	0	90. 02
90. 03 09003 WOUND CENTER	0. 000000	2, 3,2	0	2, 855, 585	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	6, 096	0	159, 004	0	90.04
90. 05 09005 VI MCARE CLI NI C	0. 000000	0, 070	0	63, 591	0	90. 05
90. 06 09006 MEDICATION MGMT CLINIC	0. 000000	0	0	298, 865	0	90.06
91. 00 09100 EMERGENCY	0. 000000	8, 225, 301		11, 864, 140	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0, 223, 301	-	2, 092, 861	0	91.00
OTHER REIMBURSABLE COST CENTERS	0.000000		<u> </u>	2, 072, 001	U	72.00
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)		75, 920, 698	234, 493	112, 718, 645	398, 716	
1.2.2. (1	, , _ 0, 0, 0		, ,	3,0,,10	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0112 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 10/29/2019 2:12 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 18, 477, 906 50.00 05000 OPERATING ROOM 0. 380899 7, 038, 216 50.00 05100 RECOVERY ROOM 0 51.00 0. 284679 947, 759 0 51.00 269, 807 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.036673 1, 926, 602 0 0 70,654 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 961648 1, 339, 093 0 0 1, 287, 736 54.00 3, 959, 353 0 0 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0.221292 876, 173 54 01 0 0 54.02 05404 ULTRA SOUND 0. 247207 1, 277, 429 315, 789 54.02 54.03 05405 MAMMOGRAPHY 0. 492701 394, 957 0 194, 596 54.03 0 05500 RADI OLOGY-THERAPEUTI C 0. 254842 8, 517, 085 0 0 2, 170, 511 55.00 55.00 0 05700 CT SCAN 0.069894 57.00 6, 332, 259 442, 587 57 00 58.00 05800 MRI 0.091902 2,064,158 189, 700 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0.186134 4, 488, 028 0 0 835, 375 59.00 06000 LABORATORY 0 60 00 0.283063 3 589 768 1,016,130 60 00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 0.273475 1, 298, 144 355, 010 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 383924 418, 826 0 0 160, 797 62.00 62.00 06500 RESPIRATORY THERAPY 0 0 65.00 0. 398298 1, 087, 787 433, 263 65.00 06600 PHYSI CAL THERAPY 0 0 0 479128 35, 274 66 00 73, 621 66 00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 0.455134 39, 949 18, 182 67.00 06800 SPEECH PATHOLOGY 0.711417 228, 970 0 162, 893 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.079177 3, 315, 956 262.547 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0.257845 70 00 1, 806, 002 465, 669 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 413091 3, 314, 934 1, 369, 369 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 380, 940 0 0 1, 912, 672 72.00 0.565722 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.363842 22, 969, 526 0 85, 713 8, 357, 278 73.00 07400 RENAL DIALYSIS 0 74.00 0.370577 C 0 0 74 00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0.348160 1,040,246 0 0 362, 172 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 90.00 09000 CLI NI C 0.501947 2, 934, 874 0 1, 473, 151 90.00 0 09001 DI ABETES CENTER 1.948679 0 90.01 0 10.329 20, 128 90.01 90.02 09002 NEUROPSYCH 0.874040 150, 098 0 131, 192 90.02 90 03 09003 WOUND CENTER 0.347019 2, 855, 585 0 0 990, 942 90.03 0 09004 HYPERBARIC OXYGEN THERAPY 159,004 0 54, 509 90.04 90.04 0.342815 09005 VIMCARE CLINIC 0 90.05 2.772139 63, 591 176, 283 90.05 90.06 09006 MEDICATION MGMT CLINIC 1. 140975 298, 865 0 0 340, 997 90.06 91.00 09100 EMERGENCY 0. 232030 11, 864, 140 0 2, 752, 836 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.407538 2, 092, 861 852, 920 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 629159 0 200.00 Subtotal (see instructions) 112, 718, 645 85, 713 35, 395, 358 200.00

0

0

85, 713

112, 718, 645

201.00

35, 395, 358 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

 Heal th Financial Apportionment of Apportion
 Systems
 COLUMBUS REGIO

 Apportion
 OTHER HEALTH SERVICES AND VACCINE COST
 In Lieu of Form CMS-2552-10 COLUMBUS REGIONAL HOSPITAL Provi der CCN: 15-0112

Peri od: Worksheet D From 01/01/2017 Part V To 12/31/2017 Date/Ti me Prepared:

				10 12/01/2017	10/29/2019 2: 12 pm
			Title XVIII	Hospi tal	PPS
		Costs			
	Cost Center Description	Cost	Cost		
			Reimbursed		
			ervi ces Not		
			Subject To		
			, I		
			ed. & Coins.		
			(see inst.)		
1110	LLLADY CEDYLOF COCT OFNITEDS	6. 00	7. 00		
	ILLARY SERVICE COST CENTERS				
	00 OPERATING ROOM	0	0		50.00
51. 00 051	OO RECOVERY ROOM	0	0		51.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 053	00 ANESTHESI OLOGY	0	o		53.00
54. 00 054	OO RADI OLOGY-DI AGNOSTI C	l ol	ol		54.00
	02 NUCLEAR MEDICINE-DIAGNOSTIC	o	ol		54. 01
	04 ULTRA SOUND	l ol	ol		54. 02
	05 MAMMOGRAPHY	0	ol		54.03
	00 RADI OLOGY-THERAPEUTI C	0	ol		55.00
	l .		- 1		
	00 CT SCAN	0	0		57.00
	OO MRI	0	0		58.00
	OO CARDI AC CATHETERI ZATI ON	0	0		59.00
60.00 060	00 LABORATORY	0	0		60.00
	01 LABORATORY-PATHOLOGI CAL	0	0		60. 01
62. 00 062	00 WHOLE BLOOD & PACKED RED BLOOD CELL	o	ol		62.00
	OO RESPIRATORY THERAPY	o	ol		65.00
	00 PHYSI CAL THERAPY	l ol	ol		66.00
	OO OCCUPATI ONAL THERAPY	l ol	ol		67.00
	00 SPEECH PATHOLOGY		ol		68.00
	00 ELECTROCARDI OLOGY	0	ol		69.00
		1	- 1		
	00 ELECTROENCEPHALOGRAPHY	0	0		70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	00 DRUGS CHARGED TO PATIENTS	0	31, 186		73.00
	00 RENAL DIALYSIS	0	0		74.00
76. 00 030	20 ACUPUNCTURE	0	0		76.00
76. 97 076	97 CARDIAC REHABILITATION	0	o		76. 97
OUTI	PATIENT SERVICE COST CENTERS				
88. 00 088	OO RURAL HEALTH CLINIC	0	0		88. 00
89. 00 089	OO FEDERALLY QUALIFIED HEALTH CENTER	l ol	ol		89.00
	OO CLI NI C	o	ol		90.00
	01 DI ABETES CENTER		ol		90. 01
	02 NEUROPSYCH		ol		90.02
	03 WOUND CENTER		ol		90.03
			- 1		
	04 HYPERBARI C OXYGEN THERAPY	0	0		90.04
	05 VIMCARE CLINIC	0	0		90. 05
	O6 MEDICATION MGMT CLINIC	0	0		90.06
	OO EMERGENCY	0	0		91.00
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHI	ER REIMBURSABLE COST CENTERS				
95. 00 095	00 AMBULANCE SERVICES	0			95.00
200.00	Subtotal (see instructions)	o	31, 186		200.00
201.00	Less PBP Clinic Lab. Services-Program	l ol	.		201.00
	Only Charges				[
202. 00	Net Charges (line 200 - line 201)	0	31, 186		202.00
202.00	1 3 933 (200 11110 201)	۱ ۹	0.7.00		1202.00

Hoal th	Financial Systems	COLUMBUS REGIO	NAI HOSDITAI		In lie	u of Form CMS-2	2552_10
	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od: From 01/01/2017	Worksheet D Part II	
			Component	CCN: 15-T112	To 12/31/2017	Date/Time Pre 10/29/2019 2:	epared: 12 nm
			Titl∈	· XVIII	Subprovi der - I RF	PPS	12 piii
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col . 26)					
	ANOLILIADY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	4 000 074	00 140 000	0.04055	-7 47 4/0	0.40	
50.00	05000 OPERATING ROOM	4, 328, 861	89, 149, 899			848	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	199, 849	6, 832, 237 0	i		78 0	1
52.00	05300 ANESTHESI OLOGY	26, 407	11, 936, 993			7	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	553, 252	5, 286, 553			1, 354	
54. 00	05402 NUCLEAR MEDICINE-DIAGNOSTIC	223, 361	10, 622, 626			47	
54. 01	05404 ULTRA SOUND	165, 276	5, 663, 587			361	
54. 03	05405 MAMMOGRAPHY	306, 016	4, 020, 226		·	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 185, 757	21, 665, 814			1, 061	
57. 00	05700 CT SCAN	411, 172	27, 816, 224	1	·	687	57.00
58. 00	05800 MRI	59, 737	8, 056, 452	1		113	
59. 00	05900 CARDI AC CATHETERI ZATI ON	582, 521	25, 281, 669			0	
60.00	06000 LABORATORY	886, 968	44, 187, 050			4, 958	
60. 01	06001 LABORATORY-PATHOLOGI CAL	113, 658	5, 289, 261			21	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 384	2, 233, 875	1		262	1
65.00	06500 RESPIRATORY THERAPY	551, 809	10, 674, 378			2, 217	65.00
66.00	06600 PHYSI CAL THERAPY	627, 140	14, 369, 329	0. 04364	862, 714	37, 652	66.00
67.00	06700 OCCUPATI ONAL THERAPY	87, 583	4, 661, 956	0. 01878	800, 709	15, 043	67.00
68.00	06800 SPEECH PATHOLOGY	88, 281	2, 060, 581	0. 04284	13 527, 159	22, 585	68.00
69.00	06900 ELECTROCARDI OLOGY	126, 166	15, 734, 141	0. 00801	19 28, 062	225	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	226, 634	6, 735, 943		15 2, 109	71	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	230, 328	19, 906, 780			1, 666	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	287, 337	18, 133, 808			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 321, 482	85, 793, 141	1		8, 597	
74. 00	07400 RENAL DIALYSIS	20, 013	1, 891, 579			763	
76. 00	03020 ACUPUNCTURE	0	0	0. 00000		0	
76. 97	07697 CARDI AC REHABI LI TATI ON	91, 363	2, 190, 164	0. 04171	15 0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	1 0		0.0000	20 0		00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0			0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0.41 2/0			0	
90.00	09000 CLINIC 09001 DI ABETES CENTER	407, 481 38, 615	5, 941, 269 203, 835	1		0	90.00
90.01	09001 DI ABETES CENTER	11, 204	261, 027	1		13	
90. 02	09002 NEUROPSTON	71, 520	5, 819, 822			0	
90. 03	09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY	92, 224	800, 102			0	
90.04	09005 VI MCARE CLINI C	212, 252	562, 369	1		0	90.04
90.06	09006 MEDICATION MGMT CLINIC	19, 213	418, 067			0	
91. 00	09100 EMERGENCY	1, 578, 373	70, 369, 835			263	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 006, 377			0	
, 2. 50	OTHER REIMBURSABLE COST CENTERS		.5,555,677	3. 33000			1 2.00
95.00							95.00
200.00		15, 178, 237	544, 576, 969		3, 442, 618	98, 892	200. 00

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	COLUMBUS REGIO		`N. 15 0112	Peri od:	eu of Form CMS-: Worksheet D	2552-10
	H COSTS	INVIOL OTHER TAG	Component C		From 01/01/2017 To 12/31/2017	Part IV	
			Title	XVIII	Subprovi der -	PPS	12 μιι
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1. 00	Adjustments 2A	2. 00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA JA	3.00	
50.00	05000 OPERATING ROOM	0	ol		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	o		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	О		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	o		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	791, 502	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0		1
54. 02	05404 ULTRA SOUND	0	0		0 0		
54. 03	05405 MAMMOGRAPHY	0	0		0 0	_	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0		
57. 00 58. 00	05700 CT SCAN	0	0				
59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON						
60.00	06000 LABORATORY	0			0 0	0	1
60.01	06001 LABORATORY-PATHOLOGI CAL	0			0 0		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	ő	
65. 00	06500 RESPI RATORY THERAPY	0	l ol		o o		
66.00	06600 PHYSI CAL THERAPY	0	o		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	o		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	_	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	740 440	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 0		1
74. 00 76. 00	03020 ACUPUNCTURE					0	
76. 97	07697 CARDI AC REHABI LI TATI ON						
70. 77	OUTPATIENT SERVICE COST CENTERS		٩			<u> </u>	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	o		0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		0 0	0	89.00
90.00	09000 CLI NI C	0	o		0 0	0	90.00
90. 01	09001 DI ABETES CENTER	0	o		0 0	0	90. 01
90. 02	09002 NEUROPSYCH	0	0		0 0		
90. 03	09003 WOUND CENTER	0	0		0 0	0	
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	90.04
90.05	09005 VI MCARE CLI NI C	0	0		0 0	0	
90.06	09006 MEDICATION MGMT CLINIC	0	0		0	0	
91.00	09100 EMERGENCY	0	0		0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			U	0	92.00
95. 00	09500 AMBULANCE SERVICES						95.00

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APP0R1	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2017 To 12/31/2017		epared:
			Title	: XVIII	Subprovi der - I RF	PPS	p
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3, and 4)	col. 8)	col. 7)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	•			_		
50.00	O5000 OPERATI NG ROOM	0		•	0 89, 149, 899		1
51.00	05100 RECOVERY ROOM	0		•	0 6, 832, 237		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1		0	0.000000	1
53.00	05300 ANESTHESI OLOGY	0	1	1	0 11, 936, 993		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	, , , , , , , , , , , , , , , , , , , ,				1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			0 10, 622, 626		1
54. 02	05404 ULTRA SOUND	0	0	•	0 5, 663, 587		1
54. 03	05405 MAMMOGRAPHY	0	0		0 4, 020, 226		1
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 21, 665, 814	l .	1
57. 00	05700 CT SCAN	0	0		0 27, 816, 224		1
58. 00	05800 MRI	0	0	•	0 8, 056, 452		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 25, 281, 669		
60.00	06000 LABORATORY	0	0		0 44, 187, 050		1
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0 5, 289, 261		1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 2, 233, 875		1
65. 00	06500 RESPI RATORY THERAPY	0	0		0 10, 674, 378		1
66. 00	06600 PHYSI CAL THERAPY	0	0		0 14, 369, 329		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	•	0 4, 661, 956		1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 2, 060, 581		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 15, 734, 141		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	•	0 6, 735, 943		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 19, 906, 780		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		•	0 18, 133, 808		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0					
74. 00 76. 00	07400 RENAL DI ALYSI S	0	0		0 1, 891, 579		
76. 00 76. 97	03020 ACUPUNCTURE	0			0 0 2, 190, 164	0.000000	1
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0 2, 190, 164	0. 000000	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•	0 0	0.000000	
90.00	09000 CLINIC	0			0 5, 941, 269	l .	1
90. 01	09001 DI ABETES CENTER	0	1	1	0 203, 835		1
90. 01	09002 NEUROPSYCH		0		0 261, 027		1
90. 02	09003 WOUND CENTER	0	0		0 5, 819, 822	l .	1
90. 03	09004 HYPERBARI C OXYGEN THERAPY	0	0	1	0 3,814,822	l .	1
90. 04	09005 VI MCARE CLINI C	0	0		0 562, 369		
90.06	09006 MEDICATION MGMT CLINIC	0	0		0 418, 067		1
91. 00	09100 EMERGENCY	0			0 70, 369, 835		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 10, 006, 377		1
72.00	OTHER RELABILE COST CENTERS				0, 10, 000, 377	0.000000	1 /2.00

1, 531, 912 544, 576, 969

1, 531, 912

92.00 95.00

200.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEEN COSTS	ERVICE OTHER PASS	Provider Component	CN: 15-0112 CCN: 15-T112	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 10/29/2019 2:	
			Title	XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7) 9.00	10. 00	x col . 10)	12.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11. 00	12.00	13. 00	
50.00	05000 OPERATING ROOM	0. 000000	17. 460		ol ol	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	2, 651			0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2,031			0	
53.00	05300 ANESTHESI OLOGY	0. 000000	3, 311			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 149720	12, 938	1, 93		0	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	2, 220		o o	0	
54. 02	05404 ULTRA SOUND	0. 000000	12, 370		o o	0	54.02
54. 03	05405 MAMMOGRAPHY	0. 000000	0		o o	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	19, 389		0 0	0	55.00
57.00	05700 CT SCAN	0. 000000	46, 496		0 0	0	57.00
58.00	05800 MRI	0. 000000	15, 225		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
60.00	06000 LABORATORY	0. 000000	247, 020		0 0	0	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	980		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	12, 640		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 000000	42, 881		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0. 000000	862, 714		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	800, 709		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0. 000000	527, 159		0 0	0	
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0. 000000 0. 000000	28, 062		0 0	0	
70.00 71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 109 143, 975			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	143, 973			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 008630	558, 165			0	
74.00	07400 RENAL DIALYSIS	0. 000030	72, 100			0	
76.00	03020 ACUPUNCTURE	0. 000000	72, 100			0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		ol ol	0	
	OUTPATIENT SERVICE COST CENTERS				-1		
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 DI ABETES CENTER	0. 000000	0		0 0	0	
90. 02	09002 NEUROPSYCH	0. 000000	299		0 0	0	
90. 03	09003 WOUND CENTER	0. 000000	0		0 0	0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
90.05	09005 VI MCARE CLI NI C	0. 000000	0		0 0	0	
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	0		0 0	0	
91.00	09100 EMERGENCY	0. 000000	11, 745		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	92.00
95.00	09500 AMBULANCE SERVICES						95.00

Heal th	Financial Systems COL	UMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od:	Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 10/29/2019 2:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and			29, 704	
2.00	Inpatient days (including private room days, ex			29, 704	2.00
3. 00	Private room days (excluding swing-bed and obse do not complete this line.	rvation bed days). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and	observation bed days)		26, 577	4.00
5. 00					5. 00
6. 00	Total swing-bed SNF type inpatient days (includ reporting period (if calendar year, enter 0 on		31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including reporting period	ng private room days) through Decembe	r 31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (includi reporting period (if calendar year, enter 0 on		31 of the cost	0	8. 00

	oost oonton bescription	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	20. 704	1 1 0
1. 00 2. 00	Inpatient days (including private room days, excluding swing-bed and newborn)	29, 704 29, 704	1.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	27, 704	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	26, 577	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	20, 377	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11, 848	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00		0	16.0
17 00	SWING BED ADJUSTMENT Medicara rate for swing bod SNE carvides applicable to carvides through December 21 of the cost	0.00	 17. 0
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.0
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18.0
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	38, 737, 686 0	21. 00 22. 00
23. 00	5 x line 17)		
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
26. 00	x line 20)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	38, 737, 686	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00		0. 00	
33.00		0. 00	
34.00		0. 00	
35.00		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 38, 737, 686	36. 0 37. 0
37.00	27 minus line 36)	30, 737, 000] 37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 204 12	30.0
38.00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 304. 12 15, 451, 214	
40.00		15, 451, 214	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	15, 451, 214	

	INPATTENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29, 704	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29, 704	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	26, 577	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	20, 377	5. 00
5.00	report in a period	o l	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room 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
0.00	reporting period (if calendar year, enter 0 on this line)	44 040	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	11, 848	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
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
14 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)	0	16.00
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
00.00	reporting period	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	38, 737, 686	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	30, 737, 000	22. 00
22.00	5 x line 17)	o o	22.00
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
24 00	X line 20)	0	26. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	38, 737, 686	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	30, 737, 000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
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) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0	36.00
37. 00	27 minus line 36)	38, 737, 686	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, 304. 12	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	15, 451, 214	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	15, 451, 214	41.00

CUMPUT.	ATION OF INPATIENT OPERATING COST		Provi der C	CIV. ID-UTIZ	Peri od:	Worksheet D-1	
					From 01/01/2017		
					To 12/31/2017	Date/Time Pre 10/29/2019 2:	
	Cost Center Description	Total	Ti tl e	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	I npati ent	Inpatient	Diem (col.	9	(col. 3 x	
		1.00	Days 2.00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
	NURSERY (title V & XIX only)	0	2.00 C				42.00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	7, 089, 599	3, 361	2, 109. 3	37 1, 321	2, 786, 478	43.00
	CORONARY CARE UNIT	7,089,599	3, 30 i	1		2, 760, 476	1
	BURN INTENSIVE CARE UNIT	O	C	1		0	
1	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.0	00	0	46. 00 47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1. 00 24, 621, 466	48. 00
	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		42, 859, 158	49. 00
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine :	services (fro	m Wkst. D. su	m of Parts I and	2, 262, 525	50.00
	111)		•				
51. 00	Pass through costs applicable to Program inp and IV)	atient anciliar	y services (r	rom WKSt. D,	sum or Parts II	2, 137, 179	51.00
	Total Program excludable cost (sum of lines		Lated non-	vololon	hotist so-	4, 399, 704	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rated, non-pn	ysician anest	netist, and	38, 459, 454	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						[
	Program discharges Target amount per discharge					0 0. 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)				>	0	
	00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57. 00 58. 00
							59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market hasket		0. 00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the Les	ser of 50% of	the amount by	0	1
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
	00 Relief payment (see instructions)					0	1
	3.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
44 00	instructions) (title XVIII only)	no costs (line	44 plus lipo	4E) (+; + o V\/!	II only) For	0	44 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Tine	64 prus rine	65)(title XVI	ii oniy). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12×1 line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00
ļ	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	, AND ICF/IID	ONLY			
1	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•		•)		70.00
	Program routine service cost (line 9 x line		70	2)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•				73.00
75. 00	Capital -related cost allocated to inpatient	•		•	Part II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
1	Program capital related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi don rocon	de)			78.00
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	tati on			•		81.00
1	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84.00
1	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
SE UU I			rough 65)				1 00.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	3 THROUGH CO31					4
87. 00	PART TV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions Adjusted general inpatient routine cost per)	line 2)			3, 127 1, 304. 12	87.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112			Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 10/29/2019 2:	pared: 12 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 884, 969	38, 737, 686	0. 12610	4 4, 077, 983	514, 250	90.00
91.00 Nursing School cost	0	38, 737, 686	0.00000	0 4, 077, 983	0	91.00
92.00 Allied health cost	o	38, 737, 686	0.00000	0 4, 077, 983	0	92.00
93.00 All other Medical Education	o	38, 737, 686	0.00000	0 4, 077, 983	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: 15-0112	Peri od:	Worksheet D-1	
		From 01/01/2017		
	Component CCN: 15-T112	To 12/31/2017	Date/Time Pre	pared:
	·		10/29/2019 2:	12 pm
	Title XVIII	Subprovi der -	PPS	
		IRF		
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		RF		
	Cost Center Description	ŀ	1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3, 676	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3, 676	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private ro	om days,	0	3.00
	do not complete this line.		0 (7)	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3, 676	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of reporting period	the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the	ne cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	0031	o .	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of t	he 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
0.00	reporting period (if calendar year, enter 0 on this line)		0.407	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-beneborn days)	ed and	2, 196	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days	:)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	'	Ü	10.00
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 of	iays)	0	12.00
10.00	through December 31 of the cost reporting period			40.00
13. 00		lays)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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
	Nursery days (title V or XIX only)	İ	0	16. 00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the co	st	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cos	.+	0.00	19. 00
17.00	reporting period	'	0.00	17.00
20.00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost		0. 00	20.00
	reporting period			
21. 00	Total general inpatient routine service cost (see instructions)		4, 366, 843	•
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting peri	od (line	0	22. 00
22.00	5 x line 17)	1 (1:00 (0	22 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period x line 18)	. (Time o	0	23. 00
24. 00		nd (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)			
	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) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		4, 366, 843	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	İ	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	•
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	•
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differenti	al (lind	0 4, 366, 843	36. 00 37. 00
37.00	27 minus line 36)	ai (IIIIe	4, 300, 643	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, 187. 93	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		2, 608, 694	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		2, 608, 694	41.00

		COLUMBUS REGIO				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2017	Worksheet D-1	
			Component	CCN: 15-T112	To 12/31/2017	Date/Time Pre 10/29/2019 2:	
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42.00	NUDCEDY (+; +l c V & VIV only)	1. 00	2. 00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.0	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	(1		l .	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	0	(0.0	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
40.00	Drogram i proti est anci llary corri co cost (Wk	o+ D 2 ool 1	2 11 2 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		1, 574, 074 4, 182, 768	1
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sorvices (fra	m Wks+ D sur	of Dorte L and	272 E42	E0 00
50. 00	Pass through costs applicable to Program imp III)	atrent routine	services (110	III WKSt. D, Sui	I OF PALES F AND	373, 562	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	105, 646	51.00
52.00	Total Program excludable cost (sum of lines					479, 208	•
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	elated, non-ph	ysician anesti	netist, and	3, 703, 560	53.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
55.00	Program di scharges Target amount per di scharge					0.00	
56.00	, ,	ing coot and to	arget emount (line E/ minue	Line E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (Time 56 minus	11 ne 53)	0	57. 00 58. 00
59. 00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	oer 31 of the	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	О	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	e 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil				1		70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (I					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (Ïine	e 72 + line 73)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, F	Part II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ li	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79.00	Aggregate charges to beneficiaries for exces			•	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST TIMITATIO	ıı (ııne /8 Mii	ius iine 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8°	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					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)	11			0	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•					88. 00 89. 00
	,					,	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T112	From 01/01/2017 To 12/31/2017		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	625, 316	4, 366, 843	0. 14319	06	0	90.00
91.00 Nursing School cost	0	4, 366, 843	0. 00000	00	0	91.00
92.00 Allied health cost	0	4, 366, 843	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 366, 843	0. 00000	00	0	93.00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Period: From 01/01/2017	Worksheet D-3	
				To 12/31/2017	Date/Time Pre 10/29/2019 2:	pared: 12 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x	

				10 12/31/2017	10/29/2019 2:	
		Title	xVIII	Hospi tal	PPS	12 piii
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
				3	col . 2)	
			1.00	2.00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•			
30.00	03000 ADULTS & PEDIATRICS			22, 406, 432		30.00
31.00	03100 INTENSIVE CARE UNIT			5, 823, 843		31.00
32.00	03200 CORONARY CARE UNIT			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
	04200 SUBPROVI DER			0		42.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 38280			50.00
	05100 RECOVERY ROOM		0. 28467			51.00
	05200 DELIVERY ROOM & LABOR ROOM		0.00000		_	52.00
	05300 ANESTHESI OLOGY		0. 03734			53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 96777			54.00
	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 22129			54. 01
	05404 ULTRA SOUND		0. 24720			54.02
1	05405 MAMMOGRAPHY		0. 49270		0	54.03
	05500 RADI OLOGY-THERAPEUTI C		0. 25484			55.00
	05700 CT SCAN		0.06989			57.00
1	05800 MRI		0. 09190			58.00
1	05900 CARDI AC CATHETERI ZATI ON		0. 18811			1
	06000 LABORATORY		0. 28306			1
	06001 LABORATORY-PATHOLOGI CAL		0. 27528			60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 38392			62.00
	06500 RESPIRATORY THERAPY		0. 39866			65.00
1	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 47993			66.00
1	06800 SPEECH PATHOLOGY		0. 45513 0. 71141			67. 00 68. 00
1	06900 ELECTROCARDI OLOGY		0. 08149		236, 508	69.00
1	07000 ELECTROENCEPHALOGRAPHY		0. 25784			1
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 41309			1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 56572			1
	07300 DRUGS CHARGED TO PATIENTS		0. 36384			73.00
	07400 RENAL DI ALYSI S		0. 37057			74.00
	03020 ACUPUNCTURE		0.00000		0	76. 00
	07697 CARDIAC REHABILITATION		0. 34965		4, 216	ı
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
	09000 CLI NI C		0. 50194	7 31, 228	15, 675	90.00
90. 01	09001 DI ABETES CENTER		1. 94867			90. 01
90. 02	09002 NEUROPSYCH		0. 87404	2, 392	2, 091	90. 02
90. 03	09003 WOUND CENTER		0. 35105			90. 03
90.04	09004 HYPERBARIC OXYGEN THERAPY		0. 34609	6, 096	2, 110	90.04
	09005 VI MCARE CLI NI C		2. 77213	9 0	0	90. 05
1	09006 MEDICATION MGMT CLINIC		1. 14097		0	90. 06
	09100 EMERGENCY		0. 24103			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 40753	3 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95.00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			75, 920, 698		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	75, 920, 698	I	202. 00

alth Financial Systems COLUMBUS REGION/ IPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0112		In Lie	Worksheet D-3	3
		CCN: 15-T112		om 01/01/2017	Date/Time Pre 10/29/2019 2:	epare
	Ti tl e	· XVIII	Sı	ubprovi der - I RF	PPS	'
Cost Center Description		Ratio of Cos	st	I npati ent	I npati ent	
		To Charges	•	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
		1.00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDI ATRI CS				0		30.
I.OO O3100 INTENSIVE CARE UNIT 2.OO O3200 CORONARY CARE UNIT				0		31.
3. 00 03300 BURN INTENSIVE CARE UNIT				o		33.
1. 00 03400 SURGICAL INTENSIVE CARE UNIT				o		34.
0. 00 04000 SUBPROVI DER - 1 PF				o		40.
I. 00 04100 SUBPROVI DER - I RF				3, 818, 585		41.
2. 00 04200 SUBPROVI DER				0		42.
3. 00 04300 NURSERY						43.
ANCILLARY SERVICE COST CENTERS 0.00 O5000 OPERATING ROOM		0. 3828	102	17, 460	6, 684	50.
I. OO O5100 RECOVERY ROOM		0. 2846		2, 651	755	1
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 0000		0	0	
3. 00 05300 ANESTHESI OLOGY		0. 0373	46	3, 311	124	53
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 9677		12, 938	12, 521	
4. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2212		2, 220	491	
4. 02 05404 ULTRA SOUND		0. 2472		12, 370	3, 058	1
1. 03 05405 MAMMOGRAPHY 5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 4927 0. 2548		0 19, 389	0 4, 941	
7. 00 05700 CT SCAN		0. 0698		46, 496	3, 250	
3. 00 05800 MRI		0. 0919		15, 225	1, 399	
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1881	14	o	0	59.
0. 00 06000 LABORATORY		0. 2830		247, 020	69, 922	
0. 01 06001 LABORATORY-PATHOLOGI CAL		0. 2752		980	270	1
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 5. 00 06500 RESPIRATORY THERAPY		0. 3839		12, 640	4, 853	
5. 00 06600 PHYSI CAL THERAPY		0. 3986 0. 4799		42, 881 862, 714	17, 095 414, 050	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 4551		800, 709	364, 430	
3. 00 06800 SPEECH PATHOLOGY		0. 7114		527, 159	375, 030	
P. 00 06900 ELECTROCARDI OLOGY		0. 0814	92	28, 062	2, 287	69.
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2578		2, 109	544	
I. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 4130		143, 975	59, 475	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 5657 0. 3638		0 558, 165	0 203, 084	
1. 00 07400 RENAL DI ALYSI S		0. 3705		72, 100	26, 719	
5. 00 03020 ACUPUNCTURE		0.0000		72, 100	0	1
5. 97 07697 CARDIAC REHABILITATION		0. 3496		o	0	1
OUTPATIENT SERVICE COST CENTERS						
B. 00 08800 RURAL HEALTH CLINIC		0.0000			0	
P. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER D. 00 09000 CLINIC		0. 0000 0. 5019			0	1
D. 00 09000 CLI NI C D. 01 09001 DI ABETES CENTER		1. 9486		0 0	0	
0. 02 09002 NEUROPSYCH		0. 8740		299	261	1
0. 03 09003 WOUND CENTER		0. 3510		0	0	1
D. 04 09004 HYPERBARI C OXYGEN THERAPY		0. 3460	90	o	0	90.
0. 05 09005 VI MCARE CLI NI C		2. 7721		0	0	
D. 06 09006 MEDICATION MGMT CLINIC		1. 1409		0	0	
I. 00 09100 EMERGENCY		0. 2410		11, 745	2, 831	
2. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 4075	38 	0	0	92.
5. 00 09500 AMBULANCE SERVICES						95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)				3, 442, 618	1, 574, 074	
01.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			0		201
Net charges (line 200 minus line 201)		I		3, 442, 618		202

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 10/29/2019 2:12 pm
•		 	

		Title XVIII	Hospi tal	10/29/2019 2: PPS	12 pm
		TI LIE AVITI	nospi tai	113	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri instructions)	ng prior to October 1 (see	0 23, 154, 554	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	1 (see	8, 025, 831	1. 02	
1. 03	DRG for federal specific operating payment for Model 4 BPCl fo 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCl fo October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			592, 503 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	0 205. 43	3. 00 4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-c	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified u ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (see	0. 00	9. 00
11.00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your recor	ds	0.00	10. 00 11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	ır ended on or after Sep	tember 30, 1997,	0. 00 0. 00	1
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program			0.00	16.00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18. 00	Adjusted rolling average FTE count				18. 00
	Current year resident to bed ratio (line 18 divided by line 4)	•		0. 000000	
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422			0	
	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	ent cap slots under 42 (FR 412.105	0.00	
	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see		24. 00 25. 00
26. 00	instructions) 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. 01
	Total IME payment (sum of lines 22 and 28)			0	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment			0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A pa	itient days (see instruc	ti ons)	6. 63	•
	Percentage of Medicaid patient days (see instructions)			23. 62	1
	Sum of lines 30 and 31			30. 25	•
	Allowable disproportionate share percentage (see instructions)			14.17	1
34.00	Disproportionate share adjustment (see instructions)			1, 104, 565	J 34. UU

	ATLON OF DELMBIDSEMENT SETTLEMENT	ONAL HOSPITAL		Worksheet E	2552-1
JALUUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Period: From 01/01/2017 To 12/31/2017	Part A Date/Time Pre	
		Title XVIII	Hospi tal	10/29/2019 2: PPS	12 piii
		THE ATTE		On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		5, 977, 483, 147 0. 000217835	6, 766, 695, 164 0. 000302844	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, 6	enter zero on this line) (l e	•
00.02	instructions)	circi zero di tina rriic) (.	1, 302, 100	2,047,233	33.0
35. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	973, 905	516, 525	35.0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 3		1, 490, 430		36.0
10.00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludi		ough 46)	I	40.0
10.00	652, 682, 683, 684 and 685 (see instructions)	ring discharges for M3-DRGS	0		40.0
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0		41.0
	instructions)	•			
11. 01		MS-DRGs 652, 682, 683, 68	34 0		41.0
12 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qu	ualify for adjustment)	0.00		42.0
12. 00 13. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	, , , , , , , , , , , , , , , , , , ,	0. 00		42.00
75. 00	instructions)	, 002, 003, 004 an 003. (3)			43.0
4. 00	Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by	7 0. 000000		44.0
	days)				
5.00	Average weekly cost for dialysis treatments (see instructi		0.00		45.0
6. 00 7. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	e 41.01)	34, 367, 883		46. C
8. 00	Hospital specific payments (to be completed by SCH and MDH	H. small rural hospitals	0		48.0
	only. (see instructions)				
				Amount	
19. 00	Total payment for inpatient operating costs (see instructi	one)		1. 00 34, 367, 883	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		.)	2, 792, 990	1
1.00	Exception payment for inpatient program capital (Wkst. L,	• • •		0	1
2. 00	Direct graduate medical education payment (from Wkst. E-4,	, line 49 see instructions).	0	52.0
3.00	Nursing and Allied Health Managed Care payment			119, 391	
4.00	Special add-on payments for new technologies			6, 019	1
4. 01 5. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir	ne 69)		0 0	1
6. 00	Cost of physicians' services in a teaching hospital (see i	· ·		Ö	1
7. 00	Routine service other pass through costs (from Wkst. D, Pt	•	through 35).	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, F	Pt. IV, col. 11 line 200)		234, 493	
9.00	Total (sum of amounts on lines 49 through 58)			37, 520, 776	
0.00	Primary payer payments Total amount payable for program beneficiaries (line 59 mi	inus line 60)		23, 015 37, 497, 761	
2. 00	Deductibles billed to program beneficiaries	inds fine oo,		3, 551, 100	
3. 00	Coinsurance billed to program beneficiaries			54, 614	1
4. 00	Allowable bad debts (see instructions)			417, 241	
	Adjusted reimbursable bad debts (see instructions)			271, 207	1
6.00		nstructions)		226, 637	
7. 00 8. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices 1	for applicable to MS_DPCs	(see instructions)	34, 163, 254 0	1
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and	• •	,	0	1
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, ,	,	0	1
0. 50	Rural Community Hospital Demonstration Project (§410A Demo	, ,	e instructions)	0	1
0.87	Demonstration payment adjustment amount before sequestrati			0	
0.88	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i			0	
0. 89 0. 90	HSP bonus payment HVBP adjustment amount (see instructions			0	70. 70.
70. 91	HSP bonus payment HRR adjustment amount (see instructions)	,		0	1
0. 92	, ,	•		ő	•
0. 72				52, 534	
70. 93	, , , , , , , , , , , , , , , , , , , ,				
0. 93 0. 94	, , , , , , , , , , , , , , , , , , , ,			-101, 225	70. 70.

Provider Co	XVIII FFY	Peri od: From 01/01/2017 To 12/31/2017 Hospi tal	Worksheet E Part A Date/Time Pre 10/29/2019 2: PPS	nared.
				12 pm
			1 773	
or in column O		(\(\(\(\(\) \) \) \)	Amount	
or in column O		0	1.00	
/1)		0	0	70. 9
er in column 0 r after 10/1)		0	0	70. 9
,			0	70.9
			0	70. 9
nes 69 & 70)			34, 114, 563	71.0
· ·			682, 291	71.0
on			0	71.0
			33, 219, 985	72.0
			0	73.0
71.02, 72, and			212, 287	74.0
ordance with			1, 715, 303	75. C
				1
sum of 2.03			0	90.0
			-	1
			-	1
			-	1
,				
tructions)		D 1 10/4		96.0
		1.00	2. 00	
		1 0		4
		0	0	100. C
		4 0000400740	4 0007700504	100
4!>				
tions)		U U	0	102.0
		0.0071	0.0050	100 0
i ana)				104.0
	ictmont	U U	U	1104.0
				200. 0
n perroa unaer	the 21St			200.0
11 45				
line 49)				201.0
				202.0
		<u> </u>		203. 0
A in first year	of the curre	nt 5-year demons	tration	1
				4
				204. 0
	nes 69 & 70) on 71.02, 72, and ordance with sum of 2.03 nstructions) tructions) onstructions) tructions) ions) tructions)	nes 69 & 70) on 71.02, 72, and ordance with sum of 2.03 nstructions) tructions) ons) tructions) tructions) tions) onstration) Adjustment n period under the 21st line 49)	nes 69 & 70) on 71.02, 72, and ordance with sum of 2.03 nstructions) tructions) nstructions) ons) tructions) Prior to 10/1 1.00 1.0020123610 0 ions) onstration) Adjustment n period under the 21st line 49)	nes 69 & 70) nes 70 nes 70

205.00

206.00

207.00

208.00

209.00 210. 00 211. 00

212. 00 213. 00

218. 00

210.00 Reserved for future use

205.00 Case-mix adjusted target amount (line 203 times line 204)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

206.00 Medicare inpatient routine cost cap (line 202 times line 205)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

Adjustment to Medicare Part A Inpatient Reimbursement

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	1	Provider CCN: 15-0112	From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 10/29/2019 2:12 pm
		Ti +1 o V/// / /	Hospi tal	DDC

PROPERTY March M				10 12/01/201/	10/29/2019 2:	
New Teach and other services (see instructions) 31,186 1.00 Medical and other services (see instructions) 31,186 1.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 70,00 70,			Title XVIII	Hospi tal		
New Teach and other services (see instructions) 31,186 1.00 Medical and other services (see instructions) 31,186 1.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 32,806,62 2.00 2.00 Medical and other services (see instructions) 70,00 70,						
Medical and other services (see Instructions)					1. 00	
Medical and other services relabursed under OPPS (see Instructions) 14, 996, 627 2.00						
200 OPPS payments			+!>			
0.00		· ·	TI ONS)			
0						
Enter the hospital specific payment to cost ratio (see instructions)					.,	
Line 2 times line 5		l	ctions)		_	
2.00 Sum of Fines 3, 4, and 4.01, divided by line 6 0.00 7.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 0.00 7.00 0.			Ctrons)			•
Transitional corridor payment (see instructions) 0 6 00 00 00 00 00 00					_	
0. 00 0 0 0 0 0 0 0 0			IV col 13 line 200		_	
1.00 Total cost (sum of lines 1 and 10) (see instructions) 31, 186 11, 00			17, 601. 13, 11116 200			
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges 85,713 12.00 Ancil larry service charges (from West. D-4, Pt. III. col. 4, line 69) 85,713 12.00 13.00 Organ acquisition charges (from West. D-4, Pt. III. col. 4, line 69) 83,713 14.00 15.0		9				
Reasonable charges					017100	
2.00 Ancil lary service charges 85,713 12,00 13,00 10 10 10 10 10 10 10						
1.0 Total reasonable charges (sum of lines 12 and 13) 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16	12.00				85, 713	12.00
1.0 Total reasonable charges (sum of lines 12 and 13) 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16		, ,	ine 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	14.00	Total reasonable charges (sum of lines 12 and 13)			85, 713	14.00
16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Nation of line 15 to line 16 (not to exceed 1.000000) 17.00 Nation of line 15 to line 16 (not to exceed 1.000000) 17.00 Nation of line 15 to line 16 (not to exceed 1.000000) 17.00 Nation of line 15 to line 16 (not to exceed 1.000000) 18.00 National Court of Payment National Cou		Customary charges				
had such payment been made in accordance with 42 CFR \$413.13(e)	15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
17. 00	16.00	Amounts that would have been realized from patients liable fo	r payment for services o	n a chargebasis	0	16.00
18. 00 Total customary charges (see instructions) 19. 00 1			e)		I	
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 54,527 19. 00 18.		,				
Instructions						
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00	19. 00		ly if line 18 exceeds li	ne 11) (see	54, 527	19. 00
Instructions		,		40) (
21. 00 Lesser of cost or charges (see instructions) 0 22. 00 22. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 22. 00 23. 00 24. 00 25. 00	20.00		Ty if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00 23.00 25.00 Total prospective payment (sum of lines 3. 4. 4.01, 8 and 9) 29, 410, 289 24.00 25.00	21 00				21 104	21 00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 2, 3. 00 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 24, 40, 20 25, 20 24, 40, 20 25, 20 2		,				
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 29, 410, 289 24, 00		, , , , , , , , , , , , , , , , , , ,	ructions)		_	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00		, , ,	ructions)		_	
25.00 Deductibles and coin surance amounts (for CAH, see instructions) 0, 26, 00	24.00				27, 410, 207	24.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 26.00	25 00		s)		5 478 677	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 50) 0 29.00 23.962,798 30.00 29.00 23.962,798 30.00 30		· ·	•	uctions)	3, 470, 077	
Instructions Inst					23 962 798	
28. 00	27.00		p. 45 1116 54 51 111165 22	ana 20] (000	1	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0	28.00		ine 50)		0	28. 00
31.00 Primary payer payments 5, 223 31.00 32.00 Subtotal (line 30 minus line 31) 23, 957, 575 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 33.00 Allowable bad debts (see instructions) 505, 449 35.00 36.00 Allowable bad debts (see instructions) 505, 449 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 537, 861 36.00 37.00 Subtotal (see instructions) 24, 463, 024 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment (see instructions) 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 24, 463, 024 40.00 40.01 Sequestration adjustment (see instructions) 24, 463, 024 40.00 40.01 Sequestration adjustment (see instructions) 23, 780, 516 41.00 42.00 1nteri m payments 23, 780, 516 41.00 42.00 1nteri m payment (see instructions) 193, 248 43.00 43.00 43.00 43.00 43.00 43.00 43.00 44	29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 (Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 (Composite rate ESRD (from Wkst. I - 5, line 11) 777, 614 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 505, 449 35.00 (Subtotal (see instructions) 537, 861 36.00 37.00 (Subtotal (see instructions) 24, 463, 024 37.00 (Subtotal (see instructions) 24, 463, 024 37.00 (Subtotal (see instructions) 0 39.00 (Subtotal (see instructions) 0 39.00 (SPECIFY) (SPECIF	30.00	Subtotal (sum of lines 27 through 29)			23, 962, 798	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00	31.00	Primary payer payments			5, 223	31.00
33.00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 777, 614 44.00 35.00 Adjusted reimbursable bad debts (see instructions) 505, 449 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 537, 861 36.00 37.00 Subtoal (see instructions) 24, 463, 024 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 91.00	32.00				23, 957, 575	32.00
34.00 Allowable bad debts (see instructions) 3777,614 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 505,449 35.00 37.00 38.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 24,463,024 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 00THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.97 39.97 39.97 39.97 39.97 39.98 39.99 3			CES)			
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38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 90 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 01 Subtotal (see instructions) 24, 463, 024 40. 00 40. 01 Sequestration adjustment (see instructions) 24, 463, 024 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 489, 260 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 41. 00 Interim payments 23, 780, 516 41. 00 42. 00 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 525, 924 44. 00 41. 00 Filipsical Complex Complex Contrac		,	ructions)			
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94.00 Total (sum of lines 91 and 93) 0 94.00						
	94.00	liotal (sum of lines 91 and 93)			. 0	94.00

In Lieu of Form CMS-2552-10 Health Financial Systems COLUMBUS REGIONAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0112 Peri od: Worksheet E-1 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 10/29/2019 2:12 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 33, 219, 985 23, 751, 416 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 07/26/2018 29, 100 3.01 3.02 0 3.02 0 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 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 29, 100 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33, 219, 985 23, 780, 516 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0

0

0

0

Contractor

Number

1.00

212, 287

33, 432, 272

0

0

0

193, 248

23, 973<u>, 7</u>64

NPR Date

(Mo/Day/Yr)

2.00

5. 51

5.52

5.99

6.00

6.01

6.02

7.00

8.00

MCRI F32 - 15. 8. 166. 2

5.51

5.52

5.99

6.00

6.01

6.02

7.00

5. 50-5. 98)

8.00 Name of Contractor

the cost report. (1)

SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	SERVI CES RENDERED	Provider CCN: 15-0112	Peri od: From 01/01/2017	Worksheet E-1 Part I	
		Component CCN: 15-T112	To 12/31/2017	Date/Time Pre 10/29/2019 2:	
		Title XVIII	Subprovi der -	PPS	
			I RF		
		Inpatient Part A	Par	t B	

		Title	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 898, 598 C		0	1
ا 00 ا ا	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
	ADJUSTMENTS TO PROVIDER				T 0	3.
02	ADJUSTIMENTS TO TROVIDER					
03						
04						
05						
	Provider to Program			4		1 .
50	ADJUSTMENTS TO PROGRAM		C)	0	3.
51			C		0	
52			C)	0	3
53			()	0	
54			()	0	3.
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C)	0	3.
á	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 898, 598	3	O	4.
	TO BE COMPLETED BY CONTRACTOR					
(List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider					
-	TENTATI VE TO PROVI DER				0 0	
02						
	Provider to Program			<u>/</u>		4 3
	TENTATI VE TO PROGRAM		(0	5
51			d		0	
2			d		0	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C)	0	5
	Determined net settlement amount (balance due) based on the cost report. (1)					6
	SETTLEMENT TO PROVIDER		99, 709)	0	
	SETTLEMENT TO PROGRAM		C		0	
00	Total Medicare program liability (see instructions)		3, 998, 307		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
20 1.		()	1. 00	2. 00	-
1 00	Name of Contractor			1	I	8

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0112		Worksheet E-1	
		From 01/01/2017		
		To 12/31/2017	Date/Time Pre 10/29/2019 2:	
	Title XVIII	Hospi tal	PPS	12 piii
	THE AVIII	nospi tui	113	
			1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTAND	RD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECT	ON AND CALCULATION			1
1.00 Total hospital discharges as defined in AA	A §4102 from Wkst. S-3, Pt. I col. 15 I	ine 14		1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col.	sum of lines 1, 8-12			2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, c	I. 6. line 2			3.00
4.00 Total inpatient days from S-3, Pt. I col.	sum of lines 1, 8-12			4.00
5.00 Total hospital charges from Wkst C, Pt. I,	col. 8 line 200			5.00
6.00 Total hospital charity care charges from W	st. S-10, col. 3 line 20			6. 00
7.00 CAH only - The reasonable cost incurred for	the purchase of certified HIT technolo	gy Wkst. S-2, Pt. I		7.00
line 168				
8.00 Calculation of the HIT incentive payment (8.00
9.00 Sequestration adjustment amount (see instr				9.00
10.00 Calculation of the HIT incentive payment a				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS				
30.00 Initial/interim HIT payment adjustment (se	instructions)			30.00
31.00 Other Adjustment (specify)				31.00
32.00 Balance due provider (line 8 (or line 10)	inus line 30 and line 31) (see instruct	ions)		32.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od: From 01/01/2017	Worksheet E-3 Part III	
		Component CCN: 15-T112	To 12/31/2017		pared: 12 pm
		Title XVIII	Subprovi der - I RF	PPS	•
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1. 00	Net Federal PPS Payment (see instructions)			3, 398, 558	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0343	
3. 00	Inpatient Rehabilitation LIP Payments (see instruction	s)		165, 170	
4. 00	Outlier Payments	-,		524, 962	
5. 00	Unweighted intern and resident FTE count in the most reto November 15, 2004 (see instructions)	ecent cost reporting period e	nding on or prior	·	
5. 01	Cap increases for the unweighted intern and resident F program or hospital closure, that would not be counted			0.00	5. 01
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instruction	s)			l
5. 00	New Teaching program adjustment. (see instructions)			0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding F	TEs in the new program growth p	period of a "new	0.00	7.00
	teaching program" (see instructions)				l
3. 00	Current year's unweighted I&R FTE count for residents	within the new program growth p	period of a "new	0. 00	8.00
	teaching program" (see instructions)				1
. 00	Intern and resident count for IRF PPS medical education	n adjustment (see instructions))	0. 00	
0.00	Average Daily Census (see instructions)			10. 071233	
1.00	Teaching Adjustment Factor (see instructions)			0. 000000	
12.00	Teaching Adjustment (see instructions)			0	
3.00	Total PPS Payment (see instructions)	+		4, 088, 690	
14.00	Nursing and Allied Health Managed Care payments (see i	nstruction)		0	
	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (s	oo instructions)		0	15. 00 16. 00
	Subtotal (see instructions)	ee mstructrons)		4, 088, 690	
	Primary payer payments			4, 000, 070	ı
	Subtotal (line 17 less line 18).			4, 088, 690	
	Deducti bl es			19, 740	
	Subtotal (line 19 minus line 20)			4, 068, 950	
	Coinsurance			1, 316	
	Subtotal (line 21 minus line 22)			4, 067, 634	
	Allowable bad debts (exclude bad debts for professiona	l services) (see instructions)		8, 487	
	Adjusted reimbursable bad debts (see instructions)	, ,		5, 517	
	Allowable bad debts for dual eligible beneficiaries (s	ee instructions)		0	26.00
27. 00	Subtotal (sum of lines 23 and 25)	·		4, 073, 151	27.00
28. 00	Direct graduate medical education payments (from Wkst.	E-4, line 49)		0	28.00
29. 00	Other pass through costs (see instructions)			6, 754	29.00
	Outlier payments reconciliation			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31. 50	Pioneer ACO demonstration payment adjustment (see inst			0	
	Demonstration payment adjustment amount before sequest			0	
	Total amount payable to the provider (see instructions)		4, 079, 905	
32. 01	Sequestration adjustment (see instructions)			81, 598	
32. 02	Demonstration payment adjustment amount after sequestr	atı on		2 000 500	
	LIDTORIM DOVMODEC				1 77

3, 898, 598 33.00

99, 709

23, 297

524, 962

34.00

35.00

36.00

50.00

0 51.00

0.00 52.00

0 53.00

Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)
Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

33.00 Interim payments

35.00

36.00

Tentative settlement (for contractor use only)

52.00 The rate used to calculate the Time Value of Money

50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4
51.00 Outlier reconciliation adjustment amount (see instructions)

TO BE COMPLETED BY CONTRACTOR

53.00 Time Value of Money (see instructions)

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

| Period: | Worksheet G | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 10/29/2019 2: 12 pm

oni y)				1270172017	10/29/2019 2:	12 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	17, 813, 668	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	71, 300, 187	1	0	0	1
5.00	Other receivable	10, 305, 032	1	0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-38, 772, 918 4, 397, 515	1	0	0 0	
8. 00	Prepai d expenses	4, 183, 746	1	0	0	
9. 00	Other current assets	4, 103, 740	Ö	0	Ö	1
10.00	Due from other funds	0	Ō	0	0	1
11. 00	Total current assets (sum of lines 1-10)	69, 227, 230	0	0	0	11.00
	FI XED ASSETS	1				
12. 00	Land	2, 421, 066	1	0	0	1
13.00	Land improvements	20, 075, 468	1	0	0	
14. 00 15. 00	Accumulated depreciation Buildings	-11, 077, 526 202, 598, 705	1	0	0 0	1
16. 00	Accumulated depreciation	-123, 785, 441	1	0	0	
17. 00	Leasehold improvements	123, 703, 441	l ő	0	Ö	1
18. 00	Accumulated depreciation	0	Ö	0	0	
19.00	Fi xed equipment	9, 435, 554	0	0	0	19.00
20.00	Accumulated depreciation	-6, 776, 495	0	0	0	
21. 00	Automobiles and trucks	2, 048, 137		0	0	
22. 00	Accumulated depreciation	-1, 523, 316		0	0	
23. 00	Major movable equipment	150, 620, 488	1	0	0	1
24. 00 25. 00	Accumulated depreciation	-108, 561, 818	0	0	0	
26. 00	Minor equipment depreciable Accumulated depreciation		0	0	0	1
27. 00	HIT designated Assets		Ö	0	Ö	1
28. 00	Accumulated depreciation		Ö	Ö	Ö	1
29. 00	Mi nor equi pmen't-nondepreci abl e	0	О	0	0	1
30.00	Total fixed assets (sum of lines 12-29)	135, 474, 822	0	0	0	30.00
	OTHER ASSETS		1 -1			
31.00	Investments	1, 208, 834	1	0	0	1
32.00	Deposits on leases	0	0	0	0	
33. 00 34. 00	Due from owners/officers Other assets	210, 758, 510	0	0	0 0	
35. 00	Total other assets (sum of lines 31-34)	211, 967, 344	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	416, 669, 396	1	o	Ö	1
	CURRENT LIABILITIES					1
37.00	Accounts payable	15, 059, 159		0	0	37. 00
38. 00	Salaries, wages, and fees payable	9, 466, 817	1	0	0	
39. 00	Payroll taxes payable	901, 828	1	0	0	1
40. 00 41. 00	Notes and Loans payable (short term)	6, 090, 000	0	0	0	
41.00	Deferred income Accelerated payments		٥	U	0	41. 00 42. 00
43. 00	Due to other funds		О	0	0	1
	Other current liabilities	7, 283, 256	1	ő	ő	
45.00	Total current liabilities (sum of lines 37 thru 44)	38, 801, 060		0	0	45.00
	LONG TERM LIABILITIES					1
46. 00	Mortgage payable	55, 875, 000	1	0	0	
47.00	Notes payable	0	0	0	0	
48. 00	Unsecured Loans Other Long term Liabilities	000 000	0	0	0	
49. 00 50. 00	Total long term Habilities (sum of lines 46 thru 49)	883, 290 56, 758, 290	1	0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	95, 559, 350		0	0	
31.00	CAPITAL ACCOUNTS	75, 557, 550	<u> </u>	<u> </u>		31.00
52.00	General fund balance	321, 110, 046				52.00
53.00	Specific purpose fund		0		I	53.00
54.00	Donor created - endowment fund balance - restricted			O	I	54.00
55. 00	Donor created - endowment fund balance - unrestricted			0	I	55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				l O	58.00
59. 00	Total fund balances (sum of lines 52 thru 58)	321, 110, 046	О	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	416, 669, 396	1	o	0	
	[59]				I	

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0112

Peri od: Worksheet G-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

10/29/2019 2:12 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4.00 5.00 2.00 1.00 Fund balances at beginning of period 302, 747, 871 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 39, 541, 742 2.00 2.00 342, 289, 613 3 00 Total (sum of line 1 and line 2) ol 3 00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 NURSING HOME CONTRIBUTIONS 9, 457, 020 0 5.00 0 6.00 0 0 6.00 0 0 7.00 Ω 7.00 0 8.00 0 0 8.00 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 9, 457, 020 0 10.00 Subtotal (line 3 plus line 10) 351, 746, 633 11.00 11 00 0 12.00 Deductions (debit adjustments) (specify) 0 0 12.00 13.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 30, 636, 587 0 0 13.00 0 14.00 0 14.00 0 15.00 0 15.00 0 16.00 0 0 0 16.00 17.00 0 17.00 18.00 30, 636, 587 Total deductions (sum of lines 12-17) 18.00 0 Fund balance at end of period per balance 19.00 321, 110, 046 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6. 00 7.00 8.00 1.00 Fund balances at beginning of period 0 0 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 Additions (credit adjustments) (specify) 4.00 4.00 5.00 NURSING HOME CONTRIBUTIONS 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 0 13.00 14.00 C 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00 19.00 Fund balance at end of period per balance 0 0 19.00

Health Financial Systems CCC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0112

			10	12/31/201/	Date/IIme Pre 10/29/2019 2:	
	Cost Center Description		Inpati ent	Outpati ent	Total	12 piii
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>'</u>				
	General Inpatient Routine Services					
1.00	Hospi tal		57, 726, 805		57, 726, 805	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		6, 374, 194		6, 374, 194	3.00
4.00	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
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		64, 100, 999		64, 100, 999	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		13, 969, 629		13, 969, 629	
12. 00	CORONARY CARE UNIT		0		0	12.00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13.00
14. 00	SURGI CAL INTENSI VE CARE UNI T		0		0	14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	13, 969, 629		13, 969, 629	16. 00
47.00	11-15)		70 070 (00		70 070 (00	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		78, 070, 628	00/ 400 400	78, 070, 628	17.00
18.00	Ancillary services		150, 432, 528	326, 129, 129	476, 561, 657	18.00
19.00	Outpati ent servi ces		15, 460, 824	54, 909, 011	70, 369, 835	
20. 00 21. 00	RURAL HEALTH CLINIC		0	0	0	20. 00 21. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		U	0	0	21.00
			0	11 000 722		
23. 00 24. 00	AMBULANCE SERVICES CMHC		U	11, 090, 733	11, 090, 733	24. 00
24. 00	CORF		0	o	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		U	o o	U	25. 00
26.00	HOSPI CE					26.00
27. 00	LEVEL 11 NURSERY		2, 466, 553	0	2, 466, 553	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	246, 430, 533	392, 128, 873	638, 559, 406	28. 00
20.00	G-3, line 1)	to mot.	210, 100, 000	072, 120, 070	000,007,100	20.00
	PART II - OPERATING EXPENSES	<u>'</u>	<u>'</u>	<u>'</u>		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			254, 003, 654		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00	PROVISION FOR BAD DEBT		6, 618, 970			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)			6, 618, 970		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38.00
39. 00			0			39.00
40.00		ļ	0			40.00
41. 00			0			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42))(transfer		260, 622, 624		43.00
	to Wkst. G-3, line 4)	I		1		

	Financial Systems	COLUMBUS REGIONAL			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0112	Peri od: From 01/01/2017	Worksheet G-3	
				To 12/31/2017	Date/Time Pre 10/29/2019 2:	
	·					
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Par				638, 559, 406	1.00
2.00	Less contractual allowances and discounts o	n patients' account	:S		360, 077, 634	2.00
3.00	Net patient revenues (line 1 minus line 2)				278, 481, 772	3.00
4.00	Less total operating expenses (from Wkst. G	i-2, Part II, line 4	43)		260, 622, 624	4.00
5.00	Net income from service to patients (line 3	minus line 4)			17, 859, 148	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				550, 822	6. 00
7.00	Income from investments				5, 936, 411	
8.00	Revenues from telephone and other miscellan	eous communication	servi ces		3, 900	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				84, 665	
11. 00	Rebates and refunds of expenses				80, 318	11.00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	iests			950, 226	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical s	supplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pa	tients			41, 020	17. 00
18.00	Revenue from sale of medical records and ab	stracts			27, 136	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			20, 480	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				100	21.00
22.00	Rental of hospital space				147, 596	22. 00
23.00	Governmental appropriations				382, 709	23.00
24.00	UNREALIZED INVESTMENT GAINS (LOSSES)				12, 386, 570	24.00
24. 01	WELLNESS REVENUE				174, 455	24. 01
24. 02	JOINT VENTURES				378, 145	24. 02
24. 03	CRHP REVENUE				1, 372, 224	
24. 04	EHR GRANT(25%)				491, 849	
24. 05	OTHER OPERATING REVENUE				543, 440	
25. 00	Total other income (sum of lines 6-24)				23, 572, 066	
	Total (line 5 plus line 25)				41, 431, 214	
	LOSS ON DISODOSAL OF ASSETS				661 207	

664, 387

1, 889, 472 28. 00 39, 541, 742 29. 00

1, 225, 085 0

27.00

27. 01 27. 02

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)

26.00 Total (line 5 plus line 25) 27. 00 LOSS ON DISOPOSAL OF ASSETS

27. 01 OTHER NON OPERATING EXPENSES 27. 02 OTHER EXPENSES (SPECIFY)

		ONAL HOSPITAL		u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0112	Peri od: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 10/29/2019 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 528, 428	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			104, 765	2.00
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cos	t reporting period (see ins	tructions)	0 82. 02	2. 01 3. 00
4.00	Number of interns & residents (see instructions)	t reporting perrou (see rns	tructrons)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0. 00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.0	1, columns 1 and	0	6.00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet	E, part A line	6. 63	7. 00
8. 00	Percentage of Medicaid patient days to total days (see in:	structions)		23. 62	8.00
9. 00	Sum of lines 7 and 8	311 40 11 0113)		30. 25	
10.00	Allowable disproportionate share percentage (see instruct	ions)		6. 32	
11.00	Disproportionate share adjustment (see instructions)	,		159, 797	11.00
12.00	Total prospective capital payments (see instructions)			2, 792, 990	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instruction	s)		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) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
3.00	Total Tripatrent program capital cost (Trie 3 x Trie 4)			U	3.00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	1. 00 2. 00
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (se	,		0. 00	
7.00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2	x line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9. 00 10. 00	Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level		locc line ()	0	9. 00 10. 00
11. 00	Carryover of accumulated capital minimum payment level over			0	11.00
. 1. 00	Worksheet L, Part III, line 14)	o. sap. tai paymont (110m pr	. c. you		11.00
	Net comparison of capital minimum payment level to capita			0	12.00
12.00	Current year exception payment (if line 12 is positive, e			0	13.00
13.00		or canital navment for the	following period	0	14.00
	Carryover of accumulated capital minimum payment level over (if line 12 is pogative, enter the amount on this line)	er capital payment for the	~ .		
13. 00 14. 00	(if line 12 is negative, enter the amount on this line)			0	15 00
13.00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions)		0	15. 00 16. 00