payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

EXPLIES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATIO AND SETTLEMENT SUMMARY	Provider CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 8:51 pm
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PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed	cost report	Date: 5/29/2019	Time: 8:51 p
use only	2. [] Manually submitted c	ost report		
		d report enter the number of times the provid Enter "F" for full or "L" for low.	er resubmitted this cost	report
Contractor use only				

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 01/01/2018 and ending 12/31/2018 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
Date

Title	XVIII			
Part A	Part B	HI T	Title XIX	
2. 00	3. 00	4. 00	5. 00	
-162, 418	262, 065	0	0	1. 00
0	0		0	2. 00
89, 795	0		0	3. 00
				4. 00
0	0		0	5. 00
)			0	6. 00
0	0		0	7. 00
0	0		0	9. 00
)	0		0	10.00
)	0		0	11. 00
-72, 623	262, 065	0	0	200. 00
	Part A 2.00 -162, 418 0 89, 795 0 0 0 0	2.00 3.00 -162,418 262,065 0 0 89,795 0 0 0 0 0 0 0 0 0 0 -72,623 262,065	Part A Part B HIT 2.00 3.00 4.00 -162,418 262,065 0 0 0 0 89,795 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Part A Part B HIT Title XIX 2.00 3.00 4.00 5.00 -162,418 262,065 0 0 0 89,795 0

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.

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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:49 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2400 EAST 17TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: COLUMBUS Zip Code: 47201-County: BARTHOLOMEW 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COLUMBUS REGIONAL 150112 18020 07/01/1966 Ν 0 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF COLUMBUS REGIONAL REHAB 15T112 18020 5 01/01/1984 Ν Р 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 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 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 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 8 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22. 02 Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas

23.00

3

Ν

adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

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

yes or "N" for 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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 8:49 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 el i gi bl e Medi cai d Medi cai d days paid days unpai d eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 914 426 35 6, 387 25 24.00 8 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 44 0 0 581 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 1. 00 2.00 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. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) 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 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) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 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 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 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances 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. 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 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 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 complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00

59.00

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.

	Financial Systems COLUMBUS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL	CCN: 15-0112	Peri od:	u of Form CMS- Worksheet S-2	
1103111	AL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA .	Provider	JON. 15-0112	From 01/01/2018 To 12/31/2018	Part I	epared:
				NAHE 413.8 Y/N	Li ne #	Pass-Through Qualification Criterion Code	ı
				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 instructions)	see inst	tructions)	Y	23. 01	1	60. 00
60. 02	If line 60 is yes, complete columns 2 and 3 for each instructions)	program.	(see		23. 02	1	60. 02
	instructions)	Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	-
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.0	0 61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see 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						61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61. 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
61. 05	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
61. 06	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
		Pro	gram Name	Program Coc		Unweighted Direct GME FTE Count	Ē
61 10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	0 61.10
01. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	01.10
61. 20	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
						1.00	-
			dmi ni strati o	n (HRSA)		1.00	
	ACA Provisions Affecting the Health Resources and Ser						
62. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ned			eriod for which	0.0	62.00

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	COLUMBUS	S REGIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA Provider CO		eriod: com 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Prep 5/29/2019 8:49	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry trained residents n-primary care all nonprovider I non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1. 00	2.00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00	0.00		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. 1/	03. 00
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te 1.00	2.00	2.00	
Section 5504 of the ACA Current	Voar ETE Doeidonte in	Nonprovi dor Sotti na		2.00	3.00	
beginning on or after July 1, 20		i Noripi ovi dei Setti iig	sLilective io	i cost reporti	ng perrous	
66.00 Enter in column 1 the number of		v care resident	0.00	0. 00	0. 000000	66. 00
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar al. Enter in column 3	ry care resident B the ratio of				
(Corumn 1 drvided by (Corumn 1 +	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
	3		FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program			0.00	0.00		67. 00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

for title V, and in column 2 for title XIX.			
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98. 03
for title V, and in column 2 for title XIX.			
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			
in column 2 for title XIX.			
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	Υ	Υ	98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	•		
column 2 for title XIX			
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Υ	Υ	98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	•	,	70.00
column 2 for title XIX.			
Rural Providers			
105.00 Does this hospital qualify as a CAH?	N		105. 00
106.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		106. 00
for outpatient services? (see instructions)			1.00.00
107.00 f this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R	N		107. 00
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If			1.07.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost			
reimbursed. If yes complete Wkst. D-2, Pt. II.			
108.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108. 00
CFR Section \$412.113(c). Enter "Y" for yes or "N" for no.	14		100.00
one section 3412. Trace). Enter 1 for year of 14 for no.		<u> </u>	
NODE FOR THE FLAVOR			
MCRI F32 - 15. 5. 166. 1			

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/ To 12/31/	2018	Worksheet S- Part I Date/Time Pi	repare
	Physi cal	Occupati onal	Speec	h	5/29/2019 8: Respi ratory	
	1. 00	2. 00	3. 00		4. 00	4
0.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109
					1.00	
Do Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes o	r "N" for no. I	f yes,		N	110
			1.00		2.00	-
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for this compared by the FCHIP demonstration properties and the FCHIP demonstration properties and the FCHIP demonstration of the	st reporting Iumn 1 is Y, ticipating i	period? Enter enter the n column 2.	N			111
				1. 00	2.00 3.00	0
Miscellaneous Cost Reporting Information						
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 t for long t s) based on for yes or "	is "E", enter erm care (inclu the definition N" for no.	in column des in CMS	N Y	0	111
7.00 s this facility legally-required to carry malpractice insurno. no. 8.00 s the malpractice insurance a claims-made or occurrence pol		,		Y 1		11
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	s I	Insurance	
		1 7 5 45			7 110 di di 100	
		1. 00	2. 00		3. 00	
3.01 List amounts of malpractice premiums and paid losses:		868, 96	7	0		0 118
			1.00		2.00	
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			N			11
and amounts contained therein.	ure risting	cost centers				111
and amounts contained therein. 0.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	Harmless pr column 1, " alifies for	ovision in ACA Y" for yes or the Outpatient	N		N	
and amounts contained therein. 2.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost impla	Harmless pr column 1, " alifies for ts? (see ins	ovision in ACA Y" for yes or the Outpatient tructions)	N		N	12
and amounts contained therein. .00 DO NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implaintents? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	Harmless pr column 1, " alifies for ts? (see ins ntable devic	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the			N	12
and amounts contained therein. 2.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 3.00 Does the cost report contain healthcare related taxes as deform Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 3.00 Does this facility operate a transplant center? Enter "Y" for	Harmless pr column 1, " alifies for ts? (see ins ntable devic ined in §190 is "Y", ent	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y		N	12
and amounts contained therein. 2.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 4.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	Harmless pr column 1, " alifies for tts? (see ins ntable devic ined in §190 is "Y", ent	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y		N	12
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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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: To 5/29/2019 8:49 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Number: 141 00 Contractor's Name: 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν 159. 00 Ν Ν Ν 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161. 00 CMHC Ν Ν N 161. 00 161. 10 CORF N Ν 161.10 Ν 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code County CBSA Name State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0 00 166 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00|s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Υ 167.00

168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 168.01 0.00169.00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170 00 01/01/2018 03/31/2018 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

Heal th	Financial Systems COLUMBUS REGIO	ONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Period: From 01/01/2018	Worksheet S-2 Part II	2
				Γο 12/31/2018 	Date/Time Pro 5/29/2019 8:4	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	snonses Enter	1.00	2.00	
	completed by ALL Hospitals	101 411 110 10	эропэсэ. Ептег	arr dates in		-
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in a	COT UIIIT 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. 00
3.00	Is the provider involved in business transactions, including		Y			3. 00
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports		1			
4. 00	Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A		4. 00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differences.	arant from	Y			5. 00
5.00	those on the filed financial statements? If yes, submit rec		'			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6.00
7.00	the legal operator of the program?					7.00
7. 00 8. 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.		I during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.		N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	the current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I	I & R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection;			st reporting	Y N	12. 00 13. 00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymon	3	o .		N	14. 00
	Bed Complement					
15. 00	Did total beds available change from the prior cost reporti		yes, see instr t A		Y Y	15. 00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Υ	04/18/2019	Υ	04/19/2010	16. 00
16.00	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 linstructions)	Ť	04/16/2019	T	04/18/2019	16.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/18/2019	Y	04/18/2019	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00
	1s. matron. Tr yes, see this tructions.	1	1	T.	ı	1

Heal th	Financial Systems COLUMBUS REGIO	ONAL	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ı	From 01/01/20		Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pro 5/29/2019 8:4	epared:
			Descri	pti on	Y/N	Y/N	
			(1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	MGD DAYS		A DISCH & PT	Y	N	20. 00
	report data for other? bescribe the other adjustments.	DATS	Y/N	Date	Y/N	Date	
			1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N		21. 00
	-						
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVO	EDT C	III I DDENC III	OCDLTALC)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPI C	HILDRENS H	USPITALS)			+
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e ins	tructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed in	ito during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the	cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he co	st reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cos	t reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntere	d into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or			bt Service R	eserve Fund)	Υ	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	ructi uri ty	ons with new	debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuan	ice of new	debt? If yes	, see	N	31. 00
32. 00 33. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instructions as yes, were the requirements of Sec. 2135.2 approx, see instructions.	uctio	ns.			N	32.00
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	ırrang	ement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in			ts with the	provi der-based	Υ	35. 00
	722, 222		-		Y/N	Date	
					1. 00	2. 00	
24 00	Home Office Costs				NI NI		24 00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repar	ed by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off						38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.				,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home	office?	If yes, see			40. 00
			1.	00	2.	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,	CATH	ERI NE		SIMMONS		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COLU	MBUS REGIO	NAL HOSPITAL			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-	376-5248		CSI MMONS@CRH. OI	RG	43.00

Heal th	Financial Systems	COLUMBUS REGION	AL HOSPITAL		In Lieu	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CC		01/01/2018		epared:
		-		20			
			3. (30			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title		ANAGER ACCOUN	ΓING			41. 00
	held by the cost report preparer in columns 1	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost r	report					42. 00
	preparer.						
43.00	Enter the telephone number and email address	of the cost					43.00
	report preparer in columns 1 and 2, respectiv	vel y.					

Heal th	Financial Systems COLUMBUS REGIONAL	L HOSPITAL		Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provi der CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part IX Date/Time Pre 5/29/2019 8:4	pared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Intersection adjustments on W/S B, Part I, column 25? Enter Y/N in and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Υ	1. 00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the repor- Part I (e.g. net of Physician's component)? Enter Y/N in columin column 2 for Title XIX. (see S-2, Part I, line 98.01)			Y	2. 00
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calcul Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.02)			Y	3. 00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Accessive reimbursed 101% of cost? Enter Y or N in column 1 for inpatien for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N 2	N	4. 00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical According to the			N	5. 00
			Title V	Title XIX	
			1. 00	2. 00	
	RCE DI SALLOWANCE				
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disallo column 4? Enter Y/N in column 1 for Title V and Y/N in column S-2, Part I, line 98.05)		Y	Υ	6. 00
7. 00	PASS THROUGH COST Do Title V or XIX follow Medicare when cost reimbursed (payment worksheets D, parts I through IV? Enter Y/N in column 1 for Tour 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7. 00	
8. 00	RHC Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Entititle V and Y/N in column 2 for Title XIX. FOHC	er Y/N in column 1 for	N	N	8. 00
9. 00	For fiscal year beginning on/after 10/01/2014, use M-series for XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for		N	N	9. 00

Component Worksheet A No. of Beds Bed Days CAH Hours No. of Beds Bed Days No. of Beds Revailable No. of Beds Revailable No. of Beds No. of Beds Revailable No. of Beds						10	J 12/31/2010	5/29/2019 8: 4	
Component									, p
Component									
1.00		Component	Worksheet A	No.	of Beds	Bed Davs	CAH Hours		
Nospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) Nospital Adults of Peds. Swing Bed Swin						,			
1.00					2. 00		4. 00	5. 00	
Hospice days) (see instructions for col. 2 2 0 0 0 0 0 0 0 0	1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		194	70, 810	0.00	0	1. 00
For the portion of LDP room available beds) 2.00 MM and other (see instructions) 2.00 3.00 MM IPF Subprovider 3.00 4.00 MM IPF Subprovider 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0.5.00 6.00 Hospital Adults & Peds. Swing Bed SNF 0.5.00 6.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 194 70,810 0.00 0.7.00 0.00		8 exclude Swing Bed, Observation Bed and							
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 5.00 Hospital Adult is & Peds. Swing Bed NF 6.00 Hospital Adult is & Peds. Swing Bed NF 7.01 Total Adult and Peds. (exclude observation beds) (see instructions) 1.02 HM1 INFESIVE CARE UNIT 1 31.00 17 6.205 0.00 0 8.00 1.03 BURN INTENSIVE CARE UNIT 32.00 0 0 0 0.00 0 0.00 0 0.00 1.04 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0.00 0 0.00 0 11.00 1.05 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0.00 0 0.00 0 11.00 1.05 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 1.05 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 1.06 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 1.07 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 1.08 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 1.09 BURN INTENSIVE CARE UNIT 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Hospice days) (see instructions for col. 2							
3. 00		for the portion of LDP room available beds)							
4. 00 MMO I RF Subprovider	2.00	HMO and other (see instructions)							2. 00
5.00 Hospit tal Adult s & Peds. Swing Bed SNF 0 6.00 0.	3.00								3. 00
6.00 Hospital Adults & Peds. Swing Bed NF 194 70,810 0.00 0.7,00 100	4.00								4. 00
7.00	5.00								5. 00
Deds) (see instructions) See instructions See	6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
8. 00 INTENSIVE CARE UNIT 31.00 17 6, 205 0.00 0 8. 00 CORONARY CARE UNIT 32.00 0 0 0.00 0.00 0.00 0.00 10.00 10.00 BURN INTENSIVE CARE UNIT 32.00 0 0 0.00 0.00 0.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 33.00 0 0 0.00 0.00 0.11.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0.00 0.00 0.11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	Total Adults and Peds. (exclude observation			194	70, 810	0.00	0	7. 00
9. 00 COROMARY CARE UNIT									
10. 00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00 11. 00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0.00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12.00 13. 00 NURSERY 43.00 211 77,015 0.00 0 13.00 15. 00 CAH visits 0 0 0 0 0 0 15. 00 CAH visits 0 0 0 0 0 16. 00 SUBPROVIDER - IPF 40.00 0 0 0 0 18. 00 SUBPROVIDER - IRF 41.00 18 6,570 0 17.00 19. 00 SUBPROVIDER 42.00 0 0 0 19. 00 SVILLED NURSING FACILITY 44.00 0 0 0 20. 00 NURSING FACILITY 44.00 0 0 0 21. 00 OTHER LONG TERM CARE 0 0 0 22. 00 OMBY HEALTH AGENCY 21.00 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 22.00 24. 00 HOSPICE 24.10 0 25. 10 CMHC - CMHC 25.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27. 00 Other Carlon Giller (D. P.) 29.00 28. 00 Observation Bed Days 29.00 29. 00 Ambul ance Trips 30.00 31.00 20. 00 Employee discount days (see instructions) 0 0 0 32. 00 Labor & delivery days (see instructions) 31.00 33. 00 ICH on non-covered days 33.00 33. 00 33.00 33.00 33. 00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 33.00 33.00 35.00 Ambul ance Trips 30.00 30.00 33.00 Comployee discount days (see instructions) 31.00 33.00 Comployee discount days (see instructions) 31.00 33.00 Comployee discount days (see instructions) 33.00 33.00 Comployee discount days (see instru					17	6, 205			
11. 00 SURGICAL INTENSIVE CARE UNIT	9.00	CORONARY CARE UNIT	32. 00		0	0	0.00		9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 143. 00 15. 00 CAH visits 0 14. 00 15. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SVILLED NURSING FACILITY 19. 00 SVILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 30. 00 SIAD O O O O O O O O O O O O O O O O O O O	10.00	BURN INTENSIVE CARE UNIT	33. 00		0	0			
13. 00 NURSERY	11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00	0	11. 00
14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMRC 25.10 CMHC - CMRC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Empl oyee discount days (see instruction) 31.00 Empl oyee discount days (see instructions) 33.00 LTOH non-covered days 33.00 LTOH non-covered days 33.00 LTOH non-covered days 30.00 CTAH visits 30.00 CTAH visits 31.00 CTAH vi	12.00	OTHER SPECIAL CARE (SPECIFY)							12. 00
15. 00 CAH visits	13.00	NURSERY	43. 00					0	13. 00
16. 00 SUBPROVIDER - IPF 40. 00 0 0 0 16. 00 17. 00 SUBPROVIDER - IRF 41. 00 18 6,570 0 17. 00 18. 00 SUBPROVIDER - IRF 42. 00 0 0 0 19. 00 SKILLED NURSING FACILITY 44. 00 0 0 20. 00 NURSING FACILITY 21. 00 0 0 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 101. 00 24. 00 HOSPICE 24. 00 24. 10 HOSPICE 24. 00 25. 00 CMHC - CMHC 25. 00 25. 10 CMHC - CMF 99. 10 26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 29. 00 28. 00 Observation Bed Days 0 29. 00 Ambul ance Trips 30. 00 20. 00 Cabor & delivery days (see instruction) 31. 00 Employee discount days - IRF 30. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 33. 00 LTCH non-covered days 33. 00 34. 00 Compare the compared to the	14.00	Total (see instructions)			211	77, 015	0.00		14. 00
17. 00 SUBPROVIDER - IRF	15. 00	CAH visits						0	15. 00
18. 00 SUBPROVI DER 42. 00 0 0 0 18. 00 19. 00 SVILLED NURSI NG FACILITY 44. 00 0 0 20. 00 NURSI NG FACILITY 20. 00 21. 00 THER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 101. 00 23. 00 HOME HEALTH AGENCY 23. 00 24. 00 HOSPI CE 24. 10 25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 229 28. 00 Subservation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 33. 00 LTCH non-covered days 33. 00 33. 00 LTCH non-covered days 33. 00 34. 00 SUBPROVIDER 44. 00 0 36. 00 0 0 0 37. 00 0 0 38. 00 0 0 39. 00 0 0 30.	16. 00	SUBPROVI DER - I PF	40. 00		0			0	16. 00
19. 00	17. 00	SUBPROVI DER - I RF	41. 00		18	6, 570			17. 00
20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 27. 00 RURAL HEALTH CLINIC 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 21. 00 22. 00 22. 00 23. 00 24. 10 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00	18. 00	SUBPROVI DER	42. 00		0	0			18. 00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 Labor & delivery days (see instructions) 33.00 LTCH non-covered days 30.00 LTCH non-covered days 30.00 LTCH non-covered days		SKILLED NURSING FACILITY	44. 00		0	0		0	19. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 101. 00 22. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 10 26. 00 25. 10 26. 00 27. 00 28. 00 29. 00 20. 00 22. 00 24. 00 24. 10 25. 10 25. 10 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 24. 00 24. 10 25. 10 25. 10 25. 10 26. 00 26. 00 27. 00 28. 00 29. 00 30. 00 29. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33. 00	20.00	NURSING FACILITY							20. 00
23. 00 24. 00 24. 00 24. 10 HOSPICE HOSPICE (non-distinct part) 25. 00 CMHC - CMHC CMHC - CORF SURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) 25. 00 28. 00 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) Employee discount days (see instructions) 22. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 23. 00 24. 10 24. 10 25. 00 24. 10 25. 00 28. 00 29. 10 20. 00 20. 00 20. 00 20. 00 21. 00 229 229 229 229 229 229 229 229 23. 00 24. 10 25. 00 25. 10 26. 00 26. 25 27. 00 28. 00 29. 00 29. 00 20. 00	21. 00	OTHER LONG TERM CARE							21. 00
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 29. 00 Ambul ance Tri ps 30. 00 29. 00 Ambul ance Tri ps 30. 00 21. 00 22. 00 23. 00 24. 10 24. 10 24. 10 25. 00 25. 10 25. 10 26. 00 27. 00 28. 00 29. 00 20. 00 Labor & delivery days (see instruction) 31. 00 32. 00 Labor & delivery days (see instructions) 31. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 00 24. 10 24. 10 25. 00 25. 10 28. 00 29. 10 29. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 10 24. 10 24. 10 25. 00 25. 10 26. 00 26. 02 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00	22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 31. 00 Utal ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 10 25. 00 25. 00 29. 10 29. 10 29. 10 29. 10 29. 10 29. 10 29. 10 29. 10 20. 1	23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 25. 00 99. 10 88. 00 29. 10 229 229 229 229 229 229 230. 00 240. 00 250. 00 260. 00 260. 00 270. 00 280. 00 290. 00 300. 00 31. 00 31. 00 32. 00 32. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 30	24.00	HOSPI CE							24. 00
25. 10 CMHC - CORF 99. 10 26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 229 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 LTCH non-covered days	24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00	25. 00	CMHC - CMHC							25. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 28. 00 Observation Bed Days 0 Disservation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 31. 00 Employee discount days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00	25. 10	CMHC - CORF	99. 10					0	25. 10
27. 00 Total (sum of lines 14-26) 229 27. 00 28. 00 29.	26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
28. 00 Observation Bed Days 0 28. 00 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room 0 0 32. 01 0 0 0 0 0 0 0 0 0	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 29.00 30.00 31.00 32.00 32.00 32.01	27.00	Total (sum of lines 14-26)			229				27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 0 0 0 0 32.01 32.01	28. 00	Observation Bed Days						0	28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 0 0 0 32.01	29. 00	Ambul ance Tri ps							29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 0 0 0 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Employee discount days (see instruction)							30. 00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01	31.00	Employee discount days - IRF							31.00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.00	32.00	Labor & delivery days (see instructions)			0	0			32. 00
33.00 LTCH non-covered days 33.00	32. 01	Total ancillary labor & delivery room							32. 01
		outpatient days (see instructions)							
33.01 LTCH site neutral days and discharges 33.01	33.00	LTCH non-covered days							33. 00
	33. 01	LTCH site neutral days and discharges							33. 01

 Heal th Financial
 Systems
 COLUMBUS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

				'	0 12/31/2010	5/29/2019 8: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	, p
	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	12, 238	5, 797	27, 213			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	0.040					0.00
2.00	HMO and other (see instructions)	3, 349	0				2.00
3.00	HMO I PF Subprovi der	505	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00 5. 00
5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	U U	0	·			6.00
6. 00 7. 00	Total Adults and Peds. (exclude observation	12, 238	5, 797	ľ			7.00
7.00	beds) (see instructions)	12, 230	5, 191	21, 213			7.00
8. 00	INTENSIVE CARE UNIT	1, 165	479	3, 212			8. 00
9. 00	CORONARY CARE UNIT	1, 100	0				9. 00
10.00	BURN INTENSIVE CARE UNIT		0	·			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	·			11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)	J	ŭ	Ĭ			12. 00
13. 00	NURSERY		1, 519	3, 197			13. 00
14. 00	Total (see instructions)	13, 403	7, 795			1, 313. 00	
15. 00	CAH visits	0	0			,	15. 00
16.00	SUBPROVIDER - IPF	o	0	0	0.00	0.00	16. 00
17. 00	SUBPROVI DER - I RF	2, 219	625	3, 918	0.00	24.00	17. 00
18.00	SUBPROVI DER		0	0	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY	o	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	0	0	0	0.00		
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	1, 337. 00	
28. 00	Observation Bed Days		806	3, 403			28. 00
29. 00	Ambul ance Tri ps	4, 153					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)	٥	0				32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	٥					33. 00
	LTCH site neutral days and discharges						33. 00
55.51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	۱ ۷		l	I .	I	

				To	12/31/2018	Date/Time Prep 5/29/2019 8:49	
		Full Time		Di sch	arges	0,2,,201, 0	, p
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0	3, 924 885	1, 735 0	9, 158	1. 00 2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	3, 924	1, 735	9, 158	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - IPF	0. 00	0		0	0	16. 00
17. 00	SUBPROVIDER - IRF	0.00	0	171	44	305	17. 00
18. 00	SUBPROVI DER	0.00	0		O	0	18. 00
19.00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10 25. 00	HOSPICE (non-distinct part)						24. 10 25. 00
25. 00	CMHC - CMHC CMHC - CORF	0.00					25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29.00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			l o			33. 00
	LTCH site neutral days and discharges			l o	ļ		33. 01
	,	'		-1	'	ı	

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0112

Mart 1 - BMC Mart Number Reported						To	12/31/2018	Date/Time Prep 5/29/2019 8:49	
MATELIT - WARD DATA					on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
MATTIL BRAIT PATE SACAMES SACATION			1. 00	2.00				6. 00	
Total salaries (see 200 00 83,948,590 -536,599 83,411,991 2,760,230,00 30.22 1.00									
Description	1. 00		200. 00	83, 948, 590	-536, 599	83, 411, 991	2, 760, 230. 00	30. 22	1.00
3.00 Non-thysician anesthetist Part 4.00 Non-thysician anesthetist Part 4.01 Physician Part A - 4.01	2. 00	instructions)							2.00
4.00 Physician Part A - Abelinistrative approximation of the physician Part B - Teaching by the physician Part B - Abelinistrative by t		Α		0	0	0			
Admin is frative		В		0	0	0			
Different Part Diff		Admi ni strati ve		0	0	0			
Non-physician-Part B for 197,077 0 197,077 4,229,00 46,60 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.		Physician and Non		1, 161, 912	0	1, 161, 912		•	1
Interns & residents (in an approved program)	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		197, 077	O	197, 077	4, 229. 00	46. 60	6. 00
7. 01 Contracted interns and residents (in an approved programs) 6. 00 Home Office and/or related on the programs of the progr	7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
Name office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0	7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
9.00 SNF 44.00 0 0 0 0 0 0 0 0 0	8. 00	Home office and/or related		0	0	0	0.00	0.00	8. 00
Instructions OTHER MAGES & RELATED COSTS		SNF	44. 00	0 5 162 072	076 900	6 020 001			
11.00 Contract labor: Direct Patient Contract labor: Top level 14.906,976 0 14.906,976 289,519.00 51.49 11.00 12.00 12.00 13.386,941 28.997.00 47.83 12.00 12.00 12.00 14.906,976 289,519.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 47.83 12.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 28.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 14.906,976 29.997.00 29.906,976 29.997.00 29.90	10.00	instructions)		5, 102, 072	070,007	0, 030, 001	230, 340. 00	20. 22	10.00
12.00 Contract Labor: Top level management and other management and other management and administrative services	11. 00	Contract Labor: Direct Patient		14, 906, 976	0	14, 906, 976	289, 519. 00	51. 49	11. 00
management and admin istrative services	12. 00	Contract Labor: Top Level		1, 386, 941	0	1, 386, 941	28, 997. 00	47. 83	12. 00
13. 00 Contract Labor: Physician - Part 6, 160, 573 0 6, 160, 573 41, 837. 00 147. 25 13. 00 A - Admin istrative 0 0 0 0 0 0 0.00 14. 00 0 0 0 0 0 0 0 0 0		management and administrative							
14. 00 Home office and/or related or o or	13. 00	Contract Labor: Physician-Part		6, 160, 573	0	6, 160, 573	41, 837. 00	147. 25	13. 00
14. 01 Home office salaries	14. 00	Home office and/or related organization salaries and		0	o	0	0.00	0.00	14. 00
Admin strative Home office and Contract Home office Physician Part A - Teaching Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin strative - Wage-related (core) Home office Physician Part A - Admin Strative - Wage-related (core) Home office Physician Part A - Admin Strative - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A - Teaching - Wage-related (core) Home office Physician Part A -	14. 02	Home office salaries Related organization salaries		0 5, 847, 495 0	_	_	55, 887. 00	104. 63	14. 02
WAGE-RELATED COSTS Wage-related costs (core) (see instructions) 17.00 Wage-related costs (core) (see instructions) 17.00 18.00 Wage-related costs (other) (see instructions) 19.00 1		- Administrative Home office and Contract		0	0	0			
Instructions Wage-related costs (other) (see instructions) 18.00	17 00	WAGE-RELATED COSTS		24 475 452		24 475 452			17 00
19.00 Excluded areas 1,946,331 0 1,946,331 19.00 20.00 Non-physician anesthetist Part		instructions)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
20. 00 Non-physician anesthetist Part A	18. 00	(see instructions)		0	0	O			18.00
22.00 Physician Part A -				1, 946, 331 0	0	1, 946, 331 0			19. 00 20. 00
Administrative Physician Part A - Teaching 0 0 0 22.01	21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching 0 0 0 0 22. 01	22. 00			0	0	0			22. 00
24. 00 Wage-rel ated costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 0 25. 50 25. 50 Home office wage-related (core) 0 0 0 0 0 25. 50 25. 51 Related organization wage-related (core) 0 0 0 0 25. 51 25. 52 Home office: Physician Part A wage-related (core) 0 0 0 0 25. 52 25. 53 Home office & Contract Physicians Part A - Teaching wage-related (core) 0 0 0 0 25. 53 26. 00 Employee Benefits Department 4. 00 228, 972 -114, 718 114, 254 3, 713. 00 30. 77 26. 00	22. 01			0	О	0			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization 25. 51 Related organization 25. 51 Home office: Physician Part A 26. 00 26. 00 27. 52 28. 52 28. 53 Physicians Part A - Teaching - wage-related (core) 27. 53 Physicians Part A - Teaching - wage-related (core) 28. 53 Physicians Part A - Teaching - wage-related (core) 27. 53 28. 54 28. 55 29. 55				438, 002	0	438, 002			23. 00
approved program Home office wage-related 0				0		0			
Core		approved program)		0	0	0			
wage-related (core) Home office: Physician Part A		(core)		0	0				25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department		wage-related (core)		0	0	0			25. 52
Physicians Part A - Teaching -		- Administrative -		_					
wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 228,972 -114,718 114,254 3,713.00 30.77 26.00	25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
26.00 Employee Benefits Department 4.00 228,972 -114,718 114,254 3,713.00 30.77 26.00		wage-related (core)	5						
27. 00 Administrative & General 5. 00 17, 855, 505 -159, 272 17, 696, 233 530, 180. 00 33. 38 27. 00	26. 00		4. 00	228, 972	-114, 718	114, 254			
	27. 00	Administrative & General	5. 00	17, 855, 505	-159, 272	17, 696, 233	530, 180. 00	33. 38	27. 00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part II | P

					''	0 12/31/2010	5/29/2019 8: 4	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		6, 201, 454	0	6, 201, 454	68, 044. 00	91. 14	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	2, 508, 820					
31. 00	Laundry & Linen Service	8. 00	34, 004		34, 085	i i		
32. 00	Housekeepi ng	9. 00	1, 885, 117	8, 049	1, 893, 166	· ·		
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	2, 109, 807	-1, 391, 219	718, 588	· ·		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	1, 393, 665	1, 393, 665			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		37. 00
38. 00	Nursing Administration	13. 00	3, 792, 160	72, 887	3, 865, 047	87, 954. 00	43. 94	38. 00
39. 00	Central Services and Supply	14. 00	96		96	8. 00	12. 00	39. 00
40.00	Pharmacy	15. 00	3, 354, 208	-349, 224	3, 004, 984	68, 206. 00	44. 06	40.00
41. 00	Medical Records & Medical	16. 00	1, 967, 882	-898, 471	1, 069, 411	36, 247. 00	29. 50	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	558, 623	3, 892	562, 515	· ·		42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

							5/29/2019 8: 49	∂ pm
		Worksheet A	Amount	Reclassi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		88, 791, 055	-536, 599	88, 254, 456	2, 818, 238. 00	31. 32	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 162, 072	876, 809	6, 038, 881	230, 346. 00	26. 22	2.00
	instructions)							
3.00	Subtotal salaries (line 1		83, 628, 983	-1, 413, 408	82, 215, 575	2, 587, 892. 00	31. 77	3.00
	minus line 2)							
4.00	Subtotal other wages & related		28, 301, 985	0	28, 301, 985	416, 240. 00	67. 99	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 675, 452	0	24, 675, 452	0.00	30. 01	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		136, 606, 420	-1, 413, 408	135, 193, 012	3, 004, 132. 00	45. 00	6.00
7.00	Total overhead cost (see		40, 496, 648	-1, 399, 479	39, 097, 169	1, 134, 740. 00	34. 45	7.00
	instructions)							
6. 00	(see inst.) Total (sum of lines 3 thru 5) Total overhead cost (see		136, 606, 420	-1, 413, 408	135, 193, 012	3, 004, 132. 00	45. 00	6. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of F	orm CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	Period: Works From 01/01/2018 Part To 12/31/2018 Date/	

	To 12/31/2018	Date/Time Prep 5/29/2019 8:49	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 672, 438	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	276, 708	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	14, 465, 306	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	447, 057	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	53, 513	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, 085, 607	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	678, 796	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	5, 994, 272	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	27, 424	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	0	21. 00
	instructions))		
22. 00		102, 487	22. 00
	Tuition Reimbursement	256, 178	
24.00	Total Wage Related cost (Sum of lines 1 -23)	27, 059, 786	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	From 01/01/2018	Worksheet S-3 Part V Date/Time Prepared:

		To 12/31/2018	Date/Time Pre 5/29/2019 8:4	
	Cost Center Description	Contract 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	14, 906, 976		
2. 00	Hospi tal	14, 906, 976	27, 059, 786	
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
11. 00	Hospi tal -Based HHA	0	0	11. 00
	Separately Certified ASC			12. 00
13. 00	Hospi tal -Based Hospi ce			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	
	Renal Dialysis	0	0	17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0112	Peri od:	Worksheet S-1	0			
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared.			
			12, 31, 2010	5/29/2019 8: 4				
				1. 00				
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 202 colu	mn 8)	0. 355316	1.00			
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid			15, 389, 239	2.00			
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?			15, 369, 239 Y	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payments from Medi	cai d?	N.	4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f			7, 151, 107	5. 00			
6.00	Medicaid charges			104, 166, 776				
7.00	Medicaid cost (line 1 times line 6)			37, 012, 122				
8. 00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line / minus sum of l	nes 2 and 5; if	14, 471, 776	8. 00			
	Children's Health Insurance Program (CHIP) (see instructions f	or each line)						
9.00	Net revenue from stand-alone CHIP	,		0	9. 00			
10. 00	Stand-alone CHIP charges				10.00			
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00			
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(line 11 minus line 9;	if < zero then	0	12. 00			
	Other state or local government indigent care program (see ins	tructions for each line	e)					
13.00	Net revenue from state or local indigent care program (Not inc			0	13. 00			
14.00	Charges for patients covered under state or local indigent car	e program (Not include	d in lines 6 or	0	14. 00			
45.00	10)				45.00			
15. 00 16. 00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		ino 15 minus Lino		15. 00 16. 00			
10.00	13; if < zero then enter zero)	digent care program (i	The 15 millius Title	0	16.00			
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state/local ind	gent care program	ıs (see				
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	unding charity care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of	9		0	1			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local		ms (sum of lines	14, 471, 776	19. 00			
	8, 12 and 16)	Uni nsured	I Insured	Total (col. 1				
		pati ents	pati ents	+ col . 2)				
		1.00	2. 00	3. 00				
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	cility 9,414,	488 6, 483, 858	15, 898, 346	20.00			
20.00	(see instructions)	7, 414,	400 0, 403, 636	15, 676, 340	20.00			
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see 3, 345,	118 6, 483, 858	9, 828, 976	21. 00			
	instructions)							
22. 00	Payments received from patients for amounts previously written	off as 52,	205 268, 223	320, 428	22. 00			
23. 00	charity care Cost of charity care (line 21 minus line 22)	3, 292,	913 6, 215, 635	9, 508, 548	23 00			
20.00	reset of order by our o (trine 21 million 22)	0,2,2,	7.0	7, 000, 010	20.00			
				1. 00				
24. 00	Does the amount on line 20 column 2, include charges for patie		n of stay limit	N	24. 00			
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond to the limit	am's length of	0	25. 00				
26. 00	stay limit Total bad debt expense for the entire hospital complex (see in		17, 519, 220	26. 00				
27. 00	Medicare reimbursable bad debts for the entire hospital complex	,		789, 445				
27. 01	Medicare allowable bad debts for the entire hospital complex (,		1, 214, 532				
28. 00	Non-Medicare bad debt expense (see instructions)			16, 304, 688				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	6, 218, 404						
3U. UU	Cost of uncompensated care (line 23 column 3 plus line 29) 15, 726, 952 30. (1.10 plus line 29)							
	Total unreimbursed and uncompensated care cost (line 19 plus	ina 30)		30, 198, 728	31 00			

3.00 DOSOOD OTHER CAP REL COSTS 0.00 DOSOOD AURILY CAP REL COSTS 0.00 DOSOOD AURILY CAP REL COSTS 0.00 DOSOOD AURILY CAP REL COSTS 1.00 DOSOOD AURILY CAP REL COSTS 0.00 DOSOOD AURILY CAP REL COSTS CENTERS 0.00 DOSOOD AURILY CAP REL COSTS CENTERS 0.00 DOSOOD AURILY CAP REL COST CENTERS 0.00 DOSOOD AURILY C	Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Case Centrar Reserviption Soil arcines Other Total Coat Total Relations First Case Total Relations First Case Total Relations First Case Total Relations First Relations First Relations First Relations First Case Total Relations First	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-0112 F	Peri od:	Worksheet A	
Cost Center Description						o 12/31/2018		
Company Comp		Cost Contor Description	Salarias	Othor	Total (col 1	Dool assi fi cati		9 pm
		cost center bescription	Sai ai i es	other				
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DEFERRAL SERVICE COST CENTERS 21,357, 468							col . 4)	
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13.00 01300 NIRSHING ADMINISTRATION 3,792,100 867,179 4,669,852 67,171 4,776,523 31.150 01500 PHARMACY 3,854,208 2,036,763 5,900,771 -302,542 5,088,429 15.100 01500 PHARMACY 1,907,892 17,273,222 3,785,205 4,457 380,202 17.100 10100 SOCIAL SERVICE (SPECIETY) 555,623 17,202 575,828 4,457 380,202 17.100 10100 SOCIAL SERVICE (SPECIETY) 555,623 17,202 575,828 4,457 380,202 17.100				1, 131, 312				
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16.00 01600MEDICAL RECORDS & LIBRARY 1,997,882 1,271,322 3,239,204 -1,612,645 1,626,559 10, 20 23.00								
17.00 01700 SOCIAL SERVICE 558, 633 17.702 575, 825 4.457 580, 282 17.103 17.002								
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54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,816,943 1,487,083 3,304,026 -121,188 3,182,838 54. 4 1,0500 NICLEAR MEDI CINE DI AGNOSTI C 390,456 1,435,206 1,825,666 -509,415 1,316,251 54. 54. 54. 03 05405 MAMMOGRAPHY 723,426 136,838 860,264 325,161 1,185,425 54. 05500 RSD0 RADI OLOGY-THERAPEUTI C 989,042 1,328,660 2,317,702 762,227 3,079,929 55. 00 05500 RADI OLOGY-THERAPEUTI C 989,042 1,328,660 2,317,702 762,227 3,079,929 55. 00 05500 RADI OLOGY-THERAPEUTI C 989,042 1,328,660 2,317,702 762,227 3,079,929 55. 00 05900 RADI OLOGY-THERAPEUTI C 989,042 1,328,660 2,317,702 762,227 3,079,929 55. 00 05900 RADI AGNOSTI AGNO			o	116, 834	116, 834	62, 727		
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90. 05 09005 VI MCARE CLINI C 592, 162 110, 090 702, 252 2, 170 704, 422 90. 09006 09006 MEDI CATI ON MGMT CLINI C 252, 258 3, 748 256, 006 1, 389 257, 395 90. 091. 00 09100 EMERGENCY 5, 091, 426 1, 148, 606 6, 240, 032 1, 827, 958 8, 067, 990 91. 00 09200 098ERVATI ON BEDS (NON-DI STINCT PART 0THER REI MBURSABLE COST CENTERS 92. 00 09200		09003 WOUND CENTER	1			-156, 844		
90. 06 09006 MEDI CATI ON MGMT CLINI C 252, 258 3, 748 250, 006 1, 389 257, 395 90. 0 1, 200 09100 EMERGENCY 5, 091, 426 1, 148, 606 6, 240, 032 1, 827, 958 8, 067, 990 91. 0 09200 0958RVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 92. 0 09200 09300			-1	ū	`		· ·	
91. 00 09100 EMERGENCY 5, 091, 426 1, 148, 606 6, 240, 032 1, 827, 958 8, 067, 990 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 92. 0								
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 0 OTHER REIMBURSABLE COST CENTERS								
OTHER REIMBURSABLE COST CENTERS			5, 091, 426	1, 148, 606	6, 240, 032	1, 827, 958	8, 067, 990	
	7 ∠. UU							J 7∠. UU
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	95. 00		3, 298, 442	359. 385	3, 657, 827	110. 477	3, 768. 304	95. 00
				,	, ., ., ., .	-, -, -, -,	.,,,	

	COLUMBUS REGIONA				u of Form CMS-2	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2018 o 12/31/2018	Date/Time Pre	nared:
			'	0 12/31/2010	5/29/2019 8: 4	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
·			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
99. 10 09910 CORF	0	0	C	0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				1		
109. 00 10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	C	0		110. 00
111. 00 11100 SLET ACQUI SITI ON	0	0	C	0		111. 00
113. 00 11300 I NTEREST EXPENSE		2, 133, 881	2, 133, 881			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	83, 781, 943	187, 775, 823	271, 557, 766	-594, 874	270, 962, 892	118. 00
NONREI MBURSABLE COST CENTERS		_1		T		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
194. 00 07950 WELLNESS COMMUNITY	0	0		318, 909		
194. 01 07951 BUI LDI NG RENTALS	0	1, 869, 355			191, 646	1
194. 02 07952 HOSPI CE	0	114, 744	114, 744	0	114, 744	1
194. 03 07953 OUTREACH CLINICS	0	0	Ü	0	-	194. 03
194. 04 07954 SPEECH - HEARING ALDS	0	0	Ü	269, 667	269, 667	
194. 05 07955 NONALLOWABLE MARKETING	00 404	0	20.704	1, 260, 493	1, 260, 493	1
194. 06 07956 CRH FOUNDATION	30, 196	508			30, 704	1
194. 07 07957 HEALTHY COMMUNITIES	136, 451	56, 703	193, 154	•	166, 337	1
194. 08 07958 CRHP	0	O	0	450, 331	450, 331	1
194. 09 07959 NEUROPSYCH PART B	02 040 500	100 017 122	272 7/5 722	0	-	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	83, 948, 590	189, 817, 133	273, 765, 723	1	273, 765, 723	J200. 00

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider CCN	: 15-0112	Peri od:	Worksheet A	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	epared:
						5/29/2019 8: 4	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6. 00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-806, 450	1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-926, 647	1				2.00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	-60, 369					3. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-21, 362, 318	1				5. 00
7. 00	00700 OPERATION OF PLANT	-123, 275	1				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	C	1				8. 00
9.00	00900 HOUSEKEEPI NG	-140					9. 00
10.00	01000 DI ETARY	-124, 677	1				10.00
11.00	01100 CAFETERI A	-1, 109, 003					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	C					13. 00
15. 00	01500 PHARMACY	-55, 847	1,,				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-22, 932	1				16. 00
17. 00	01700 SOCIAL SERVICE	· c	1				17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	C	1 -1				23. 00
23. 01	02301 XRAY EDUCATION	-20, 524	1				23. 01
23. 02	02302 PHARMACY RESIDENCY PROG		391, 122				23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-1, 166, 917	16, 663, 497				30.00
31. 00	03100 I NTENSI VE CARE UNI T	-1, 100, 917 C	1				31.00
32. 00	03200 CORONARY CARE UNIT	Č	1				32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	C	o				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	0				34.00
40.00	04000 SUBPROVI DER - I PF	C	1				40. 00
41.00	04100 SUBPROVI DER - I RF	C					41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	C					42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY						44. 00
11.00	ANCILLARY SERVICE COST CENTERS		, o				11.00
50.00		-1, 083, 261	19, 946, 956				50.00
51. 00	05100 RECOVERY ROOM	C					51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	-1				52. 00
53.00	05300 ANESTHESI OLOGY	-2, 309					53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	-22, 185 C					54. 00 54. 01
54. 01	05404 ULTRA SOUND						54. 01
54. 03	05405 MAMMOGRAPHY	-2, 205	1				54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	-27, 166	1				55. 00
57.00	05700 CT SCAN	C	1, 010, 175				57. 00
58. 00	05800 MRI	C	1				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	-90, 723	1				59.00
60.00	1 1	-2, 104	1				60.00
60. 01 62. 00	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	-9, 584 C	1				60. 01
65. 00	06500 RESPIRATORY THERAPY	-9, 172	1				65. 00
66. 00	1	-24, 394					66.00
67.00	06700 OCCUPATI ONAL THERAPY	C	1, 237, 821				67.00
68. 00	06800 SPEECH PATHOLOGY	-855					68. 00
69. 00	06900 ELECTROCARDI OLOGY	-34, 624	1				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C					70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		7, 754, 922 9, 159, 917				71. 00
73. 00			18, 891, 321				73. 00
74. 00	07400 RENAL DI ALYSI S		1				74. 00
76.00	03020 ACUPUNCTURE	C	1				76. 00
76. 97		-1, 359	327, 866				76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	C	1				88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	_11 409	1 236 248				89. 00 90. 00
90.00	09000 CEINIC 09001 DI ABETES CENTER	-11, 408	1, 236, 248 188, 279				90.00
90.01	09002 NEUROPSYCH	-197, 077	1				90. 01
90. 03	09003 WOUND CENTER	-20, 327	1				90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	-1, 432	1				90. 04
90. 05	09005 VIMCARE CLINIC	C					90. 05
90.06	09006 MEDICATION MGMT CLINIC	070,000					90.06
91.00	09100 EMERGENCY	-379, 386	7, 688, 604				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	-510, 427	3, 257, 877				95. 00
	09910 CORF	010, 127	1				99. 10
	10100 HOME HEALTH AGENCY	C	1				101.00
			•				

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

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 8: 49 pm

			5/29/2019 8: 49 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	or Allocation	
	6.00	7. 00	
SPECIAL PURPOSE COST CENTERS			
109.00 10900 PANCREAS ACQUISITION	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	О	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	О	111. 00
113.00 11300 INTEREST EXPENSE	0	О	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-28, 209, 097	242, 753, 795	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	318, 909	194. 00
194. 01 07951 BUILDING RENTALS	0	191, 646	194. 01
194. 02 07952 HOSPI CE	0	114, 744	194. 02
194. 03 07953 OUTREACH CLINICS	o	o	194. 03
194.04 07954 SPEECH - HEARING AIDS	o	269, 667	194. 04
194. 05 07955 NONALLOWABLE MARKETING	o	1, 260, 493	194. 05
194.06 07956 CRH FOUNDATION	o	30, 704	194. 06
194. 07 07957 HEALTHY COMMUNITIES	o	166, 337	194. 07
194. 08 07958 CRHP	-297, 442	152, 889	194. 08
194. 09 07959 NEUROPSYCH PART B	0	ol	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-28, 506, 539	245, 259, 184	200.00

Provider CCN: 15-0112 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: Worksheet Non-CMS W

		-	To 12/31/2018 Date/Time Pr 5/29/2019 8:	
	Cost Center Description	CMS Code	Standard Label For	, p
			Non-Standard Codes	
	GENERAL SERVI CE COST CENTERS	1.00	2.00	
1.00	CAP REL COSTS-BLDG & FLXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3. 00 4. 00	OTHER CAP REL COSTS EMPLOYEE BENEFITS DEPARTMENT	00300 00400		3. 00 4. 00
5. 00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7. 00
8. 00 9. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	00800 00900		8. 00 9. 00
10.00	DIETARY	01000		10.00
11. 00	CAFETERI A	01100		11.00
13.00	NURSI NG ADMINI STRATI ON	01300		13.00
14. 00 15. 00	CENTRAL SERVICES & SUPPLY PHARMACY	01400 01500		14. 00 15. 00
16. 00	MEDICAL RECORDS & LIBRARY	01600		16. 00
17. 00	SOCI AL SERVI CE	01700		17. 00
23. 00	PARAMED ED PRGM-(SPECIFY) XRAY EDUCATION	02300		23. 00
23. 01 23. 02	PHARMACY RESIDENCY PROG	02301 02302		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDI ATRI CS	03000		30.00
31. 00 32. 00	INTENSIVE CARE UNIT	03100 03200		31. 00 32. 00
33. 00	BURN INTENSIVE CARE UNIT	03300		33. 00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34. 00
40.00	SUBPROVI DER - I PF	04000		40.00
41. 00 42. 00	SUBPROVI DER	04100 04200		41. 00 42. 00
43. 00	NURSERY	04300		43. 00
44. 00	SKILLED NURSING FACILITY	04400		44. 00
50. 00	ANCILLARY SERVICE COST CENTERS OPERATING ROOM	05000		50.00
51. 00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52. 00
53.00	ANESTHESI OLOGY	05300		53.00
54. 00 54. 01	RADI OLOGY-DI AGNOSTI C NUCLEAR MEDI CI NE-DI AGNOSTI C	05400 05402		54. 00 54. 01
54. 02	ULTRA SOUND	05404		54. 02
54. 03	MAMMOGRAPHY RABI OLOGO TUEBARENTI O	05405		54. 03
55. 00 57. 00	RADI OLOGY-THERAPEUTI C CT SCAN	05500 05700		55. 00 57. 00
58. 00	MRI	05800		58.00
59. 00	CARDI AC CATHETERI ZATI ON	05900		59. 00
60. 00 60. 01	LABORATORY LABORATORY-PATHOLOGI CAL	06000 06001		60. 00 60. 01
	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62. 00
65. 00	RESPI RATORY THERAPY	06500		65. 00
66.00	PHYSI CAL THERAPY	06600		66.00
67. 00 68. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	06700 06800		67. 00 68. 00
69. 00	ELECTROCARDI OLOGY	06900		69.00
70. 00	ELECTROENCEPHALOGRAPHY	07000		70. 00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72. 00 73. 00	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	07200 07300		72. 00 73. 00
74. 00	RENAL DIALYSIS	07400		74. 00
76. 00	ACUPUNCTURE	03020	ACUPUNCTURE	76. 00
76. 97	CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	07697		76. 97
88. 00	RURAL HEALTH CLINIC	08800		88. 00
89. 00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89. 00
90.00	CLINIC DIAPETES CENTED	09000		90.00
90. 01 90. 02	DI ABETES CENTER NEUROPSYCH	09001 09002		90. 01
90. 03	WOUND CENTER	09003		90. 03
90. 04	HYPERBARI C OXYGEN THERAPY	09004		90. 04
90. 05 90. 06	VIMCARE CLINIC MEDICATION MGMT CLINIC	09005 09006		90. 05 90. 06
91.00	EMERGENCY	09100		91.00
92. 00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92. 00
05 00	OTHER REIMBURSABLE COST CENTERS AMBULANCE SERVICES	09500		95. 00
75.00	ANNIDOLANOL SERVICES	04300	1	70.00

DLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
Provider CCN: 15-0112	Peri od:	Worksheet Non-CMS W
	From 01/01/2018	
	DLUMBUS REGIONAL HOSPITAL Provider CCN: 15-0112	Provi der CCN: 15-0112 Peri od:

		To 12/31/2018 Date/Time I 5/29/2019 8	
Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
99. 10 CORF	09910		99. 10
101.00 HOME HEALTH AGENCY	10100		101. 00
SPECIAL PURPOSE COST CENTERS			
109.00 PANCREAS ACQUISITION	10900		109. 00
110.00 INTESTINAL ACQUISITION	11000		110. 00
111.00 SLET ACQUISITION	11100		111. 00
113.00 I NTEREST EXPENSE	11300		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
NONREI MBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190. 00
194. 00 WELLNESS COMMUNITY	07950		194. 00
194. 01 BUILDING RENTALS	07951		194. 01
194. 02 HOSPI CE	07952		194. 02
194. 03 OUTREACH CLINICS	07953		194. 03
194. 04 SPEECH - HEARING AIDS	07954		194. 04
194. 05 NONALLOWABLE MARKETING	07955		194. 05
194. 06 CRH FOUNDATION	07956		194. 06
194. 07 HEALTHY COMMUNITIES	07957		194. 07
194. 08 CRHP	07958		194. 08
194. 09 NEUROPSYCH PART B	07959		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)			200. 00

| Period: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0112

					To 12/31/2018 Date/Time 5/29/2019	
		Increases			372472014	0. 47 pili
	Cost Center	Li ne #	Salary	Other		
	2.00 B - RECLASS DEPREC BLDG/EQUIP	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 615, 481		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	518, 400		2. 00
	0			2, 133, 881		
	C - RECLASS INSURANCE	, - aal	ما	a :=a		
1. 00 2. 00	OCCUPATIONAL THERAPY CAP REL COSTS-BLDG & FLXT	67. 00 1. 00	0	1, 651 634, 167		1. 00 2. 00
3.00	AMBULANCE SERVICES	95. 00	0	44, 012		3. 00
4. 00	LABORATORY	60.00	Ö	4, 075		4. 00
	0		0	683, 905		
	D - RECLASS BILLING COST	= 00	047.000			
1. 00	ADMI NI STRATI VE & GENERAL		91 <u>7, 902</u> 917, 902	71 <u>4, 1</u> 74 714, 174		1. 00
	E - RECLASS HYPERBARI C THERAPY	Y EXPENSE	717, 702	714, 174		
1.00	HYPERBARIC OXYGEN THERAPY	90.04	70, 149	104, 997		1. 00
	0		70, 149	104, 997		
1 00	F - RECLASS CAFETERIA EXPENSE	11 00	1 202 051	747 440		1 00
1. 00	CAFETERI A		1, 392, 051 1, 392, 051	74 <u>6, 4</u> 42 746, 442		1. 00
	G - RECLASS WELLNESS		1, 372, 031	770, 442		
1.00	WELLNESS COMMUNITY	194.00	185, 846	70, 304		1. 00
	0		185, 846	70, 304		
1 00	H - RECLASS PHYSICIAN FEES	F4 00		EQ. 000		1 00
1. 00 2. 00	RADI OLOGY-DI AGNOSTI C ADULTS & PEDI ATRI CS	54. 00 30. 00	0	50, 000 1, 447, 543		1. 00 2. 00
3.00	INTENSIVE CARE UNIT	31. 00	0	5, 650		3. 00
4. 00	SUBPROVI DER - I RF	41.00	Ö	206, 871		4. 00
5.00	OPERATING ROOM	50.00	0	815, 280		5. 00
6.00	ANESTHESI OLOGY	53. 00	0	60, 000		6. 00
7. 00 8. 00	RADI OLOGY-THERAPEUTI C CARDI AC CATHETERI ZATI ON	55. 00 59. 00	0	84, 375 73, 919		7. 00 8. 00
9. 00	LABORATORY-PATHOLOGI CAL	60. 01	0	225, 000		9. 00
10. 00	RESPI RATORY THERAPY	65. 00	Ö	28, 526		10.00
11.00	PHYSI CAL THERAPY	66.00	O	50, 000		11. 00
12.00	ELECTROCARDI OLOGY	69. 00	0	93, 301		12.00
13. 00 14. 00	ELECTROENCEPHALOGRAPHY CARDI AC REHABI LI TATI ON	70. 00 76. 97	0	8, 650 3, 698		13. 00 14. 00
15. 00	EMERGENCY	91. 00	0	1, 408, 873		15. 00
16. 00	AMBULANCE SERVICES	95. 00	Ö	13, 125		16. 00
17. 00	WOUND CENTER	90. 03	0	36, 800		17. 00
18. 00	HYPERBARI C OXYGEN THERAPY	90. 04	0	2, 550		18. 00
19. 00	EMERGENCY	91.00	0	384, 772		19. 00
	I - RECLASS REHAB SERVICES		U _I	4, 998, 933		
1.00	OCCUPATI ONAL THERAPY	67. 00	35, 851	12, 861		1.00
2.00	PHYSI CAL THERAPY	66. 00	48, 784	11, 863		2. 00
3.00	SPEECH PATHOLOGY	68. 00	21, 170	14, 077		3. 00
4.00	SUBPROVI DER - I RF	41.00	142, 317	6, 779		4.00
5. 00 6. 00	ELECTROENCEPHALOGRAPHY SOCI AL SERVI CE	70. 00 17. 00	17, 311 1, 731	5, 649 565		5. 00 6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	13, 324	3, 954		7. 00
8.00	NEUROPSYCH	90. 02	13, 862	4, 519		8. 00
9. 00	WOUND CENTER	90. 03	24	9, 860		9. 00
10.00	HYPERBARI C OXYGEN THERAPY	90. 04	2 (22)	4, 466		10.00
11. 00	WELLNESS COMMUNITY	1 <u>94.</u> 00	<u>3, 6</u> 03 297, 979			11. 00
	J - RECLASS PHARMACY RES PROGR	RAM	271, 717	10, 123		
1.00	PHARMACY RESIDENCY PROG	23. 02	181, 695	0		1.00
2.00	PHARMACY RESIDENCY PROG	23. 02	0	2, 722		2. 00
3.00	PHARMACY RESIDENCY PROG	23.02	0	<u>1, 665</u>		3. 00
	O K - RECLASS RENT EXPENSE		181, 695	4, 387		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16, 031		1.00
2. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	196, 294		2. 00
3.00	OPERATION OF PLANT	7. 00	0	49, 050		3. 00
4.00	XRAY EDUCATION	23. 01	0	11, 860		4.00
5.00	MAMMOGRAPHY	54. 03	0	140, 965		5. 00
6. 00 7. 00	LABORATORY PHYSI CAL THERAPY	60. 00 66. 00	0	14, 909 316, 348		6. 00 7. 00
8. 00	OCCUPATI ONAL THERAPY	67. 00	0	118, 401		8. 00
9. 00	SPEECH PATHOLOGY	68. 00	o	52, 950		9. 00
10.00	ELECTROENCEPHALOGRAPHY	70. 00	0	127, 536		10. 00
11.00	WOUND CENTER	90. 03	0	73, 773		11.00
12. 00	HYPERBARI C OXYGEN THERAPY	90. 04	0	38, 063		12. 00

					Ic	12/31/2018	Date/lime Prepared: 5/29/2019 8:49 pm
		Increases			<u>'</u>		97 2 77 2 8 7 7 pm
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
13.00	AMBULANCE SERVICES	95.00	0	15, 000			13. 00
14. 00	WELLNESS COMMUNITY	194. 00	0	56, 198			14. 00
15. 00	CRHP	194. 08	0	45 <u>0, 3</u> 31			15. 00
	TOTALS		0	1, 677, 709			
	L - RECLASS MARKETING EXPENSE						
1.00	NONALLOWABLE MARKETING	1 <u>94.</u> 05	•	14 <u>0, 0</u> 00			1.00
	0		0	140, 000			
	M - RECLASS DEPRECIATION EXPE		اه	10 (07 005			
1. 00	CAP REL COSTS-MVBLE EQUIP		0	12, 687, 225			1.00
	U DECLACE MALNITENANCE EVDEN	ICE	U	12, 687, 225			
1 00	N - RECLASS MAINTENANCE EXPEN		ما	0.227			1.00
1.00	RESPIRATORY THERAPY	65. 00 69. 00	0	8, 337			1.00
2.00	ELECTROCARDI OLOGY CARDI AC CATHETERI ZATI ON	59. 00	0	7, 190			2.00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	258, 768 114, 773			3. 00 4. 00
5. 00	OPERATING ROOM	50.00	0	243, 493			5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	660, 341			6. 00
7. 00	LABORATORY	60.00	0	111, 148			7. 00
8. 00	LABORATORY-PATHOLOGI CAL	60. 01	0	6, 300			8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	852			9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	243, 416			10.00
11. 00	MAMMOGRAPHY	54. 03	0	239, 400			11. 00
12. 00	ULTRA SOUND	54. 02	0	28, 966			12. 00
13. 00	CT SCAN	57. 00	Ö	189, 932			13. 00
14. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	Ö	173, 861			14. 00
15. 00	MRI	58. 00	0	131, 327			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, 497			18. 00
19. 00	ANESTHESI OLOGY	53.00	o	3, 125			19. 00
20.00	WHOLE BLOOD & PACKED RED	62.00	O	2, 500			20.00
	BLOOD CELL			,			
	0 — — — — —		_	2, 492, 477			
	O - RECLASS DIRECTOR PHARMACY	<u>'</u>					
1.00	EMERGENCY	91.00	70, 325	0			1. 00
2.00	RESPI RATORY THERAPY	65. 00	58, 604	0			2. 00
3.00	AMBULANCE_SERVICES	<u>95.</u> 00	4 <u>6, 8</u> 83	<u>0</u>			3. 00
	TOTALS		175, 812	0			
	Q - RECLASS XRAY EDUCATION EX						
1. 00	XRAY EDUCATION	23. 01	115	0			1.00
2.00	XRAY EDUCATION	23. 01	55	0			2. 00
3. 00	XRAY EDUCATION	23. 01	0	13, 206			3. 00
4.00	XRAY EDUCATION	23.01	325, 525	<u>2, 665</u>			4. 00
	O DEGLACE ADMINISTRAÇÃO	MUNITIES	325, 695	15, 871			
1 00	R - RECLASS ADMIN HEALTHY COM		20, 122	0			1 00
1. 00	ADMI NI STRATI VE & GENERAL		39, 123	<u>0</u>			1.00
	S - RECLASS NON ALLOW ADVERTI	CLNC COSTS	39, 123	U			
1 00	NONALLOWABLE MARKETING		ام	1 120 402			1 00
1. 00	O INDIVALLED IN ARKETTING	1 <u>94.</u> 05	0	1, 12 <u>0, 4</u> 93 1, 120, 493			1.00
	U - RECLASS CHARGEABLE SUPPLY	' COST	U	1, 120, 473			
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	247, 466			1.00
1.00	PATIENT	71.00	٩	277, 400			1. 90
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	151, 282			2. 00
	PATI ENT	, 50	Ĭ	. 3 . , 2 3 2			2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	7, 143			3. 00
	PATI ENT		1				
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 723			4. 00
	PATI ENT		ļ				
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 927, 663			5. 00
	PATI ENT						
6.00	IMPL. DEV. CHARGED TO	72. 00	0	6, 655, 430			6. 00
7.00	PATI ENTS			_ =			
7. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	5, 760			7. 00
0.00	PATI ENT	74 60	[00.000			
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	99, 090			8. 00
0.00	PATIENT	71 00		601 125			0.00
9. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	681, 435			9. 00
10. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 125			10.00
10.00	PATIENT	71.00	٩	1, 120			10.00
11. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	o	56, 799			11. 00
	PATI ENT	, 50	Ĭ	30,			66
		•	•	,			•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

					To 12/31/2018 Date/lime Pr 5/29/2019 8:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
12.00	2.00	3.00	4.00	5. 00		12.00
12. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	U	6, 610		12. 00
13.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	683, 584		13. 00
	PATI ENT					
14. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	125, 280		14. 00
15. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 963, 073		15. 00
15.00	PATI FNT	71.00	O	1, 903, 073		15.00
16. 00	IMPL. DEV. CHARGED TO	72.00	O	2, 504, 487		16. 00
	PATI ENTS		_			
17. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	55, 295		17. 00
18. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71.00	0	23, 426		18. 00
10.00	PATI ENT	71.00	Ŭ	20, 120		10.00
19. 00	SPEECH - HEARING AIDS	194. 04	0	269, 667		19. 00
20. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	546, 706		20. 00
21. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71 00	0	97, 225		21. 00
21.00	PATIENT	71.00	U	91, 223		21.00
22. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	36, 868		22. 00
	PATI ENT					
23. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	26, 730		23. 00
24. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71.00	0	5, 716		24. 00
24.00	PATI ENT	71.00	O	3, 710		24.00
25. 00	MEDICAL SUPPLIES CHARGED TO	71.00	O	2, 923		25. 00
	PATI ENT					
	0	I MI NATI ON DD	0	17, 184, 506		
1.00	V - RECL PTO COST FOR STD ELI EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 689		1. 00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 461		2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 924		3. 00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 036		4. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	10, 585		5. 00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43, 580		6. 00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 273		7. 00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	382		8. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14, 181		9. 00
10. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 753		10. 00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 098		11. 00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22, 034		12. 00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36, 650		13. 00
14.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 800		14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99, 482		15. 00
16. 00 17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	14, 427		16. 00 17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16, 064		18.00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19, 768 15, 211		19. 00
20. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 925		20. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	10, 422		21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 686		22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 089		23. 00
24.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 600		24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 225		25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	22, 970		26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	24, 374		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 638		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22, 045		29. 00
30. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 427		30. 00
31.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	785		31. 00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 205		32. 00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35, 911		33.00
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9, 912 1 247		34.00
35. 00 36. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	1, 347 3, 426		35. 00 36. 00
36.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 426 214		37. 00
57.00	0	 	— — — ö	536, 599		37.00
	W - RECLASS DEPT 9902 EMP BEI	NEFI TS		,,		1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	461, 502		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	203, 589		2. 00
3.00	OPERATING ROOM	50.00	0	2, 337, 497		3. 00
4.00	RECOVERY ROOM	51.00	0	321, 348		4. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	398		5. 00
7. 00	RADI OLOGY-THERAPEUTI C	55.00	0	29, 912		7. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 8: 49 pm Provider CCN: 15-0112

					5/29/	2019 8: 49 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
8.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	774, 738	0		8. 00
9.00	OPERATION OF PLANT	7.00	46, 124	0		9. 00
10.00	LAUNDRY & LINEN SERVICE	8. 00	463	0		10.00
11.00	HOUSEKEEPI NG	9.00	22, 230	0		11. 00
12.00	DI ETARY	10.00	7, 585	0		12. 00
13.00	CAFETERI A	11. 00	14, 712	0		13. 00
14.00	NURSING ADMINISTRATION	13.00	95, 036	0		14.00
15.00	PHARMACY	15. 00	44, 933	0		15. 00
16. 00	MEDICAL RECORDS & LIBRARY	16.00	30, 231	0		16. 00
17. 00	SOCI AL SERVI CE	17. 00	9, 197	Ö		17. 00
18. 00	XRAY EDUCATION	23. 01	926	Ö		18. 00
19. 00	PHARMACY RESIDENCY PROG	23. 02	695	O		19. 00
20. 00	ADULTS & PEDIATRICS	30.00	112, 829	Ö		20. 00
21. 00	INTENSIVE CARE UNIT	31.00	16, 827	ő		21. 00
22. 00	SUBPROVI DER - I RF	41.00	8, 798	ő		22. 00
23. 00	NURSERY	43.00	4, 862	0		23. 00
24. 00	OPERATING ROOM	50.00	7, 998	0		24. 00
		1				
25. 00	RADI OLOGY-DI AGNOSTI C	54.00	26, 365	0		25. 00
26. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	2, 084	0		26.00
27. 00	ULTRA SOUND	54. 02	3, 473	0		27. 00
28. 00	MAMMOGRAPHY	54. 03	10, 519	0		28. 00
29. 00	RADI OLOGY-THERAPEUTI C	55. 00	4, 631	0		29. 00
30.00	CT SCAN	57. 00	3, 473	0		30. 00
31. 00	MRI	58. 00	1, 621	0		31. 00
32.00	CARDI AC CATHETERI ZATI ON	59. 00	14, 564	0		32. 00
33.00	LABORATORY	60.00	42, 300	0		33. 00
34.00	LABORATORY-PATHOLOGI CAL	60. 01	1, 852	0		34.00
35.00	RESPI RATORY THERAPY	65.00	13, 823	0		35. 00
36.00	PHYSI CAL THERAPY	66.00	32, 929	0		36. 00
37.00	OCCUPATI ONAL THERAPY	67.00	8, 170	0		37. 00
38.00	SPEECH PATHOLOGY	68.00	3, 276	0		38. 00
39.00	ELECTROCARDI OLOGY	69.00	3, 473	0		39. 00
40.00	ELECTROENCEPHALOGRAPHY	70.00	6, 739	0		40. 00
41.00	CLINIC	90.00	6, 251	0		41.00
42.00	DI ABETES CENTER	90. 01	463	0		42. 00
43.00	NEUROPSYCH	90. 02	1, 621	0		43. 00
44.00	WOUND CENTER	90. 03	6, 497	0		44.00
46. 00	EMERGENCY	91.00	33, 198	Ö		46. 00
47. 00	AMBULANCE SERVICES	95. 00	28, 099	Ö		47. 00
48. 00	CARDI AC REHABI LI TATI ON	76. 97	1, 158	Ö		48. 00
49. 00	HEALTHY COMMUNITIES	194. 07	12, 306	Ö		49. 00
50. 00	VIMCARE CLINIC	90. 05	4, 631	Ö		50.00
51. 00	MEDICATION MGMT CLINIC	90.06	1, 389	o		51.00
53. 00	WELLNESS COMMUNITY	194. 00	5, 045	0		53.00
55.00	O COMMONT I		1, 478, 134	3, 354, 246		33.00
	X - RECLASS OT SALARIES AND O	TUED EVD	1, 470, 134	3, 334, 240		
1. 00	OCCUPATI ONAL THERAPY	67. 00	402, 895	92, 299		1. 00
1.00						1.00
	O DECL MILL BASE FOR WELLINGS	C (OD (DT	402, 895	92, 299		
1 00	Y - RECL MILLRACE FOR WELLNES		اء	0.000		4.00
1.00	OCCUPATIONAL THERAPY	67.00	0	2, 090		1. 00
2.00	OCCUPATI ONAL THERAPY	6700	•	3, 217		2. 00
	0		0	5, 307		
	Z - RECLASS LAB BLOOD SUPERVI			, 1		
1.00	WHOLE BLOOD & PACKED RED	62. 00	73, 892	0		1. 00
	BLOOD CELL	+	+			
	0		73, 892	0		
500.00	Grand Total: Increases		5, 541, 173	48, 839, 478		500.00

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						5/29/2019	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
1 00	B - RECLASS DEPREC BLDG/EQUIP		٥	1 /15 /01	11		1 00
1.00	INTEREST EXPENSE	113.00	0	1, 615, 481	l I		1. 00 2. 00
2. 00	I NTEREST EXPENSE	113.00	0	51 <u>8, 4</u> 00 2, 133, 881			2.00
	C - RECLASS INSURANCE		<u> </u>	2, 133, 001			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	O	1, 651	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	0	634, 167			2. 00
3. 00	ADMINISTRATIVE & GENERAL	5.00	0	44, 012	I I		3. 00
4. 00	ADMINISTRATIVE & GENERAL	5.00	0	4, 075			4. 00
4.00	0		— —	683, 905			4.00
	D - RECLASS BILLING COST		<u> </u>	000, 700			
1.00	MEDICAL RECORDS & LIBRARY	16.00	917, 902	714, 174	0		1.00
	0		917, 902				
	E - RECLASS HYPERBARIC THERAP	Y EXPENSE		.,			
1.00	WOUND CENTER	90. 03	70, 149	104, 997	0		1. 00
			70, 149	104, 997			
	F - RECLASS CAFETERIA EXPENSE						
1.00	DI ETARY	10.00	1, 392, 051	746, 442	0		1. 00
	0 — — — — —		1, 392, 051	74 <u>6, 4</u> 42			1
	G - RECLASS WELLNESS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	185, 846	7 <u>0, 3</u> 04			1. 00
	0		185, 846	70, 304			
	H - RECLASS PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	50, 000	l 1		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 447, 543			2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 650	0		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	206, 871	0		4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00	0	815, 280	l 1		5. 00
6. 00	OPERATING ROOM	50. 00	0	60, 000	l 1		6. 00
7. 00	ADMINISTRATIVE & GENERAL	5. 00	0	84, 375			7. 00
8. 00	ADMINISTRATIVE & GENERAL	5. 00	0	73, 919	l 1		8. 00
9. 00	ADMINISTRATIVE & GENERAL	5. 00	0	225, 000	I I		9. 00
10.00	ADMINISTRATIVE & GENERAL	5. 00	0	28, 526	I I		10.00
11. 00	ADMINISTRATIVE & GENERAL	5. 00	0	50, 000			11.00
12.00	ADMINISTRATIVE & GENERAL	5. 00	0	93, 301	I I		12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	0	8, 650	l 1		13.00
14. 00	ADMINISTRATIVE & GENERAL	5.00	0	3, 698	l 1		14.00
15. 00	ADMINISTRATIVE & GENERAL	5.00	0	1, 408, 873			15. 00
16. 00	ADMINISTRATIVE & GENERAL	5.00	0	13, 125	l 1		16.00
17. 00	ADMINISTRATIVE & GENERAL	5.00	0	36, 800	l 1		17. 00
18. 00	ADMINISTRATIVE & GENERAL	5.00	0	2, 550			18.00
19. 00	OPERATING ROOM	5000		384, 772			19. 00
	I - RECLASS REHAB SERVICES		U	4, 998, 933			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	35, 851	12, 861	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	48, 784	11, 863			2. 00
3. 00	ADMINISTRATIVE & GENERAL	5.00	21, 170	14, 077			3. 00
4. 00	ADMINISTRATIVE & GENERAL	5. 00	142, 317	6, 779			4. 00
5. 00	ADMINISTRATIVE & GENERAL	5.00	17, 311	5, 649			5. 00
6. 00	ADMINISTRATIVE & GENERAL	5.00	1, 731	565	l 1		6. 00
7. 00	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00	13, 324	3, 954			7.00
8. 00	ADMINISTRATIVE & GENERAL	5.00	13, 862	4, 519			8. 00
9. 00	ADMINISTRATIVE & GENERAL	5.00	24	9, 860	l I		9. 00
10. 00	ADMINI STRATI VE & GENERAL	5.00	2	4, 466			10.00
11. 00	ADMI NI STRATI VE & GENERAL	5. 00	3, 603	1, 130			11. 00
00	0	— — 	297, 979	<u>1, 130</u>			55
	J - RECLASS PHARMACY RES PROG	SRAM .	2,,,,,,	.0, ,20			
1.00	PHARMACY	15. 00	181, 695	0	0		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 722	I I		2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 665	l 1		3. 00
- =	0	— — †	181, 695	$\frac{1}{4,387}$			
	K - RECLASS RENT EXPENSE		,	.,			
1.00	BUILDING RENTALS	194. 01	0	16, 031	0		1. 00
2.00	BUILDING RENTALS	194. 01	o	196, 294	l 1		2. 00
3.00	BUILDING RENTALS	194. 01	O	49, 050			3. 00
4. 00	BUILDING RENTALS	194. 01	o	11, 860	0		4. 00
5. 00	BUILDING RENTALS	194. 01	ol	140, 965			5. 00
6.00	BUILDING RENTALS	194. 01	o	14, 909			6. 00
7.00	BUILDING RENTALS	194. 01	O	316, 348			7. 00
8.00	BUILDING RENTALS	194. 01	0	118, 401			8. 00
9.00	BUILDING RENTALS	194. 01	0	52, 950			9. 00
10.00	BUILDING RENTALS	194. 01	0	127, 536			10. 00
11.00	BUILDING RENTALS	194. 01	0	73, 773	l 1		11. 00
12.00	BUILDING RENTALS	194. 01	0	38, 063	l 1		12. 00
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Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

						To 12/31/2018 Date/lime Pr 5/29/2019 8:	
		Decreases		•			
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.	_	
13. 00	6. 00 BUI LDI NG RENTALS	7. 00 194. 01	8.00	9. 00 15, 000	10. 00		13. 00
14. 00	BUILDING RENTALS	194.01	ol Ol	56, 198			14. 00
15. 00	BUILDING RENTALS	194. 01	0	450, 331			15. 00
10.00	TOTALS		— — ў	1, 677, 709	<u> </u>	<u>, </u>	10.00
	L - RECLASS MARKETING EXPENSE	•	-1	, , , , , , , , , , , , , , , , , , , ,	l.		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	140, 000	C		1. 00
	0		0	140, 000			
	M - RECLASS DEPRECIATION EXPE				T		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	<u>12, 687, 225</u>		<u>)</u>	1. 00
	N - RECLASS MAINTENANCE EXPEN	ICE	ΟĮ	12, 687, 225			
1. 00	OPERATION OF PLANT	7.00	ol	8, 337			1.00
2. 00	OPERATION OF PLANT	7. 00	o	7, 190			2. 00
3.00	OPERATION OF PLANT	7. 00	0	258, 768			3. 00
4.00	OPERATION OF PLANT	7. 00	O	114, 773	C		4. 00
5.00	OPERATION OF PLANT	7. 00	0	243, 493	C		5. 00
6. 00	OPERATION OF PLANT	7. 00	0	660, 341	C		6. 00
7.00	OPERATION OF PLANT	7.00	0	111, 148			7. 00
8. 00 9. 00	OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	6, 300 852			8. 00 9. 00
10. 00	OPERATION OF PLANT	7.00	Ö	243, 416			10.00
11. 00	OPERATION OF PLANT	7. 00	o	239, 400			11. 00
12. 00	OPERATION OF PLANT	7. 00	O	28, 966			12. 00
13.00	OPERATION OF PLANT	7. 00	O	189, 932	C		13. 00
14.00	OPERATION OF PLANT	7. 00	0	173, 861	C		14. 00
15. 00	OPERATION OF PLANT	7. 00	0	131, 327	C		15. 00
16.00	OPERATION OF PLANT	7.00	0	46, 682			16. 00
17. 00	OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	3, 569			17. 00 18. 00
18. 00 19. 00	OPERATION OF PLANT	7.00	0	18, 497 3, 125			19. 00
20. 00	OPERATION OF PLANT	7.00	0	2, 500			20.00
20.00	0			2, 492, 477			20.00
	O - RECLASS DIRECTOR PHARMACY	′	,			1	
1.00	PHARMACY	15. 00	70, 325	0			1. 00
2.00	PHARMACY	15. 00	58, 604	0	C		2. 00
3. 00	PHARMACY	15.00	46, 883	0	<u> </u>)	3. 00
	TOTALS Q - RECLASS XRAY EDUCATION EX	/DENSES	175, 812	0			
1.00	NURSI NG ADMI NI STRATI ON	13. 00	115	0	C		1.00
2.00	RESPI RATORY THERAPY	65. 00	55	0			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 206	C		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	325, 525				4. 00
	0		325, 695	15, 871			
1 00	R - RECLASS ADMIN HEALTHY CON HEALTHY COMMUNITIES		20, 122				1 00
1. 00	O COMMONTTIES	194.07	3 <u>9, 123</u> 39, 123	$ \frac{0}{0}$			1.00
	S - RECLASS NON ALLOW ADVERTI	SING COSTS	37, 123				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 120, 493	C		1.00
	0			1, 120, 493			
	U - RECLASS CHARGEABLE SUPPLY					_	
1.00	ADULTS & PEDIATRICS	30.00	0	247, 466		I .	1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	151, 282			2.00
3. 00 4. 00	SUBPROVI DER - I RF NURSERY	41. 00 43. 00	0	7, 143 3, 723			3. 00 4. 00
5. 00	OPERATING ROOM	50. 00	ol Ol	3, 723 2, 927, 663			5. 00
6. 00	OPERATING ROOM	50.00	Ö	6, 655, 430			6. 00
7. 00	DI ABETES CENTER	90. 01	o	5, 760			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	O	99, 090	C		8. 00
9.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	681, 435			9. 00
10.00	ELECTROENCEPHALOGRAPHY	70. 00	0	1, 125			10.00
11. 00	MAMMOGRAPHY	54.03	0	56, 799			11.00
12.00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	6, 610			12. 00 13. 00
13. 00 14. 00	MRI	57. 00 58. 00	0	683, 584 125, 280			14. 00
15. 00	CARDIAC CATHETERIZATION	59.00	Ö	1, 963, 073			15. 00
16. 00	CARDIAC CATHETERIZATION	59.00	ō	2, 504, 487			16. 00
17. 00	RESPIRATORY THERAPY	65. 00	О	55, 295			17. 00
18. 00	PHYSICAL THERAPY	66.00	0	23, 426			18. 00
19.00	SPEECH PATHOLOGY	68.00	0	269, 667			19. 00
20.00	ELECTROCARDI OLOGY	69.00	0	546, 706			20.00
21. 00 22. 00	WOUND CENTER EMERGENCY	90. 03 91. 00	0	97, 225 36, 868			21. 00 22. 00
23. 00	AMBULANCE SERVICES	95. 00	0	26, 730			23. 00
24. 00	NURSING ADMINISTRATION	13. 00	Ö	5, 716			24. 00
				.,			

Peri od: From 01/01/2018 To 12/31/2018

RECEAS	STITCATIONS			Frovider		From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Doorsoos					5/29/2019 8: 4	
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8.00	9. 00	10. 00			
25. 00	CLINIC	90.00		<u>2, 923</u>		<u> </u>		25. 00
	V - RECL PTO COST FOR STD ELI		0	17, 184, 506				
1.00	RADI OLOGY-DI AGNOSTI C	54.00	13, 689	0	(1. 00
2.00	VIMCARE CLINIC	90. 05	2, 461	0	(2. 00
3.00	MAMMOGRAPHY	54. 03	8, 924	0				3. 00
4. 00 5. 00	SOCIAL SERVICE ULTRA SOUND	17. 00 54. 02	7, 036 10, 585	0	· ·))		4. 00 5. 00
6. 00	ADMINISTRATIVE & GENERAL	5. 00	43, 580	0	(6. 00
7. 00	OPERATION OF PLANT	7. 00	11, 273	0	(7. 00
8.00	LAUNDRY & LINEN SERVICE	8.00	382	0	(8. 00
9.00	HOUSEKEEPI NG	9.00	14, 181	0	· ·			9. 00
10. 00 11. 00	DI ETARY CAFETERI A	10. 00 11. 00	6, 753 13, 098	0	(10. 00 11. 00
12. 00	NURSI NG ADMI NI STRATI ON	13. 00	22, 034	Ö	(•	12. 00
13.00	PHARMACY	15. 00	36, 650	0	(13.00
14.00	MEDI CAL RECORDS & LI BRARY	16.00	10, 800	0	· ·			14.00
15. 00 16. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	99, 482 14, 427	0	-))		15. 00 16. 00
17. 00	SUBPROVI DER - I RF	41.00	16, 064	0	(17. 00
18. 00	NURSERY	43. 00	19, 768	0	(18. 00
19. 00	OPERATING ROOM	50.00	15, 211	0	(19. 00
20.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	3, 925	0	())		20.00
21. 00 22. 00	RADI OLOGY-THERAPEUTI C LABORATORY-PATHOLOGI CAL	55. 00 60. 01	10, 422 1, 686	0	(•	21. 00 22. 00
23. 00	NEUROPSYCH	90. 02	1, 089	Ö	(23. 00
24.00	CT SCAN	57. 00	4, 600	0	(24.00
25. 00	MRI	58.00	3, 225	0	(25. 00
26. 00 27. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	22, 970 24, 374	0	(26. 00 27. 00
28. 00	RESPIRATORY THERAPY	65.00	10, 638	0	(28. 00
29. 00	PHYSI CAL THERAPY	66.00	22, 045	0	(29. 00
30. 00	WOUND CENTER	90. 03	11, 427	0	(30. 00
31. 00 32. 00	SPEECH PATHOLOGY	68. 00 69. 00	785	0	() 		31. 00 32. 00
33. 00	ELECTROCARDI OLOGY EMERGENCY	91.00	2, 205 35, 911	0	(33. 00
34. 00	AMBULANCE SERVICES	95. 00	9, 912	0	(34. 00
35. 00	ELECTROENCEPHALOGRAPHY	70.00	1, 347	0	(35. 00
36.00	CLINIC	90.00	3, 426	0	(36. 00
37. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	<u>214</u> 536, 599		'	4		37. 00
	W - RECLASS DEPT 9902 EMP BEI	NEFITS	333, 311	-				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	461, 502				1. 00
2. 00 3. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	203, 589 2, 337, 497	())		2. 00 3. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	321, 348	· ·			4. 00
5. 00	ANESTHESI OLOGY	53. 00	ō	398				5. 00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29, 912	(7. 00
8.00	ADMINISTRATIVE & GENERAL	5. 00	774, 738	0	(8. 00
9. 00 10. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	46, 124 463	0	(9. 00 10. 00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	22, 230	Ö				11. 00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 585	0	(12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	14, 712	0				13.00
14. 00 15. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	95, 036 44, 933	0	(14. 00 15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	30, 231	0				16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	9, 197	0	(17.00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	926	0				18. 00
19.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	695	0	()		19. 00
20. 00 21. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	112, 829 16, 827	0	(20. 00 21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8, 798	0	(22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 862	0				23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7, 998	0	(1		24. 00
25. 00 26. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	26, 365 2, 084	0	(25. 00 26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 473	0				27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	10, 519	0	(28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 631	0				29. 00
30. 00 31. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	3, 473 1, 621	0))		30. 00 31. 00
31.00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 621	0	(31.00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	42, 300	0	(1		33. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

						5/29/2019 8:4	+7 PIII		
		Decreases							
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.				
	6. 00	7. 00	8.00	9. 00	10. 00				
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 852	0	0		34.00		
35.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13, 823	0	0		35. 00		
36.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	32, 929	0	0		36. 00		
37.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8, 170	0	0		37. 00		
38.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 276	0	0		38. 00		
39.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 473	0	0		39. 00		
40.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6, 739	0	0		40.00		
41.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6, 251	0	0		41.00		
42.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	463	0	0		42.00		
43.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 621	0	0		43.00		
44.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	6, 497	0	0		44.00		
46.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	33, 198	0	0		46. 00		
47.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28, 099	0	0		47. 00		
48.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 158	0	0		48. 00		
49.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	12, 306	0	0		49. 00		
50.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 631	0	0		50.00		
51.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 389	0	0		51.00		
53.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5, 045	0	0		53. 00		
	0 — — — — —	$ \dagger$	1, 478, 134	3, 354, 246					
	X - RECLASS OT SALARIES AND OTHER EXP								
1.00	PHYSI CAL THERAPY	66.00	402, 895	92, 299	0		1. 00		
	0 — — — — —		402, 895	92, 299					
	Y - RECL MILLRACE FOR WELLNESS/OP/PT								
1.00	PHYSI CAL THERAPY	66.00	0	2, 090	0		1. 00		
2.00	WELLNESS COMMUNITY	194. 00	0	3, 217	0		2. 00		
	0			5, 307					
	Z - RECLASS LAB BLOOD SUPERVI SOR								
1.00	LABORATORY	60. 00	73, 892	0	0		1. 00		
	0		73, 892	0					
500.00	Grand Total: Decreases		6, 077, 772	48, 302, 879			500.00		

							5/29/2019 8: 4	9 pm	
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	ases Sal ary	Other	
	2.00	3. 00	4. 00	5. 00	6. 00	7.00	8. 00	9. 00	
	B - RECLASS DEPREC BLD								
1. 00	CAP REL COSTS-BLDG &	1. 00	0	1, 615, 481	INTEREST EXPENSE	113. 00	0	1, 615, 481	1. 00
2. 00	CAP REL COSTS-MVBLE	2. 00	0	518, 400	INTEREST EXPENSE	113. 00	o	518, 400	2. 00
	EQUI P		1			_ _]			
	O C - RECLASS INSURANCE		0	2, 133, 881	0		0	2, 133, 881	
1. 00	OCCUPATIONAL THERAPY	67. 00	0	1, 651	ADMINISTRATIVE &	5.00	O	1, 651	1. 00
			_		GENERAL				
2. 00	CAP REL COSTS-BLDG &	1. 00	0	634, 167	ADMINISTRATIVE & GENERAL	5. 00	0	634, 167	2. 00
3.00	AMBULANCE SERVICES	95. 00	О	44, 012	ADMINISTRATIVE &	5. 00	o	44, 012	3. 00
	L ADODATODY				GENERAL				
4. 00	LABORATORY	60. 00	0		ADMINISTRATIVE & GENERAL	5. 00	0	4, 075	4. 00
	0			683, 905				683, 905	
	D - RECLASS BILLING CO		047 000		MEDIAN DECORDO A	144 00	0.17.000		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	917, 902		MEDICAL RECORDS & LIBRARY	16. 00	917, 902	714, 174	1. 00
	0		917, 902				917, 902	714, 174	
	E - RECLASS HYPERBARIO								
1. 00	HYPERBARIC OXYGEN THERAPY	90. 04	70, 149	104, 997	WOUND CENTER	90. 03	70, 149	104, 997	1. 00
	0		70, 149			$-\vdash$	— — 70, 1 49	104, 997	
	F - RECLASS CAFETERIA	EXPENSE							
1.00	CAFETERI A	11. 00	1, 392, 051		DI ETARY	10. 00	1, 392, 051	74 <u>6, 4</u> 42	1. 00
	G - RECLASS WELLNESS		1, 392, 051	746, 442	0		1, 392, 051	746, 442	
1.00	WELLNESS COMMUNITY	194. 00	185, 846	70, 304	EMPLOYEE BENEFITS	4.00	185, 846	70, 304	1. 00
	L				DEPARTMENT	_			
	H - RECLASS PHYSICIAN	TEEC	185, 846	70, 304	0		185, 846	70, 304	
1. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	50,000	ADMINISTRATIVE &	5.00	O	50, 000	1. 00
00	The second of th	0 00	Ĭ	00, 000	GENERAL	0.00	٩	33, 333	00
2.00	ADULTS & PEDIATRICS	30. 00	0	1, 447, 543	ADMINISTRATIVE &	5. 00	0	1, 447, 543	2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	0	5, 650	GENERAL ADMINISTRATIVE &	5. 00	0	5, 650	3. 00
			1		GENERAL			2, 223	
4. 00	SUBPROVI DER - I RF	41. 00	0		ADMINISTRATIVE &	5. 00	0	206, 871	4. 00
5. 00	OPERATING ROOM	50. 00	0		GENERAL ADMINISTRATIVE &	5. 00	0	815, 280	5. 00
					GENERAL				
6.00	ANESTHESI OLOGY	53. 00	0		OPERATING ROOM	50.00	0	60, 000	6. 00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	o		ADMINISTRATIVE & GENERAL	5. 00	0	84, 375	7. 00
8.00	CARDI AC	59. 00	0		ADMINISTRATIVE &	5. 00	o	73, 919	8. 00
0.00	CATHETERI ZATI ON	(0.01		005 000	GENERAL	F 00		225 222	0.00
9. 00	LABORATORY-PATHOLOGIC	60. 01	0		ADMINISTRATIVE & GENERAL	5. 00	0	225, 000	9. 00
10.00	RESPIRATORY THERAPY	65. 00	0		ADMINISTRATIVE &	5. 00	o	28, 526	10.00
44.00	DUNCHOAL THEDADY				GENERAL	F 00		F0 000	44.00
11. 00	PHYSI CAL THERAPY	66. 00	0	50, 000	ADMINISTRATIVE & GENERAL	5. 00	0	50, 000	11. 00
12.00	ELECTROCARDI OLOGY	69. 00	0	93, 301	ADMINISTRATIVE &	5. 00	0	93, 301	12.00
40.00	EL FOTDOFNOFDUAL CODA DU	70.00		0. (50	GENERAL	F 00		0 (50	40.00
13. 00	ELECTROENCEPHALOGRAPH	70. 00	0	8, 650	ADMINISTRATIVE & GENERAL	5.00	0	8, 650	13. 00
14.00	CARDI AC	76. 97	0	3, 698	ADMINISTRATIVE &	5. 00	o	3, 698	14.00
15 00	REHABI LI TATI ON	01.00		1 400 070	GENERAL ADMINISTRATIVE &	F 00		1 400 070	15 00
15. 00	EMERGENCY	91. 00	0	1, 408, 873	ADMINISTRATIVE & GENERAL	5.00	0	1, 408, 873	15. 00
16.00	AMBULANCE SERVICES	95. 00	0	13, 125	ADMINISTRATIVE &	5. 00	o	13, 125	16. 00
47.00	WOUND OF NEED	00.00		0.4.000	GENERAL				47.00
17. 00	WOUND CENTER	90. 03	0	36, 800	ADMINISTRATIVE & GENERAL	5.00	0	36, 800	17. 00
18. 00	HYPERBARI C OXYGEN	90. 04	0	2, 550	ADMINISTRATIVE &	5. 00	0	2, 550	18. 00
10.00	THERAPY	01.00	ا	00: ===	GENERAL DOOM	F0 35	۔	201 ===	10.00
19. 00	EMERGENCY	91. 00	0	38 <u>4, 7</u> 72 4, 998, 933	OPERATING ROOM	50.00		38 <u>4, 7</u> 72 4, 998, 933	19. 00
	I - RECLASS REHAB SERV	/I CES	U ₁	4, 770, 733	<u> </u>		U	4, 770, 733	
1.00	OCCUPATI ONAL THERAPY	67. 00	35, 851	12, 861	ADMINISTRATIVE &	5.00	35, 851	12, 861	1. 00
2.00	DUVCLCAL TUEDADY	44 00	40 704	11 0/0	GENERAL ADMINISTRATIVE *	F 00	40 704	11 0/0	2.00
2. 00	PHYSI CAL THERAPY	66. 00	48, 784	11, 863	ADMINISTRATIVE & GENERAL	5.00	48, 784	11, 863	2. 00
3.00	SPEECH PATHOLOGY	68. 00	21, 170		ADMINISTRATIVE &	5. 00	21, 170	14, 077	3. 00
					GENERAL				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

								5/29/2019 8: 4	9 pm
	Cost Center	Li ne #	eases Sal ary	Other	Cost Center	Decre Li ne #		Other	
	2.00	3. 00	4. 00	5. 00	6.00	7.00	8. 00	9. 00	
4. 00	SUBPROVI DER - I RF	41.00			ADMINISTRATIVE &	5.00	142, 317	6, 779	4. 00
5. 00	ELECTROENCEPHALOGRAPH	70. 00	17, 311	5, 649	GENERAL ADMINISTRATIVE &	5. 00	17, 311	5, 649	5. 00
6. 00	SOCIAL SERVICE	17. 00	1, 731	565	GENERAL ADMINISTRATIVE &	5. 00	1, 731	565	6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	13, 324	3, 954	GENERAL ADMI NI STRATI VE & GENERAL	5. 00	13, 324	3, 954	7. 00
8.00	NEUROPSYCH	90. 02	13, 862	4, 519	ADMINISTRATIVE &	5. 00	13, 862	4, 519	8. 00
9. 00	WOUND CENTER	90. 03	24	9, 860	ADMINISTRATIVE & GENERAL	5. 00	24	9, 860	9. 00
10. 00	HYPERBARIC OXYGEN THERAPY	90. 04	2	4, 466	ADMINISTRATIVE &	5. 00	2	4, 466	10. 00
11. 00	WELLNESS COMMUNITY	194. 00	3, 603	1, 130	ADMINISTRATIVE & GENERAL	5. 00	3, 603	1, 130	11. 00
	0		297, 979	75, 723			297, 979	75, 723	
4 00	J - RECLASS PHARMACY R				DUADMAOV	1 45 00	404 (05		4 00
1. 00	PHARMACY RESIDENCY PROG	23. 02	181, 695	Ü	PHARMACY	15.00	181, 695	0	1. 00
2. 00	PHARMACY RESIDENCY PROG	23. 02	0	2, 722	ADMINISTRATIVE & GENERAL	5. 00	0	2, 722	2. 00
3.00	PHARMACY RESIDENCY PROG	23. 02	0	1, 665	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 665	3. 00
	0		181, 695	4, 387	0		181, 695	4, 387	
1 00	K - RECLASS RENT EXPEN		ol	1/ 021	DULL DI NC DENTAL C	104 01	ol	17 021	1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE &	4. 00 5. 00			BUILDING RENTALS BUILDING RENTALS	194. 01 194. 01	0	16, 031 196, 294	1. 00 2. 00
	GENERAL			•					
3. 00 4. 00	OPERATION OF PLANT XRAY EDUCATION	7. 00			BUILDING RENTALS BUILDING RENTALS	194. 01 194. 01	0 0	49, 050 11, 860	3. 00 4. 00
5. 00	MAMMOGRAPHY	54. 03			BUILDING RENTALS	194. 01	0	140, 965	5. 00
6. 00	LABORATORY	60.00			BUILDING RENTALS	194. 01	o	14, 909	6. 00
7.00	PHYSICAL THERAPY	66.00	o		BUILDING RENTALS	194.01	0	316, 348	7. 00
8.00	OCCUPATIONAL THERAPY	67.00	o	118, 401	BUILDING RENTALS	194.01	o	118, 401	8.00
9.00	SPEECH PATHOLOGY	68. 00	0	52, 950	BUILDING RENTALS	194.01	0	52, 950	9. 00
10. 00	ELECTROENCEPHALOGRAPH Y	70.00	0	127, 536	BUILDING RENTALS	194. 01	0	127, 536	10. 00
11. 00 12. 00	WOUND CENTER HYPERBARI C OXYGEN THERAPY	90. 03 90. 04			BUILDING RENTALS BUILDING RENTALS	194. 01 194. 01	0	73, 773 38, 063	11. 00 12. 00
13.00	AMBULANCE SERVICES	95. 00	o		BUILDING RENTALS	194. 01	0	15, 000	13.00
14.00	WELLNESS COMMUNITY	194.00	o		BUILDING RENTALS	194. 01	0	56, 198	14.00
15. 00	CRHP	194. 08			BUILDING RENTALS	194. 01	0	45 <u>0, 3</u> 31	15.00
	TOTALS	EVERNO	0	1, 677, 709	TOTALS		0	1, 677, 709	
1. 00	L - RECLASS MARKETING NONALLOWABLE	194. 05		140,000	ADMINISTRATIVE &	5.00	ol	140, 000	1. 00
1.00	MARKETI NG	194. 05	١		GENERAL	5.00	۷	140, 000	1.00
	0		o				0	140, 000	
	M - RECLASS DEPRECIATI	ON EXP	ENSE						
1. 00	CAP REL COSTS-MVBLE	2. 00	0	12, 687, 225	CAP REL COSTS-BLDG &	1.00	0	12, 687, 225	1. 00
	EQUI P		<u> </u>	12, 687, 225	FIXT	<u> </u>	<u> </u>		
	N - RECLASS MAINTENANC	E EXPE					-	,,	
1.00	RESPIRATORY THERAPY	65. 00			OPERATION OF PLANT	7.00		8, 337	1. 00
2.00	ELECTROCARDI OLOGY	69. 00			OPERATION OF PLANT	7. 00		7, 190	2. 00
3.00	CARDI AC	59. 00	0	258, 768	OPERATION OF PLANT	7. 00	0	258, 768	3. 00
4. 00	CATHETERI ZATI ON CENTRAL SERVI CES & SUPPLY	14. 00	0	114, 773	OPERATION OF PLANT	7. 00	0	114, 773	4. 00
5.00	OPERATING ROOM	50.00	О	243, 493	OPERATION OF PLANT	7.00	О	243, 493	5. 00
6.00	RADI OLOGY-THERAPEUTI C	55.00	0	660, 341	OPERATION OF PLANT	7.00	0	660, 341	6.00
7.00	LABORATORY	60.00	0	111, 148	OPERATION OF PLANT	7.00	0	111, 148	7.00
8. 00	LABORATORY-PATHOLOGIC AL	60. 01	0	6, 300	OPERATION OF PLANT	7. 00	0	6, 300	8. 00
9. 00	ADULTS & PEDIATRICS	30.00			OPERATION OF PLANT	7. 00		852	9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00			OPERATION OF PLANT	7.00		243, 416	10.00
11.00	MAMMOGRAPHY	54. 03			OPERATION OF PLANT	7.00		239, 400	
12.00	ULTRA SOUND	54. 02			OPERATION OF PLANT	7.00		28, 966	12.00
13.00	CT SCAN	57.00			OPERATION OF PLANT	7.00		189, 932 172, 961	13.00
14. 00	NUCLEAR MEDI CI NE-DI AGNOSTI C	54. 01	0	173,861	OPERATION OF PLANT	7.00	0	173, 861	14. 00
15. 00	MRI	58. 00	О	131. 327	OPERATION OF PLANT	7.00	О	131, 327	15. 00
16. 00	PHARMACY	15. 00			OPERATION OF PLANT	7.00		46, 682	
	-	*	· '		•	•	. '	<u>'</u>	

Health Financial Systems RECLASSIFICATIONS

COLD CONTINUES COLD							!	o 12/31/2018	Date/lime Pre 5/29/2019 8:4	
2		Coot Conton			Othor	Coot Conton			Othon	
17.00 AMERICAN 91.00 0 13.560/GPERATION OF PLANT 7.00 0 13.560/GPERATION OF PLANT 7.00 0 13.126/GPERATION OF PLANT 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 2.407,477 7.00 0 3.500 0 2.407,477 7.00 0 3.500 0 2.407,477 7.00 0 3.500 0 2.407,477 7.00 0 3.500 0 2.407,477 7.00 0 3.500 0 2.407,477 7.00 0 3.500 0										
19. 00 ORGANISTICS RECOVERY S.S. 00 0 3, 128 09ERATI ON OF PLANT 7. 00 0 2, 200 07. 00 0. 2, 200 0. 00 0. 0. 00 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		EMERGENCY	91. 00	0	3, 569	OPERATION OF PLANT	7. 00	0	3, 569	
RED BLOOD CELL		GENERAL		0				0	·	
0 - RECLASS DIRECTOR PHARMACY 15. 00 70, 325 0 9 1. 00 1	20. 00		62. 00	1		<u></u>	7. 00			20. 00
DERCENCY 91.00 70.325 O PAPAMACY 15.00 50.40 0.2 0.3 0.3 0.3 0.3 0.3 0.4 0.4 0.4 0.5			HARMACY		2, 492, 477	<u> </u> 0		0]	2, 492, 477	
AMERICANS SAMY EDUCATION 175, 812 0 0 175, 812 0 0 175, 812 0 0 175, 812 0 0 175, 812 0 0 1 1 1 1 1 1 1 1	1.00				C	PHARMACY	15.00	70, 325	0	1. 00
TOTALS 175, 817 0 0 0 0 0 0 0 0 0		•	1						- 1	
0 - RECLASS TAME FOLICATION 23.01 115 0 0 1.00	3.00		95. 00				15.00		0	3. 00
ADMINISTRATION 23.01 325.02 3.00 3			TION EX			ITOTALS		175, 612	U	
2.00 MARY FOUCATION 23.01 5.5 OPERATION TITERAPY 65.00 5.0 0.20 3.00	1.00	XRAY EDUCATION	23. 01	115	O		13. 00	115	0	1. 00
3.00 RRAY EDUCATION 23.01 0 13.206 EMPLOYEE BENEFITS 4.00 0 13.206 3.00 4.00 XRAY EDUCATION 23.01 325.675 1.00 325.675 1.00 325.675 1.00 5. RECLASS ADMIN HEAL HY COMMUNITIES 1.00 0 1.00 6. RECLASS NON ALLOW ADVERTISING COSTS 0 0 0 379.123 0 1.00 S. RECLASS NON ALLOW ADVERTISING COSTS 0 0 0 379.123 0 1.00 S. RECLASS NON ALLOW ADVERTISING COSTS 0 0 0 379.123 0 1.00 MEDICAL SUPPLIES 1.00 0 1.120.493 1.00 MEDICAL SUPPLIES 71.00 0 247.466 ADULTS & PEDIATRICS 30.00 0 247.466 1.00 MEDICAL SUPPLIES 71.00 0 151.282 INTENSIVE CARE UNIT 31.00 0 121.282 2.00 MEDICAL SUPPLIES 71.00 0 37.123 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 3.723 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 3.723 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 3.723 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 3.723 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 3.723 NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS NURSERY 42.00 0 3.723 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS ADULTS ADULTS ADULTS ADULTS ADULTS 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS ADULTS ADULTS ADULTS ADULTS 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS ADULTS ADULTS ADULTS ADULTS ADULTS ADULTS ADULTS ADULTS 3.00 MEDICAL SUPPLIES 71.00 0 6.655.430 O ADULTS ADU	2 00	XRAY EDUCATION	23 01	55	0	1	65.00	55	0	2 00
ACCOUNT ACCO		•				EMPLOYEE BENEFITS			-	
R - RECLASS ADMIN HEALTHY COMMUNITIES 194. 07 39, 123 0 1.00 OCHEGAL 39, 123 0 0 39, 123 0 0 S - RECLASS NON ALLOW ADVERTISING COSTS 1.120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 194. 08 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 247, 464 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 100 0 151, 282 INTERNSIVE CARE UNIT & 31, 00 0 247, 464 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 100 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 100 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 247, 464 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 100 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 247, 464 ADMIN'S STRATIVE & 5.00 DISSECTION 1, 100 0 1, 120, 493 ADMIN'S STRATIVE & 5.00 0 247, 464 ADMIN'S STRATIVE & 5.00 0 3, 723 ADMIN'S STRATIVE & 5.00 0 2, 20, 60 ADMIN'S STRATIVE & 5.00 0 4, 655, 430 ADMIN'S STRATIVE & 5.00 0 5, 760 ADMIN'S STRATIVE & 5.00 0	4.00	XRAY EDUCATION	23. 01			RADI OLOGY-DI AGNOSTI C	54.00			4. 00
1.00 ADMIN STRATIVE & 5.00 39,123 O CHALTHIY COMMUNITIES 194,07 39,123 O O O O O O O O O O		R - RECLASS ADMIN HEAL	THY COM		15, 871	[0		325, 695	15, 871	
1.00 SPECIASS NON ALLOW ADVERTISING COSTS 1.120, 493 ADMINISTRATIVE & 5.00 0 1.120, 493 1.00	1.00				O	HEALTHY COMMUNITIES	194. 07	39, 123	0	1. 00
S		GENERAL						20.122		
1.00 MORALCWABLE 194, 05 0 1,120,493 MAIN ISTRATIVE & 5.00 0 1,120,493 1,00		S - RECLASS NON ALLOW	ADVFRTI			iju		39, 123	U	
	1.00	NONALLOWABLE			1, 120, 493		5. 00	0	1, 120, 493	1. 00
1.00 MEDICAL SUPPLIES 71.00 247,466 ADULTS & PEDIATRICS 30.00 0 247,466 1.00		0			1, 120, 493	0		0	1, 120, 493	
2. 00 MEDICAL SUPPLIES 71. 00 0 151. 282 INTENSIVE CARE UNIT 31. 00 0 151. 282 2. 00	1.00	MEDI CAL SUPPLI ES			247, 466	ADULTS & PEDIATRICS	30.00	0	247, 466	1. 00
3.00 MEDICAL SUPPLIES 71.00 0 7.143 SUBPROVIDER - IRF 41.00 0 7.143 3.00	2.00	MEDICAL SUPPLIES	71. 00	0	151, 282	INTENSIVE CARE UNIT	31.00	0	151, 282	2. 00
A. OO	3.00	MEDICAL SUPPLIES	71. 00	0	7, 143	SUBPROVI DER - I RF	41. 00	0	7, 143	3. 00
S. OO MEDI CAL SUPPLIES T1. OO O 2, 927, 663 OPERATING ROOM 50. OO O 2, 927, 663 5. OO CARRED TO PATIENT OO O O O O O O O O	4. 00	MEDICAL SUPPLIES	71. 00	0	3, 723	NURSERY	43. 00	0	3, 723	4. 00
6. 00 IMPL DEV. CHARGED TO 72. 00 0 6, 655, 430 0 0 0 6, 655, 430 0 0 0 0 0 0 0 0 0	5.00	MEDICAL SUPPLIES	71. 00	0	2, 927, 663	OPERATING ROOM	50.00	0	2, 927, 663	5. 00
CHARGED TO PATIENT	6. 00		72. 00	0	6, 655, 430	OPERATING ROOM	50.00	0	6, 655, 430	6. 00
CHARGED TO PATIENT CHARGED	7. 00		71. 00	0	•		90. 01	0	5, 760	7. 00
CHARGED TO PATIENT CHARGED TO PATIENT CHARGED TO PATIENT T1.00 MEDI CAL SUPPLIES T1.00 CHARGED TO PATIENT T1.00 MEDI CAL SUPPLIES T1.00 CHARGED TO PATIENT T1.00 MEDI CAL SUPPLIES T1.00 CHARGED TO PATIENT T1.00 CHAR		CHARGED TO PATIENT			,				·	
CHARGED TO PATIENT 11. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 12. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 13. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 14. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 15. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 16. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 17. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 18. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 19. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 20. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 21. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 22. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 23. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 24. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 25. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 26. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 27. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 28. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 29. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 29. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 20.		CHARGED TO PATIENT				MEDICINE-DIAGNOSTIC			·	
CHARGED TO PATI ENT 12. 00 MEDI CAL SUPPLIES		CHARGED TO PATIENT				Υ				
CHARGED TO PATIENT CHARGED		CHARGED TO PATIENT			•				·	
CHARGED TO PATLENT TO CARDI AC CATHETERIZATION TO CATHETER		CHARGED TO PATIENT							·	
15. 00 CHARGED TO PATIENT NEDICAL SUPPLIES T1. 00 NEDICAL SUPPLIES T2. 00 NEDICAL SUPPLIES T3. 00 NEDICAL SUPPLIES T4. 00 NEDICAL SUPPLIES T4. 00 NEDICAL SUPPLIES T5. 00 NEDICAL SUPPLIES T5. 00 NEDICAL SUPPLIES T5. 00 NEDICAL SUPPLIES T6. 00 NEDICAL SUPPLIES T6. 00 NEDICAL SUPPLIES T7. 00 NEDICAL SUPPLIES NEDICAL		CHARGED TO PATIENT							·	
CHARGED TO PATI ENT 16. 00		CHARGED TO PATIENT							·	
PATI ENTS 17. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 18. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 19. 00 SPEECH - HEARI NG AI DS CHARGED TO PATI ENT 20. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 21. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 22. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 23. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 24. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 25. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 26. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 27. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 28. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 29. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 20. 00 ME		CHARGED TO PATIENT				CATHETERI ZATI ON				
CHARGED TO PATIENT NEDICAL SUPPLIES T1.00 CHARGED TO PATIENT T1.00 CHARGED TO PATIENT T2.00 CHARGED TO PATIENT T3.00 CHARGED TO PATIENT T4.00 CHARGED TO PATIENT T5.00 T5.716 NURSING T5.00 T5.716 24.00 T5.716 24.00 T5.716 CHARGED TO PATIENT T5.716 CT.00 CHARGED TO PATIENT T5.00 CHARGED TO PATIENT T5.716 CT.00		PATI ENTS				CATHETERI ZATI ON				
CHARGED TO PATIENT 19.00 SPEECH - HEARING AIDS 71.00 0 269,667 SPEECH PATHOLOGY 68.00 0 269,667 19.00 20.00 MEDICAL SUPPLIES 71.00 0 97,225 WOUND CENTER 90.03 0 97,225 21.00 21.00 MEDICAL SUPPLIES 71.00 0 36,868 EMERGENCY 91.00 0 36,868 22.00 23.00 MEDICAL SUPPLIES 71.00 0 26,730 AMBULANCE SERVICES 95.00 0 26,730 23.00 24.00 MEDICAL SUPPLIES 71.00 0 5,716 NURSING 13.00 0 5,716 24.00		CHARGED TO PATIENT								
20. 00 MEDI CAL SUPPLI ES 71. 00 0 546, 706 ELECTROCARDI OLOGY 69. 00 0 546, 706 20. 00 CHARGED TO PATI ENT 71. 00 0 97, 225 WOUND CENTER 90. 03 0 97, 225 21. 00 CHARGED TO PATI ENT 71. 00 0 36, 868 EMERGENCY 91. 00 0 36, 868 22. 00 CHARGED TO PATI ENT 71. 00 0 26, 730 AMBULANCE SERVI CES 95. 00 0 26, 730 23. 00 CHARGED TO PATI ENT 71. 00 0 5, 716 NURSI NG 13. 00 0 5, 716 24. 00		CHARGED TO PATIENT			•			0	·	
21. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		MEDICAL SUPPLIES		-				Ö		
CHARGED TO PATIENT 23.00 MEDICAL SUPPLIES 71.00 0 26,730 AMBULANCE SERVICES 95.00 0 26,730 23.00 CHARGED TO PATIENT 24.00 MEDICAL SUPPLIES 71.00 0 5,716 NURSING 13.00 0 5,716 24.00	21. 00	MEDICAL SUPPLIES	71. 00	0	97, 225	WOUND CENTER	90. 03	0	97, 225	21. 00
CHARGED TO PATIENT 24.00 MEDICAL SUPPLIES 71.00 0 5,716 NURSING 13.00 0 5,716 24.00		CHARGED TO PATIENT						0		
		CHARGED TO PATIENT						0		
	24. 00		71. 00	0	5, 716		13. 00	0	5, 716	24. 00

In Lieu of Form CMS-2552-10

Period: Worksheet A-6
From 01/01/2018 Non-CMS Worksheet
To 12/31/2018 Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

							o 12/31/2018		pared:
	0.10.1	Incre		011	0 1 0 1	Decre			, b
	Cost Center 2.00	Li ne #	Sal ary 4.00	0ther 5.00	Cost Center 6.00	Li ne #	Sal ary 8.00	0ther 9.00	
25. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0		CLI NI C	90.00	0	2, 923	25. 00
	0		₀	17, 184, 506	0 — — —		<u> </u>	17, 184, 506	
1. 00	V - RECL PTO COST FOR EMPLOYEE BENEFITS	STD ELI 4.00	MINATION PD O	13 689	RADI OLOGY-DI AGNOSTI C	54.00	13, 689	0	1. 00
	DEPARTMENT								
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 461	VIMCARE CLINIC	90. 05	2, 461	0	2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 924	MAMMOGRAPHY	54. 03	8, 924	0	3. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 036	SOCIAL SERVICE	17. 00	7, 036	0	4. 00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	10, 585	ULTRA SOUND	54. 02	10, 585	0	5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	43, 580	ADMINISTRATIVE & GENERAL	5. 00	43, 580	0	6. 00
7. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 273	OPERATION OF PLANT	7. 00	11, 273	0	7. 00
8. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	382	LAUNDRY & LINEN SERVICE	8. 00	382	O	8. 00
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	14, 181	HOUSEKEEPI NG	9. 00	14, 181	0	9. 00
10. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 753	DI ETARY	10.00	6, 753	0	10. 00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	13, 098	CAFETERI A	11.00	13, 098	0	11. 00
12. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	22, 034	NURSI NG ADMI NI STRATI ON	13. 00	22, 034	0	12. 00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	36, 650	PHARMACY	15. 00	36, 650	0	13. 00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	10, 800	MEDICAL RECORDS & LIBRARY	16.00	10, 800	0	14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	99, 482	ADULTS & PEDIATRICS	30.00	99, 482	0	15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	14, 427	INTENSIVE CARE UNIT	31.00	14, 427	0	16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	16, 064	SUBPROVIDER - IRF	41.00	16, 064	0	17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		NURSERY	43.00	19, 768	0	18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	15, 211	OPERATING ROOM	50.00	15, 211	0	19. 00
20. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 925	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	3, 925	0	20. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		RADI OLOGY-THERAPEUTI C	55.00	10, 422	0	21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	·	LABORATORY-PATHOLOGIC AL	60. 01	1, 686	0	22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 089	NEUROPSYCH	90. 02	1, 089	0	23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 600	CT SCAN	57.00	4, 600	0	24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 225	MRI	58. 00	3, 225	0	25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		CARDI AC CATHETERI ZATI ON	59.00	•		26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		LABORATORY	60.00			27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		RESPI RATORY THERAPY	65.00			28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		PHYSI CAL THERAPY	66.00		0	29. 00
30. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		WOUND CENTER	90.03	•		30. 00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		SPEECH PATHOLOGY	68. 00			31. 00
32. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		ELECTROCARDI OLOGY	69.00	•		32. 00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		EMERGENCY	91.00		0	33. 00
34. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		AMBULANCE SERVICES	95.00		0	34. 00
35. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		ELECTROENCEPHALOGRAPH Y	70.00			35. 00
36. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 426	CLINIC	90.00	3, 426	0	36. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

	Coot Contor	Increa	ses						
	Cost Center	Line #	Sal ary	Other	Cost Center	Decrea Li ne #	Salary	Other	
07.00	2.00	3. 00	4. 00	5.00	6. 00	7.00	8. 00	9. 00	07.00
37. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	214	EMPLOYEE BENEFITS DEPARTMENT	4.00	214	0	37. 00
	0	EMD DENE	0	536, 599	0		536, 599		
1. 00	W - RECLASS DEPT 9902 I ADMINISTRATIVE &	5. 00	-115	461, 502	EMPLOYEE BENEFITS	4.00	0	461, 502	1. 00
2.00	GENERAL CENTRAL SERVICES &	14 00	0	202 500	DEPARTMENT	4 00	0	202 500	2.00
2. 00	SUPPLY	14. 00	٩	·	EMPLOYEE BENEFITS DEPARTMENT	4.00	٥	203, 589	2. 00
3. 00	OPERATING ROOM	50. 00	0	2, 337, 497	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 337, 497	3. 00
4.00	RECOVERY ROOM	51. 00	О	321, 348	EMPLOYEE BENEFITS	4.00	О	321, 348	4. 00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	398	DEPARTMENT ANESTHESI OLOGY	53.00	0	398	5. 00
7. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	29, 912	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29, 912	7. 00
8. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	774, 738	0	ADMINISTRATIVE & GENERAL	5. 00	774, 738	0	8. 00
9. 00	OPERATION OF PLANT	7. 00	46, 124	0	EMPLOYEE BENEFITS	4.00	46, 124	0	9. 00
10. 00	LAUNDRY & LINEN	8. 00	463	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	463	О	10. 00
11. 00	SERVI CE HOUSEKEEPI NG	9. 00	22, 230	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	22, 230	0	11. 00
					DEPARTMENT				
12. 00	DI ETARY	10. 00	7, 585	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	7, 585	0	12. 00
13. 00	CAFETERI A	11. 00	14, 712	0	EMPLOYEE BENEFITS	4.00	14, 712	О	13. 00
14. 00	NURSI NG	13. 00	95, 036	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	95, 036	О	14. 00
15. 00	ADMI NI STRATI ON PHARMACY	15. 00	44, 933	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	44, 933	0	15. 00
16. 00	MEDICAL RECORDS &	16. 00	30, 231	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	30, 231	0	16. 00
	LI BRARY				DEPARTMENT				
17. 00	SOCIAL SERVICE	17. 00	9, 197	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	9, 197	0	17. 00
18. 00	XRAY EDUCATION	23. 01	926	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	926	0	18. 00
19. 00	PHARMACY RESIDENCY PROG	23. 02	695	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	695	0	19. 00
20. 00	ADULTS & PEDIATRICS	30. 00	112, 829	0	EMPLOYEE BENEFITS	4.00	112, 829	О	20. 00
21. 00	INTENSIVE CARE UNIT	31. 00	16, 827	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	16, 827	0	21. 00
22. 00	SUBPROVI DER - I RF	41. 00	8, 798	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	8, 798	О	22. 00
23. 00	NURSERY	43. 00	4, 862	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	4, 862	0	23. 00
24. 00	OPERATING ROOM	50. 00	7, 998	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	7, 998	0	24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54. 00	26, 365	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	26, 365	o	25. 00
26. 00	NUCLEAR	54. 01	2, 084		DEPARTMENT EMPLOYEE BENEFITS	4.00	2, 084	0	26. 00
27. 00	MEDICINE-DIAGNOSTIC ULTRA SOUND	54. 01	3, 473		DEPARTMENT EMPLOYEE BENEFITS	4.00	3, 473	0	27. 00
					DEPARTMENT				
28. 00	MAMMOGRAPHY	54. 03	10, 519	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	10, 519	0	28. 00
29. 00	RADI OLOGY-THERAPEUTI C	55. 00	4, 631	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 631	O	29. 00
30. 00	CT SCAN	57. 00	3, 473	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 473	0	30. 00
31. 00	MRI	58. 00	1, 621	0	EMPLOYEE BENEFITS	4.00	1, 621	0	31. 00
32. 00	CARDI AC	59. 00	14, 564	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	14, 564	0	32. 00
33. 00	CATHETERI ZATI ON LABORATORY	60. 00	42, 300	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	42, 300	0	33. 00
34. 00	LABORATORY-PATHOLOGIC	60. 01	1, 852	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	1, 852	0	34. 00
35. 00	AL RESPIRATORY THERAPY	65. 00	13, 823	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	13, 823	0	35. 00
36. 00	PHYSI CAL THERAPY	66. 00	32, 929	0	DEPARTMENT EMPLOYEE BENEFITS	4.00	32, 929	0	36. 00
37. 00	OCCUPATI ONAL THERAPY	67. 00	8, 170	0	DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00	8, 170	0	37. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

Peri od:	Worksheet A-6
From 01/01/2018	Worksheet A-6 Non-CMS Worksheet
To 12/31/2018	Date/Time Prepared: 5/29/2019 8:49 pm
	5/29/2019 8:49 pm

								5/29/2019 8: 4	9 pm
		Increa				Decrea	ises		
	Cost Center	Li ne #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5.00	6. 00	7.00	8. 00	9. 00	
38. 00	SPEECH PATHOLOGY	68. 00	3, 276	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 276	0	38. 00
39. 00	ELECTROCARDI OLOGY	69. 00	3, 473	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 473	0	39. 00
40. 00	ELECTROENCEPHALOGRAPH	70. 00	6, 739	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	6, 739	0	40. 00
41. 00	CLINIC	90. 00	6, 251	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	6, 251	0	41. 00
42. 00	DI ABETES CENTER	90. 01	463	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	463	0	42. 00
43. 00	NEUROPSYCH	90. 02	1, 621	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 621	0	43. 00
44. 00	WOUND CENTER	90. 03	6, 497	O	EMPLOYEE BENEFITS DEPARTMENT	4.00	6, 497	0	44. 00
46. 00	EMERGENCY	91. 00	33, 198	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	33, 198	0	46. 00
47. 00	AMBULANCE SERVICES	95. 00	28, 099	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	28, 099	0	47. 00
48. 00	CARDI AC REHABI LI TATI ON	76. 97	1, 158	O	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 158	0	48. 00
49. 00	HEALTHY COMMUNITIES	194. 07	12, 306	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	12, 306	0	49. 00
50.00	VIMCARE CLINIC	90. 05	4, 631	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 631	0	50. 00
51. 00	MEDICATION MGMT	90. 06	1, 389	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 389	0	51. 00
53. 00	WELLNESS COMMUNITY	194. 00	5, 045	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	5, 045	0	53. 00
		- $+$	1, 478, 134	3, 354, 246			1, 478, 134	3, 354, 246	
	X - RECLASS OT SALARIE	S AND O		0,001,210	.10		17 17 07 10 1	0,001,210	
1.00	OCCUPATI ONAL THERAPY	67. 00	402, 895	92 299	PHYSI CAL THERAPY	66.00	402, 895	92, 299	1. 00
	0		402, 895	92, 299		-	402, 895	92, 299	
	Y - RECL MILLRACE FOR	WELLNESS		, _,,	1		,	,,	
1.00	OCCUPATI ONAL THERAPY	67. 00	0	2, 090	PHYSICAL THERAPY	66, 00	0	2, 090	1. 00
2. 00	OCCUPATI ONAL THERAPY	67. 00	ő		WELLNESS COMMUNITY	194.00	ol	3, 217	2. 00
	0		— — ö f			-	 	${5,307}$	
	Z - RECLASS LAB BLOOD	SUPERVIS	-	2,007	1-		<u> </u>	2,007	
1.00	WHOLE BLOOD & PACKED	62. 00	73, 892	O	LABORATORY	60.00	73, 892	0	1. 00
	RED BLOOD CELL	\vdash	73, 892		<u> </u>	-		— — <u> </u>	
500.00	<u> </u>		5, 541, 173		Grand Total:	+ +	6, 077, 772	48, 302, 879	E00 00
300.00	Increases		5, 541, 1/3	48, 839, 4/8	Decreases		0, 077, 772	48, 302, 879	300. UU
	II IICI edses	1	I		Ineci eggez	1 1	I	ļ	

				Ė	To 12/31/2018	Date/Time Pre 5/29/2019 8:4	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	2, 421, 066	0	(0	445, 014	1. 00
2.00	Land Improvements	20, 075, 468	798, 201	(798, 201	0	2. 00
3.00	Buildings and Fixtures	96, 970, 197	4, 790, 599	(4, 790, 599	388, 525	3. 00
4.00	Building Improvements	105, 628, 508	460, 011	(460, 011	214, 358	4. 00
5.00	Fixed Equipment	9, 435, 554	155, 102	(155, 102	96, 740	5. 00
6.00	Movable Equipment	152, 668, 624	29, 459, 227	(29, 459, 227	27, 114, 119	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	387, 199, 417	35, 663, 140	(35, 663, 140	28, 258, 756	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	387, 199, 417	35, 663, 140	(35, 663, 140	28, 258, 756	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 976, 052	0				1. 00
2.00	Land Improvements	20, 873, 669	0				2. 00
3.00	Buildings and Fixtures	101, 372, 271	0				3. 00
4.00	Building Improvements	105, 874, 161	0				4. 00
5.00	Fi xed Equipment	9, 493, 916	0				5. 00
6.00	Movable Equipment	155, 013, 732	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	394, 603, 801	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	394, 603, 801	0				10. 00

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0112	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		pared.
					127 017 2010	5/29/2019 8: 4	
			Sl	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	21, 357, 468	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	21, 357, 468	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	21, 357, 468				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	o	0				2. 00
3.00	Total (sum of lines 1-2)	o	21, 357, 468				3. 00

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018		pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1.00	2.00	3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	239, 590, 070	0	239, 590, 07	0. 607166	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	155, 013, 732					2. 00
3.00	Total (sum of lines 1-2)	394, 603, 802	0	394, 603, 80	1.000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART 111 DECOMOUNTED OF OARLES COOKS	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C	1	1 0		0 (70 00/	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0			0 8, 679, 026 0 12, 150, 037		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0			0 20, 829, 063		3.00
3.00	Total (suil of Titles 1-2)	U	SI	JMMARY OF CAPI		U	3.00
			50	SWINIART OF CALL	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions) Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONOLILIATION OF CARLTY COCTO	11.00	12.00	13. 00	14.00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		(24.147			10 112 441	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	800, 248 128, 941		1	0 0	10, 113, 441 12, 278, 978	1. 00 2. 00
3.00	Total (sum of lines 1-2)	929, 189		1	0 0		
3.00	Total (Suil of Titles 1-2)	727, 107	034, 107	I	o _l o	22, 372, 417	J. 00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

Cost Center Description Dest Product Cost Center Line 2 West A-7 Ref					To	12/31/2018	Date/Time Prep	
Dest Centur Description Resis/Celst (2) Amount Dest Centur Linu # Not A-7 Buf							3/29/2019 8.4	у рііі
10					To/From Which the Amount is	to be Adjusted		
10								
10								
1.00 Investment Income - CAP REL S		Cost Center Description						
1.00 1.00	1. 00	II						1. 00
Investment income - other 0 0.00 0.00 0.3.00	2. 00		В	-124, 800	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
Chapter 2)	3 00			0		0.00	0	3 00
discounts (chipter 8)		(chapter 2)	, n	101 070	ADMINISTRATIVE & CENEDAL			
6.00 Rental of gravit dars space by suppliers (chapter 8) 7.00 Tolevision and radio service 8.00 Tolevision and radio service 10.00 Parking (of the physician A-8-2) 8.00 Parking (of the physician A-8-3) 9.00 Parking (of the physician A-8-3		di scounts (chapter 8)						
8.00 Rental of provider space by 0 0.00 0.6.00 0.6.00 0.00 0.6.00 0.	5. 00		В	-2, 076	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Services Servic	6.00	Rental of provider space by		0		0. 00	О	6. 00
8. 00. Television and radio service (Chapter 21) 9. 00. Parking lot (chapter 21) 10. 00 Parking lot (chapter 21) 10. 01 Parking lot (chapter 21) 10. 02 Parking lot (chapter 21) 10. 03 Parking lot (chapter 21) 10. 04 Parking lot (chapter 21) 10. 05 Parking lot (chapter 21) 10. 06 Parking lot (chapter 21) 10. 07 Parking lot (chapter 21) 10. 08 Parking lot (chapter 21) 10. 09 Parking lot (chapter 21) 10. 09 Parking lot (chapter 21) 10. 00 Parking lot (chapter 14) 10. 00 Parkin	7. 00	Tel ephone servi ces (pay	A	-141, 053	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
Chapter 21 B								
Parking lot (chapter 21)	8.00	II	А	-9, 843	OPERATION OF PLANT	7. 00	0	8. 00
adjustment (10.0 Sale of scrap, waste, etc. (10.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0		Parking Lot (chapter 21)	1			7. 00	_	
Chapter 23)	10.00		A-8-2	-8, 293, 984			0	10.00
12.00 Related organization transactions (chapter 10) 12.00 12.00 13.00 13.00 14.00 15.00 16.00 16.00 15.00 1	11. 00			0		0. 00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	-1, 128, 280			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 17.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 0 0 0 0 0 0	13. 00	Laundry and linen service		0		0. 00	0	13. 00
and others				-752, 506 0	CAFETERI A		-	
Supplies to other than Datients		and others		-			0	
17. 00 Sale of drugs to other than patients 0 0.00	10.00	supplies to other than		0		0.00		10.00
18.00 Sale of medical records and abstracts B -22,932 MEDICAL RECORDS & LIBRARY 16.00 0 18.00 18.00 abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 23.01 0 19.00 19.00 23.01 0 19.00 20.00 2	17. 00			0		0. 00	0	17. 00
abstracts	18 00	1.	В	-22 932	MEDICAL RECORDS & LIBRARY	16 00	0	18 00
education (tuition, fees, books, etc.)		abstracts						
20.00 Vending machines B	19.00		В	-20, 524	XRAY EDUCATION	23.01	0	19.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and provided the repay of the pay Medicare overpayments and provided the repay of the pay Medicare overpayments and provided the repay of the pay Medicare overpayments and provided the pay of the pay Medicare overpayments and provided the pay of	20. 00		В	-140	HOUSEKEEPI NG	9. 00	0	20. 00
Charges (chapter 21)	21. 00	Income from imposition of		0		0. 00	О	21. 00
overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT 1.00 0 26. 00 COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 0.00 0 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 19. 00 0 27. 00 0 29. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		charges (chapter 21)						
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 26.00 27.00 27.00 28.00 Non-physicians' assistant O *** Cost Center Deleted *** 114.00 26.00 27.00 28.00 Non-physicians' assistant O *** Cost Center Deleted *** 19.00 28.00 29	22. 00			0		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	23 00	1 1 3	Δ_8_3	0	RESDIRATORY THERADY	65.00		23 00
A-8-3 A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist Physicians' assistant A-8-3 OCAP REL COSTS-MVBLE EQUIP	25.00	therapy costs in excess of	A 0 3	O	RESITION THERAIT	03.00		23.00
limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 26.00 COSTS-BLDG & FIXT 1.00 O 26.00 COSTS-BLDG & FIXT 1.00 O 27.00 COSTS-BLDG & FIXT O CAP REL COSTS-BLDG & FIXT O CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL COSTS-MVBLE EQUIP Depreciation - CAP REL COSTS-MVBLE EQUIP O CAP REL COSTS-	24. 00		A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT								
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP 0 CAP REL COSTS-MVBLE EQUIP 2. 00 0 *** Cost Center Deleted *** 19. 00 0 29. 00 0 29. 00 0 30. 00 0 29. 00 0 30. 00 0		(chapter 21)		_				
COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O**** Cost Center Deleted *** 19. 00 28. 00 29. 00 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 00 30. 99 OADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 32. 00	26. 00			0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0.00 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 0 0 *** Cost Center Deleted *** 19. 00 0.00 0 29. 00 A-8-3 0 OCCUPATIONAL THERAPY 67. 00 A-8-3 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 30. 99 OADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00			A-8-3	0	OCCUPATI ONAL THERAPY		-	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest		pathology costs in excess of limitation (chapter 14)						
	32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	33. 00		В	-900	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0112 Peri od: Worksheet A-8 From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				To	12/31/2018	Date/Time Pre 5/29/2019 8:4	pared:
				Expense Classification on	Worksheet A	372972019 6.4	9 pili
				To/From Which the Amount is			
					Ţ		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3.00	4. 00	5. 00	
34. 00	DEPR PAT PHONES NEW EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2.00		34. 00
35.00	TV DEPR NEW EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2.00		35. 00
36.00	CAFETERIA VISITORS	A	-356, 497	CAFETERI A	11.00	0	36. 00
37. 00	MEALS TO GO	A		DI ETARY	10. 00		37. 00
37. 01	CANCER CENTER ADMIN CRHP OTHER	В	-11, 408	CLINIC	90. 00	0	37. 01
20.00	REV	В	4 250	OPERATING ROOM	50.00	0	20.00
38. 00 39. 00	OPERATING ROOM OTHER REV	В		PHYSICAL THERAPY	66.00		38. 00 39. 00
40. 00	EAP REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		40. 00
41. 00	BOND AMORTIZATION	A		CAP REL COSTS-BLDG & FIXT	1. 00		41. 00
42. 00	LAND RENT MOB	В		ADMINISTRATIVE & GENERAL	5. 00		42.00
43.00	SPEECH THERAPY OTHER REV	В	-855	SPEECH PATHOLOGY	68.00	0	43.00
44.00	LABORATORY OTHER REVENUE	В		LABORATORY	60.00	0	44. 00
44. 01	EMPLOY BENEFITS OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00		44. 01
45. 00	EMERGENCY ROOM OTHER REV	В		EMERGENCY	91.00		45. 00
45. 01	MEDICAL STAFF INCOME	В		ADMI NI STRATI VE & GENERAL	5.00		45. 01
45. 02 45. 03	RADIOLOGY OTHER REVENUE BREAST FILM COPIES	B B		RADI OLOGY-DI AGNOSTI C MAMMOGRAPHY	54. 00 54. 03		45. 02 45. 03
45. 04	CARDIAC CATH LAB OTHER REVENUE			CARDI AC CATHETERI ZATI ON	59. 00		45. 03
45. 05	FACILITIES OTHER REVENUE	B		OPERATION OF PLANT	7. 00		45. 05
45. 06	SI CK BAY	В		ADULTS & PEDIATRICS	30.00		45. 06
45. 07	RADIATION ONCOLOGY OTHER	В	-19, 917	RADI OLOGY-THERAPEUTI C	55.00		45. 07
	REVENUE						
45. 08	CRHP OTHER REVENUE ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00		
45. 09	CRHP OTHER REVENUE BUILDING	В	-297, 442	CRHP	194. 08	0	45. 09
45. 10	RENTALS CRHP OTHER REVENUE EMPLOYEE	В	201 472	ADMINISTRATIVE & GENERAL	5. 00	0	45. 10
45. 10	BENEFITS	В	-201, 472	ADMINISTRATIVE & GENERAL	5.00	0	45. 10
45. 11	FOOD OTHER REVENUE	В	-40, 023	DI ETARY	10.00	0	45. 11
45. 12	WELLCONNECT OTHER REVENUE	В	-450	ADMINISTRATIVE & GENERAL	5.00	0	45. 12
45. 13	PROTECTI VE SERV OTHER REVENUE	В	-8, 400	OPERATION OF PLANT	7. 00	0	45. 13
45. 14	PHARMACY OTHER REVENUE	В		PHARMACY	15. 00		45. 14
45. 15	HUMAN RESOURCES OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		45. 15
45. 16	LACTATION AND PREPARE OTHER REVENUE	В	-4, 885	ADULTS & PEDIATRICS	30. 00	0	45. 16
45. 17	VOLUNTEER OTHER REVENUE	В	-82 220	ADMINISTRATIVE & GENERAL	5. 00	0	45. 17
45. 18	RENTAL PROPERTIES DEPRECIATION			CAP REL COSTS-BLDG & FIXT	1.00		45. 18
45. 19	OTHER ADJUSTMENTS (SPECIFY)	В	0		0.00		45. 19
	(3)						
45. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	45. 20
4E 21	(3)	_	11 010	CAD DEL COSTS DIDO 9 FLVT	1 00	_	4E 21
45. 21	LOSS ON DISPOSAL DEMOLITION UNALLOWABLE PHYS RECRUITMENT	A A		CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	1. 00 5. 00		45. 21 45. 22
45. 22	DEPRECIATION RELIFED BUILDING	A		CAP REL COSTS-BLDG & FIXT	1. 00		
45. 24	INFO SERVICES OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		
45. 25	OTHER ADJUSTMENTS (SPECIFY)	В	0		0.00		
	(3)						
45. 27	PRIOR YEAR AUDIT ADJUSTMENT	Α		CAP REL COSTS-BLDG & FIXT	1. 00		
45. 28	NONALLOWABLE INT EXP BUILDING	A		CAP REL COSTS-BLDG & FIXT	1.00		
45. 29	NONALLOWABLE INT EXP EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2.00		45. 29
45. 30	UNALLOWABLE AHA MEMBERSHIP DUES	A	-14, 251	ADMINISTRATIVE & GENERAL	5. 00	0	45. 30
45. 31	AMBULANCE SERVICES	В	-509. 097	AMBULANCE SERVICES	95.00	0	45. 31
45. 32	DEPRECIATION RELIFED EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2.00		
45. 33	CARDI OLOGY OTHER REVENUE	В	· ·	ELECTROCARDI OLOGY	69. 00		45. 33
45. 34	HAF ADJUSTMENT	A	-12, 201, 088	ADMINISTRATIVE & GENERAL	5.00	0	45. 34
50. 00	TOTAL (sum of lines 1 thru 49)		-28, 506, 539				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

 zoon pootou to normonout m	cor anni s r aria, or 2, tric anoar	it aironabro on	cara be riiai carca rii ceraiiir i	or time parti	
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	Е	J BICKEL	0.00	CI	HEALTH MANAGEMENT	0.00	6. 00
	E	D DICKEL	0.00	ادا	HEALTH MANAGEMENT	0.00	0.00
7.00	E	D TRAPP	0.00	SI	HEALTH MANAGEMENT	0.00	7. 00
8.00	E	Z ELLISON	0.00	SI	HEALTH MANAGMENT	0.00	8.00
9.00	E	R SHEDD	0.00	SI	HEALTH MANAGEMENT	0.00	9. 00
10.00	E	S STARK	0.00	SI	HEALTH MANAGEMENT	0.00	10.00
10. 01	E	D DOUP	0.00	SI	HEALTH MANAGMENT	0.00	10. 01
10. 02	E	D MI CHAEL	0.00	SI	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.

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0112	Peri od:	Worksheet A-8-1
OFFICE COSTS		From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/29/2019 8:49 pm
Net Wkst. A-7 Ref.			
Adjustments			
(col. 4 minus			
col. 5)*			
6. 00 7. 00			
A. COSTS INCURRED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED (ORGANIZATIONS OR (CLAIMED
HOME OFFICE COSTS:			
1. 00 -1, 128, 280 0			1.00
2.00 0 0			2.00
3.00 0 0			3.00
4.00 0 0			4.00
5. 00 -1, 128, 280			5. 00
* The amounts on lines 1-4 (and sub	scripts as appropriate) are transferred in detail to Wor	ksheet A. column	6. lines as
	e cost and negative amounts decrease cost. For related or		

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

Type of Business

6.00

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

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

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

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

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

						lo 12/31/2018	3 Date/lime Pre 5/29/2019 8:4	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provi der Component	RCE Amount	Physi ci an/Prov i der Component Hours	, jo
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	5, 546, 637			211, 500		1.00
2.00		ADULTS & PEDIATRICS	1, 447, 544			211, 500		2. 00
3.00		INTENSIVE CARE UNIT	5, 650		5, 650	211, 500		3.00
4.00		SUBPROVI DER – I RF	206, 871		206, 871	211, 500		4. 00
5.00		OPERATI NG ROOM	2, 692, 922			246, 400		5. 00
6.00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	60,000		60,000	246, 400	1	6.00
7. 00 8. 00		RADI OLOGY-DI AGNOSTI C	50, 000 84, 375		50, 000 84, 375	271, 900 271, 900	1	7. 00 8. 00
9. 00		CARDI AC CATHETERI ZATI ON	73, 919		73, 919	211, 500	1	9. 00
10. 00		LABORATORY-PATHOLOGI CAL	225, 000		225, 000	260, 200	1, 722	10. 00
11. 00		RESPIRATORY THERAPY	29, 000		29, 000	211, 500		11. 00
12. 00		PHYSI CAL THERAPY	50, 000	1	50, 000	211, 500	1	12. 00
13.00		ELECTROCARDI OLOGY	93, 301	0	93, 301	211, 500	1	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	8, 650	0	8, 650	211, 500	86	14.00
15.00	76. 97	CARDIAC REHABILITATION	3, 698	0	3, 698	211, 500	23	15.00
16.00	90. 02	NEUROPSYCH	197, 077	197, 077	0	211, 500	0	16.00
17. 00	•	WOUND CENTER	36, 800		36, 800	211, 500		17. 00
18. 00	•	HYPERBARIC OXYGEN THERAPY	2, 550		2, 550	211, 500		18. 00
19. 00		EMERGENCY	2, 242, 745	1	2, 242, 745	211, 500		19. 00
20. 00	95.00	AMBULANCE SERVICES	13, 125		13, 125	211, 500		20.00
200.00	Wkst. A Line #	Cost Center/Physician	13, 069, 864 Unadj usted RCE		6, 380, 569 Cost of	Provi der	Physician Cost	200. 00
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &	Component	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	169, 912					1.00
2.00		ADULTS & PEDIATRICS	286, 440			l		2.00
3. 00 4. 00		INTENSIVE CARE UNIT SUBPROVIDER - IRF	5, 796 432, 762		_	0	0	3. 00 4. 00
5.00		OPERATING ROOM	1, 613, 920				0	5. 00
6. 00		ANESTHESI OLOGY	57, 691	2, 885			0	6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	45, 229				Ö	7. 00
8. 00		RADI OLOGY-THERAPEUTI C	77, 126		_		o o	8. 00
9. 00		CARDIAC CATHETERIZATION	46, 571	2, 329		Ö	o	9. 00
10.00		LABORATORY-PATHOLOGI CAL	215, 416		0	0	О	10.00
11.00	65. 00	RESPI RATORY THERAPY	19, 828	991	0	0	0	11.00
12.00		PHYSI CAL THERAPY	25, 624		0	0	0	12.00
13. 00		ELECTROCARDI OLOGY	67, 822			0		13. 00
14.00		ELECTROENCEPHALOGRAPHY	8, 745			0	0	14. 00
15. 00		CARDI AC REHABI LI TATI ON	2, 339	1		0	0	15.00
16.00		NEUROPSYCH	0	0	_	0	0	16.00
17. 00 18. 00	•	WOUND CENTER HYPERBARIC OXYGEN THERAPY	16, 473 1, 118			0	0	17. 00 18. 00
19. 00		EMERGENCY	1, 898, 213				0	19. 00
20. 00	•	AMBULANCE SERVICES	11, 795			ĺ		20. 00
200.00	70.00		5, 002, 820					200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1.00		ADMINISTRATI VE & GENERAL	15.00			5, 376, 725		1. 00
2.00		ADULTS & PEDIATRICS	0			1, 161, 912	1	2. 00
3.00		INTENSIVE CARE UNIT	Ö			0	1	3. 00
4.00		SUBPROVIDER - IRF	0			0		4.00
5.00	50.00	OPERATING ROOM	0	1, 613, 920	986, 572	1, 079, 002		5.00
6.00	53. 00	ANESTHESI OLOGY	0	57, 691	2, 309	2, 309		6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	45, 229	4, 771	4, 771		7. 00
8.00		RADI OLOGY-THERAPEUTI C	0					8. 00
9. 00		CARDI AC CATHETERI ZATI ON	0					9. 00
10.00		LABORATORY-PATHOLOGI CAL	0			9, 584		10.00
11.00		RESPIRATORY THERAPY	0			9, 172	1	11.00
12.00		PHYSI CAL THERAPY	0 0			l	1	12.00
13. 00 14. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		•		25, 479	1	13. 00 14. 00
15. 00		CARDI AC REHABI LI TATI ON						15. 00
16. 00		NEUROPSYCH			1, 337	197, 077	1	16. 00
17. 00		WOUND CENTER		•	20, 327	20, 327	1	17. 00
18. 00		HYPERBARI C OXYGEN THERAPY	Ö	•		1, 432		18. 00
19. 00		EMERGENCY	0					19. 00
20. 00	95. 00	AMBULANCE SERVICES	0			1, 330		20. 00
200.00			0	5, 002, 820	1, 604, 689	8, 293, 984		200. 00

	n Financial Systems	COLUMBUS REGIO			In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2018	Worksheet B Part I	
				T	o 12/31/2018	Date/Time Pre 5/29/2019 8:4	pared: 9 pm
			CAPI TAL RE	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	·	for Cost			BENEFI TS		
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
		0	1.00	2.00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT	10, 113, 441	10, 113, 441	I			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	12, 278, 978		12, 278, 978			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	29, 433, 700	l e				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	35, 783, 384	1			47, 768, 638	1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	7, 057, 059 691, 985				13, 457, 736 715, 279	
9. 00	00900 HOUSEKEEPI NG	2, 793, 254	1	1	,	3, 621, 025	1
10.00		978, 781	108, 959			1, 362, 369	
11.00		1, 031, 104	1			1, 649, 372	
13. 00 14. 00	1	4, 726, 523 1, 061, 640	1			6, 250, 170 1, 262, 025	
15. 00	1	5, 032, 582				6, 447, 731	1
16. 00	1	1, 603, 627				2, 061, 018	
17.00	1	580, 282 0	1	75		787, 856	1
23. 00 23. 01	1 1	488, 388	1	2, 058	-	0 663, 653	1
23. 02	· · · · · · · · · · · · · · · · · · ·	391, 122	5, 210			533, 696	1
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1/ //0 407	4 0/0 470	047.740	4 000 544	00 045 050	
30. 00 31. 00		16, 663, 497 3, 274, 787	1, 062, 478 151, 842			22, 845, 259 4, 355, 678	
32. 00		3,274,707	1	0		4, 333, 070	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00		0	0	0	0	0	
40. 00 41. 00		1, 847, 226	153, 588	16, 650	535, 574	0 2, 553, 038	
42. 00		0	0	0	0	2, 333, 030	1
43.00		678, 413	8, 078	16, 226	244, 003	946, 720	43.00
44. 00		0	0	0	0	0	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	19, 946, 956	540, 640	1, 213, 177	267, 028	21, 967, 801	50.00
51.00		1, 278, 810	1			1, 354, 340	51.00
52.00		177 252	1	0	-	102.02(
53. 00 54. 00		177, 252 3, 160, 653	1			183, 026 3, 925, 006	
54. 01	1	1, 316, 251	46, 056			1, 562, 017	1
54. 02	1	553, 508	1			820, 543	1
54. 03 55. 00		1, 183, 220	ľ			1, 597, 121 4, 397, 269	
		3, 052, 763 1, 010, 175	l ·			1, 466, 765	
	1 1	437, 999	1			565, 508	1
59.00	1 1	2, 544, 945	1			3, 357, 469	1
60. 00 60. 01	1	7, 807, 163 800, 913	1			9, 586, 165 958, 522	
62. 00	1	624, 270				661, 088	
65.00	1	2, 282, 499	l			3, 036, 134	1
66. 00 67. 00	1	4, 369, 422 1, 237, 821	3, 145 3, 062			5, 786, 013 1, 607, 017	
68. 00		843, 135	1	20, 188		1, 136, 741	1
69. 00	1	698, 762	l .			1, 085, 766	
70.00	1	1, 029, 363		8, 623		1, 268, 199	
71. 00 72. 00		7, 754, 922 9, 159, 917	l .	0		7, 754, 922 9, 159, 917	1
73. 00		18, 891, 321				18, 891, 321	1
74.00	07400 RENAL DIALYSIS	776, 642	ł	60		776, 702	74.00
76. 00	1	0		0	-	0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	327, 866	21, 905	12, 168	77, 812	439, 751	76. 97
88. 00		0	O	0	0	0	88. 00
89. 00	1	0		0		0	
90.00	1 1	1, 236, 248	1			1, 785, 471	1
90. 01 90. 02	1 1	188, 279 110, 839	1	1		230, 491 147, 373	1
90. 03	09003 WOUND CENTER	1, 315, 015	O	1, 335	143, 094	1, 459, 444	90. 03
90.04	1 1	218, 795		93		244, 243	1
90. 05 90. 06	1 1	704, 422 257, 395	58, 955 12, 705			984, 219 365, 517	1
91. 00	1 1	7, 688, 604				10, 162, 157	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		<u> </u>	<u> </u>	<u> </u>	0	92.00

Health Financial Systems	COLUMBUS REGIO	NAI HOSDITAI		Inlie	u of Form CMS-	2552_10
COST ALLOCATION - GENERAL SERVICE COSTS	COLUMBOS REGIO	Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I	pared:
		CAPI TAL REI	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, 257, 877	111, 287	373, 64	7 1, 215, 704	4, 958, 515	
99. 10 09910 CORF	0	0		0	0	
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						100 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0		0		110. 00 111. 00
113.00 11300 INTEREST EXPENSE	U	U		U U	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	242, 753, 795	9, 988, 354	10, 734, 92	4 29, 495, 012	240, 963, 816	
NONREI MBURSABLE COST CENTERS	242, 755, 795	9, 900, 334	10, 734, 92	4 29, 493, 012	240, 903, 610]110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 073	34	4 0	10 417	190. 00
194. 00 07950 WELLNESS COMMUNITY	318, 909	0,070	8, 02			
194. 01 07951 BUI LDI NG RENTALS	191, 646	0	0,02	0 0	191, 646	
194. 02 07952 HOSPI CE	114, 744	0		0	114, 744	
194. 03 07953 OUTREACH CLINICS	0	0		o o		194. 03
194. 04 07954 SPEECH - HEARING AIDS	269, 667	0		o o	269, 667	
194. 05 07955 NONALLOWABLE MARKETING	1, 260, 493	0		0	1, 260, 493	
194. 06 07956 CRH FOUNDATION	30, 704		69	0 10, 914		194. 06
194. 07 07957 HEALTHY COMMUNITIES	166, 337			0 39, 626		
194. 08 07958 CRHP	152, 889				1, 766, 474	
194.09 07959 NEUROPSYCH PART B	0	7, 177	1, 40	3 0	8, 580	194. 09
200 00 Cross Foot Adjustments	1				l n	200 00

10, 113, 441

245, 259, 184

29, 615, 850

0 200. 00 0 201. 00 245, 259, 184 202. 00

12, 278, 978

200.00 201.00

202.00

Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

				1	0 12/31/2018	Date/lime Pre 5/29/2019 8:4	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	January 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	5.00	7. 00	8.00	9. 00	10.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T T		I			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	47, 768, 638					5. 00
7.00	00700 OPERATION OF PLANT	3, 255, 130	16, 712, 866				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	173, 010	44, 912				8. 00
9.00	00900 HOUSEKEEPI NG	875, 846	293, 460	1	.,	0 470 500	9. 00
10.00	01000 DI ETARY	329, 527	445, 946	1	,	2, 172, 532	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	398, 947 1, 511, 779	350, 507 552, 555	1	67, 068 12, 334	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	305, 256	431, 599	1	44, 712	0	14. 00
15. 00	01500 PHARMACY	1, 559, 564	268, 509	1	58, 588	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	498, 515	207, 151	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	190, 565	17, 126	0	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	160, 523	0	0	-	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	129, 089	21, 322	0	4, 625	0	23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 525, 785	4, 348, 480	309, 507	1, 861, 706	1, 664, 705	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 053, 543	621, 454	1		1, 664, 763	
32. 00	03200 CORONARY CARE UNIT	0	021, 434	37, 137	77, 703	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	o	0	0	
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	617, 524	628, 600	36, 047	292, 169	238, 614	
42.00	04200 SUBPROVI DER	0	0	0 (01	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	228, 991	33, 060	9, 631 0	1, 542	0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	l o	0	0	U	0	44.00
50. 00	05000 OPERATI NG ROOM	5, 313, 528	2, 212, 716	231, 538	706, 138	6, 626	50.00
51. 00	05100 RECOVERY ROOM	327, 585	180, 613		60, 130	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	44, 270	6, 748	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	949, 373	485, 697			2, 399	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	377, 818	188, 495	1	82, 486	0	54. 01
54. 02	05404 ULTRA SOUND 05405 MAMMOGRAPHY	198, 471	85, 288	1	23, 127	0	54. 02
54. 03 55. 00	05500 RADI OLOGY-THERAPEUTI C	386, 308 1, 063, 603	15, 481 456, 096			9, 475	54. 03 55. 00
57. 00	05700 CT SCAN	354, 778	101, 960			0,473	57.00
58. 00	05800 MRI	136, 784	51, 036	1			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	812, 098	606, 257	1		6, 215	
60.00	06000 LABORATORY	2, 318, 682	616, 634	0	67, 839	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	231, 845	68, 729	1	-,	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	159, 903	29, 715	1	2, 313	0	62.00
65. 00	06500 RESPI RATORY THERAPY	734, 374	375, 629	1	124, 885	0	65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 399, 509 388, 702	12, 873 12, 532			0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	274, 953	12, 332	4, 0,4	0	0	07.00
69. 00	06900 ELECTROCARDI OLOGY	262, 623	79, 277	Ö	21, 585	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	306, 749	0	2, 039		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 875, 745	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 215, 582	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 569, 395	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	187, 867	0	0	0	0	74.00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	106, 366	89, 654		3, 084	0	76. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	100, 300	07, 004		3, 064	0	70. 77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	431, 866	438, 290	37, 647	70, 151	34, 230	90. 00
90. 01	09001 DI ABETES CENTER	55, 751	43, 948	1	1, 542	0	90. 01
90. 02	09002 NEUROPSYCH	35, 646	5, 954	1	0	0	90. 02
90. 03	09003 WOUND CENTER	353, 007	0	2, 818		0	90. 03
90. 04 90. 05	09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLI NI C	59, 077 238, 061	241, 289	180 4, 790		0	90. 04 90. 05
90.05	09006 MEDICATION MGMT CLINIC	88, 411	52, 001		21, 585	0	90.05
91.00	09100 EMERGENCY	2, 458, 002	1, 023, 849		409, 344	14, 710	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_, .55, 562	., 525, 517		.57,511	,	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>]
	09500 AMBULANCE SERVI CES	1, 199, 356	455, 472	57, 977	0	0	
	09910 CORF	0	0	0	0	0	
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

					5/29/2019 8: 49 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7.00	8. 00	9. 00	10.00
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)	46, 729, 682	16, 200, 914	933, 201	4, 751, 786	<u>2, 172, 532</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 520	41, 226	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	96, 080	0	0	0	0 194. 00
194.01 07951 BUILDING RENTALS	46, 355	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	27, 754	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	65, 227	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	304, 886	0	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	12, 965	46, 216	0	36, 232	0 194. 06
194.07 07957 HEALTHY COMMUNITIES	53, 823	67, 765	0	2, 313	0 194. 07
194. 08 07958 CRHP	427, 271	327, 371	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	2, 075	29, 374	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)	47, 768, 638	16, 712, 866	933, 201	4, 790, 331	2, 172, 532 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Tim

			10	12/31/2018	Date/lime Pre 5/29/2019 8:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<i>y</i> 1 1 1 1 1 1 1 1 1 1
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A	2, 465, 894					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	93, 786	8, 420, 624				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	27, 450	0	2, 071, 042			14. 00
15. 00 01500 PHARMACY	77, 774	548, 528	0	8, 960, 694		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	80, 061	0	0	0	2, 846, 745	16. 00
17. 00 01700 SOCIAL SERVICE	18, 300	0	0	0	0	17. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	14 013	0	0	0	0	23. 00
23. 01 02301 XRAY EDUCATION 23. 02 02302 PHARMACY RESIDENCY PROG	16, 012 9, 150	66, 232	0	0	0	23. 01 23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7, 130	00, 232	0	<u> </u>	0	23.02
30. 00 03000 ADULTS & PEDIATRICS	551, 286	3, 909, 449	79, 269	9, 476	542, 554	30. 00
31.00 03100 INTENSIVE CARE UNIT	73, 199	513, 271	3, 418	2, 490	33, 256	31. 00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER - 1 RF	54, 899	382, 511	0	364	53, 780	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	20, 587	152, 170	0	1	0	42. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	20, 307	132, 170	0	0	0	44. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	٥,	<u> </u>	<u> </u>		
50. 00 05000 OPERATING ROOM	265, 347	0	1, 862, 125	34, 642	1, 096, 321	50. 00
51.00 05100 RECOVERY ROOM	29, 737	0	0	286	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	44, 953	7, 031	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	48, 037	0	3, 166	2, 485	0	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	11, 437	0	0	103, 311	0	54. 01
54. 02 05404 ULTRA SOUND 54. 03 05405 MAMMOGRAPHY	13, 725 25, 162	0	2, 774	241 361	0	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	29, 737	0	2, 774	30	74, 494	55. 00
57. 00 05700 CT SCAN	20, 587	o	0	9, 376	0	57. 00
58. 00 05800 MRI	9, 150	O	0	557	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	48, 037	0	16, 672	3, 580	18, 814	59. 00
60. 00 06000 LABORATORY	185, 285	0	0	9, 474	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	11, 437	0	0	0	173, 693	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 287	200.450	2 727	11 047	104 530	62. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	54, 899 114, 374	389, 450	3, 727 36, 790	11, 847 1, 124	104, 520 0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	32, 025	0	30, 770	1, 124	18, 243	
68. 00 06800 SPEECH PATHOLOGY	20, 587	ő	0	Ö	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	18, 300	0	0	3, 998	276, 693	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	20, 587	0	0	2	170, 083	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	682, 133	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 997, 091	0	73. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 ACUPUNCTURE	0	0	0	7, 435	0	74. 00 76. 00
76. 00 03020 ACOPONCTORE 76. 97 07697 CARDIAC REHABILITATION	6, 862	0	0	0	0	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	0, 802	U U	U U		0	70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	o	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	41, 174	0	9, 611	57	277, 263	90.00
90. 01 09001 DI ABETES CENTER	4, 575	0	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	2, 287	0	0	0	0	90. 02
90. 03 09003 WOUND CENTER	16, 012	0	46, 597	4, 999	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY 90. 05 09005 VI MCARE CLI NI C	2, 287 25, 162	170 070	84	10 490	0	90. 04 90. 05
90. 06 09006 MEDICATION MGMT CLINIC	6, 862	178, 878 42, 274	6, 809	10, 480	0	90.05
91. 00 09100 EMERGENCY	203, 585	1, 135, 789	0, 009 N	15, 358	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	200, 000	., 155, 767	J	15, 550		92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	155, 548	1, 102, 072	0	4, 044	0	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

			10	12/31/2018	5/29/2019 8: 4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 447, 595	8, 420, 624	2, 071, 042	8, 960, 195	2, 846, 745	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	9, 150	0	0	0		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0		194. 01
194. 02 07952 HOSPI CE	0	0	0	499		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 05
194.06 07956 CRH FOUNDATION	2, 287		0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES	4, 575	0	0	0		194. 07
194. 08 07958 CRHP	0	0	0	0		194. 08
194. 09 07959 NEUROPSYCH PART B	2, 287	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 465, 894	8, 420, 624	2, 071, 042	8, 960, 694	2, 846, 745	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:49 pm

	Cost Center Description	SOCIAL SERVICE	PARAMED ED	XRAY EDUCATION	PHARMACY	5/29/2019 8: 4 Subtotal	
	·	17. 00	PRGM 23. 00	23. 01	RESI DENCY PROG 23. 02	24. 00	
	GENERAL SERVICE COST CENTERS	17.00	23.00	23.01	23.02	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5. 00 7. 00	00700 OPERATION OF PLANT						5. 00 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 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	1, 013, 847					17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
23. 01	02301 XRAY EDUCATION	0		840, 188	7/4 114		23. 01
23. 02	02302 PHARMACY RESI DENCY PROG I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0			764, 114		23. 02
30. 00	03000 ADULTS & PEDIATRICS	313, 617	0	0	ol	41, 961, 093	30.00
31. 00	03100 INTENSIVE CARE UNIT	89, 219	0	0	o	7, 076, 128	31.00
	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34.00
40. 00 41. 00	04100 SUBPROVIDER - TPF	0 216, 287	0	0	0	0 5, 073, 833	40. 00 41. 00
42. 00	04200 SUBPROVI DER	210, 207	0	0	o	0, 073, 033	42.00
43. 00	04300 NURSERY	O	0	Ö	Ö	1, 392, 702	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS			1 0	ما	00 (0/ 700	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0	33, 696, 782 1, 991, 762	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	1, 991, 702	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	Ö	286, 028	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	840, 188	0	6, 443, 997	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	2, 325, 564	1
54. 02	05404 ULTRA SOUND	0	0	0	0	1, 141, 395	54. 02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	31, 091	0	0	0	2, 082, 353 6, 143, 903	54. 03 55. 00
57. 00	05700 CT SCAN	31,091	0	0	0	1, 967, 342	57.00
58. 00	05800 MRI	0	0	o o	o	770, 744	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	o	5, 023, 934	59. 00
60.00	06000 LABORATORY	0	0	0	0	12, 784, 079	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	0	0	1, 448, 080	60. 01
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	0	0	0	0	855, 306 4, 835, 465	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	7, 377, 065	1
	06700 OCCUPATI ONAL THERAPY	o	0	ő	o	2, 063, 393	1
68.00	06800 SPEECH PATHOLOGY	0	0	0	o	1, 432, 281	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	1, 748, 242	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 891, 002	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10, 312, 800 11, 375, 499	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	764, 114	32, 221, 921	
	07400 RENAL DI ALYSI S	0	0	o o	0	972, 004	74. 00
	03020 ACUPUNCTURE	0	0	0	O	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	4, 055	0	0	0	649, 772	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS				ما	0	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00	09000 CLINIC	162, 216	0	0	o	3, 287, 976	90.00
90. 01	09001 DI ABETES CENTER	0	0	o	o	336, 307	90. 01
90. 02	09002 NEUROPSYCH	0	0	0	0	191, 260	90. 02
90. 03	09003 WOUND CENTER	0	0	0	0	1, 882, 877	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	0	0	305, 787	•
90. 05	09005 VIMCARE CLINIC	0	0	0	0	1, 870, 290	90.05
90. 06 91. 00	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY	197, 362	0		O O	583, 459 15, 620, 156	90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	177, 302	0		\circ	13, 020, 130	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	7, 932, 984	
	09910 CORF	0	0	•	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
-							

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To | 12/31/2018 | Date/Time | Prepared: |

				12/31/2016	5/29/2019 8: 49 pm
Cost Center Description	SOCIAL SERVICE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal
		PRGM		RESIDENCY PROG	
	17. 00	23. 00	23. 01	23. 02	24. 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)	1, 013, 847	0	840, 188	764, 114	<u>239, 355, 565</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	54, 163 190. 00
194. 00 07950 WELLNESS COMMUNITY	0	0	0	0	502, 457 194. 00
194. 01 07951 BUILDING RENTALS	0	0	0	0	238, 001 194. 01
194. 02 07952 HOSPI CE	0	0	0	0	142, 997 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	334, 894 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	1, 565, 379 194. 05
194. 06 07956 CRH FOUNDATION	0	0	0	0	151, 300 194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	350, 996 194. 07
194. 08 07958 CRHP	0	0	0	0	2, 521, 116 194. 08
194.09 07959 NEUROPSYCH PART B	0	0	0	0	42, 316 194. 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)	1, 013, 847	0	840, 188	764, 114	245, 259, 184 202. 00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0112

			To 12/31/2018 Date/Time Pre	
Cost Center Description	Intern &	Total	5/29/2019 8: 4	19 pili
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4. 00 O0400 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 9.00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11. 00
13.00 O1300 NURSING ADMINISTRATION				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY				14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY				16.00
17. 00 01700 SOCIAL SERVICE				17. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01 02301 XRAY EDUCATION				23. 01
23. 02 02302 PHARMACY RESIDENCY PROG I NPATI ENT ROUTI NE SERVI CE COST CENTERS				23. 02
30. 00 03000 ADULTS & PEDIATRICS	0	41, 961, 093		30.00
31.00 03100 INTENSIVE CARE UNIT	0	7, 076, 128		31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	o		40.00
41. 00 04100 SUBPROVI DER - I RF	0	5, 073, 833		41. 00
42. 00 04200 SUBPROVI DER	0	0		42. 00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	1, 392, 702 0		43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>] 44.00
50. 00 05000 OPERATING ROOM	0	33, 696, 782		50. 00
51. 00 05100 RECOVERY ROOM	0	1, 991, 762		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0 286, 028		52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	6, 443, 997		54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 325, 564		54. 01
54. 02 05404 ULTRA SOUND	0	1, 141, 395		54. 02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	2, 082, 353 6, 143, 903		54. 03 55. 00
57. 00 05700 CT SCAN	0	1, 967, 342		57. 00
58. 00 05800 MRI	0	770, 744		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	5, 023, 934		59. 00
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL	0	12, 784, 079 1, 448, 080		60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	855, 306		62. 00
65. 00 06500 RESPIRATORY THERAPY	0	4, 835, 465		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	7, 377, 065		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	2, 063, 393		67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	1, 432, 281 1, 748, 242		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 891, 002		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 312, 800		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 375, 499 32, 221, 921		72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	0	972, 004		74.00
76. 00 03020 ACUPUNCTURE	0	0		76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	649, 772		76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		89. 00
90. 00 09000 CLI NI C	0	3, 287, 976		90.00
90. 01 09001 DI ABETES CENTER	0	336, 307		90. 01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	0	191, 260		90. 02 90. 03
90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARI C OXYGEN THERAPY		1, 882, 877 305, 787		90. 03
90. 05 09005 VI MCARE CLI NI C	o	1, 870, 290		90. 05
90.06 09006 MEDICATION MGMT CLINIC	0	583, 459		90. 06
91. 00 09100 EMERGENCY	0	15, 620, 156		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			92.00
95. 00 09500 AMBULANCE SERVICES	0	7, 932, 984		95. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0112	Peri od:	Worksheet B	

To 12/31/2018 Date/Time Pr	49 piii
Cost Center Description Intern & Total	
Resi dents Cost	
& Post	
Stepdown	
Adjustments 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 INTEREST EXPENSE	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 239, 355, 565	118. 00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 54, 163	190. 00
194. 00 07950 WELLNESS COMMUNITY 0 502, 457	194. 00
194. 01 07951 BUI LDI NG RENTALS 0 238, 001	194. 01
194. 02 07952 H0SPI CE 0 142, 997	194. 02
194. 03 07953 OUTREACH CLINICS 0 0	194. 03
194. 04 07954 SPEECH - HEARING AIDS 0 334, 894	194. 04
194. 05 07955 NONALLOWABLE MARKETING 0 1, 565, 379	194. 05
194. 06 07956 CRH FOUNDATION 0 151, 300	194. 06
194. 07 07957 HEALTHY COMMUNITIES 0 350, 996	194. 07
194. 08 07958 CRHP 0 2, 521, 116	194. 08
194. 09 07959 NEUROPSYCH PART B 0 42, 316	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) 0 245, 259, 184	202. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION STATISTICS	Provi der CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 8:49 pm

			5/29/2019 8:	49 pm
	Cost Center Description	Stati sti cs	Statistics Description	
		Code		
		1.00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQ FEET	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DEPR	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SAL	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQ FEET	7. 00
8.00	LAUNDRY & LINEN SERVICE	9	LDRY LBS	8. 00
9.00	HOUSEKEEPI NG	10	TIME SPT	9.00
10.00	DI ETARY	11	MEALS	10.00
11. 00	CAFETERI A	12	FTES	11. 00
13.00	NURSING ADMINISTRATION	13	NURS HRS	13.00
14.00	CENTRAL SERVI CES & SUPPLY	14	STER SUP	14. 00
15. 00	PHARMACY	15	DRG COST	15. 00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPT	16. 00
17. 00	SOCI AL SERVI CE	17	TIME SPT	17. 00
23.00	PARAMED ED PRGM-(SPECIFY)	18	PERCENT	23. 00
	•	•	•	

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0112

					To	12/31/2018	Date/Time Pre	
				CAPI TAL REI	_ATED COSTS		5/29/2019 8: 49	9 pm
		Coot Conton Decement on	Directly	DIDC 0 FLVT	MVDLE FOLLID	Subtotal	EMDL OVEE	
		Cost Center Description	Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2. 00	2A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	16, 302	176, 740	5, 410	198, 452	198, 452	4. 00
5.00		ADMINISTRATIVE & GENERAL	771, 662	892, 734		6, 780, 777	40, 046	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	126, 014	4, 960, 456 10, 974		5, 607, 308 10, 974	6, 161 83	7. 00 8. 00
9. 00	1	HOUSEKEEPI NG	4, 727	71, 702		148, 234	4, 585	9. 00
10.00	1	DI ETARY	773	108, 959		124, 635	1, 740	10. 00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0 11, 186	85, 641 135, 008	28, 902 55, 206	114, 543 201, 400	3, 375 8, 935	11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	399	105, 454		200, 749	0, 733	14. 00
15. 00	1	PHARMACY	6, 002	65, 606		271, 487	7, 704	15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 338 374	50, 614 4, 184		72, 202 4, 633	2, 590 1, 362	16. 00 17. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	1	9, 033	0	23. 00
23. 01		XRAY EDUCATION	11, 860			13, 918	1, 161	23. 01
23. 02		PHARMACY RESIDENCY PROG ENT ROUTINE SERVICE COST CENTERS	0	5, 210	0	5, 210	920	23. 02
30. 00		ADULTS & PEDIATRICS	344, 271	1, 062, 478	316, 743	1, 723, 492	32, 182	30. 00
31. 00		INTENSIVE CARE UNIT	18, 786		1	315, 566	5, 254	31. 00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0) 0		0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0		o	0	34. 00
40.00		SUBPROVI DER - I PF	O	0	0	o	0	40. 00
41. 00 42. 00		SUBPROVI DER - I RF SUBPROVI DER	64, 705	153, 588	16, 650	234, 943	3, 589 0	41. 00 42. 00
42.00		NURSERY	0	8, 078	16, 226	24, 304	1, 635	42.00
44. 00	04400	SKILLED NURSING FACILITY	0	0		0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	544, 999	540, 640	1, 213, 177	2, 298, 816	1, 789	50. 00
51. 00	1	RECOVERY ROOM	19	44, 130		75, 549	1, 789	51. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	O	0	52. 00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 4, 741	1, 649		5, 774	0	53. 00 54. 00
54. 00		NUCLEAR MEDICINE-DIAGNOSTIC	10, 708	118, 672 46, 056		225, 456 116, 013	3, 643 941	54. 00
54. 02	05404	ULTRA SOUND	0	20, 839	69, 680	90, 519	1, 183	54. 02
54. 03 55. 00		MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	143, 431	3, 783		295, 281	1, 756	
57. 00		CT SCAN	28, 404 43	111, 439 24, 912		1, 017, 525 224, 394	2, 381 1, 556	55. 00 57. 00
58. 00	05800	MRI	16	12, 470	7, 030	19, 516	724	58. 00
59.00	1	CARDI AC CATHETERI ZATI ON	397, 846	148, 129		616, 228	3, 981	59. 00
60. 00 60. 01		LABORATORY LABORATORY-PATHOLOGI CAL	28, 390 842	150, 664 16, 793		388, 551 31, 657	9, 508 850	
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	27	7, 260		10, 138	179	
65. 00		RESPIRATORY THERAPY	81, 476			275, 795	3, 748	
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	328, 634 119, 555	3, 145 3, 062		353, 494 127, 642	9, 326 2, 420	
68. 00	1	SPEECH PATHOLOGY	54, 053			74, 241	1, 832	
69.00	1	ELECTROCARDI OLOGY	4, 422	19, 370		173, 968	1, 457	69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	136, 747	0	8, 623 0	145, 370 0	1, 543 0	70. 00 71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	ō	0	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 76. 00		RENAL DI ALYSI S ACUPUNCTURE	0	0		60 0	0	74. 00 76. 00
76. 97		CARDI AC REHABI LI TATI ON	45			34, 118	521	76. 97
		TIENT SERVICE COST CENTERS				ام		
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88. 00 89. 00
90. 00		CLINIC	9	107, 089		143, 283	2, 720	
90. 01	1	DI ABETES CENTER	139			11, 606	206	90. 01
90. 02 90. 03	1	NEUROPSYCH WOUND CENTER	37 74, 004	1, 455 0		1, 776 75, 339	233 959	90. 02 90. 03
90. 04	1	HYPERBARI C OXYGEN THERAPY	124, 336	-	1	124, 429	170	
90. 05	1	VIMCARE CLINIC	5, 412	58, 955	1	70, 394	1, 439	90. 05
90. 06 91. 00		MEDICATION MGMT CLINIC EMERGENCY	297 11, 226	12, 705 250, 160	1	16, 741 620, 101	614 12, 495	90. 06 91. 00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	11,220	230, 100	330, 713	020, 101	12, 475	92. 00
					•	·		

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0112	Period: Worksheet B
		From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

				From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/29/2019 8:4	
		CAPI TAL REL	LATED 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		1.00	2.00	ZN	4.00	
95. 00 09500 AMBULANCE SERVICES	28, 976	111, 287	373, 64	513, 910	8, 146	95. 00
99. 10 09910 CORF	0	0	. (o	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	(0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 507, 233	9, 988, 354	10, 734, 92	24, 230, 511	197, 642	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 073	34			190. 00
194.00 07950 WELLNESS COMMUNITY	56, 215	0	8, 020			194. 00
194. 01 07951 BUI LDI NG RENTALS	55, 307	0	(55, 307		194. 01
194. 02 07952 HOSPI CE	0	0	(이		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0		194. 05
194.06 07956 CRH FOUNDATION	0	11, 292	690	11, 982	73	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	16, 557	(16, 557	266	194. 07
194. 08 07958 CRHP	450, 331	79, 988	1, 533, 59	2, 063, 916	0	194. 08
194. 09 07959 NEUROPSYCH PART B	0	7, 177	1, 403	8, 580	0	194. 09
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	(0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 069, 086	10, 113, 441	12, 278, 978	26, 461, 505	198, 452	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0112

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8:49 pm

				''	0 12/31/2010	5/29/2019 8: 4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	•					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	6, 820, 823					5. 00
7. 00	00700 OPERATION OF PLANT	464, 790	l e				7. 00
			1				
8.00	00800 LAUNDRY & LINEN SERVICE	24, 704	16, 334		004 (0)		8. 00
9.00	00900 HOUSEKEEPI NG	125, 059			384, 606	222 227	9.00
10.00	01000 DI ETARY	47, 052	162, 185		2, 785	338, 397	10.00
11. 00	01100 CAFETERI A	56, 964	127, 475		5, 385	0	11. 00
13.00	01300 NURSING ADMINISTRATION	215, 862	200, 957		990	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	43, 587	156, 967	' 0	3, 590	0	14.00
15.00	01500 PHARMACY	222, 685	97, 653	0	4, 704	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	71, 181	75, 338	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	27, 210	6, 228	0	0	0	17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	l		0	0	23. 00
23. 01	02301 XRAY EDUCATION	22, 921		0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	18, 432	7, 755	i .	371	0	23. 02
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	10, 102	7,700	'L	071		20.02
30. 00	03000 ADULTS & PEDIATRICS	789, 099	1, 581, 490	17, 278	149, 472	259, 297	30.00
31. 00	03100 I NTENSI VE CARE UNI T	150, 432			7, 860	30, 460	1
		150, 432	220,013	2,073	7,000		
32. 00	03200 CORONARY CARE UNIT				U	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0) O	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	C	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	88, 174	228, 614	2, 012	23, 458	37, 167	
42.00	04200 SUBPROVI DER	0	C	0	0	0	42. 00
43.00	04300 NURSERY	32, 697	12, 024	538	124	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	l c	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	<u>'</u>	•	•			
50.00	05000 OPERATING ROOM	758, 702	804, 737	12, 925	56, 694	1, 032	50.00
51.00	05100 RECOVERY ROOM	46, 775			4, 828	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1		., 525	0	52. 00
53. 00	05300 ANESTHESI OLOGY	6, 321	2, 454	_	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				9, 841	374	
		135, 558					
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	53, 947	68, 553		6, 623	0	
54. 02	05404 ULTRA SOUND	28, 339	1		1, 857	0	54. 02
54. 03	05405 MAMMOGRAPHY	55, 160				0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	151, 868	165, 876	581	5, 756	1, 476	55. 00
57.00	05700 CT SCAN	50, 658	37, 081	0	1, 114	0	57. 00
58.00	05800 MRI	19, 531	18, 561	0	619	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	115, 957	220, 488	2, 918	8, 232	968	59. 00
60.00	06000 LABORATORY	331, 077	224, 262	0	5, 447	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	33, 104	24, 996		309	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	22, 832			186	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	104, 859	l		10, 027	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	199, 832				0	
67. 00	06700 OCCUPATI ONAL THERAPY	55, 502				0	
	1 1		l	1	0		
68. 00	06800 SPEECH PATHOLOGY	39, 260		0	1 722	0	
69. 00	06900 ELECTROCARDI OLOGY	37, 499	l		.,	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	43, 800	l e	114	9, 903	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	267, 832		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	316, 356		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	652, 450	ŀ	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	26, 825	C	0	0	0	74. 00
76.00	03020 ACUPUNCTURE	0	C	0	0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	15, 188	32, 606	0	248	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l	0	0	0	89. 00
90.00	09000 CLI NI C	61, 665	159, 401	2, 102	5, 632	5, 332	
90. 01	09001 DI ABETES CENTER	7, 960	l		124	0	90. 01
90. 02	09002 NEUROPSYCH	5, 090	1		0	0	
90. 02	09003 WOUND CENTER	50, 405	l	157	٥	0	90. 03
90. 03			ł	10	0	0	
	09004 HYPERBARI C OXYGEN THERAPY	8, 435	ł		15 040		
90.05	09005 VI MCARE CLINI C	33, 992			15, 040	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	12, 624	l		1, 733	0	90.06
91.00	09100 EMERGENCY	350, 970	372, 361	0	32, 865	2, 291	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	171, 252	165, 650	3, 237	0	0	
	09910 CORF	0		0	0	0	
101.00	10100 HOME HEALTH AGENCY	0	C	0	0	0	101. 00
				•	·		

					5/29/2019 8: 4	9 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
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 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 672, 474	5, 892, 069	52, 095	381, 511	338, 397	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	360	14, 993	0	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	13, 719	0	0	0	0	194. 00
194.01 07951 BUILDING RENTALS	6, 619	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	3, 963	0	0	0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	9, 313	0	0	0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	43, 534	0	0	0	0	194. 05
194.06 07956 CRH FOUNDATION	1, 851	16, 808	0	2, 909	0	194. 06
194.07 07957 HEALTHY COMMUNITIES	7, 685	24, 645	0	186	0	194. 07
194. 08 07958 CRHP	61, 009	119, 061	0	0	0	194. 08
194. 09 07959 NEUROPSYCH PART B	296	10, 683	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, 820, 823	6, 078, 259	52, 095	384, 606	338, 397	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 8: 49 pm

		1				5/29/2019 8: 4	9 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	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	01000 DI ETARY	207 742					10.00
11.00	01100 CAFETERI A	307, 742					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	11, 704	l I	400 210			13. 00 14. 00
15. 00	01500 PHARMACY	3, 426 9, 706	l i	408, 319	655, 619		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	9, 992		0	000,019	231, 303	16. 00
17. 00	01700 SOCIAL SERVICE	2, 284		0	0	231, 303	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	2,204		0	0	Ö	23. 00
23. 01	02301 XRAY EDUCATION	1, 998	o	0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	1, 142	5, 033	0	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS		, , , , , ,	- 1			
30.00	03000 ADULTS & PEDI ATRI CS	68, 806	297, 063	15, 628	693	44, 083	30.00
31.00	03100 INTENSIVE CARE UNIT	9, 135	39, 001	674	182	2, 702	31.00
32.00	03200 CORONARY CARE UNIT	C	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	C	0	0	0	0	33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	C	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	C	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	6, 851	29, 065	0	27	4, 370	1
42. 00	04200 SUBPROVI DER	C	0	0	0	0	42. 00
43. 00	04300 NURSERY	2, 569		0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	C	0	0	0	0	44. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	00.445		2/7 420	0. 505	00.070	F0 00
50.00	05000 OPERATI NG ROOM	33, 115	1	367, 130	2, 535	89, 078	1
51.00	05100 RECOVERY ROOM	3, 711	0	0	21 0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	C	0	0	· ·	0 571	52. 00 53. 00
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	5, 995	1	624	3, 289 182	0	54.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 427		024	7, 559	0	54. 00
54. 01	05404 ULTRA SOUND	1, 713		0	18	0	54. 02
54. 02	05405 MAMMOGRAPHY	3, 140	1	547	26	Ö	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 711		0.17	20	6, 053	1
57. 00	05700 CT SCAN	2, 569	o	0	686	0	57. 00
58. 00	05800 MRI	1, 142	l ol	0	41	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 995	o	3, 287	262	1, 529	1
60.00	06000 LABORATORY	23, 123	0	0	693	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 427	o	0	0	14, 113	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	285	0	0	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	6, 851	29, 593	735	867	8, 492	65. 00
66.00	06600 PHYSI CAL THERAPY	14, 274	0	7, 253	82	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 997	l I	0	0	1, 482	
68. 00	06800 SPEECH PATHOLOGY	2, 569	l I	0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	2, 284		0	293	22, 482	69. 00
	07000 ELECTROENCEPHALOGRAPHY	2, 569	l .	0	0	13, 820	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	49, 909	0	71.00
72. 00	07200 NPL. DEV. CHARGED TO PATIENTS		0	0	U FOE 11E	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS			0	585, 115	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE		0	0	544 0	0	74. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON	856	١	0	0	0	76. 00
10. 71	OUTPATIENT SERVICE COST CENTERS	000	<u> </u>	<u> </u>		0	70.77
88. 00	08800 RURAL HEALTH CLINIC	C	ol	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89. 00
90.00	09000 CLI NI C	5, 139	-	1, 895	4	22, 528	1
90. 01	09001 DI ABETES CENTER	571	l ol	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	285	o	0	0	0	90. 02
90. 03	09003 WOUND CENTER	1, 998		9, 187	366	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	285	l i	0	0	0	90. 04
90. 05	09005 VI MCARE CLI NI C	3, 140	13, 592	17	767	0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	856	3, 212	1, 342	0	0	90. 06
91.00	09100 EMERGENCY	25, 407	86, 304	0	1, 124	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	19, 412	l	0	296	0	
	09910 CORF	C		0	0	0	
101.00	10100 HOME HEALTH AGENCY	<u>C</u>	0	0	0	0	101. 00

				127 017 2010	5/29/2019 8: 49 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11.00	13. 00	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 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)	305, 459	639, 848	408, 319	655, 583	231, 303 118. 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, 142	0	0	0	0 194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	0	0	0	36	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 194. 05
194.06 07956 CRH FOUNDATION	285	0	0	0	0 194. 06
194.07 07957 HEALTHY COMMUNITIES	571	0	0	0	0 194. 07
194. 08 07958 CRHP	0	0	0	0	0 194. 08
194.09 07959 NEUROPSYCH PART B	285	0	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)	307, 742	639, 848	408, 319	655, 619	231, 303 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0112

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/29/2019 8:49 pm Cost Center Description SOCIAL SERVICE PARAMED ED XRAY EDUCATION PHARMACY Subtotal **PRGM** RESI DENCY PROG 17.00 23.01 24.00 23.00 23.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 41,717 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) C 23.00 23.01 02301 XRAY EDUCATION 0 39, 998 23.01 02302 PHARMACY RESIDENCY PROG 23.02 0 38, 863 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 4, 991, 487 30.00 03000 ADULTS & PEDIATRICS 12.904 30.00 03100 INTENSIVE CARE UNIT 31.00 3,671 793, 025 31.00 32.00 03200 CORONARY CARE UNIT 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 04000 SUBPROVI DER - I PF 40.00 0 40.00 04100 SUBPROVI DER - I RF 8,900 667, 170 41.00 41.00 04200 SUBPROVI DER 42.00 0 Λ 42.00 43.00 04300 NURSERY 0 85, 454 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 4, 426, 553 50.00 198, 751 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 53 00 05300 ANESTHESI OLOGY 18 409 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 561, 948 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 255, 063 54.01 54.01 0 54.02 05404 ULTRA SOUND 154, 647 54.02 05405 MAMMOGRAPHY 0 54.03 365, 825 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 279 1, 356, 508 55.00 57.00 05700 CT SCAN 0 318, 058 57.00 0 58 00 05800 MRI 60.134 58 00 05900 CARDIAC CATHETERIZATION 59.00 979, 845 59.00 0 06000 LABORATORY 982, 661 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 000000000000 106, 456 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 44, 427 62 00 65.00 06500 RESPIRATORY THERAPY 577, 578 65.00 66.00 06600 PHYSI CAL THERAPY 590, 416 66.00 06700 OCCUPATIONAL THERAPY 195, 873 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 117, 902 68 00 69.00 06900 ELECTROCARDI OLOGY 268, 548 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 217, 119 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 317, 741 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 316, 356 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 237, 565 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 27, 429 74.00 03020 ACUPUNCTURE 0 76.00 0 76.00 76. 97 07697 CARDIAC REHABILITATION 167 83, 704 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 6,675 416, 376 90.00 90. 01 09001 DI ABETES CENTER 0 36, 450 90.01 09002 NEUROPSYCH 90.02 0 9, 549 90.02 90.03 09003 WOUND CENTER 0 138, 411 90.03 09004 HYPERBARIC OXYGEN THERAPY 0 90.04 133, 329 90.04 90.05 09005 VIMCARE CLINIC 0 226, 402 90.05 09006 MEDICATION MGMT CLINIC 90.06 0 56,034 90.06 91.00 09100 EMERGENCY 8, 121 1, 512, 039 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 965, 645 95.00 99. 10 09910 CORF 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 101.00

			''	0 12/31/2016	5/29/2019 8: 4	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal	
		PRGM		RESIDENCY PROG		
	17. 00	23.00	23. 01	23. 02	24. 00	
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					l	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	41, 717	0	0	0	23, 810, 887	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				25, 770	190. 00
194.00 07950 WELLNESS COMMUNITY	0				79, 567	194. 00
194. 01 07951 BUI LDI NG RENTALS	0				61, 926	1
194. 02 07952 HOSPI CE	0				3, 999	194. 02
194. 03 07953 OUTREACH CLINICS	0				0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0				9, 313	194. 04
194. 05 07955 NONALLOWABLE MARKETI NG	0				43, 534	194. 05
194.06 07956 CRH FOUNDATION	0				33, 908	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0				49, 910	194. 07
194. 08 07958 CRHP	0				2, 243, 986	194. 08
194.09 07959 NEUROPSYCH PART B	0				19, 844	194. 09
200.00 Cross Foot Adjustments		0	39, 998	38, 863	78, 861	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	41, 717	0	39, 998	38, 863	26, 461, 505	202. 00

			To 12/31/2018 Date/Time Pre 5/29/2019 8:4	
Cost Center Description	Intern &	Total	372772017 0.4) piii
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00 00200 CAP REL COSTS-BUDG & TTXT				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 & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY				14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY				15. 00 16. 00
17. 00 01700 SOCIAL SERVICE				17. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01 02301 XRAY EDUCATION				23. 01
23. 02 02302 PHARMACY RESI DENCY PROG				23. 02
30.00 O3000 ADULTS & PEDIATRICS	0	4, 991, 487		30.00
31. 00 03100 NTENSI VE CARE UNI T		793, 025		31.00
32.00 03200 CORONARY CARE UNIT	0	0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF	0	0		34. 00 40. 00
41. 00 04000 SUBPROVI DER - TPF 41. 00 04100 SUBPROVI DER - TRF		667, 170		41.00
42. 00 04200 SUBPROVI DER	o	0		42. 00
43. 00 04300 NURSERY	0	85, 454		43. 00
44. 00 O4400 SKILLED NURSING FACILITY	0	0		44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	4, 426, 553		50.00
51. 00 05100 RECOVERY ROOM	O	198, 751		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	О		52. 00
53. 00 05300 ANESTHESI OLOGY	0	18, 409		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	561, 948 255, 063		54. 00 54. 01
54. 02 05404 ULTRA SOUND		154, 647		54. 01
54. 03 05405 MAMMOGRAPHY	O	365, 825		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 356, 508		55. 00
57. 00 05700 CT SCAN	0	318, 058		57. 00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	60, 134 979, 845		58. 00 59. 00
60. 00 06000 LABORATORY		982, 661		60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	106, 456		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	44, 427		62. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	577, 578 590, 416		65.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	195, 873		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	Ö	117, 902		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	268, 548		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	217, 119		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS	0	317, 741 316, 356		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 237, 565		73. 00
74.00 07400 RENAL DIALYSIS	0	27, 429		74. 00
76. 00 03020 ACUPUNCTURE	0	0		76. 00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	83, 704		76. 97
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	o		89. 00
90. 00 09000 CLI NI C	0	416, 376		90. 00
90. 01 09001 DI ABETES CENTER	0	36, 450		90. 01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	0	9, 549 138, 411		90. 02 90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	133, 329		90.03
90. 05 09005 VI MCARE CLI NI C	0	226, 402		90. 05
90.06 09006 MEDICATION MGMT CLINIC	0	56, 034		90.06
91. 00 09100 EMERGENCY	0	1, 512, 039		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			92.00
95. 00 09500 AMBULANCE SERVICES	0	965, 645		95. 00
·			'	

Health Financial Systems	COLUMBUS REGIONA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0112	Peri od: From 01/01/2018	Worksheet B	pared:
Cost Center Description	Intern & Residents Cost & Post	Total				

			To 12/31/2018 Date/Time Pr 5/29/2019 8:	epared:
Cost Center Description	Intern &	Total	372772017 0.	77 piii
	Residents 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	23, 810, 887		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 770		190. 00
194.00 07950 WELLNESS COMMUNITY	0	79, 567		194. 00
194. 01 07951 BUILDING RENTALS	0	61, 926		194. 01
194. 02 07952 HOSPI CE	0	3, 999		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	9, 313		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	43, 534		194. 05
194. 06 07956 CRH FOUNDATION	0	33, 908		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	49, 910		194. 07
194. 08 07958 CRHP	0	2, 243, 986		194. 08
194.09 07959 NEUROPSYCH PART B	0	19, 844		194. 09
200.00 Cross Foot Adjustments	0	78, 861		200. 00
201.00 Negative Cost Centers	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	26, 461, 505		202. 00

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0112

						o 12/31/2018	Date/Time Prep 5/29/2019 8:49	
			CAPITAL REL	ATED COSTS			3/29/2019 8.4	7 DIII
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMINI STRATI VE	
		cost center bescription	(SQ FEET)	(DEPR)	BENEFITS	incconci i i a ti on	& GENERAL	
					DEPARTMENT (GROSS SAL)		(ACCUM. COST)	
			1.00	2. 00	4. 00	5A	5. 00	
4 00		AL SERVICE COST CENTERS	700 005		I			1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	729, 925	12, 687, 225				1. 00 2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12, 756	5, 590	81, 938, 753			4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	64, 432 358, 015	5, 286, 488 538, 155			197, 490, 546 13, 457, 736	5. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	792	0	34, 085		715, 279	8. 00
9.00	1	HOUSEKEEPI NG	5, 175	74, 192			3, 621, 025	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	7, 864 6, 181	15, 398 29, 863			1, 362, 369 1, 649, 372	10. 00 11. 00
13.00	1	NURSING ADMINISTRATION	9, 744	57, 041	3, 689, 235	0	6, 250, 170	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	7, 611 4, 735	98, 051 206, 525	1		1, 262, 025 6, 447, 731	14. 00 15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	3, 653	20, 923		0	2, 061, 018	16. 00
17. 00 23. 00		SOCIAL SERVICE PARAMED ED PRGM-(SPECIFY)	302 0	78 0			787, 856 0	
23. 00		XRAY EDUCATION	0	2, 126			663, 653	23. 00 23. 01
23. 02		PHARMACY RESIDENCY PROG	376	0	380, 047	0	533, 696	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	76, 683	327, 274	13, 287, 279	0	22, 845, 259	30. 00
31. 00	03100	INTENSIVE CARE UNIT	10, 959	149, 757			4, 355, 678	31.00
32.00		CORONARY CARE UNIT	0	0		0	0	32. 00 33. 00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	1	0	0	34. 00
40. 00	04000	SUBPROVI DER - I PF	O	0	· -	0	0	40. 00
41. 00 42. 00		SUBPROVI DER - I RF SUBPROVI DER	11, 085 0	17, 204 0	1, 481, 782	0	2, 553, 038 0	41. 00 42. 00
43. 00		NURSERY	583	16, 765	675, 088	_	946, 720	
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50.00		OPERATING ROOM	39, 020	1, 253, 513	738, 791	0	21, 967, 801	50. 00
51.00		RECOVERY ROOM	3, 185	32, 444			1, 354, 340	51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0 119	0 4, 262	· -	0	0 183, 026	52. 00 53. 00
54. 00	05400	RADI OLOGY-DI AGNOSTI C	8, 565	105, 436		0	3, 925, 006	
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	3, 324 1, 504	61, 219 71, 997		0	1, 562, 017 820, 543	54. 01 54. 02
54. 02		MAMMOGRAPHY	273	152, 990		0	1, 597, 121	
55. 00		RADI OLOGY-THERAPEUTI C	8, 043	906, 863		0	4, 397, 269	55. 00
57. 00 58. 00	05700	CT SCAN MRI	1, 798 900	206, 070 7, 264		0	1, 466, 765 565, 508	57. 00 58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	10, 691	72, 589		0	3, 357, 469	59. 00
60.00		LABORATORY LABORATORY-PATHOLOGI CAL	10, 874	216, 462		0	9, 586, 165 958, 522	
60. 01 62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	1, 212 524	14, 488 2, 946		0	661, 088	
65. 00	1	RESPI RATORY THERAPY	6, 624	105, 949		0	3, 036, 134	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	227 221	22, 437 5, 192			5, 786, 013 1, 607, 017	66. 00 67. 00
68. 00	06800	SPEECH PATHOLOGY	O	20, 859	756, 471	0	1, 136, 741	68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 398	155, 169 8, 910		0	1, 085, 766 1, 268, 199	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0, 410	030, 734	0	7, 754, 922	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	9, 159, 917	72. 00
73. 00 74. 00	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	62		0	18, 891, 321 776, 702	73. 00 74. 00
76. 00	03020	ACUPUNCTURE	o	0	0	0	0	76. 00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	1, 581	12, 573	215, 283	0	439, 751	76. 97
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	1 705 471	89. 00
90. 00 90. 01	1	CLI NI C DI ABETES CENTER	7, 729 775	37, 388 753	1		1, 785, 471 230, 491	90. 00 90. 01
90. 02	09002	NEUROPSYCH	105	293	96, 269		147, 373	90. 02
90. 03 90. 04	1	WOUND CENTER HYPERBARI C OXYGEN THERAPY	0	1, 379 96	1	0	1, 459, 444 244, 243	90. 03 90. 04
90. 04	1	VIMCARE CLINIC	4, 255	6, 227		0	984, 219	90.04
90. 06	09006	MEDICATION MGMT CLINIC	917	3, 863	253, 647	0	365, 517	90. 06
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	18, 055	370, 641	5, 159, 038	0	10, 162, 157	91. 00 92. 00
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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

COST ALLOCATION - STATISTICAL BASIS		Provi der CO	F	Period: From 01/01/2018	Worksheet B-1	
				o 12/31/2018	Date/Time Pre 5/29/2019 8:4	
	CAPITAL REL	ATED COSTS			372772017 0.4	y piii
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQ FEET)	(DEPR)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
			(GROSS SAL)			
	1. 00	2. 00	4. 00	5A	5. 00	
OTHER REIMBURSABLE COST CENTERS		201.070				
95. 00 09500 AMBULANCE SERVICES	8, 032	386, 070			4, 958, 515	
99. 10 09910 CORF	0	0	(,	0	1
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	U		0	0	101. 00
109. 00 10900 PANCREAS ACQUISITION	O	0				109. 00
110.00 11000 INTESTINAL ACQUISITION		0				1109.00
111. 00 11100 SLET ACQUISITION	0	0				111.00
113. 00 11300 NTEREST EXPENSE	٥	O		,	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	720, 897	11, 091, 834	81, 604, 429	-47, 768, 638	193, 195, 178	
NONREI MBURSABLE COST CENTERS	720,077	11,071,004	01,004,42	47,700,030	173, 173, 176	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	355	(0	10. 417	190. 00
194. 00 07950 WELLNESS COMMUNITY	0	8, 287	194, 494	0	397, 227	
194. 01 07951 BUILDING RENTALS	o	0	. (0	191, 646	
194. 02 07952 HOSPI CE	o	0	(0	114, 744	
194. 03 07953 OUTREACH CLINICS	o	0	(0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(0	269, 667	
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0	1, 260, 493	194. 05
194.06 07956 CRH FOUNDATION	815	713				194. 06
194. 07 07957 HEALTHY COMMUNITIES	1, 195	0	109, 634	0	222, 520	
194. 08 07958 CRHP	5, 773	1, 584, 586	(0	1, 766, 474	
194. 09 07959 NEUROPSYCH PART B	518	1, 450	(0	8, 580	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	40 440 444	40 070 070	00 /45 05/		47 7/0 /00	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	10, 113, 441	12, 278, 978)	47, 768, 638	
203.00 Unit cost multiplier (Wkst. B, Part I)	13. 855452	0. 967822	0. 361439		0. 241878	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)			198, 452	2	6, 820, 823	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 002422	2	0. 034537	205. 00
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)						

Provider CCN: 15-0112

				10	12/31/2010	Date/lime Pre 5/29/2019 8:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
		PLANT	LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
		(SQ FEET) 7.00	(LDRY LBS) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	294, 722					5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	792	1, 124, 758				8.00
9. 00	00900 HOUSEKEEPING	5, 175	0	6, 214			9. 00
10.00	01000 DI ETARY	7, 864	0	45	163, 941		10.00
11. 00	01100 CAFETERI A	6, 181	0	87	0	1, 078	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	9, 744	0	16	0	41	13. 00 14. 00
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	7, 611 4, 735	0	58 76	0	12 34	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 653	0	1	Ö	35	1
17. 00	01700 SOCIAL SERVICE	302	0	0	0	8	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01 23. 02	02301 XRAY EDUCATION	0 376	0	0	0	7	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG INPATIENT ROUTINE SERVICE COST CENTERS	370	0	0	U	4	23. 02
30. 00	03000 ADULTS & PEDI ATRI CS	76, 683	373, 038	2, 415	125, 620	241	30.00
31.00	03100 INTENSIVE CARE UNIT	10, 959	44, 762	127	14, 757	32	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33.00	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	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	11, 085	43, 446	379	18, 006	24	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	583	11, 608	2	0	9	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	39, 020	279, 066	916	500	116	50.00
51. 00	05100 RECOVERY ROOM	3, 185	47, 091	78	0	13	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	119	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 565	78, 432	159	181	21	54.00
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	3, 324 1, 504	0	107 30	0	5 6	54. 01 54. 02
54. 03	05405 MAMMOGRAPHY	273	7, 002		o	11	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 043	12, 553		715	13	1
57. 00	05700 CT SCAN	1, 798	0	18	0	9	57. 00
58. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	900	(2,001	10	0	4	58. 00 59. 00
59. 00 60. 00	06000 LABORATORY	10, 691 10, 874	62, 991 0	133 88	469	21 81	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	0	5	o	5	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	524	0	3	0	1	62. 00
65. 00	06500 RESPI RATORY THERAPY	6, 624	0	162	0	24	1
	06600 PHYSI CAL THERAPY	227	31, 798	0	0	50	
68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	221	5, 874 0] 0	0	14	67. 00 68. 00
	1 1	1, 398	0	28	o	8	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	2, 458		0	9	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 NPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	
76. 00	03020 ACUPUNCTURE	o o	0	l o	Ö	0	1
76. 97	07697 CARDI AC REHABILITATION	1, 581	0	4	0	3	
a -	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	7, 729	45, 375	91	2, 583	0 18	89. 00 90. 00
90. 01	09001 DI ABETES CENTER	775	0	2	2, 333	2	90. 01
	1 1	105	0	0	0	1	90. 02
90. 03	09003 WOUND CENTER	0	3, 396		O	7	90. 03
	09004 HYPERBARI C OXYGEN THERAPY	0	217		0	1	90.04
90. 05 90. 06	O9005 VIMCARE CLINIC O9006 MEDICATION MGMT CLINIC	4, 255 917	5, 773	243 28	0	11	90. 05 90. 06
91. 00	09100 EMERGENCY	18, 055	0	531	1, 110	89	ı
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
_	OTHER REIMBURSABLE COST CENTERS						ļ
	09500 AMBULANCE SERVICES	8, 032	69, 878	1	0	68	
	09910 CORF 10100 HOME HEALTH AGENCY	0	0	_	0	0	99. 10 101. 00
	1	<u> </u>		<u> </u>	<u> </u>		1.230

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 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:49 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 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 285, 694 1, 124, 758 163, 941 1, 070 118. 00 6, 164 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 727 0 194. 00 07950 WELLNESS COMMUNITY 0 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 0 194. 03 194. 03 07953 OUTREACH CLINICS 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 0 0 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 194. 05 194.06 07956 CRH FOUNDATION 1 194. 06 0 47 815 194. 07 07957 HEALTHY COMMUNITIES 2 194. 07 1, 195 C 3 194. 08 07958 CRHP 5,773 0 0 194. 08 194. 09 07959 NEUROPSYCH PART B o 194. 09 518 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 16, 712, 866 4, 790, 331 2, 172, 532 2, 465, 894 202. 00 933, 201 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 0.829690 770. 893305 13. 251914 2, 287. 471243 203. 00 56 707222 204.00 Cost to be allocated (per Wkst. B, 6,078,259 52,095 384,606 338, 397 307, 742 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 20. 623703 0.046317 61.893466 2.064139 285. 474954 205. 00 11) 206 00 NAHE adjustment amount to be allocated 206. 00

207. 00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

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

Cost Center Bescription					10	12/31/2010	Date/lime Pre 5/29/2019 8:4	
COLOR COLO		Cost Center Description	NURSI NG	CENTRAL				
Company Comp			ADMI NI STRATI ON		(DRG COST)		(TIME SDT)	
Chesant Standter COST LEMINES			(NURS HRS)				(TIME 3FT)	
1.00			13. 00	14. 00	15. 00	16. 00	17. 00	
2.00 00000 CAR PEL COSTS-MPRILE EQUIP 4.00 00000 PER PRIMER STOPPER PRIMER STOPPE	4 00							4 00
4.00 00000 DEPLOYEE BERKET TS DEPARTMENT		1						
5.00 000000 ADMINISTRATIVE & GENERAL		1 1						
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1						
8.00 0000000 MAINDRY ALT ILINEN SERVICE 9.00 10.00 015000 DETARRY 1.00 DETARRY								7. 00
10.00 101000 DIETARY		1 1					•	8. 00
11.00 01100 CAFETERIA 1.077.032 1.077.032 1.3.00 1.00 CAFETERIA 1.00 1.00 C	9.00	00900 HOUSEKEEPI NG						9. 00
13.00 1300 NURSING ADMINISTRATION 1,077,632 13.00		1 1						10.00
14.00 01400 CNITRAL SERVICES & SUPPLY 0 73.913 14.90 15.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.0								11. 00
15.00 101500 PHARMACY 70.198			1, 077, 632	70.040				
16.00 01-600 MEDICAL RECORDS & LIBRARY 0 0 0 0 14,990 17.00 17.00 01-700			70 100		21 002 000			
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 23 00 2300 02		1	70, 190	0	21, 003, 990	1/ 080		
23.00 02300 PARAMED ED PRICU-(SPECIFY) 0 0 0 0 0 0 23.00 23.01 02300 PARAMED RAY PEDICATION 8.476 0 0 0 0 0 23.00 23.01 02300 PARAMED RAY PEDICATION 8.476 0 0 0 0 0 0 23.00 23.02 PARAMED RAY PEDICATION 8.476 0 0 0 0 0 0 23.00 23.02 PARAMED RAY PEDICATION 8.476 0 0 0 0 0 0 0 0 0				0	0	14, 700	750	
23.01 0.303 NRAY FEMILATION 0 0 0 0 0 23.01				o	0	0		23. 00
Impart Int ROUTINE SERVICE COST CENTERS 500, 313 2, 829 23, 142 2, 855 232 30, 00 3100 AULTS & PETOL PATRICS 500, 313 2, 829 23, 142 2, 855 232 30, 00 3100 CORONARY CARE UNIT 0, 0 0 0 0 0 0 0 0 0 32, 33, 30 30, 00 3300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 34, 00 40, 00 40, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 01	1 1	o	0	0	0	0	23. 01
30.00	23. 02	02302 PHARMACY RESIDENCY PROG	8, 476	0	0	0	0	23. 02
31.00 03100 INTERSIVE CARE UNIT 65,686 122 6,082 175 66 31.00 32.00 32.00 03200 CORNAMY CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
32 00 0 3200 (COROMARY CARE UNIT		l l						
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00			1			175		
34.00 03400 SURRGIAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		1	0	0	0	0		
40.00 04000 SUBPROVIDER IPF		1 1	0	0	0	0	_	
1.00 0.1000 SUBPROVI DER				0	0	0	_	
42.00 04200 SUBPROVIDER 19,474 0 0 0 0 0 42.00		1 1	48, 952	Ö	889	283	_	
43.00 04300 NURSERY 19, 474 0 2 0 0 43.00		1 1	0	Ö	0	0		42. 00
MACILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 50.00 60.06 60.86 50.00 51.00 51.00 51.00 50.00 51.00 51.00 52.	43.00	1 1	19, 474	О	2	0	0	43.00
50.00	44.00		0	0	0	0	0	44. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0								
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00			1	66, 457		5, 769		
53.00 05300 ANESTHESI DLOGY 0 0 109, 786 37 0 53.00			0	0		0		
54. 00 05400 RADIO LOGY-DI AGNOSTIC 0 113 6, 068 0 0 54. 00		1 1	0	0	-	0 27	_	
54. 01		1 1		113	·	0	_	
54. 03 05404 ILTRA SOUND 0 0 589 0 0 54. 02 54. 03 05405 MAMMOGRAPHY 0 0 9 881 0 0 54. 02 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 74 392 23 55. 00 57. 00 05700 CT SCAN 0 0 0 0 22, 898 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 595 8, 744 99 0 59. 00 60. 00 05000 LABORATORY 0 0 0 23, 138 0 0 60. 00 60. 00 05000 LABORATORY PATHOLOGI CAL 0 0 0 0 914 0 60. 00 60. 01 05000 MINI EDODO & PACKED RD BLOOD CELL 0 0 0 0 0 914 0 60. 00 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 60. 00 05000 WIGUE BLOOD & PACKED RD BLOOD CELL 0 0 0 0 6		1 1				0		
55 00 05500 RADI OLOGY-THERAPEUTI C		1 1	o	O		0		54. 02
57.00 05700 CT SCAN 0 0 0 22,898 0 0 57.00 05800 MRI 0 0 0 1,361 0 0 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 595 8,744 99 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 23,138 0 0 60.00	54.03	05405 MAMMOGRAPHY	o	99	881	0	0	54. 03
S8.00 05900 NR 0 0 1, 361 0 0 58.00		1	0	0		392		55. 00
S9. 00 05900 CARDIAC CATHETERIZATION 0 595 8,744 99 0 59. 00		1	0	0		0	_	57. 00
60.00 06000 LABORATORY 0 0 0 23,138 0 0 60.00 060.01 06001 LABORATORY-PATHOLOGICAL 0 0 0 0 0 0 0 0 0			0	0	·	0	_	
60.01			0	595		99	_	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 65.00				0	23, 130 N	914		
65.00 06500 RESPIRATORY THERAPY 49,840 133 28,932 550 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,313 2,744 0 0 66.00 66.00 67.00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 0 0 0 0 0 0 0 0 0		1 1		Ö	0	0		
66.00 06600 PHYSI CAL THERAPY 0 1,313 2,744 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 9,764 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 1,665,920 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 19,530,667 0 0 72.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 18,158 0 0 74.00 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 89.00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 99.00 09900 EDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 90.01 09001 DI ABETES CENTER 0 0 0 0 0 90.02 09002 RUROPSYCH 0 0 0 0 0 90.03 09003 WUROPSYCH 0 0 0 0 0 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 90.05 09005 WINGARE CLINI C 22,892 3 25,595 0 0 90.00 90.06 09006 MEDICATION MGMT CLINI C 5,410 243 0 0 0 0 90.07 09000 DSSERVATI ON MGMT CLINI C 5,410 243 0 0 0 0 90.08 09500 AMBULANCE SERVI CES 141,038 0 9,877 0 95.00 95.00 09500 AMBULANCE SERVI CES 141,038 0 9,877 0 95.00 95.00 09500 AMBULANCE SERVI CES			49, 840	133	28, 932	550		65. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 9,764 1,456 0 69. 00 70. 00 70000 ELECTROENCEPHALGGRAPHY 0 0 0 4 895 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 19,530,667 0 0 72. 00 74. 00 07400 RENAL DI ALYSIS 0 0 18,158 0 0 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATION 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATION 0 0 0 0 0 89. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 89. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 90. 01 09000 CLINIC DIABETES CENTER 0 0 0 0 0 0 90. 01 09000 DI ABETES CENTER 0 0 0 0 0 0 90. 02 09002 NEUROPSYCH 0 0 0 0 0 0 90. 03 09003 WOUND CENTER 0 0 0 0 0 0 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 90. 05 09005 VI MCARE CLINIC 22,892 3 25,595 0 0 90. 05 90. 06 09006 MEDICALTION MGMT CLINIC 5,410 243 0 0 0 0 91. 00 09100 DEMERGENCY 145,353 0 37,508 0 146 91. 00 91. 00 09500 AMBULANCE SERVICES 141,038 0 9,877 0 95.00	66.00	06600 PHYSI CAL THERAPY	o	1, 313		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 9,764 1,456 0 69. 00 70. 00			0	0	0	96	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 4 895 0 70. 00 71. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 19, 530, 667 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0			0	0	0	0	_	
71. 00			0	0	9, 764			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 74. 0		1 1	0	0	1 445 020	895	-	
73. 00				0	1, 000, 920	0	_	
74. 00				0	19 530 667	0	_	
76. 00				o		0	_	74. 00
S8. 00 ORGANIC RURAL HEALTH CLINIC O O O O O O O O O	76.00	03020 ACUPUNCTURE	o	О		0	0	76. 00
88. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	O	0	0	0	3	76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 343 138 1,459 120 90. 00 90. 01 09001 DI ABETES CENTER 0 0 0 0 0 0 0 0 90. 01 90. 01 90. 02 09002 NEUROPSYCH 0 0 0 0 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 0 1,663 12,209 0 0 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 22,892 3 25,595 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 5,410 243 0 0 0 0 90. 06 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 9,877 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 141,038 0 9,877 0 0 95. 00 95. 00 0 0 0 0 0 0 0 0 0								
90. 00			0	0	0	0	_	88. 00
90. 01 09001 DI ABETES CENTER 0 0 0 0 0 0 0 0 0			0	0	120	1 450	_	
90. 02 09002 NEUROPSYCH 0 0 0 0 0 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 0 1,663 12,209 0 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 22,892 3 25,595 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 5,410 243 0 0 0 90. 06 91. 00 09100 EMERGENCY 145,353 0 37,508 0 146 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0)			0	343	138	1, 459		
90. 03 09003 WOUND CENTER 0 1,663 12,209 0 0 90.03 90.04 90.04 90.04 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0				٥	0	0	_	
90. 04 09004 HYPERBARI C 0XYGEN THERAPY		1 1		1, 663	12. 209	0		
90. 05 09005 VI MCARE CLINI C 22,892 3 25,595 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLINI C 5,410 243 0 0 0 90. 06 91. 00 09100 EMERGENCY 145,353 0 37,508 0 146 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 09500 AMBULANCE SERVI CES 141,038 0 9,877 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 141,038 0 9,877 0 0 95. 00 96. 05 09500 095				0	0	0	_	90. 04
91. 00 09100 EMERGENCY 145, 353 0 37, 508 0 146 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 095. 00 09500 AMBULANCE SERVI CES 141, 038 0 9, 877 0 0 95. 00 095. 00			22, 892	3	25, 595	0	_	90. 05
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 141, 038 0 9, 877 0 0 95. 00				243	0	0		90. 06
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 141,038 0 9,877 0 0 95.00			145, 353	0	37, 508	0	146	91.00
95. 00 09500 AMBULANCE SERVI CES 141, 038 0 9, 877 0 0 95. 00	92. 00							92. 00
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	77. 10	10.7.10 0010	<u>ı</u> <u> </u>	<u> </u>	U _I	O ₁	<u> </u>	, ,, 10

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0112	Peri od: Worksheet B-1
		From 01/01/2018
		To 12/31/2018 Date/Time Prepared

COST ALLOCATION - STATISTICAL BASIS		Provider CC		rom 01/01/2018	WOLKSHEEL D-1	
				o 12/31/2018		nared:
			'	0 12/31/2010	5/29/2019 8: 4	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(DRG COST)	RECORDS &		
		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	o	o	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	l ol	o	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE					I	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 077, 632	73, 913	21, 882, 780	14, 980	750	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	o	0	0	0	0	194. 00
194. 01 07951 BUI LDI NG RENTALS	o	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	o	0	1, 218	0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 05
194. 06 07956 CRH FOUNDATION	0	0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0		194. 07
194. 08 07958 CRHP	0	0	0	0		194. 08
194. 09 07959 NEUROPSYCH PART B	0	0	0	0		194. 09
200.00 Cross Foot Adjustments		-	_		1	200.00
201.00 Negative Cost Centers					I	201. 00
202.00 Cost to be allocated (per Wkst. B,	8, 420, 624	2, 071, 042	8, 960, 694	2, 846, 745		
Part I)	0, 120, 02 1	2/0/1/012	0,,00,0,	2,010,710	1,010,017	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 814007	28. 019996	0. 409463	190. 036382	1, 351. 796000	203. 00
204.00 Cost to be allocated (per Wkst. B,	639, 848	408, 319				
Part II)	0077010	100/01/	000,017	201,000	1, , , ,	20 11 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 593754	5. 524319	0. 029959	15. 440788	55. 622667	205 00
	0.070701	0.02.017	0.02,707	10. 110700	1	200.00
206.00 NAHE adjustment amount to be allocated					I	206. 00
(per Wkst. B-2)					I	
207.00 NAHE unit cost multiplier (Wkst. D,					I	207. 00
Parts III and IV)					I	
			1	,		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0112

Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

5/29/2019 8:49 pm Cost Center Description PARAMED ED XRAY EDUCATION PHARMACY PRGM RESIDENCY PROG (PERCENT) (PERCENT) (PERCENT) 23.00 23.01 23.02 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 02301 XRAY EDUCATION 23. 01 100 23.01 02302 PHARMACY RESIDENCY PROG 100 23 02 23 02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 С 03100 INTENSIVE CARE UNIT 31.00 000000 0 31.00 0 03200 CORONARY CARE UNIT 0 32 00 Ω 32 00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04000 SUBPROVI DER - I PF 0 40 00 0 40 00 04100 SUBPROVIDER - IRF 0 41.00 C 41.00 42.00 04200 SUBPROVI DER 0 42.00 0 0 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 Ω 0 53.00 05300 ANESTHESI OLOGY C 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 100 54.00 0 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC C 54.01 0 05404 ULTRA SOUND 54.02 C 54.02 0 54.03 05405 MAMMOGRAPHY 0 54.03 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05700 CT SCAN 0 57.00 57.00 0 05800 MRI 58.00 Ω 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 60.00 06001 LABORATORY-PATHOLOGI CAL 0 60.01 0 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 65.00 06500 RESPIRATORY THERAPY 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 100 73.00 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 0 76.00 03020 ACUPUNCTURE C 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0000000 89.00 0 90.00 09000 CLI NI C 0 90.00 0 90 01 09001 DI ABETES CENTER Ω 90 01 90.02 09002 NEUROPSYCH 0 90.02 09003 WOUND CENTER 0 0 90.03 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 0 90.04 09005 VIMCARE CLINIC 0 90.05 Ω 90.05 90.06 09006 MEDICATION MGMT CLINIC 0 0 90.06 09100 EMERGENCY 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 99. 10 09910 CORF 0 99.10

| Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				To		Date/Time Prepared: 5/29/2019 8:49 pm
Cost Center Descript	i on	PARAMED ED	KRAY EDUCATION	PHARMACY		37 2 77 20 17 0. 47 pili
·		PRGM		RESIDENCY PROG		
		(PERCENT)	(PERCENT)			
				(PERCENT)		
		23. 00	23. 01	23. 02		
101.00 10100 HOME HEALTH AGENCY		0	0	0		101. 00
SPECIAL PURPOSE COST CENTE						
109. 00 10900 PANCREAS ACQUISITION		0	0	0		109. 00
110.00 11000 I NTESTI NAL ACQUI SI TI	ON	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON		0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LI		0	100	100		118. 00
NONREI MBURSABLE COST CENTE		ء ا		1		100.00
190. 00 19000 GIFT, FLOWER, COFFEE	SHOP & CANTEEN	0	0	1		190. 00
194. 00 07950 WELLNESS COMMUNITY		0	0	0		194. 00
194. 01 07951 BUILDING RENTALS		0	0	0		194. 01
194. 02 07952 HOSPI CE		0	0	0		194. 02
194. 03 07953 OUTREACH CLINICS		0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AID		0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETI	NG	0	0	0		194. 05
194. 06 07956 CRH FOUNDATION		0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES		0	0	0		194. 07
194. 08 07958 CRHP		0	0	0		194. 08
194. 09 07959 NEUROPSYCH PART B		O	0	0		194. 09
200.00 Cross Foot Adjustmen						200. 00
201.00 Negative Cost Center			0.40, 400	7/4 444		201. 00
202.00 Cost to be allocated	(per wkst. B,	U	840, 188	764, 114		202. 00
Part I) 203.00 Unit cost multiplier	(Wkst B Bost I)	0. 000000	8, 401. 880000	7, 641. 140000		203. 00
204.00 Cost to be allocated		0. 000000	39, 998			204. 00
Part II)	(per wkst. b,	U	39, 990	30, 003		204.00
205.00 Unit cost multiplier	(Wkst R Part	0. 000000	399. 980000	388. 630000		205. 00
II)	(WKSt. B, Tart	0.000000	377. 700000	300.030000		203.00
206.00 NAHE adjustment amou	nt to be allocated	0	0	0		206. 00
(per Wkst. B-2)]	· ·]		[=====
207.00 NAHE unit cost multi	plier (Wkst. D,	0. 000000	0. 000000	0. 000000		207. 00
Parts III and IV)						
	· ·	·		•	•	•

Provider CCN: 15-0112

					1	0 12/31/2018	Date/IIme Pre 5/29/2019 8:4	
				Title	XVIII	Hospi tal	PPS	, p
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst. B,	Adj .		Di sal I owance		
			Part I, col.					
			26) 1.00	2.00	3.00	4. 00	5. 00	
	INPAT	IENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00		ADULTS & PEDIATRICS	41, 961, 093		41, 961, 093	O	41, 961, 093	30. 00
31.00	03100	INTENSIVE CARE UNIT	7, 076, 128		7, 076, 128		7, 076, 128	31.00
32. 00		CORONARY CARE UNIT	0		0	0	0	32. 00
33. 00		BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF	5, 073, 833		5, 073, 833	0	0 5, 073, 833	40. 00 41. 00
42.00	1	SUBPROVI DER	3,073,633		0,073,633		5, 073, 633	42.00
43. 00		NURSERY	1, 392, 702		1, 392, 702	١	1, 392, 702	43. 00
44. 00	1	SKILLED NURSING FACILITY	0		0	I	0	
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	33, 696, 782		33, 696, 782		34, 683, 354	
51.00		RECOVERY ROOM	1, 991, 762		1, 991, 762		1, 991, 762	
52. 00		DELIVERY ROOM & LABOR ROOM	0		20/ 020	0	0	52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	286, 028 6, 443, 997		286, 028 6, 443, 997		288, 337 6, 448, 768	53. 00 54. 00
54. 00		NUCLEAR MEDICINE-DIAGNOSTIC	2, 325, 564		2, 325, 564		2, 325, 564	
54. 02		ULTRA SOUND	1, 141, 395		1, 141, 395		1, 141, 395	
54. 03		MAMMOGRAPHY	2, 082, 353		2, 082, 353		2, 082, 353	
55.00	05500	RADI OLOGY-THERAPEUTI C	6, 143, 903		6, 143, 903	7, 249	6, 151, 152	55. 00
57. 00	1	CT SCAN	1, 967, 342		1, 967, 342	· · · · · · · · · · · · · · · · · · ·	1, 967, 342	
58. 00	05800		770, 744		770, 744		770, 744	
59.00	1	CARDI AC CATHETERI ZATI ON LABORATORY	5, 023, 934 12, 784, 079		5, 023, 934		5, 051, 282	
60. 00 60. 01	1	LABORATORY-PATHOLOGI CAL	1, 448, 080		12, 784, 079 1, 448, 080		12, 784, 079 1, 457, 664	60. 00 60. 01
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	855, 306		855, 306		855, 306	62. 00
65. 00		RESPI RATORY THERAPY	4, 835, 465	0	1	1	4, 844, 637	65. 00
66.00	06600	PHYSI CAL THERAPY	7, 377, 065	0	7, 377, 065	24, 376	7, 401, 441	66. 00
67. 00		OCCUPATIONAL THERAPY	2, 063, 393	0	_, -,	1	2, 063, 393	67. 00
68. 00	1	SPEECH PATHOLOGY	1, 432, 281	0	1, 432, 281	1	1, 432, 281	68. 00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 748, 242 1, 891, 002		1, 748, 242 1, 891, 002		1, 773, 721 1, 891, 002	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	10, 312, 800		10, 312, 800	1	10, 312, 800	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	11, 375, 499		11, 375, 499	1	11, 375, 499	
73.00		DRUGS CHARGED TO PATIENTS	32, 221, 921		32, 221, 921	o	32, 221, 921	73. 00
74.00		RENAL DIALYSIS	972, 004		972, 004	0	972, 004	74. 00
76. 00		ACUPUNCTURE	0		0	0	0	76. 00
76. 97		CARDI AC REHABI LI TATI ON	649, 772		649, 772	1, 359	651, 131	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0		0	ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
90.00	09000	CLINIC	3, 287, 976		3, 287, 976	O	3, 287, 976	90.00
90. 01		DI ABETES CENTER	336, 307		336, 307	0	336, 307	90. 01
90. 02	1	NEUROPSYCH	191, 260		191, 260		191, 260	
90. 03		WOUND CENTER	1, 882, 877		1, 882, 877	20, 327	1, 903, 204	
90.04		HYPERBARI C OXYGEN THERAPY VIMCARE CLINIC	305, 787		305, 787		307, 219	
90. 05 90. 06		MEDICATION MGMT CLINIC	1, 870, 290 583, 459		1, 870, 290 583, 459		1, 870, 290 583, 459	
91. 00	1	EMERGENCY	15, 620, 156		15, 620, 156	· · · · · · · · · · · · · · · · · · ·	15, 964, 688	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	4, 664, 016		4, 664, 016		4, 664, 016	
	OTHER	REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	7, 932, 984		7, 932, 984	1, 330	7, 934, 314	
	09910	l .	0		0		0	
101.00		HOME HEALTH AGENCY	0		0		0	101. 00
100 00		AL PURPOSE COST CENTERS PANCREAS ACQUISITION	0				0	109. 00
		INTESTINAL ACQUISITION	0					110.00
		I SLET ACQUI SI TI ON	O		0			111. 00
		INTEREST EXPENSE						113. 00
200.00		Subtotal (see instructions)	244, 019, 581	0			245, 485, 421	
201. 00 202. 00		Less Observation Beds	4, 664, 016 239, 355, 565	0	4, 664, 016		4, 664, 016 240, 821, 405	
202. UC	וי	Total (see instructions)	237, 300, 000	0	239, 355, 565	1, 465, 840	240, 021, 405	₁ 202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/79/2019	8:49 pm

					'	0 12/31/2016	5/29/2019 8: 4	
				Title	XVIII	Hospi tal	PPS	
				Charges		·		
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Rati o	I npati ent	
							Ratio	
			6.00	7. 00	8. 00	9. 00	10. 00	
00.00		ENT ROUTINE SERVICE COST CENTERS	(4.400.07/		/4 400 07/			00.00
30.00	1	ADULTS & PEDI ATRI CS	61, 122, 976		61, 122, 976			30.00
31.00		INTENSIVE CARE UNIT	13, 543, 265		13, 543, 265			31.00
32. 00		CORONARY CARE UNIT	0					32.00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0					33. 00 34. 00
40. 00	1	SUBPROVIDER - IPF	0					40. 00
41. 00		SUBPROVI DER - I RF	7, 090, 975		7, 090, 975			41. 00
42. 00		SUBPROVI DER	7,070,775		7,070,773			42. 00
43. 00		NURSERY	2, 570, 892		2, 570, 892			43. 00
44.00		SKILLED NURSING FACILITY	0		0			44.00
	ANCI L	LARY SERVICE COST CENTERS						1
50.00	05000	OPERATING ROOM	26, 627, 705	65, 406, 619	92, 034, 324	0. 366133	0. 000000	50.00
51.00	05100	RECOVERY ROOM	2, 340, 789	4, 294, 032	6, 634, 821	0. 300198	0. 000000	51.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0		0. 000000	
53.00		ANESTHESI OLOGY	4, 888, 112	7, 917, 558			0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	1, 384, 415	4, 261, 472			0. 000000	
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	1, 560, 174	9, 492, 550			0. 000000	1
54. 02		ULTRA SOUND	1, 310, 703	4, 741, 088			0.000000	1
54. 03		MAMMOGRAPHY	589	3, 912, 204			0.000000	1
55. 00 57. 00	1	RADI OLOGY-THERAPEUTI C	314, 166	18, 148, 836			0. 000000 0. 000000	
58.00	05800	CT SCAN	7, 377, 617 1, 723, 310	24, 422, 215 6, 861, 689			0. 000000	1
59.00		CARDI AC CATHETERI ZATI ON	16, 475, 230	13, 887, 706			0. 000000	
60.00		LABORATORY	15, 374, 217	35, 841, 248			0. 000000	1
60. 01		LABORATORY-PATHOLOGI CAL	626, 399	5, 144, 543			0. 000000	1
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	1, 474, 587	873, 109			0. 000000	1
65. 00	1	RESPI RATORY THERAPY	7, 327, 096	2, 841, 507			0. 000000	1
66.00	1	PHYSI CAL THERAPY	4, 561, 921	8, 570, 287			0.000000	1
67.00		OCCUPATI ONAL THERAPY	2, 952, 063	4, 597, 356			0. 000000	1
68.00	06800	SPEECH PATHOLOGY	1, 184, 964	826, 087	2, 011, 051	0. 712205	0. 000000	68. 00
69. 00		ELECTROCARDI OLOGY	7, 078, 710	11, 682, 553	18, 761, 263	0. 093184	0. 000000	69. 00
70.00		ELECTROENCEPHALOGRAPHY	160, 502	7, 188, 603			0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	11, 750, 993	9, 817, 556			0. 000000	1
72. 00		IMPL. DEV. CHARGED TO PATIENTS	10, 863, 460	8, 542, 025			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	29, 772, 187	56, 544, 563			0.000000	
74. 00		RENAL DI ALYSI S	2, 732, 688	0			0.000000	1
76. 00 76. 97		ACUPUNCTURE CARDI AC REHABI LI TATI ON	0 36, 648	0 1, 954, 404			0. 000000 0. 000000	
70. 77		TIENT SERVICE COST CENTERS	30, 040	1, 754, 404	1, 991, 032	0. 320340	0.00000	70. 97
88. 00		RURAL HEALTH CLINIC	0	0	0			88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	o o	0	•			89. 00
90.00		CLINIC	38, 043	5, 698, 839	5, 736, 882	0. 573129	0. 000000	1
90. 01	09001	DI ABETES CENTER	267	248, 266			0. 000000	90. 01
90. 02	09002	NEUROPSYCH	2, 790	222, 237	225, 027	0. 849942	0.000000	90. 02
90. 03	09003	WOUND CENTER	38, 814	6, 359, 948	6, 398, 762	0. 294256	0. 000000	90. 03
90. 04		HYPERBARIC OXYGEN THERAPY	8, 448	1, 009, 008	1, 017, 456	0. 300541	0. 000000	
90. 05		VIMCARE CLINIC	2, 051	820, 194			0. 000000	
90. 06		MEDICATION MGMT CLINIC	1, 899	829, 393			0. 000000	1
91.00		EMERGENCY	17, 114, 417	55, 742, 386			0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0	11, 497, 822	11, 497, 822	0. 405643	0. 000000	92. 00
05 00		REI MBURSABLE COST CENTERS		12 000 775	12 000 775	0.//0500	0.000000	05 00
95. 00 99. 10	09500	AMBULANCE SERVICES	0	12, 008, 775 0		0. 660599	0. 000000	95. 00 99. 10
	1	HOME HEALTH AGENCY	0	0				101.00
101.00		AL PURPOSE COST CENTERS	<u> </u>	0				101.00
109 00		PANCREAS ACQUISITION	0	0	0			109. 00
		INTESTINAL ACQUISITION	0	0				110. 00
	1	I SLET ACQUISITION		0				111. 00
		INTEREST EXPENSE]					113. 00
200.00		Subtotal (see instructions)	261, 434, 082	412, 206, 678	673, 640, 760			200. 00
201.00	1	Less Observation Beds						201. 00
202.00)	Total (see instructions)	261, 434, 082	412, 206, 678	673, 640, 760			202. 00

Health 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 01/01/2018 | To 12/31/2018 | Part I Date/Time Prepared: 5/29/2019 8:49 pm

				5/29/2019 8:49 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 NTENSI VE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE 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				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50. 00 05000 OPERATING ROOM	0. 376852			50.00
51.00 05100 RECOVERY ROOM	0. 300198			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 022516			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 142206			54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 210406			54. 01
54. 02 05404 ULTRA SOUND	0. 188604			54. 02
54. 03 05405 MAMMOGRAPHY	0. 532191			54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 333161			55. 00
57. 00 05700 CT SCAN	0. 061866			57. 00
58. 00 05800 MRI	0. 089778			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 166363			59. 00
60. 00 06000 LABORATORY	0. 249614			60. 00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 252587			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 364317			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 476431			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 563610			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 273318			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 712205			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 094542			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 257311			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 478141			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 586200			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 373299			73. 00
74. 00 07400 RENAL DIALYSIS	0. 355695			74. 00
76. 00 03020 ACUPUNCTURE	0. 000000			76. 00
76. 97 O7697 CARDI AC REHABILITATION	0. 327029			76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLI NI C	0. 573129			90.00
90. 01 09001 DI ABETES CENTER	1. 353168			90. 01
90. 02 09002 NEUROPSYCH	0. 849942			90. 02
90. 03 09003 WOUND CENTER	0. 297433			90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 301948			90. 04
90. 05 09005 VI MCARE CLI NI C	2. 274614			90.05
90. 06 09006 MEDICATION MGMT CLINIC	0. 701870			90.06
91. 00 09100 EMERGENCY	0. 219124			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 405643			92. 00
OTHER REIMBURSABLE COST CENTERS	0 ((0710			05.00
95. 00 09500 AMBULANCE SERVI CES	0. 660710			95. 00
99. 10 09910 CORF				99. 10
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				100.00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION				109. 00 110. 00
111.00 11100 TNTESTINAL ACQUISITION				111.00
111.00 11100 15LE1 ACQUISTITON 113.00 11300 1NTEREST EXPENSE				
				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds 202.00 Total (see instructions)				201. 00 202. 00
202.00 Total (366 HISTI UCTI 0113)	1			1202.00

Health Financial Systems	COLUMBUS REGIO	NAI HOSPITAI		In lie	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C	CN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part I	pared:
		Ti tl e	: XVIII	Hospi tal	PPS	•
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cos (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)	0.00	2)	4.00	F 00	
INDATION DOUTING CODYLOG COCT CONTEDC	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 11.00 INTENSIVE CARE UNIT 22.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	4, 991, 487 793, 025 0 0 0 667, 170 85, 454 0 6, 537, 136 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	4, 991, 44 793, 02 667, 1 85, 49	25 3, 212 0 0 0 0 0 0 0 0 0 0 70 3, 918 0 0 54 3, 197 0 0	163. 04 246. 89 0. 00 0. 00 0. 00 170. 28 0. 00 26. 73 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
LNDATI ENT. DOUTLING CEDI// OF COCT. OFNITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	12, 238 1, 165 0 0 0 0 2, 219 0 0 0 15, 622	287, 627 0 0 0 0 0 377, 851 0 0				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 15-0112		Worksheet D Part II Date/Time Prepared:

AFFORT	TOWNENT OF THEATTENT ANGILLARY SERVICE CAPITY	AL 00313	Frovider	F	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/29/2019 8:4	pared: 9 pm
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 + col .	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50.00	05000 OPERATING ROOM	4, 426, 553		•		570, 724	
51. 00	05100 RECOVERY ROOM	198, 751	6, 634, 821	0. 029956		33, 290	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	_			0	52. 00
53.00	05300 ANESTHESI OLOGY	18, 409				2, 961	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	561, 948		0. 099532		74, 991	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	255, 063		0. 023077		20, 742	
54. 02	05404 ULTRA SOUND	154, 647		0. 025554	1	16, 893	1
54. 03	05405 MAMMOGRAPHY	365, 825				11	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 356, 508				11, 463	
57. 00	05700 CT SCAN	318, 058				36, 645	
58. 00	05800 MRI	60, 134				6, 041	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	979, 845	30, 362, 936	0. 032271	6, 795, 311	219, 291	59. 00
60.00	06000 LABORATORY	982, 661	51, 215, 465	0. 019187	7, 121, 201	136, 634	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	106, 456	5, 770, 942	0. 018447	309, 263	5, 705	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 427	2, 347, 696	0. 018924	737, 810	13, 962	62.00
65.00	06500 RESPI RATORY THERAPY	577, 578	10, 168, 603	0. 056800	3, 949, 266	224, 318	65.00
66.00	06600 PHYSI CAL THERAPY	590, 416	13, 132, 208	0. 044959	1, 753, 571	78, 839	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	195, 873	7, 549, 419	0. 025945	824, 981	21, 404	67. 00
68. 00	06800 SPEECH PATHOLOGY	117, 902	2, 011, 051	0. 058627	162, 560	9, 530	68. 00
69.00	06900 ELECTROCARDI OLOGY	268, 548	18, 761, 263	0. 014314	3, 442, 998	49, 283	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	217, 119	7, 349, 105	0. 029544	92, 311	2, 727	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	317, 741	21, 568, 549	0. 014732	5, 867, 615	86, 442	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	316, 356	19, 405, 485	0. 016302	5, 729, 752	93, 406	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 237, 565				190, 433	
74.00	07400 RENAL DIALYSIS	27, 429	2, 732, 688	0. 010037		11, 071	74. 00
76.00	03020 ACUPUNCTURE	0		0. 000000		0	76. 00
	07697 CARDI AC REHABI LI TATI ON	83, 704	1, 991, 052	0. 042040	12, 916	543	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89. 00
90.00	09000 CLI NI C	416, 376	5, 736, 882			2, 263	90.00
90. 01	09001 DI ABETES CENTER	36, 450				0	1
90. 02	09002 NEUROPSYCH	9, 549	225, 027	0. 042435	1, 240	53	90. 02
90. 03	09003 WOUND CENTER	138, 411	6, 398, 762			642	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	133, 329				1, 107	90. 04
90. 05	09005 VI MCARE CLINI C	226, 402				128	1
90. 06	09006 MEDICATION MGMT CLINIC	56, 034				128	1
91. 00	09100 EMERGENCY	1, 512, 039	· ·			195, 367	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	554, 808				0	
,2.00	OTHER REIMBURSABLE COST CENTERS	551,000	11, 177, 022	0.010230	,		1 /2.00
95. 00	09500 AMBULANCE SERVICES						95. 00
200. 00	l I	16, 862, 914	577, 303, 877		82, 703, 683	2, 117, 037	
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1,,	1	1 22, 122, 000	=, , 007	1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co	CN: 15-0112 P	eri od:	Worksheet D	
			Į <u>F</u>	rom 01/01/2018	Part III	
			ļ	o 12/31/2018	Date/Time Pre 5/29/2019 8:4	parea:
		Ti +l o	xVIII	Hospi tal	PPS	э рш
Cost Center Description	Nursing School	Nursing School			All Other	
cost center bescription	Post-Stepdown	Nul Si lig School	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	171	1.00	271	2. 00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	0	0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T					0	31. 00
32. 00 03200 CORONARY CARE UNIT		1	-	_	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0	_	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		1		_	0	34.00
	1	1	1	_		
40. 00 04000 SUBPROVI DER - 1 PF	C		0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF		0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	C	0	0	0	0	42.00
43. 00 04300 NURSERY	C	1	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	C) 0	0	0		44. 00
200.00 Total (lines 30 through 199)	C	0	0	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	,	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	I					
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	30, 616		12, 238	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	3, 212		1, 165	31. 00
32. 00 03200 CORONARY CARE UNIT		0	0		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	0	0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	C	0	0	0.00	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	C	0	3, 918	0.00	2, 219	41.00
42. 00 04200 SUBPROVI DER	C	0	0	0.00	0	42.00
43. 00 04300 NURSERY		0	3, 197	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00 Total (lines 30 through 199)		0	40, 943		15, 622	200. 00
Cost Center Description	I npati ent	PSA Adj. All	·			
'	Program	Other Medical				
	Pass-Through	Education Cost				
	Cost (col. 7 x					
	col . 8)					
	9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	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						33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T						34.00
40. 00 04000 SUBPROVI DER - PF		1				40.00
41. 00 04100 SUBPROVI DER - 1 RF		1	1			41. 00
42. 00 04200 SUBPROVI DER		1	1			42.00
43. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			ł			42.00
44.00 04400 SKI LLED NURSING FACILITY						44. 00
		l .				1
200.00 Total (lines 30 through 199)	(C	0	Ί			200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				'	0 12/01/2010	5/29/2019 8: 4	9 pm
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0) (0	0	50.00
51.00	05100 RECOVERY ROOM	0	0) (0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0) (0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0) (0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	840, 188	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0) (0	0	54. 01
54. 02	05404 ULTRA SOUND	0	0) (0	0	54. 02
54. 03	05405 MAMMOGRAPHY	0	0) (0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0) (0	0	55. 00
57.00	05700 CT SCAN	0	0) (0	0	57. 00
58.00	05800 MRI	0	0) (0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0) (0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0) (0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) (0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0) (0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0) (0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0) (0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0) (0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0) (0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70.00
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) (0	764, 114	73. 00
74.00	07400 RENAL DIALYSIS	0	0) (0	0	74. 00
76.00	03020 ACUPUNCTURE	0	0) (0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0) (0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	O) (0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l c) (0	0	89. 00
90.00	09000 CLI NI C	0	0) (0	0	90.00
90. 01	09001 DI ABETES CENTER	0	l c) (0	0	90. 01
90. 02	09002 NEUROPSYCH	0	l c) (0	0	90. 02
90. 03	09003 WOUND CENTER	0	l c) (0	0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	l c) (0	0	90. 04
90.05	09005 VI MCARE CLI NI C	0	l c) (0	0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	0	l c) (0	0	90. 06
91.00	09100 EMERGENCY	0	l c) (0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		•		•		1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	o c) c	0	1, 604, 302	200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

				Т	o 12/31/2018	Date/Time Prep 5/29/2019 8:49	
			Title	xVIII	Hospi tal	PPS	9 рііі
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	`	Cost (sum of		(col . 5 ÷ col .	
		Ladouti oii ooot	4)	col s. 2, 3,	8)	7)	
			.,	and 4)			
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				•		
50.00	05000 OPERATING ROOM	0	0	C	92, 034, 324	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	l c	6, 634, 821	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	l c	0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	l c	12, 805, 670	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	840, 188	840, 188	5, 645, 887	0. 148814	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	C	11, 052, 724	0.000000	54. 01
54.02	05404 ULTRA SOUND	0	0	C	6, 051, 791	0.000000	54. 02
54.03	05405 MAMMOGRAPHY	0	0	l c	3, 912, 793	0.000000	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	18, 463, 002	0.000000	55. 00
57.00	05700 CT SCAN	0	0	C	31, 799, 832	0.000000	57. 00
58.00	05800 MRI	0	0	C	8, 584, 999	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	30, 362, 936	0.000000	59.00
60.00	06000 LABORATORY	0	0	C	51, 215, 465	0.000000	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	l c	5, 770, 942	0.000000	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	l c	2, 347, 696	0.000000	62. 00
65.00	06500 RESPI RATORY THERAPY	0	0	l c	10, 168, 603	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	l c	13, 132, 208	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	l c	7, 549, 419	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	C	2, 011, 051	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	18, 761, 263	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	7, 349, 105	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	21, 568, 549	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	19, 405, 485	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	764, 114	764, 114	86, 316, 750	0. 008852	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	2, 732, 688	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	0	C	0	0.000000	76.00
76. 97	07697 CARDIAC REHABILITATION	0	0	C	1, 991, 052	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	C	-,		
90. 01	09001 DI ABETES CENTER	0	0	C	2.0,000		
90. 02	09002 NEUROPSYCH	0	0	C	225, 027	0.000000	90. 02
90. 03	09003 WOUND CENTER	0	0	C	6, 398, 762	0.000000	90. 03
90. 04	09004 HYPERBARIC OXYGEN THERAPY	0	0	C	1, 017, 456	0.000000	90. 04
90. 05	09005 VIMCARE CLINIC	0	0	C	822, 245		
90. 06	09006 MEDICATION MGMT CLINIC	0	0	C	831, 292	0.000000	90. 06
91. 00	09100 EMERGENCY	0	0	C	72, 856, 803	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	11, 497, 822	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	1, 604, 302	1, 604, 302	577, 303, 877	1	200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu of Form C		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 8:49 pm	

THROUGH GGG15			T	12/31/2018	Date/Time Pre 5/29/2019 8:4	pared: 9 nm
		Title	XVIII	Hospi tal	PPS	, biii
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	11, 866, 100	0	19, 771, 338	0	50. 00
51. 00 05100 RECOVERY ROOM	0. 000000	1, 111, 290		958, 551	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 059, 106		2, 061, 339	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 148814	753, 439		1, 420, 329	211, 365	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	898, 804	0	3, 983, 971	0	54. 01
54. 02 05404 ULTRA SOUND	0. 000000	661, 069		1, 394, 123	0	54. 02
54. 03 05405 MAMMOGRAPHY	0. 000000	120		324, 083	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	156, 015	0	7, 781, 615	0	55. 00
57.00 05700 CT SCAN	0. 000000	3, 663, 808	0	6, 509, 469	0	57. 00
58. 00 05800 MRI	0. 000000	862, 353		2, 199, 772	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 795, 311	0	5, 174, 793	0	59. 00
60. 00 06000 LABORATORY	0. 000000	7, 121, 201	0	3, 840, 168	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	309, 263	0	1, 462, 751	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	737, 810	0	308, 249	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 949, 266	0	1, 016, 433	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 753, 571	0	94, 020	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	824, 981	0	55, 818	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	162, 560	0	175, 265	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 442, 998	0	3, 666, 701	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	92, 311	0	2, 172, 362	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 867, 615	0	3, 748, 157	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 729, 752	0	3, 514, 958	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 008852	13, 282, 644	117, 578	24, 515, 648	217, 013	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 102, 974	0	0	0	74. 00
76. 00 03020 ACUPUNCTURE	0. 000000	0	0	0	0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	12, 916	0	1, 043, 828	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	_	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	_	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	31, 183		2, 804, 426	0	90. 00
90. 01 09001 DI ABETES CENTER	0. 000000	0	0	6, 270	0	90. 01
90. 02 09002 NEUROPSYCH	0. 000000	1, 240	0	122, 503	0	90. 02
90. 03 09003 WOUND CENTER	0. 000000	29, 693	0	2, 759, 022	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	8, 448		316, 272	0	90. 04
90. 05 09005 VI MCARE CLI NI C	0. 000000	466	0	88, 756	0	90. 05
90.06 09006 MEDICATION MGMT CLINIC	0. 000000	1, 899		552, 563	0	90. 06
91. 00 09100 EMERGENCY	0. 000000	9, 413, 477	0	11, 109, 768	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	2, 102, 719	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES		00 700 :		447 05/	400	95. 00
200.00 Total (lines 50 through 199)		82, 703, 683	229, 700	117, 056, 040	428, 378	200.00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

THROUGH COSTS

THOUGH COSTS

THOUGH COSTS

THE COLUMBUS REGIONAL HOSPITAL

From 01/01/2018
To 12/31/2018

To 12/31/2018

The Columbus Regional Hospital

From 01/01/2018

					5/29/2019 8: 4	9 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj. Non	PSA Adj. All				
	Physi ci an	Other Medical				
	Anestheti st	Education Cost				
	Cost					
	21.00	24.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				54. 01
54. 02 05404 ULTRA SOUND	0	0				54. 02
54. 03 05405 MAMMOGRAPHY		0				54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C		l o				55. 00
57. 00 05700 CT SCAN		_				57. 00
58. 00 05800 MRI		_				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59. 00
60. 00 06000 LABORATORY		_				60.00
		0				
60. 01 06001 LABORATORY-PATHOLOGI CAL		1				60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 00 03020 ACUPUNCTURE	0	0				76.00
76. 97 07697 CARDIAC REHABILITATION	0	0				76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	1 0	0				90.00
90. 01 09001 DI ABETES CENTER	0	0				90. 01
90. 02 09002 NEUROPSYCH	0	0				90. 02
90. 03 09003 WOUND CENTER		0				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	1	l o				90. 04
90. 05 09005 VI MCARE CLI NI C		l o				90. 05
90. 06 09006 MEDICATION MGMT CLINIC		0				90. 06
91. 00 09100 MEDICATION MGMT CETNIC						91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						91.00
OTHER REIMBURSABLE COST CENTERS		·I U				72.00
95. 00 09500 AMBULANCE SERVICES		1				95. 00
	0	О				200. 00
200.00 Total (lines 50 through 199)	1	ıl U	I			200.00

From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/29/2019 8:49 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 366133 19, 771, 338 7, 238, 939 50.00 51.00 05100 RECOVERY ROOM 0.300198 958, 551 0 0 51.00 287, 755 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.022336 2,061,339 0 46,042 53.00 1, 621, 108 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1.141361 1, 420, 329 0 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 210406 3.983.971 0 0 838, 251 54 01 0 54.02 05404 ULTRA SOUND 0.188604 1, 394, 123 262, 937 54.02 54.03 05405 MAMMOGRAPHY 0.532191 324, 083 172, 474 54.03 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 332768 7, 781, 615 0 2, 589, 472 55.00 0 402, 715 05700 CT SCAN 6, 509, 469 57 00 0.061866 57 00 58.00 05800 MRI 0.089778 2, 199, 772 197, 491 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.165463 5, 174, 793 0 856, 237 59.00 0 0 0 06000 LABORATORY 0. 249614 3, 840, 168 0 958, 560 60.00 60.00 0 60.01 06001 LABORATORY - PATHOLOGICAL 0 250926 1, 462, 751 367, 042 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.364317 308, 249 0 112, 300 62.00 06500 RESPIRATORY THERAPY 0. 475529 0 65.00 1,016,433 483, 343 65.00 0 06600 PHYSI CAL THERAPY 94, 020 0 52, 816 66.00 0.561754 66, 00 0 06700 OCCUPATIONAL THERAPY 0.273318 67.00 55, 818 15, 256 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.712205 175, 265 0 124, 825 68.00 06900 ELECTROCARDI OLOGY 0 0 341, 678 69.00 0.093184 3, 666, 701 69.00 07000 ELECTROENCEPHALOGRAPHY 2, 172, 362 0 70.00 0.257311 0 558, 973 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1, 792, 148 71.00 0 478141 3, 748, 157 1, 048 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.586200 3, 514, 958 0 2,060,468 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0.373299 24, 515, 648 0 127, 175 9, 151, 667 73.00 07400 RENAL DIALYSIS 0 74.00 0.355695 74.00 C 0 0 0 76.00 03020 ACUPUNCTURE 0.000000 0 Λ 76.00 0. 326346 07697 CARDIAC REHABILITATION 1,043,828 340, 649 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 1, 607, 298 90.00 09000 CLI NI C 0.573129 2, 804, 426 0 0 90.00 09001 DI ABETES CENTER 0 0 90.01 1. 353168 6, 270 8, 484 90.01 90.02 09002 NEUROPSYCH 0.849942 122, 503 104, 120 90.02 90.03 09003 WOUND CENTER 0. 294256 2, 759, 022 0 0 0 0 811, 859 90.03 09004 HYPERBARI C OXYGEN THERAPY 0.300541 316, 272 0 95, 053 90.04 90.04 90.05 09005 VIMCARE CLINIC 2. 274614 88, 756 0 201, 886 90.05 90.06 09006 MEDICATION MGMT CLINIC 0.701870 552, 563 0 387, 827 90.06 91.00 09100 EMERGENCY 0. 214395 11, 109, 768 0 2, 381, 879 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 102, 719 0 92.00 92.00 0.405643 852, 953 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0.660599 0 95.00 0 200.00 Subtotal (see instructions) 117, 056, 040 128, 223 37, 324, 505 200.00 Less PBP Clinic Lab. Services-Program 0 201 00 201 00 Only Charges 202.00 Net Charges (line 200 - line 201) 117, 056, 040 0 128, 223 37, 324, 505 202. 00 Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0112 Period: From 01/01/2018 Part V

Date/Time Prepared: 12/31/2018 5/29/2019 8:49 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.01 05404 ULTRA SOUND 0 54.02 54.02 54.03 05405 MAMMOGRAPHY 0 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 05700 CT SCAN 0 57 00 57 00 58.00 05800 MRI 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 60.00 06001 LABORATORY-PATHOLOGI CAL 0 60.01 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 501 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C 07300 DRUGS CHARGED TO PATIENTS 73.00 47, 474 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 03020 ACUPUNCTURE 76.00 0 76.00 76. 97 76. 97 07697 CARDIAC REHABILITATION 0 OUTPATIENT SERVICE COST CENTERS 88.00 0 08800 RURAL HEALTH CLINIC 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 0 90.00 00000000 90.00 09001 DI ABETES CENTER 0 90.01 90.01 09002 NEUROPSYCH 0 90.02 90.02 90.03 09003 WOUND CENTER 0 90.03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 90.04 09005 VIMCARE CLINIC 90.05 0 90.05 90.06 09006 MEDICATION MGMT CLINIC 0 90.06 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 0 47, 975 200.00 Less PBP Clinic Lab. Services-Program 201.00 201 00

47, 975

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

	Financial Systems	COLUMBUS REGIO				eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0112	Peri od:	Worksheet D	
			Component	CCN: 15-T112	From 01/01/2018 To 12/31/2018		nared:
			Component	0011. 15 1112	10 12/31/2010	5/29/2019 8: 4	9 pm
			Titl∈	XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	4, 426, 553	92, 034, 324	0.04809	7 31, 555	1, 518	50.00
51. 00	05100 RECOVERY ROOM	198, 751					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1			
53. 00	05300 ANESTHESI OLOGY	18, 409	12, 805, 670	1			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	561, 948		1			1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	255, 063				0	54. 01
54. 02	05404 ULTRA SOUND	154, 647	6, 051, 791	0. 02555	0	0	54. 02
54. 03	05405 MAMMOGRAPHY	365, 825	3, 912, 793	0. 09349	05	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 356, 508	18, 463, 002	0. 07347	'2 0	0	55. 00
57.00	05700 CT SCAN	318, 058	31, 799, 832	0. 01000	51, 837	518	57.00
58.00	05800 MRI	60, 134	8, 584, 999	0.00700	38, 172	267	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	979, 845	30, 362, 936	0. 03227	27, 232	879	59. 00
60.00	06000 LABORATORY	982, 661	51, 215, 465	0. 01918	283, 517	5, 440	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	106, 456		1		61	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 427		1		117	62. 00
65. 00	06500 RESPI RATORY THERAPY	577, 578				2, 930	1
66.00	06600 PHYSI CAL THERAPY	590, 416		1	· ·		1
67. 00	06700 OCCUPATI ONAL THERAPY	195, 873		1	· ·		67. 00
68. 00	06800 SPEECH PATHOLOGY	117, 902					
69. 00	06900 ELECTROCARDI OLOGY	268, 548					
70.00	07000 ELECTROENCEPHALOGRAPHY	217, 119		1	· ·		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	317, 741			· ·	864	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	316, 356					1
74.00	07400 RENAL DIALYSIS	1, 237, 565 27, 429		1			
76. 00	03020 ACUPUNCTURE	27, 429		1	· ·	1, 130	
76. 97	07697 CARDI AC REHABI LI TATI ON	83, 704	1				
10. 71	OUTPATIENT SERVICE COST CENTERS	03,704	1, 991, 032	0.04204	.0 0	0	70. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0					
90.00	09000 CLINIC	416, 376	1				
90. 01	09001 DI ABETES CENTER	36, 450		1			
90. 02	09002 NEUROPSYCH	9, 549					90. 02
90. 03	09003 WOUND CENTER	138, 411		1		0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	133, 329				0	90. 04
90. 05	09005 VI MCARE CLI NI C	226, 402			6 0	0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	56, 034	831, 292	0. 06740	06	0	90. 06
91.00	09100 EMERGENCY	1, 512, 039	72, 856, 803	0. 02075	7, 317	152	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11, 497, 822	0.00000	00	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	16, 308, 106	577, 303, 877	1	3, 567, 735	116, 320	200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT . THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112 Component CCN: 15-T112	Peri od: From 01/01/2018 To 12/31/2018	
		Title XVIII	Subprovi der -	PPS

		Title	e XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	IRF I Allied Health	Allied Health	
cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Allieu nealth	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2/(2.00	571	0.00	
50. 00 05000 OPERATING ROOM	0	(0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0			0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0	840, 188	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			0	0	54. 01
54.02 05404 ULTRA SOUND	0			0	0	54. 02
54. 03 05405 MAMMOGRAPHY	0	(0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0	0	55. 00
57.00 05700 CT SCAN	0	(0	0	57.00
58. 00 05800 MRI	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0	0	59. 00
60. 00 06000 LABORATORY	0	(0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	(0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0			0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0			0	0	66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	(0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	(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 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(0	764, 114	73. 00
74. 00 07400 RENAL DI ALYSI S	0	(0	0	74.00
76. 00 03020 ACUPUNCTURE	0	,		0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	(0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0		1	0	1	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	1	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)	0	0	90.06
91. 00 09100 EMERGENCY	0	(0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						05.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)	0			0 0	1, 604, 302	95.00
200.00 Total (Tries 50 till ough 199)		1	1	o _l 0	1,004,302	1200.00

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEEL COSTS	RVICE OTHER PAS		CN: 15-0112 CCN: 15-T112	Period: From 01/01/2018 To 12/31/2018		pared:
			Title	XVIII	Subprovider -	PPS	у рііі
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
		4.00	5. 00	and 4) 6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	6.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 92, 034, 324	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 6, 634, 821	0.00000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0,034,021	0. 000000	
53.00	05300 ANESTHESI OLOGY	0			0 12, 805, 670	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		840, 18	,,	0. 148814	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			0 11, 052, 724	0. 000000	
54. 02	05404 ULTRA SOUND	0	Ö		0 6, 051, 791	0. 000000	
54. 03	05405 MAMMOGRAPHY	0			0 3, 912, 793	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	Ö	0		0 18, 463, 002	0. 000000	
57.00	05700 CT SCAN	0	0		0 31, 799, 832	0.000000	
58. 00	05800 MRI	0	0		0 8, 584, 999	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 30, 362, 936	0.000000	
60.00	06000 LABORATORY	0	0		0 51, 215, 465	0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0 5, 770, 942	0.000000	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 2, 347, 696	0.000000	62. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 10, 168, 603	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 13, 132, 208	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 7, 549, 419	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 2, 011, 051	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 18, 761, 263	0. 000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 7, 349, 105	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 21, 568, 549	0. 000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 19, 405, 485	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	764, 114	764, 11	4 86, 316, 750	0. 008852	
74.00	07400 RENAL DI ALYSI S	0			0 2, 732, 688	0. 000000	74. 00
76. 00	03020 ACUPUNCTURE	0			0	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 991, 052	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0			0	0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0. 000000	
90.00	09000 CLI NI C	0	1		0 5, 736, 882	0. 000000	
90. 01	09001 DI ABETES CENTER	0	0		0 248, 533	0.000000	
90. 02	09002 NEUROPSYCH	0	0		0 225, 027	0. 000000	
90. 03	09003 WOUND CENTER	0	0		0 6, 398, 762	0.000000	
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0 1, 017, 456	0.000000	
90.05	09005 VI MCARE CLI NI C	0	0		0 822, 245	0.000000	1
90.06	09006 MEDICATION MGMT CLINIC	0	0		0 831, 292	0.000000	
91.00	09100 EMERGENCY	0	-		0 72, 856, 803	0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 11, 497, 822	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES						95. 00
95.00							

APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	COLUMBUS REGION RVICE OTHER PASS	AL HOSPITAL Provider CO	CN: 15-0112	In Lie Period: From 01/01/2018	eu of Form CMS- Worksheet D Part IV	<u>2552-10</u>
THROUG	H COSTS		Component	CCN: 15-T112	To 12/31/2018	Date/Time Pre 5/29/2019 8:4	epared:
			Title	· XVIII	Subprovi der - I RF	PPS	p
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	40.00	x col . 10)	40.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11.00	12. 00	13. 00	
50. 00	05000 OPERATING ROOM	0. 000000	31, 555	I	0 0		50.00
51. 00	05100 RECOVERY ROOM	0. 000000	5, 662				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	5, 662	l .			
53. 00	05300 ANESTHESI OLOGY	0. 000000	8, 714		0 0		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 148814	22, 359		-		
54. 00	05400 NADI OLOGI - DI AGNOSTI C	0. 000000	22, 339	3, 3,	0 0		
54. 01	05404 ULTRA SOUND	0.000000	0		0 0		
54. 02	05405 MAMMOGRAPHY	0. 000000	0		0 0		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	ĺ	
57. 00	05700 CT SCAN	0. 000000	51, 837		0 0	ĺ	
58. 00	05800 MRI	0. 000000	38, 172	l .	0 0	ĺ	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	27, 232		0 0	ĺ	
60.00	06000 LABORATORY	0. 000000	283, 517		0 0	ĺ	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	3, 297		0 0	ĺ	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	6, 187		0 0	Ö	
65.00	06500 RESPI RATORY THERAPY	0. 000000	51, 592		0 0	l o	1
66.00	06600 PHYSI CAL THERAPY	0. 000000	906, 119	l .	0 0	l o	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	834, 989		0 0	l	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	487, 350		0 0	l c	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	30, 050		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 460		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	58, 631		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	769		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 008852	597, 768	5, 29	91 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	113, 158		0 0	0	74.00
76.00	03020 ACUPUNCTURE	0. 000000	0		0 0	0	76. 00
76. 97	07697 CARDI AC REHABILI TATI ON	0. 000000	0		0 0	C	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	l .	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	1	
90.00	09000 CLI NI C	0. 000000	0		0 0	0	
90. 01	09001 DI ABETES CENTER	0. 000000	0		0 0	0	
90. 02	09002 NEUROPSYCH	0. 000000	0		0 0	0	
90. 03	09003 WOUND CENTER	0. 000000	0	1	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	7, 317		0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES			I			95. 00
200.00	1		3, 567, 735	8, 6	18 0		200.00
200.00		1	3, 301, 133	1 0,0	.0	1	1200.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2018	Worksheet D
TIKOUGII COSTS		Component CCN: 15-T112		Date/Time Prepared: 5/29/2019 8:49 pm
		Title XVIII	Subprovi der -	PPS

		11116	ZVIII	IRF	113	
Cost Center Description	PSA Adj. Non	PSA Adj. All				
	Physi ci an	Other Medical				
		Education Cost				
	Cost					
	21. 00	24. 00				
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	C	1	1			50.00
51. 00 05100 RECOVERY ROOM	C		2			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	_	Ί "				52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	C					53. 00 54. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C						54. 00
54. 01 05402 NOCLEAR MEDICINE-DIAGNOSTIC						54. 01
54. 03 05405 MAMMOGRAPHY						54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C						55. 00
57. 00 05700 CT SCAN						57. 00
58. 00 05800 MRI						58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
60. 00 06000 LABORATORY						60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL						60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL						62. 00
65. 00 06500 RESPIRATORY THERAPY						65. 00
66. 00 06600 PHYSI CAL THERAPY						66. 00
67. 00 06700 OCCUPATI ONAL THERAPY						67. 00
68. 00 06800 SPEECH PATHOLOGY						68. 00
69. 00 06900 ELECTROCARDI OLOGY						69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY						70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS						72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	l c	0				73. 00
74.00 07400 RENAL DIALYSIS		0				74. 00
76. 00 03020 ACUPUNCTURE	C	0				76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	C	0				76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	C	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0				89. 00
90. 00 09000 CLI NI C	C	0				90. 00
90. 01 09001 DI ABETES CENTER	C	0				90. 01
90. 02 09002 NEUROPSYCH	C	0)			90. 02
90. 03 09003 WOUND CENTER	C	0)			90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	C	0				90. 04
90. 05 09005 VI MCARE CLI NI C	C	0)			90. 05
90.06 09006 MEDICATION MGMT CLINIC	C	1	1			90. 06
91. 00 09100 EMERGENCY	C	0)			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C) 0)			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	[C	0	P			200. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-	10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-011	From 01/01/2018	Date/Time Prepared	
	Title XVIII	Hospi tal	5/29/2019 8: 49 pm PPS	—
Cost Center Description				

		Title XVIII	Hospi tal	5/29/2019 8: 49 PPS	9 pm
	Cost Center Description	THE AVIII	поэрт саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			30, 616	
2. 00	Inpatient days (including private room days, excluding swing-			30, 616	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	vate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		27, 213	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost		1
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private roo	om 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 roor	m days) through Docombor	21 of the cost	0	7.00
7.00	reporting period	iii days) trii dagii beceiibei	of the cost		/. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	12, 238	9.00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including private	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
00	reporting period	oo tiii dagii badaiibai di d		0.00	.,
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			41, 961, 093	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	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	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December (21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	31 of the cost reporting	perrou (Trie 8	U	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		41, 961, 093	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	dd		0	20.00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	iic 31 <i>)</i>		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line		
	27 minus line 36)	•			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO			-
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 270 57	20.00
38 00	Adjusted general inpatient routine service cost per diem (see	,		1, 370. 56 16, 772, 913	
					1 07.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		0	40.00

	Financial Systems	COLUMBUS REGION		CN. 1E 0110		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0112	Peri od: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 8:4	pared: 9 pm
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent costi		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0		0.1	00		42.00
43.00	INTENSIVE CARE UNIT	7, 076, 128	3, 212	1			1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	C	1			
46. 00	SURGICAL INTENSIVE CARE UNIT	0	C	1		0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk			,		26, 812, 285	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		46, 151, 728	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	m of Parts I and	2, 282, 911	50.00
51. 00		atient ancillar	u services (fr	om Wkst D «	sum of Parts II	2, 346, 737	51.00
31.00	and IV)		y services (ii	om wkst. D, .	3411 01 141 (3 11	2, 340, 737	31.00
52.00	Total Program excludable cost (sum of lines			! _!		4, 629, 648	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-pny	sician anesti	netrst, and	41, 522, 080	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,				_	1
	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56. 00
57. 00 58. 00	Difference between adjusted inpatient operat	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period (ending 1996, u	pdated and co	ompounded by the		59.00
	market basket					0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	60.00
	which operating costs (line 53) are less tha	n expected costs					
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			o o	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	mher 31 of the	cost reporti	ng period (See	I 0	64. 00
04.00	instructions)(title XVIII only)	ts through becer	ilber 31 of the	cost reporti	riig perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	ost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line 6	5)(title XVII	II only). For	0	66. 00
(7.00	CAH (see instructions)		D				(7.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 C	or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 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 (ine 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY			1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	,		` ')		70.00
72. 00	Program routine service cost (line 9 x line		THE 70 . TITLE	2)			72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				aus Lino 70)		79. 00 80. 00
80.00	Inpatient routine service costs for comp		ost iriiii tati Ol	. (E /O IIII	143 IIII <i>19)</i>		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					3, 403	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 370. 56	88. 00
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				4, 664, 016	89. UU

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 991, 487	41, 961, 093	0. 11895	5 4, 664, 016	554, 808	90. 00
91.00 Nursing School cost	0	41, 961, 093	0.00000	0 4, 664, 016	0	91.00
92.00 Allied health cost	0	41, 961, 093	0.00000	0 4, 664, 016	0	92.00
93.00 All other Medical Education	0	41, 961, 093	0.00000	0 4, 664, 016	0	93. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0112	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T112	To 12/31/2018	Date/Time Prepared: 5/29/2019 8:49 pm
	Title XVIII	Subprovi der -	PPS
		IRE	

Cost Center Description Description 1.00			II the Aviii	I RF	FF3	
INPATITION DATE INPATITION		Cost Center Description				
NATLERT GAYS		DART I - ALL PROVIDER COMPONENTS			1.00	
1.00 Impatient days (including private room days, excluding saing-bed and nesborn days) 3,918 2,00						
2.00 2.00 2.00 3.00						
do not complete this line. 1. Ose imprivate room days (excluding swing-bed and observation bed days) through becember 31 of the cost proporting period (if callendar year, enter 0 on this line) period (if callendar year, enter 0 on t						
Seelptr vate room days (excluding swing-bed and observation bed days) (and ing placed Sir type inpatient days) (including private room days) (and ing placed Sir type inpatient days) (including private room days) (and including private placed Sir type) (and including private proom days) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including sir type) (and including private placed Sir type) (and including si	3.00	, , , , , , , , , , , , , , , , , , , ,	/s). If you have only pri	vate room days,	O	3.00
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10	7.00		n days) through December	31 of the cost	0	7. 00
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,873,627 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	liotal Program general inpatient routine service cost (line 39	+ IINE 4U)	I	2, 8/3, 627	41.00

	Financial Systems	COLUMBUS REGION.				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	F	Period: rom 01/01/2018	Worksheet D-1	
			Component CC	CN: 15-T112 T	o 12/31/2018	Date/Time Pre 5/29/2019 8:4	
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷						
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00 0. 00		0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00		0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			e)		1, 531, 638 4, 405, 265	
47.00	PASS THROUGH COST ADJUSTMENTS					4, 403, 203	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from \	Wkst. D, sum	of Parts I and	377, 851	50. 00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (from	m Wkst. D, su	m of Parts II	124, 938	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				502, 789	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital rel	ated, non-phys	ician anesthe	tist, and	3, 902, 476	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ng cost and tar	aet amount (li	ne 56 minus l	ine 53)	0	56. 00 57. 00
58.00	Bonus payment (see instructions)				•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	nding 1996, up	dated and com	pounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year				ha amaunt hu	0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00
	Allowable Inpatient cost plus incentive payments	ent (see instruc	tions)			Ö	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	a period (See	0	64. 00
/F 00	instructions)(title XVIII only)						4F 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is after Decembe	r 31 or the co	st reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	4 plus line 65	(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 of	the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of t	he cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x line	e 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ce costs (line	72 + line 73)	•			74. 00
75. 00 76. 00	Capital-related cost allocated to inpatient (26, line 45) Per diem capital-related costs (line 75 ÷ li)		costs (from Wo	rksheet B, Pa	rt II, column		75. 00 76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess	.*	ovi der records)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the co			s line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	diem (line 27 ÷	line 2)			ł	88. 00 89. 00
U7. UU	Topservation bed cost (Time of X Time of) (Set	, manuch uns)				1 0	1 07.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 8:49	
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	667, 170	5, 073, 833	0. 13149	2 0	0	90.00
91.00 Nursing School cost	0	5, 073, 833	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	5, 073, 833	0. 00000	o o	0	92.00
93.00 All other Medical Education	0	5, 073, 833	0. 00000	0 0	0	93.00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL		In Lieu of Form CMS-2552-10		
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0112	Peri od:	Worksheet D-3		

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 8:49 pm Title XVIII Hospi tal **PPS** Cost Center Description Ratio of Cost Inpati ent Inpati ent To Charges Program Costs Program Charges (col. 1 x col 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 23, 872, 562 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 5, 440, 940 31 00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 40.00 04000 SUBPROVI DER - I PF 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.376852 11, 866, 100 4, 471, 764 50.00 05100 RECOVERY ROOM 0.300198 51.00 1, 111, 290 333, 607 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.022516 2, 059, 106 46, 363 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1.142206 753, 439 860, 583 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54 01 0 210406 898 804 189 114 54 01 54.02 05404 ULTRA SOUND 0.188604 661, 069 124, 680 54.02 54.03 05405 MAMMOGRAPHY 0.532191 120 54.03 64 55.00 05500 RADI OLOGY-THERAPEUTI C 0.333161 156, 015 51, 978 55.00 57 00 05700 CT SCAN 0.061866 226, 665 3.663.808 57 00 58.00 05800 MRI 0.089778 862, 353 77, 420 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.166363 6, 795, 311 1, 130, 488 59.00 1, 777, 551 60 00 06000 LABORATORY 0.249614 7, 121, 201 60 00 06001 LABORATORY-PATHOLOGI CAL 309, 263 60.01 0. 252587 78, 116 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.364317 737, 810 268, 797 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 0.476431 3, 949, 266 1,881,553 65.00 06600 PHYSI CAL THERAPY 66 00 0.563610 1, 753, 571 988.330 66 00 06700 OCCUPATIONAL THERAPY 67.00 0.273318 824, 981 225, 482 67.00 162, 560 06800 SPEECH PATHOLOGY 0.712205 115, 776 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.094542 3, 442, 998 325, 508 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.257311 92, 311 23, 753 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.478141 5, 867, 615 2, 805, 547 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 729, 752 72.00 0.586200 3, 358, 781 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.373299 13, 282, 644 4, 958, 398 73.00 07400 RENAL DIALYSIS 392, 322 74.00 0.355695 1, 102, 974 74.00 76.00 03020 ACUPUNCTURE 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 0.327029 12, 916 4, 224 76.97 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0.000000 Λ 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.573129 31, 183 17,872 90.00 09001 DIABETES CENTER 90.01 1.353168 0 90.01 90.02 09002 NEUROPSYCH 0.849942 1, 240 1,054 90.02 90.03 09003 WOUND CENTER 0.297433 29, 693 8,832 90.03 09004 HYPERBARIC OXYGEN THERAPY 0.301948 8, 448 90.04 90.04 2.551 09005 VIMCARE CLINIC 90.05 2. 274614 466 1,060 90.05 09006 MEDICATION MGMT CLINIC 0.701870 1,899 1, 333 90.06 90.06 91.00 09100 EMERGENCY 0.219124 9, 413, 477 2, 062, 719 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.405643 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 26, 812, 285 200. 00 82, 703, 683 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 202.00 Net charges (line 200 minus line 201) 82, 703, 683 202.00

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT			CN: 15-0112	Peri od:	Worksheet D-3	
			Component	CCN: 15-T112	From 01/01/2018 To 12/31/2018		pared:
			Title	e XVIII	Subprovi der - I RF	PPS	у рііі
	Cost Center Description			Ratio of Cos		Inpatient	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col. 2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
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 40. 00	03400 SURGICAL INTENSIVE CARE UNIT				0		34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF				4, 028, 272		41.00
42. 00	04200 SUBPROVI DER				4, 020, 272		42. 00
43. 00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS					<u>'</u>	
50.00	05000 OPERATI NG ROOM			0. 37685		11, 892	50.00
51. 00	05100 RECOVERY ROOM			0. 30019		1, 700	
52.00	05200 DELIVERY ROOM & LABOR ROOM			0.00000		0	
53.00	05300 ANESTHESI OLOGY			0. 02251		196	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C			1. 14220 0. 21040	· ·	25, 539 0	1
54. 01	05404 ULTRA SOUND			0. 18860		1	
54. 03	05405 MAMMOGRAPHY			0. 53219		0	
55. 00	05500 RADI OLOGY-THERAPEUTI C			0. 33316		0	1
57.00	05700 CT SCAN			0. 06186	51, 837	3, 207	57. 00
58. 00	05800 MRI			0. 08977	78 38, 172	3, 427	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON			0. 16636		4, 530	
60.00	06000 LABORATORY			0. 24961		70, 770	1
60. 01	06001 LABORATORY-PATHOLOGI CAL			0. 25258	· ·	833	1
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY			0. 36431 0. 47643	· ·	2, 254 24, 580	
66. 00	06600 PHYSI CAL THERAPY			0. 56361	· ·		
67. 00	06700 OCCUPATI ONAL THERAPY			0. 27331		228, 218	
68. 00	06800 SPEECH PATHOLOGY			0. 71220			
69. 00	06900 ELECTROCARDI OLOGY			0. 09454	12 30, 050	2, 841	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY			0. 25731			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 47814	·	28, 034	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			0. 58620		451	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS			0. 37329			
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE			0. 35569 0. 00000		40, 250 0	1
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON			0. 32702			
10. 71	OUTPATIENT SERVICE COST CENTERS			0. 32/02	- /1 0		1 ,0. ,,
88. 00	08800 RURAL HEALTH CLINIC			0.00000	00	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	1
90.00	09000 CLI NI C			0. 57312	29 0	0	90.00

59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 166363	27, 232	4, 530	59. 00
60.00	06000 LABORATORY	0. 249614	283, 517	70, 770	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 252587	3, 297	833	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 364317	6, 187	2, 254	62.00
65.00	06500 RESPI RATORY THERAPY	0. 476431	51, 592	24, 580	65.00
66.00	06600 PHYSI CAL THERAPY	0. 563610	906, 119	510, 698	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 273318	834, 989	228, 218	67.00
68.00	06800 SPEECH PATHOLOGY	0. 712205	487, 350	347, 093	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 094542	30, 050	2, 841	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 257311	1, 460	376	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 478141	58, 631	28, 034	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 586200	769	451	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 373299	597, 768	223, 146	73.00
74.00	07400 RENAL DI ALYSI S	0. 355695	113, 158	40, 250	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 327029	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0.000000		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLI NI C	0. 573129	0	0	90.00
90. 01	09001 DI ABETES CENTER	1. 353168	0	0	90. 01
90. 02	09002 NEUROPSYCH	0. 849942	0	0	90. 02
90. 03	09003 WOUND CENTER	0. 297433	0	0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 301948	0	0	90.04
90.05	09005 VI MCARE CLI NI C	2. 274614	0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 701870	0	0	90.06
91. 00	09100 EMERGENCY	0. 219124	7, 317	1, 603	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 405643	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES				95.00
200.00			3, 567, 735	1, 531, 638	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)		3, 567, 735		202. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112		Worksheet E Part A Date/Time Prepared: 5/29/2019 8:49 pm

		T		5/29/2019 8: 4	9 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
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 (s	see	0 25, 191, 127	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurriinstructions)	1 (see	8, 731, 748	1. 02	
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	0	1. 03		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			766, 694 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	rting period (see instru	ctions)	0 201. 68	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-o	n to the cap for	0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 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), 413.75	thic and osteopathic pro	grams for	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 side appears strandle shall a 2011, see instructions	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. 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) (9	see	0.00	9. 00
10. 00 11. 00 12. 00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	ent year from your record	ds		10. 00 11. 00 12. 00
	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	ar ended on or after Sep	tember 30, 1997,	0. 00 0. 00	13. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.				15. 00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clos	sure		0.00	16. 00 17. 00
18. 00	Adjusted rolling average FTE count	our C		0.00	1
19. 00	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.		FR 412. 105	0.00	23. 00
24. 00 25. 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	0. 00 0. 00	ı
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0.000000	28. 00
	IME add-on adjustment amount - Managed Care (see instructions))		0	1
29. 00	Total IME payment (sum of lines 22 and 28)			0	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment			0	
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	5. 98	
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31				31.00
	Allowable disproportionate share percentage (see instructions)			29. 16 13. 27	1
	Disproportionate share adjustment (see instructions)	,		1, 125, 392	1
	(====)		,	, 2	

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	DNAL HOSPITAL Provider CCN: 15-0112	Peri od:	Worksheet E	2552-10
			From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2019 8: 49 PPS	9 pm
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35. 00
35. 00	Factor 3 (see instructions)		0. 000302844	0. 000357119	
35. 02	Hospital uncompensated care payment (If line 34 is zero, elinstructions)	nter zero on this line) (se	e 2, 049, 255	2, 954, 400	35. 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 3		1, 532, 730 2, 277, 401	744, 671	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludit 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGs	0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	, 683, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding I an 685. (see instructions)	MS-DRGs 652, 682, 683, 684	0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quantotal Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	•	0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41.01)	0 38, 092, 362		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	, small rural hospitals	0		48. 00
	John y. (See Tristructions)			Amount	
40.00	Total normant for impatient energing costs (see instructi	999)		1. 00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I			38, 092, 362 3, 049, 864	
51. 00	Exception payment for inpatient program capital (Wkst. L, I	Pt. III, see instructions)		0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	line 49 see instructions).		0 155, 087	52. 00 53. 00
54. 00	Special add-on payments for new technologies			5, 250	
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see i			0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57. 00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58)	t. IV, cor. II line 200)		229, 700 41, 532, 263	58. 00 59. 00
60.00	Primary payer payments			54, 052	
61. 00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		41, 478, 211	
62. 00	Deductibles billed to program beneficiaries	,		3, 824, 764	
63. 00	Coinsurance billed to program beneficiaries			24, 790	63. 00
64. 00	Allowable bad debts (see instructions)			414, 182	64.00
65. 00	Adjusted reimbursable bad debts (see instructions)			269, 218	65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		178, 066	66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			37, 897, 875	67. 00
68. 00	Credits received from manufacturers for replaced devices for			0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	6).(For SCH see instruction	S)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	netration) adjustment (see	instructions)	0	70.00
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration	, ,	instructi UNS)	0	70. 50 70. 87
70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see in				70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	, , , , , , , , , , , , , , , , , , , ,			0	70. 92
10. 72				24 400	70 00
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			24, 490 -121, 503	

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C	CN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/29/2019 8:4	
		Ti tl e	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal year the corresponding federal year for the period		n column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal year the corresponding federal year for the period	ar (yyyy) (Enter ir			0	0	70. 97
70.98 Low Volume Payment-3					0	70. 98

70. 97				
10.71	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 97
		U	0	10.91
70.00	the corresponding federal year for the period ending on or after 10/1)			
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		37, 800, 862	71. 00
71. 01	Sequestration adjustment (see instructions)		756, 017	71. 01
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
72.00	Interim payments		37, 207, 263	
73. 00	Tentative settlement (for contractor use only)		07,207,200	73.00
74. 00			142 410	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		-162, 418	74.00
75 00	73)		4 070 700	7- 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with		1, 873, 720	/5.00
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94. 00	The rate used to calculate the time value of money (see instructions)		0.00	
95. 00			0.00	95.00
	Time value of money for operating expenses (see instructions)		1	
96. 00	Time value of money for capital related expenses (see instructions)	10.1 1.40/4	0	96. 00
			On/After 10/1	
		1. 00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1. 0007799581	1.0005262539	101. 00
	HVBP adjustment amount for HSP bonus payment (see instructions)	0		102. 00
	HRR Adjustment for HSP Bonus Payment			
103 00	HRR adjustment factor (see instructions)	0. 9958	0. 9985	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)	0. 7730		104. 00
104.00			ıl U	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
			1	
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200. 00
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			
201. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement			201. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)			201. 00 202. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	nt 5-vear demons		200. 00 201. 00 202. 00 203. 00
201. 00 202. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre	nt 5-year demons		201. 00 202. 00
201. 00 202. 00 203. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period)	nt 5-year demons	tration	201. 00 202. 00 203. 00
201. 00 202. 00 203. 00 204. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare PPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare PPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the curre period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	nt 5-year demons	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

	ATION OF DSH PAYMENT PERCENTAGE		Provider CC		Peri od:	Worksheet DSH	1002 10
					From 01/01/2018 To 12/31/2018	Date/Time Pre	
			Title	XVIII	Hospi tal	5/29/2019 8: 4 PPS	9 piii
		Original .mcrxAd		HFS Look Up	Overri de Val ue	Revi sed Value	
		Val ues 1.00	Val ues 2. 00	3. 00	4. 00	5. 00	
1 00	CALCULATION OF THE DSH PAYMENT PERCENTAGE	F 00	0.00	0.00	0.00	0.00	1 00
1. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5. 98	0. 00	0.00	0.00	0.00	1. 00
2. 00	Percentage of Medicaid patient days to total days (From line 27)	23. 18	0. 00			23. 18	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	29. 16	0. 00			23. 18	3. 00
4. 00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4. 00
5. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	201. 68	0. 00			201. 68	5. 00
6. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	13. 27	0. 00			8. 34	6. 00
7. 00	Oualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7. 00
8.00	S-2, Li ne 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10. 00 11. 00	S-2, Line 45 Is the provider reimbursed under the fully	Yes Yes				Yes Yes	10. 00 11. 00
	prospective method? (Worksheet L, Part I, line 1 geater than -0-)						
12. 00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	5. 98	0. 00	0.00	0.00	0. 00	12. 00
13. 00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13. 00
14. 00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2. 57	0. 00	0.00	0.00	0.00	14. 00
	CALCULATION OF THE PERCENTAGE OF MEDICALD DAY						
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	914	0			914	15. 00
16. 00		426	0			426	16. 00
17. 00		8	0			8	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	35	0			35	18. 00
18. 01 19. 00	N/A	0 6, 387	0			0 6. 387	18. 01 19. 00
	column 5) Other Medicaid days (Worksheet S-2, line 24,	25	0				20. 00
21. 00	column 6) Total Medicaid patient days for the DSH	7, 795	0			7, 795	21. 00
22. 00	calculation (sum of lines 15-20) Total patient days (Worksheet S-3, Part I,	33, 622	0			33, 622	22. 00
23. 00		0	0			0	23. 00
24. 00	, ,	O	0			0	24. 00
25. 00	S-3, Part I, Column 8, Line 30) Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	O	0			0	25. 00
26. 00	calculation (sum of lines 22-24, less line	33, 622	0			33, 622	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	23. 18	0. 00			23. 18	27. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 15-0112	Period: Worksheet DSH

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CO	CN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet DSH Date/Time Pre 5/29/2019 8:4	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .m	ncrx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3. 00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	13. 27		0.00	True	28. 00
29. 00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0. 00		0.00	Fal se	29. 00
30.00	Line 28 or 29 as applicable		13. 27		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and		13. 27		0.00		31.00
	fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.						
		Original .mcrx	Adjusted .mcax	HFS Look Up	Overri de Val ue	Revi sed Value	
		Val ues	Val ues	·			
		1.00	2.00	3. 00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32. 00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32. 00
33. 00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33. 00
34. 00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34. 00
35. 00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35. 00
36. 00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36. 00

Health Financial Systems	COLUMBUS REGIONA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0112		Worksheet DSH	
			From 01/01/2018		
			To 12/31/2018	Date/Time Prep	
				5/29/2019 8: 49	9 pm
		Title XVIII	Hospi tal	PPS	
	Revi sed				
	Percentage				

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	8. 34				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29. 00	If line 3 is less than 20.2% - 2.5% plus 65%	0. 00				29. 00
	of the difference between 15% and line 3					
30. 00	Line 28 or 29 as applicable	8. 34				30.00
31. 00	If Urban and fewer than 100 beds, Rural and	8. 34				31. 00
	fewer than 500 beds, or an SCH with less					
	than 100 beds the lower of line 30 or .1200,					
	if RRC, MDH or otherwise enter line 30.					

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112		Worksheet E Part B Date/Time Prepared: 5/29/2019 8:49 pm

		5/29/2019 8: 4	9 pm
	Title XVIII Hospital	PPS	
	AND A MEN AN AND ATTITUDE OF A STATE OF A ST	1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	47.075	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	47, 975 36, 896, 127	1. 00 2. 00
3.00	OPPS payments	30, 418, 003	•
4. 00	Outlier payment (see instructions)	182, 329	4. 00
4. 01	Outlier reconciliation amount (see instructions)	102, 327	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
6. 00	Line 2 times line 5	0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	•
8. 00	Transitional corridor payment (see instructions)	0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	428, 378	•
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	47, 975	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES	•	
	Reasonable charges		
12.00	Ancillary service charges	128, 223	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	128, 223	14. 00
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	1
18.00	Total customary charges (see instructions)	128, 223	•
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	80, 248	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
20.00	instructions)		20.00
21. 00	Lesser of cost or charges (see instructions)	47, 975	21. 00
22. 00		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	31, 028, 710	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	•	
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	5, 798, 711	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	25, 277, 974	27. 00
	instructions)		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27 through 29)	25, 277, 974	ı
31. 00 32. 00	Primary payer payments Subtatal (Line 30 minus Line 31)	30, 136 25, 247, 838	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	25, 247, 838	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34. 00		797, 774	1
35. 00		518, 553	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	511, 684	1
37.00	Subtotal (see instructions)	25 766 391	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	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
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. 00	Subtotal (see instructions)	25, 766, 391	1
40. 01	Sequestration adjustment (see instructions)	515, 328	1
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
41.00	Interim payments	24, 988, 998	1
42.00	Tentative settlement (for contractors use only)	2/2 0/5	42.00
43.00	Balance due provider/program (see instructions)	262, 065	•
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	639, 926	44. 00
	TO BE COMPLETED BY CONTRACTOR		
90. 00		0	90. 00
	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92. 00	The rate used to calculate the Time Value of Money	l l	92. 00
	Time Value of Money (see instructions)	0.00	1
	Total (sum of lines 91 and 93)	•	94. 00
		•	•

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Pre 5/29/2019 8:4	
		Ti tl	e XVIII	Hospi tal	PPS	
					Overri des	
					1. 00	
WORKSHEET OVERRIDE VALUES						
112.00 Override of Ancillary service charges (line	12)				0	112. 00

| Peri od: | Worksheet E-1 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0112

				10 12/31/2016	5/29/2019 8: 49	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		37, 171, 66		24, 988, 998	1.00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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	08/14/2018	35, 60		0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Describer to Describe			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 50	ADJUSTWENTS TO PROGRAW			0	0	3. 50
3. 52				0	ol	3. 52
3. 53					0	3. 53
3. 54				o o	o o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		35, 60	O	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		37, 207, 26	3	24, 988, 998	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR					Г 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52	Subtatal (our of lines F 01 F 40 minus and lines			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			U	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	262, 065	6. 01
6. 02	SETTLEMENT TO PROGRAM		162, 41	-	0	6. 02
7. 00	Total Medicare program liability (see instructions)		37, 044, 84		25, 251, 063	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
2.00		()	1. 00	2. 00	0.05
8. 00	Name of Contractor					8. 00

Health Financial Systems	COLU	JMBUS REGIONAL HOSE	PI TAL	In Lie	eu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FO	R SERVICES RENDERED	Prov	/ider CCN: 15-011	Peri od:	Worksheet E-1

		Title	XVIII	Subprovider -	PPS	<u> у рш</u>
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 832, 08	8	0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	
3.04				0	0	
3.05				0	0	3. 05
	Provi der to Program			al	1	
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3. 51 3. 52				0	0 0	3. 51 3. 52
3. 52				0		
3. 53 3. 54				0	0	3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		
3. 77	3. 50-3. 98)			O O		3.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		3, 832, 08	8	0	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	
5.03				0	0	5. 03
F F0	Provider to Program				1 0	
5. 50 5. 51	TENTATI VE TO PROGRAM			0	0	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
5. 77	5. 50-5. 98)					3. 77
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		89, 79	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 921, 88		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	Name of Continuous	()	1. 00	2. 00	0.00
8. 00	Name of Contractor			I	I	8.00

<u> </u>	rm CMS-2552-10
	eet E-1
From 01/2/2018 Part /	
	ime Prepared: 2019 8:49 pm
Title XVIII Hospital	PPS
1.	00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1. 00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3. 00
4.00 Total inpatient days from S-3, Pt. I col. 8 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 Wkst. S-10, col. 3 line 20	6. 00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I	7. 00
line 168	
8.00 Calculation of the HIT incentive payment (see instructions)	8. 00
9.00 Sequestration adjustment amount (see instructions)	9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10. 00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32. 00
Over	ri des
1.	00
CONTRACTOR OVERRIDES	
108.00 Override of HIT payment	108. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-T112		
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF	113	
	DADT III MEDICADE DADT A SEDVICES I DE DOS	1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	3, 460, 028	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0257	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	192, 032	3. 00
4. 00	Outlier Payments	379, 039	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)	1	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
9. 00	teaching program" (see instructions)	0.00	9. 00
10.00	Intern and resident count for IRF PPS medical education adjustment (see instructions) Average Daily Census (see instructions)	10. 734247	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	4, 031, 099	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	1	15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	4, 031, 099	17.00
18.00	Primary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	4, 031, 099	19.00
20.00	Deducti bl es	18, 736	
21. 00	Subtotal (line 19 minus line 20)	4, 012, 363	
22. 00	Coi nsurance	20, 734	
23. 00	Subtotal (line 21 minus line 22)	3, 991, 629	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2, 576	
25. 00	Adjusted reimbursable bad debts (see instructions)	1, 674	
26. 00 27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 316	
28. 00	Subtotal (sum of lines 23 and 25) Direct graduate medical education payments (from Wkst. E-4, line 49)	3, 993, 303 0	27. 00 28. 00
29. 00	Other pass through costs (see instructions)	8, 618	
30. 00	Outlier payments reconciliation	0, 010	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ő	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ol	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 001, 921	32.00
32. 01	Sequestration adjustment (see instructions)	80, 038	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3, 832, 088	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	89, 795	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	23, 297	36. 00
	§115. 2		
EO 00	TO BE COMPLETED BY CONTRACTOR	270,020	EO 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)	379, 039 0	50. 00 51. 00
52. 00	The rate used to calculate the Time Value of Money	- 1	
	Time Value of Money (see instructions)	0.00	53. 00
55.50	1	۲۱	-0.00

Health Financial Systems

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

Provider CCN: 15-0112 | Period: From 01/01/20

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 8:49 pm

oni y)					5/29/2019 8: 4	9 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	00.07/.047	T Z			4 00
1.00	Cash on hand in banks	23, 076, 347			0	1. 00 2. 00
2. 00	Temporary investments Notes receivable	0		-	0	3.00
4. 00	Accounts receivable	63, 957, 968	1	1	0	
5.00	Other recei vable	-830, 246	•		0	
6. 00	Allowances for uncollectible notes and accounts receivable	-31, 589, 804	•	o o	0	
7. 00	Inventory	5, 061, 467		o o	ő	7. 00
8.00	Prepai d expenses	4, 422, 064		0	0	
9.00	Other current assets	0	(0	0	9. 00
10.00	Due from other funds	0	(0	0	10.00
11.00	Total current assets (sum of lines 1-10)	64, 097, 796	(0	0	11. 00
	FIXED ASSETS					
12. 00	Land	1, 976, 052			-	
13. 00	Land improvements	20, 873, 669		-	0	
14. 00	Accumulated depreciation	-11, 644, 555		-		14.00
15. 00	Bui I di ngs	207, 246, 432	1	-	0	15. 00
16.00	Accumulated depreciation	-130, 900, 731		-	0	16.00
17. 00	Leasehold improvements	0	(1	0	17.00
18.00	Accumulated depreciation	0 402 017	(1	0	18.00
19.00	Fixed equipment	9, 493, 917		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-7, 219, 586	1	0	0	20.00
21.00	Accumulated depreciation	2, 375, 448 -1, 579, 227		-	0	21.00
23. 00	Major movable equipment	152, 638, 285		-	0	23.00
24. 00	Accumul ated depreciation	-94, 192, 838			0	24.00
25. 00	Mi nor equi pment depreci abl e	1 - 74, 172, 030			0	25. 00
26. 00	Accumulated depreciation				0	26.00
27. 00	HIT designated Assets	0			Ö	27. 00
28. 00	Accumul ated depreciation	0			0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	l o		o o	Ō	
30.00	Total fixed assets (sum of lines 12-29)	149, 066, 866		0	0	30.00
	OTHER ASSETS					1
31.00	Investments	157, 494, 670	(0	0	31.00
32.00	Deposits on Leases	0	(0	0	32.00
33.00	Due from owners/officers	0	(0	0	33.00
34.00	Other assets	33, 468, 482	(0	0	34.00
35.00	Total other assets (sum of lines 31-34)	190, 963, 152		·	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	404, 127, 814	(0	0	36.00
	CURRENT LI ABI LI TI ES		1		_	
37. 00	Accounts payable	13, 766, 149		-		37.00
38. 00	Sal ari es, wages, and fees payable	10, 097, 682		-	0	38. 00
39. 00	Payroll taxes payable	981, 827		0	0	39.00
40.00	Notes and Loans payable (short term)	6, 425, 000		0	0	40.00
41. 00	Deferred income	0		U	0	41.00
42. 00 43. 00	Accel erated payments	0	,	0	0	42.00
44. 00	Due to other funds Other current liabilities	6, 976, 816		0		
45. 00	Total current liabilities (sum of lines 37 thru 44)	38, 247, 474				
43.00	LONG TERM LIABILITIES	30, 247, 474		0	0	45.00
46. 00	Mortgage payable	49, 450, 000		0	0	46. 00
47. 00	Notes payable	1.7, 100, 000		1		
48. 00	Unsecured Loans	483, 329		-	0	48. 00
49. 00	Other long term liabilities	0		-	Ō	
50.00	Total long term liabilities (sum of lines 46 thru 49)	49, 933, 329		0		
51.00	Total liabilities (sum of lines 45 and 50)	88, 180, 803		0	0	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	315, 947, 011				52.00
53.00	Specific purpose fund		(53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FC 5-	repl acement, and expansi on	045 075 5				
59. 00	Total fund balances (sum of lines 52 thru 58)	315, 947, 011		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	404, 127, 814		0	0	60.00
	[59]	I	I	1	I	I

Provider CCN: 15-0112

					0 12/31/2010	5/29/2019 8: 49	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	•
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		321, 110, 046		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19, 207, 639				2.00
3.00	Total (sum of line 1 and line 2)		340, 317, 685		0		3. 00
4. 00	Additions (credit adjustments) (specify)	0		0		0	4. 00
5.00	NURSING HOME CONTRIBUTIONS	12, 095, 547		0		0	5. 00
6.00		0		0		0	6. 00
7.00		0		0		0	7. 00
8. 00 9. 00		0		0			8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	١	12, 095, 547	U	0	· -	10. 00
11. 00	Subtotal (line 3 plus line 10)		352, 413, 232		0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	332, 413, 232	0	O	o	12. 00
13. 00	EQUITY TRANSFERS WHOLLY OWNED SUBS	36, 464, 273		0		ا	13. 00
14. 00	RESTRICTED FUND CHANGE	1, 948		o o		l o	14. 00
15. 00	THE STATE OF THE S	0		0		l ol	15. 00
16. 00		O		0		0	16. 00
17. 00		o		0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		36, 466, 221		0		18.00
19. 00	Fund balance at end of period per balance		315, 947, 011		0		19.00
	sheet (line 11 minus line 18)		51 .	L			
		Endowment Fund	PI ant	Funa			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5. 00	NURSING HOME CONTRIBUTIONS		0				5. 00
6. 00			0				6. 00
7.00			0				7. 00
8. 00 9. 00			0				8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		U	0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0	o o			12. 00
13. 00	EQUITY TRANSFERS WHOLLY OWNED SUBS		0				13. 00
14. 00	RESTRICTED FUND CHANGE		0				14. 00
15. 00			0				15. 00
16.00			0				16.00
17. 00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19. 00	Fund balance at end of period per balance	0		0			19. 00
	sheet (line 11 minus line 18)						

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

		11	0 12/31/2018	5/29/2019 8:4			
	Cost Center Description	I npati ent	Outpati ent	Total			
	'	1.00	2. 00	3.00			
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal	61, 122, 618		61, 122, 618	1. 00		
2.00	SUBPROVI DER - I PF	0		0	2.00		
3.00	SUBPROVI DER - I RF	7, 090, 975		7, 090, 975	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)	68, 213, 593		68, 213, 593	10.00		
	Intensive Care Type Inpatient Hospital Services						
11. 00	INTENSIVE CARE UNIT	13, 543, 265		13, 543, 265	11. 00		
12.00	CORONARY CARE UNIT	0		0	12.00		
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00		
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00		
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00		
16. 00	Total intensive care type inpatient hospital services (sum of lines	13, 543, 265		13, 543, 265	16. 00		
	11-15)						
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	81, 756, 858		81, 756, 858	17. 00		
18. 00	Ancillary services	159, 107, 266		506, 073, 238	18. 00		
19. 00	Outpati ent servi ces	17, 114, 417	55, 742, 386	72, 856, 803			
20. 00	RURAL HEALTH CLINIC	0	0	0	20. 00		
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00		
22. 00	HOME HEALTH AGENCY		0	0	22. 00		
23. 00	AMBULANCE SERVICES	0	12, 008, 775	12, 008, 775	23. 00		
24. 00	CMHC				24. 00		
24. 10	CORF	0	0	0	24. 10		
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00		
26. 00	HOSPI CE		_		26. 00		
27. 00	LEVEL 11 NURSERY	2, 570, 892		2, 570, 892	27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	260, 549, 433	414, 717, 133	675, 266, 566	28. 00		
	G-3, line 1)						
29. 00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		273, 765, 723		29. 00		
30. 00	ADD (SPECIFY)	0	213, 103, 123		30.00		
31. 00	PROVISION FOR BAD DEBT	6, 836, 727			31. 00		
32. 00	PROVISION FOR DAD DEBT	0, 630, 727			32.00		
33. 00		0			33. 00		
34. 00		0			34. 00		
35. 00		0			35. 00		
36. 00	Total additions (sum of lines 30-35)	0	6, 836, 727		36. 00		
37. 00	DEDUCT (SPECIFY)	0	0, 030, 727		37. 00		
38. 00	DEDUCT (SIEGITT)	0			38. 00		
39. 00					39. 00		
40. 00		0			40. 00		
41. 00					41. 00		
42. 00	Total deductions (sum of lines 37-41)		n		42. 00		
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	280, 602, 450		43. 00		
	to Wkst. G-3, line 4)		100, 111, 100				
		'	'		"		

	Financial Systems MENT OF REVENUES AND EXPENSES	COLUMBUS REGIONAL F	Provider CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet G-3	
STATEN	MENT OF REVENUES AND EXPENSES	-	7 OVI der CCN: 15-0112	From 01/01/2018	worksneet G-3	
					5/29/2019 8: 4	9 pm
				-	1. 00	
1. 00	Total patient revenues (from Wkst. G-2, F	art L column 3 line	28)	,	675, 266, 566	1. 00
2.00	Less contractual allowances and discounts		20)		376, 298, 335	
3.00	Net patient revenues (line 1 minus line 2				298, 968, 231	•
4. 00	Less total operating expenses (from Wkst.	•)		280, 602, 450	
5. 00	Net income from service to patients (line		,		18, 365, 781	
	OTHER I NCOME			· '	., ,	
6.00	Contributions, donations, bequests, etc				510, 131	6.00
7.00	Income from investments				14, 659, 326	7.00
8.00	Revenues from telephone and other miscell	aneous communication s	ervi ces		0	8.00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				102, 781	
11. 00	Rebates and refunds of expenses				2, 076	11. 00
12.00	Parking Lot receipts				0	
13.00	Revenue from Laundry and Linen service				0	13.00
14. 00	Revenue from meals sold to employees and	guests			973, 602	
15. 00	Revenue from rental of living quarters				0	
16. 00	Revenue from sale of medical and surgical	• •	n patients		0	
17. 00	Revenue from sale of drugs to other than				40, 997	
18.00	Revenue from sale of medical records and				22, 932	
19.00	Tuition (fees, sale of textbooks, uniform				20, 524	
20.00	Revenue from gifts, flowers, coffee shops	, and canteen			0	
21. 00 22. 00	Rental of vending machines				140	
	Rental of hospital space Governmental appropriations				151, 825 486, 000	
23. 00 24. 00	UNREALIZED INVESTMENT LOSSES				-18, 870, 279	1
24. 00	WELLNESS REVENUE				204, 520	
24. 01	JOINT VENTURES				585, 115	
24. 02	CRHP REVENUE				2, 922, 439	
24. 03	OTHER NON OPERATING EXPENSES				616, 297	
24. 05	OTHER (SPECIFY)				010, 297	ł
25. 00	Total other income (sum of lines 6-24)				2, 428, 426	
	Total (line 5 plus line 25)				20, 794, 207	
27. 00	LOSS ON DISPOSAL OF ASSETS				179, 189	
27. 01	OTHER NON OPERATING EXPENSES				1, 407, 379	
	Total other expenses (sum of line 27 and	subscri pts)			1, 586, 568	
	Net income (or loss) for the period (line	1 /			19, 207, 639	

Heal th	Financial Systems COLUMBUS REGION	NAI HOSPITAI	Inlie	u of Form CMS-2	2552_10	
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0112	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:	
	PPS					
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier	2, 762, 479	1.00			
1. 01	Model 4 BPCI Capital DRG other than outlier		0			
2.00	Capital DRG outlier payments		119, 426			
2. 01	Model 4 BPCI Capital DRG outlier payments	0 83. 36				
3. 00 4. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)				4.00	
5.00	Number of interns & residents (see instructions)				5.00	
6. 00	, , , , , , , , , , , , , , , , , , , ,					
0.00	1.01) (see instructions)	The Sum of Titles I and I.O.	, corumns i and	0	0.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	5. 98	7. 00	
8. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		23. 18	8. 00	
9. 00	Sum of lines 7 and 8	ructions)		29. 16 29. 16	1	
10. 00						
11. 00	Disproportionate share adjustment (see instructions)	113)		6. 08 167, 959		
	0 Total prospective capital payments (see instructions)				1	
12.00	prospective capital payments (see thisti detroils)			3, 049, 864	12.00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)				1.00	
2.00	Program inpatient ancillary capital cost (see instructions)				2. 00	
3.00	Total inpatient program capital cost (line 1 plus line 2)				3. 00	
4.00	Capital cost payment factor (see instructions)				4. 00	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
	DART LLL COMPUTATION OF EVERTION DAMENTS			1. 00		
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				4 00	
1.00	Program inpatient capital costs (see instructions)	(!+:)		0		
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0		
4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)		0.00	1 0.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00		
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	1	
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0.00			
8.00	Capital minimum payment level (line 5 plus line 7)		0			
9. 00	Current year capital payments (from Part I, line 12, as applicable)			0		
10. 00			less line 9)	Ö		
11. 00				0		
	Worksheet L, Part III, line 14)					
12.00				0		
13.00			0			
14. 00	(if line 12 is negative, enter the amount on this line)	0	14. 00			
15.00				0	15. 00	
16. 00	0 Current year operating and capital costs (see instructions)			0	16. 00 17. 00	
17. 00	7.00 Current year exception offset amount (see instructions)					