This report is	required by law (42 USC 1395g; 42 CFR 41	3.20(b)). Fai	lure to repor	t can resu	ult in all interim	FORM APPRO	√ED
payments made	since the beginning of the cost reporting	period being	deemed overp	oayments (4	42 USC 1395g).	OMB NO. 093	38-0050
						EXPIRES 03	-31-2022
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT C SUMMARY	CERTI FI CATI ON	Provider CCN	: 15-0112	Peri od: From 01/01/2020 To 12/31/2020		l Prepared:
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared cost repo	ort			Date: 7/14/20	21 Time:	10: 20 am
use only	2. [] Manually prepared cost report						
	3. [0] If this is an amended report enter 4. [F] Medicare Utilization. Enter "F" f			provi der ı	resubmitted this o	ost report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contractor (2) Settled without Audit 8. [N]Init (3) Settled with Audit 9. [N] Fina (4) Reopened	r No.	r this Provic this Provider	11. der CCN 12.	NPR Date: Contractor's Vendo [O]If line 5, co number of tim	olumn 1 is 4	

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 01/01/2020 and ending 12/31/2020 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)

Title
Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	672, 540	41, 669	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	55, 970	0		0	3.00
4. 00 SUBPROVI DER I						4.00
5. 00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9. 00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200. 00 Total	0	728, 510	41, 669	0	0	200.00

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

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

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0112

From 01/01/2020

From 01/01/2020

To 12/21/2020 Part I

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi d	ler CCN:		Peri od:		Workshe	et S-2	
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	nared·
								7/14/20	21 10:	20 am
	1.00	2.00		3. 00			1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 2400 EAST 17TH STREET	PO Box:								1.00
2. 00	City: COLUMBUS	State: IN	Zip Cod	e: 47201	- Count	y: BARTHOLOI	MFW			2.00
	10.00	Component Name	CCN	CBSA	Provi der	7		nt Syst	em (P,	
		·	Number	Number	Type	Certi fi ed		0, or		
		1.00			1.00		V	XVIII		
	Hospital and Hospital-Based Componer	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
3. 00	Hospi tal	COLUMBUS REGIONAL	150112	18020	1	07/01/1966	N	Р	Р	3.00
0.00	l sopr tur	HOSPI TAL	.002	10020		077 0 17 1700				0.00
4.00	Subprovi der - IPF									4.00
5. 00	Subprovi der - IRF	COLUMBUS REGIONAL REHAB	15T112	18020	5	01/01/1984	N	P	N	5. 00
6. 00	Subprovi dos (Othor)	UNIT								6.00
7. 00	Subprovider - (Other) Swing Beds - SNF									7.00
8. 00	Swing Beds - NF									8.00
9.00	Hospital -Based SNF									9.00
10.00	Hospi tal -Based NF									10.00
11.00	Hospi tal -Based OLTC									11.00
12.00	Hospital-Based HHA Separately Certified ASC									12. 00 13. 00
	1 .									14.00
	Hospital -Based Health Clinic - RHC									15.00
16.00	Hospital -Based Health Clinic - FQHC									16.00
	Hospital -Based (CMHC) I									17.00
	Hospital -Based (CORF) I									17. 10
18. 00 19. 00	Renal Dialysis									18. 00 19. 00
19.00	Other					From:		To		19.00
						1.00		2. 0		
	Cost Reporting Period (mm/dd/yyyy)					01/01/20	020	12/31/	′2020	20.00
21. 00	Type of Control (see instructions)					8				21.00
				\vdash	1. 00	2. 00		3. 0)O	
	Inpatient PPS Information				1.00	2.00		3. 0	,,,	
22.00	Does this facility qualify and is it	currently receiving pay	ments fo	r	Υ	N				22. 00
	disproportionate share hospital adju			R						
	§412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		enament							
22. 01	Did this hospital receive interim ur		s for th	is	Υ	Y				22. 01
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft									
22. 02	Is this a newly merged hospital that				N	N				22. 02
22.02	payments to be determined at cost re									22.02
	Enter in column 1, "Y" for yes or "N	" for no, for the portic	n of the	.						
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th October 1.	ne cost reporting period	on or ar	ter						
22. 03	Did this hospital receive a geograph	nic reclassification from	urban t	0	N	N		N		22. 03
	rural as a result of the OMB standar	ds for delineating stati	stical a	reas						
	adopted by CMS in FY2015? Enter in o	column 1, "Y" for yes or	"N" for	no						
	for the portion of the cost reporting			er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least	•	,							
	counted in accordance with 42 CFR 41									
	yes or "N" for no.									
23. 00	Which method is used to determine Me					3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, enter									

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

Ν

N

58.00

59.00

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

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

	1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for whi	ch 0.0	00 62.00
your hospital received HRSA PCRE funding (see instructions)		
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospi	tal 0.0	00 62.01
during in this cost reporting period of HRSA THC program. (see instructions)		
Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Ent	er N	63.00
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		

Health Financial Systems	COLUMBU	IS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D)ATA	Provi der CO		Period: From 01/01/2020 To 12/31/2020		pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	ZO dili
				1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after 5				-This base yea	ar is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained on-primary on all nonpro ed non-prima n column 3	residents care ovider ary care the ratio	0. 0	0.00	0. 000000	64.00
	Program Name	Progra	ım Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.	00	3. 00	4. 00	5. 00	1
65.00 Enter in column 1, if line 63 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 FTEs Nonprovi der	Unwei ghted FTEs in		65.00
				Si te	'	,,	
				1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		in Nonprovi	der Settino	gsEffective	for cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider se ary care res 3 the ratio	ttings. sident oof	0. 0	0. 00	0. 000000	66.00
	Program Name		m Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.	00	3. 00	4. 00	5. 00	1
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. 0	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/14/2021 10:20 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 75 00 Υ subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this along term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 Ν C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 N bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 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) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 Ν N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 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, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 Ν 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems COLUMBUS REGIO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Peri od:	Worksheet S-	
			rom 01/01/2020 o 12/31/2020		
		<u> </u>	V 1 00	XIX	- 20 am
108.00 Is this a rural hospital qualifying for an exception to the	e CRNA fee sche	edul e? See 42	1.00 N	2. 00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	,
	1. 00	2. 00	3. 00	4.00	
109.00 f 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. 00
				1.00	\dashv
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110. 00
111.00 f this facility qualifies as a CAH, did it participate in	the Frantier (`ammuni +u	1.00	2. 00	111 00
Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.	N		111. 00
		1.00	2.00	3. 00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heademonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital content of participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	period? s "Y", enter the	N			112.00
In column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	Y			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insu	ırance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 Is the mal practice insurance a claims-made or occurrence po			1		118.00
if the policy is claim-made. Enter 2 if the policy is occur	тепсе.	Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		669, 850			0118.01
			1.00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein.			N		118. 02
119.00D0 NOT USE THIS LINE 120.00Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments."	n column 1, "Y qualifies for t	" for yes or the Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	1 is "Y", ente		N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e		fication date			126. 00
in column 1 and termination date, if applicable, in column	2.				127. 00
	nter the certif	ication date			1127.00
127.00 If this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er	2.				128.00

Health Financial Systems COLUMBUS REC	GLONAL HOSPITAL			In Lie	u of Form CMS	i-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO	CN: 15-0112	Peri od:		Worksheet S	
				1/01/2020 2/31/2020		repared:
					7/14/2021 10	
				1. 00	2. 00	-
130.00 If this is a Medicare certified pancreas transplant cent	er, enter the cer	ti fi cati on		1.00	2.00	130.00
date in column 1 and termination date, if applicable, in						
131.00 If this is a Medicare certified intestinal transplant cell date in column 1 and termination date, if applicable, in		erti fi cati oı	า			131. 00
132.00 If this is a Medicare certified islet transplant center,		ication date	e			132. 00
in column 1 and termination date, if applicable, in colu						
133.00 Removed and reserved	+b ODOb					133.00
134.00 If this is an organ procurement organization (0P0), ente and termination date, if applicable, in column 2.	r the OPO number	in column i				134. 00
All Providers						
140.00 Are there any related organization or home office costs				Υ		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. are claimed, enter in column 2 the home office chain num			ts			
	2. 00	tt ons)		3. 00		
If this facility is part of a chain organization, enter		ough 143 the	name an	d address	of the home	
office and enter the home office contractor name and con		0	taul a Nice			141 00
141.00 Name: Contractor's Name: 42.00 Street: PO Box:		Contrac	tor's Nu	mber:		141. 00 142. 00
143. 00 Ci ty: State:		Zi p Cod	e:			143. 00
144 00 Are provider based physicians' costs included in Worksho	o+ 12				1. 00 Y	144 00
144.00 Are provider based physicians' costs included in Workshe	et A?				Y	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line				Υ		145. 00
inpatient services only? Enter "Y" for yes or "N" for no no, does the dialysis facility include Medicare utilizat						
period? Enter "Y" for yes or "N" for no in column 2.	TOIL TOIL TILLS COST	reporting				
146.00 Has the cost allocation methodology changed from the pre				N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pu	b. 15-2, chapter	40, §4020)	lf			
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" f					N	147. 00
148.00 Was there a change in the order of allocation? Enter "Y"	•				N	148. 00
149.00 Was there a change to the simplified cost finding method	Part A	Part B		tle V	N Title XIX	149. 00
	1.00	2. 00		3. 00	4.00	
Does this facility contain a provider that qualifies for						
or charges? Enter "Y" for yes or "N" for no for each com 155.00 Hospi tal	N Ponent for Part F	N and Part B	. (See 4	<u>2 CFR 941</u> N	3. 13) N	155. 00
156. 00 Subprovi der - IPF	N N	N N		N	N N	156. 00
157.00 Subprovi der - IRF	N	N		N	N	157. 00
158. 00 SUBPROVI DER		,				158. 00
159. 00 SNF 160. 00 HOME HEALTH AGENCY	N N	l N N		N N	N N	159. 00 160. 00
161. 00 CMHC	IV.	N N		N	N N	161. 00
161. 10 CORF		N		N	N	161. 10
					1.00	
					1. 00	
Multicampus						
Multicampus 165.00 Is this hospital part of a Multicampus hospital that has	one or more camp	uses in dif	ferent Cl	BSAs?	N	165. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no.	<u> </u>					165. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name	County	State Z	ip Code	CBSA	FTE/Campus	165. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	<u> </u>				FTE/Campus 5.00	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	County	State Z	ip Code	CBSA	FTE/Campus 5.00	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	County	State Z	ip Code	CBSA	FTE/Campus 5.00	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	County	State Z	ip Code	CBSA	FTE/Campus 5.00	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	County	State Z	ip Code	CBSA	FTE/Campus 5.00	165. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name O	County	State Z	ip Code	CBSA	FTE/Campus 5.00 0.0	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name 0	County 1.00	State Z 2.00	i p Code 3.00	CBSA	FTE/Campus 5.00	
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name 0	County 1.00	State Z 2.00	i p Code 3.00	CBSA	FTE/Campus 5.00 0.0	00 166. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name 0	County 1.00 rican Recovery ar r "Y" for yes or	State Z 2.00 and Reinvestm "N" for no.	ip Code 3.00	CBSA 4.00	FTE/Campus 5.00 0.0	167. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name	County 1.00 rican Recovery ar r "Y" for yes or ningful user (lin	State Z 2.00 and Reinvestm "N" for no. e 167 is "Y"	ent Act	CBSA 4.00	FTE/Campus 5.00 0.0	167. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name 0	County 1.00 rican Recovery ar r "Y" for yes or ningful user (lin tions) does this provide	State Z 2.00 and Reinvestm "N" for no. e 167 is "Y"	ent Act '), enter	CBSA 4.00	FTE/Campus 5.00 0.0	167. 00
165.00 Is this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no. Name	County 1.00 rican Recovery ar r "Y" for yes or nigful user (lin tions) does this provide "N" for no. (see	State Z 2.00 Mad Reinvestm "N" for no. e 167 is "Y' er qualify for instructions	ent Act '), enter	CBSA 4.00	FTE/Campus 5.00 0.0	167. 00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA	Provider CCN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
				7/14/2021 10:	20 am
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider has section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see inst	on Wkst. S-3, Pt. I, f column 1 is yes, er	line 2, col. 6? Enter	N on	C	171.00

	Financial Systems COLUMBUS REGIO				u of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-0112	Period: From 01/01/2020 To 12/31/2020		
					7/14/2021 10	: 20 am
				Y/N 1. 00	Date	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO r	esnonses Ent		2. 00	
	completed by All Hospitals	101 411 110 1	сэропэсэ. Епт	er arr dates m		
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in o	corullin 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	(coo metrastrono)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports		T		0.4.400.40004	٠.,
1. 00	Column 1: Were the financial statements prepared by a Ceraccountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/28/2021	4.00
5. 00	Are the cost report total expenses and total revenues difficulties on the filed financial statements? If yes, submit reconstructions		Y			5.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is t	he provider i	s N		6.00
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y N		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.00
0. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I&RIN AN AP	proved	N	Y/N	11.00
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			ost reporting	Y N	12. 00 13. 00
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see in	structi ons.	N	14.00
5.00	Did total beds available change from the prior cost report				Y	15.00
			rt A		t B	
		Y/N 1. 00	2. 00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	04/08/2021	Y	04/08/2021	16.00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/08/2021	Y	04/08/2021	17.00
3. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems COLUMBUS REGIO	ONAL HOSPITAL		In Lie	u of Form CN	IS-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S Part II	S-2 Prepared:
		Desc	ription	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	MCD CADE DAD	O T A DISCH & PT	1. 00 Y	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:	DAYS	I A DISCH & PI	ī	IV	20.00
		Y/N	Date	Y/N	Date	
01.00	III	1.00	2.00	3.00	4. 00	01.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
00.00	Capital Related Cost					
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00
23.00	reporting period? If yes, see instructions.	e due to appre	ii sai s iiiade du	iring the cost	IV	25.00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into durir	ng this cost r	eporting period?	N	24.00
25. 00	Have there been new capitalized leases entered into during	g the cost rep	orting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost reper	ting ported?	lf voc. coo	N	26. 00
20.00	instructions.	the cost repor	tring perrou?	ii yes, see	IV	20.00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost report	ing period? I	f yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into d	luring the cos	t reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (Debt Service	Reserve Fund)	Υ	29. 00
	treated as a funded depreciation account? If yes, see instructions					
30. 00	Has existing debt been replaced prior to its scheduled matinstructions.	turity with ne	ew debt? If ye	s, see	N	30.00
31. 00						
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se		shed through c	ontractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ning to compet	itive bidding? If	,	33.00
	no, see instructions.					
34. 00	Provider-Based Physicians Are services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Y	34.00
01.00	If yes, see instructions.	arrangement wi	tii provider b	asea physicians.	•	01.00
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nents with the	provi der-based	Υ	35. 00
				Y/N	Date	
	h 000 0			1.00	2. 00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	prepared by th	ne home office			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			f		38.00
39. 00	If line 36 is yes, did the provider render services to oth			S,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	P If yes, see			40.00
	i nstructi ons.					
			1. 00	2.	00	
41 00	Cost Report Preparer Contact Information	KEDDY		DE LADANO		44.00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO		41.00
42. 00	Enter the employer/company name of the cost report	BKD, LLP				42.00
43. 00	preparer. Enter the telephone number and email address of the cost	317-383-4000		KBEJARANO@BKD.	COM	43. 00
10.00	report preparer in columns 1 and 2, respectively.	17 333 4000		NOES/ IIVINO END.		15.00

Health Financial Systems COLUM	MBUS REGIONA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provi der		Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pre 7/14/2021 10:	pared:
		:	3. 00	_		
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/pos		RECTOR				41.00
held by the cost report preparer in columns 1, 2,	and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost repor	-t					42.00
preparer.						
43.00 Enter the telephone number and email address of t						43.00
report preparer in columns 1 and 2, respectively.						

 Heal th Financial
 Systems
 COLUMBUS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0112 Peri od: Worksheet S-3

					rom 01/01/2020 o 12/31/2020	Part I Date/Time Pre 7/14/2021 10:	pared:
						1/P Days / 0/P Visits /	20 aiii
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1 00	The state Allie A Balle Code as 5 (7 and	1. 00	2. 00	3.00	4. 00	5. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	210	76, 860	0. 00	0	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		210	76, 860	0.00	0	7. 00
8.00	INTENSIVE CARE UNIT	31.00	19	6, 954	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33. 00	0	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		229	83, 814	0.00	0	14.00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVIDER - IPF	40. 00	0	0		0	16.00
17. 00	SUBPROVIDER - IRF	41. 00	22	8, 052		0	17.00
18.00	SUBPROVI DER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44. 00	O	0		0	19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	101 00				0	21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	101. 00				0	22. 00 23. 00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25.00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88.00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		251			_	27. 00
28. 00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges	l l					33. 01

Health Financial SystemsCOLUMBUSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0112

				'	0 12/31/2020	7/14/2021 10:	
		I/P Days	/ O/P Visits	/ Trins	Full Time	Equi val ents	20 4111
		in the says	, 0,. 1.0.10	,ps		equi vai onto	
	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	10, 250	6, 364	26, 115			1.00
	8 exclude Swing Bed, Observation Bed and		.,	-,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 385	ol				2.00
3. 00	HMO IPF Subprovider	0	ol				3.00
4. 00	HMO IRF Subprovider	342	ol				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0.2	ő	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		ő	0			6.00
7. 00	Total Adults and Peds. (exclude observation	10, 250	6, 364	26, 115			7.00
7.00	beds) (see instructions)	10, 200	0,001	20, 110			7.00
8. 00	INTENSIVE CARE UNIT	915	248	3, 186			8.00
9. 00	CORONARY CARE UNIT	713	240	3, 100 0			9.00
10.00	BURN INTENSIVE CARE UNIT		0	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT		0	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)		ď	0			12.00
13. 00	NURSERY		1, 138	3, 003			13.00
14. 00	Total (see instructions)	11, 165	7, 750	32, 304		1, 265. 00	
15. 00	CAH visits	0	7, 730	32, 304	0.00	1, 203. 00	15.00
16. 00	SUBPROVI DER - I PF		o	0	0.00	0.00	
17. 00	SUBPROVI DER - I RF	2, 094	484	3, 712	0.00	•	1
18. 00	SUBPROVI DER	2,074	0	3, 712	0.00	l	1
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	•	1
20. 00	NURSING FACILITY		ď	0	0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		ď	0	0.00	0.00	23.00
24. 00	HOSPI CE						24.00
24. 00	HOSPICE (non-distinct part)			0			24. 00
25. 00	CMHC - CMHC			U			25.00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	0	0	0			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0.00		
27. 00	Total (sum of lines 14-26)	٥	۷	U	0.00	l	
28. 00	1 '		643	3, 099		1, 209. 00	28.00
29. 00	Observation Bed Days	4, 061	043	3, 099			29.00
30.00	Ambulance Trips	4, 061		0			30.00
	Employee discount days (see instruction)			0			
31.00	Employee discount days - IRF			ū			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days	0					33.00
33. UI	LTCH site neutral days and discharges	ı 이	ļ		I	ļ	J 33. UI

Health Financial SystemsCOLUMBUSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0112

					J 12/31/2020	7/14/2021 10:	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 995	1, 796	8, 417	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			830	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE 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	2, 995	1, 796	8, 417	
15. 00	CAH visits		_		_	_	15.00
16.00	SUBPROVIDER - I PF	0.00	0	1	0	0	16.00
17. 00	SUBPROVIDER - IRF	0.00	0		33	281	17.00
18.00	SUBPROVI DER	0.00	0		U	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
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
25. 00	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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Histraction)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
JZ. U1	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
55.51	1 - 1 - 1 - Nout a. days and a sonal god			. 9	ı		, 50.01

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0112

					Ť	o 12/31/2020	Date/Time Pre 7/14/2021 10:	pared: 20 am
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	85, 893, 888	-860, 368	85, 033, 520	2, 642, 040. 00	32. 18	1.00
	instructions)							
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4.00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 2, 036, 275	0	0 2, 036, 275	0. 00 8, 096. 00	0. 00 251. 52	
	Physician-Part B			_				
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		203, 440	0	203, 440	3, 985. 00	51. 05	6.00
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7.00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8.00
9. 00	SNF	44.00	0	0	0	0.00	0.00	
10.00	Excluded area salaries (see instructions)		6, 568, 376	764, 048	7, 332, 424	268, 316. 00	27. 33	10.00
	OTHER WAGES & RELATED COSTS							1
11. 00	Contract Labor: Direct Patient Care		14, 143, 669	0	14, 143, 669	262, 131. 00	53. 96	11.00
12.00	Contract Labor: Top Level		924, 623	241, 825	1, 166, 448	22, 459. 00	51. 94	12.00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part		6, 356, 364	0	6, 356, 364	54, 629. 00	116. 36	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0. 00	14.00
	organization salaries and							
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0. 00	14. 01
14. 02	Related organization salaries		4, 402, 059	0	4, 402, 059			14.02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0. 00	0. 00	16.00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
	- Teachi ng		_	_				
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
47.00	WAGE-RELATED COSTS		00.000.007					1
17. 00	Wage-related costs (core) (see instructions)		22, 932, 907	0	22, 932, 907			17.00
18. 00	Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		2, 203, 393	0	2, 203, 393			19.00
20.00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	A Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A -		0	О	0			22. 00
22. 01	Administrative Physician Part A - Teaching		Λ	0	0			22. 01
23. 00	Physician Part B		673, 034	0	673, 034			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
	approved program)		0					
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		1, 416, 597	О	1, 416, 597			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	_			25. 52
_3. 32	- Administrative -		O	l	I			_0.02
	wage-related (core)							

Worksheet S-3 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/14/2021 10:20 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 141, 863 -128, 645 13, 218 316.00 41. 83 26.00 27.00 Administrative & General 5.00 18, 327, 333 16, 776 18, 344, 109 487, 861. 00 37.60 27.00 28.00 7, 082, 704 7, 082, 704 87, 364. 00 81.07 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 2, 696, 682 2, 719, 324 81, 506. 00 33. 36 30.00 22, 642 2, 081. 00 . Laundry & Linen Service 8.00 35, 822 17. 21 31.00 31.00 35, 822 Housekeepi ng 16. 93 32.00 9.00 2, 088, 485 -18, 338 2,070,147 122, 275. 00 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 2,019,243 -1, 205, 947 813, 296 42, 305. 00 19. 22 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 1, 171, 323 1, 171, 323 64, 538. 00 18. 15 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 Nursing Administration 4, 732, 643 42.03 38.00 38.00 13.00 214,080 4, 946, 723 117, 686. 00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 2, 809, 671 60, 811. 00 40.00 Pharmacy 15.00 3, 160, 194 -350, 523 46. 20 40.00 Medical Records & Medical Records Library 1, 007, 531 1, 867, 614 41.00 16.00 -860, 083 35, 905. 00 28.06 41.00

0

0

0.00

0.00

0

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0112	Period: Worksheet S-3

						From 01/01/2020 Fo 12/31/2020		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		90, 736, 877	-860, 368	89, 876, 509	2, 717, 323. 00	33. 08	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 568, 376	764, 048	7, 332, 42	268, 316. 00	27. 33	2.00
	instructions)							
3.00	Subtotal salaries (line 1		84, 168, 501	-1, 624, 416	82, 544, 08	2, 449, 007. 00	33. 71	3.00
	minus line 2)							
4.00	Subtotal other wages & related		25, 826, 715	241, 825	26, 068, 540	379, 931. 00	68. 61	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 349, 504	0	24, 349, 504	0.00	29. 50	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		134, 344, 720	-1, 382, 591	132, 962, 129	2, 828, 938. 00	47. 00	6.00
7.00	Total overhead cost (see		42, 152, 583	-1, 138, 715	41, 013, 868	1, 102, 648. 00	37. 20	7.00
	instructions)							
				•	•	•		

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet S-3
			Date/Time Prepared:

	To 12/31/2020	Date/Time Pre 7/14/2021 10:	
		Amount	20 4
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 688, 818	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)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	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)	12, 786, 442	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	305, 658	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57, 073	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, 445, 063	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1, 069, 049	
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	6, 131, 978	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	170, 081	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
	Tuition Reimbursement	155, 173	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	25, 809, 335	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet S-3 Part V

	i i	o 12/31/2020	Date/Time Pre 7/14/2021 10:	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		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, 143, 669	25, 809, 335	1.00
2.00	Hospi tal	14, 143, 669	25, 809, 335	2.00
3.00	Subprovi der - IPF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (Other)	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
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17.00	Renal Dialysis	0	0	17.00
18. 00	Other	0	0	18. 00

	Financial Systems COLUMBUS REGIONAL HO			u of Form CMS-2				
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-0112	Peri od: From 01/01/2020	Worksheet S-1	0			
			To 12/31/2020		pared: 20 am			
				1. 00				
	Uncompensated and indigent care cost computation			1.00				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	ded by line 202 colu	mn 8)	0. 346670	1.00			
2. 00	Net revenue from Medicaid			15, 892, 771	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?	N	4.00			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	n Medicaid		7, 151, 109	1			
6.00	Medicaid charges			110, 592, 356	1			
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (li	no 7 minus sum of I	ines 2 and 5: if	38, 339, 052 15, 295, 172	1			
0.00	<pre>< zero then enter zero)</pre>	ne / iiii nas saiii oi i	THES Z and S, TT	13, 273, 172	0.00			
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			1			
9. 00	Net revenue from stand-alone CHIP			0				
10.00	Stand-alone CHIP charges			0				
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (li	no 11 minus lino 0:	if < zoro thon	0				
12.00	enter zero)	ne ii iiiiius iine 9,	ii < Zeio tileli		12.00			
	Other state or local government indigent care program (see instru	ctions for each lin	e)		1			
13. 00	Net revenue from state or local indigent care program (Not include	ded on lines 2, 5 or	9)	0	13.00			
14. 00	Charges for patients covered under state or local indigent care p 10)	orogram (Not include	d in lines 6 or	0	14.00			
15. 00	State or local indigent care program cost (line 1 times line 14)			0	15.00			
16. 00	Difference between net revenue and costs for state or local indig	gent care program (I	ine 15 minus line	0	16.00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and atata/lacal ind	lant oone progra	ma (222	-			
	instructions for each line)		rgent care progra	,				
	Private grants, donations, or endowment income restricted to fund	9			17.00			
18. 00 19. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i		ms (sum of lines	0 15, 295, 172				
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1				
		patients	pati ents	+ col . 2)				
		1.00	2.00	3. 00				
	Uncompensated Care (see instructions for each line)							
20. 00	Charity care charges and uninsured discounts for the entire facil (see instructions)	i ty 16, 129, 5	4, 064, 134	20, 193, 705	20.00			
21. 00	Cost of patients approved for charity care and uninsured discount instructions)	s (see 5,591,6	4, 064, 134	9, 655, 772	21.00			
22. 00	Payments received from patients for amounts previously written of charity care	f as	0 0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)	5, 591, 6	4, 064, 134	9, 655, 772	23. 00			
				1. 00				
24 00	Does the amount on line 20 column 2, include charges for patient	days beyond a Lengt	h of stav limit	N N	24.00			
	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	rogram?	•	0				
	stay limit		0 . dgtii 0i					
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (*		6, 437, 879 581, 763				
27. 00 27. 01	Medicare allowable bad debts for the entire hospital complex (see	•		895, 021	27.00			
28. 00	Non-Medicare bad debt expense (see instructions)			5, 542, 858	1			
20.00		se (see instruction	s)					
29. 00	, ,							
29. 00 30. 00	Cost of non-medicare and non-reimbursable medicare bad debt exper Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	•	3)	11, 890, 573 27, 185, 745	30.00			

	Financial Systems	COLUMBUS REGIONA		011 45 0440		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0112	Period: From 01/01/2020	Worksheet A	
				-	Γο 12/31/2020	Date/Time Pre	pared:
	Coot Contar Department on	Colorias	O+box	Total (col 1	Dool oooi fi oot	7/14/2021 10:	20 am
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 001. 2)	A-6)	(col . 3 +-	
					,	col . 4)	
	JOSUS DA LA CONTROL DE LA CONT	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		22, 936, 146	22, 936, 140	-12, 728, 568	10, 207, 578	1.00
2. 00	00200 CAP REL COSTS-BEDG & TTAT		22, 930, 140		14, 581, 858		
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	141, 863	29, 155, 058	29, 296, 92 ⁻	1 -1, 671, 852	27, 625, 069	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	18, 327, 333	48, 341, 083			61, 533, 401	5. 00
7.00	00700 OPERATION OF PLANT	2, 696, 682	7, 098, 961				
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	35, 822 2, 088, 485	728, 624 576, 507			764, 446 2, 646, 654	
10.00	01000 DI ETARY	2, 019, 243	819, 469			1, 149, 108	
11.00	01100 CAFETERI A	0	0	1	1, 654, 980		
13.00	01300 NURSING ADMINISTRATION	4, 732, 643	722, 500				
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	687, 576			907, 322	
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	3, 160, 194 1, 867, 614	1, 788, 691 462, 963				
17. 00	01700 SOCIAL SERVICE	1,007,014	402, 703	2, 330, 37	0	1, 333, 676	17.00
23. 00	02300 PARAMED ED PRGM	o	0		0	0	23. 00
23. 01	02301 XRAY EDUCATION	158, 969	9, 860				
23. 02	02302 PHARMACY RESIDENCY PROG	210, 659	4, 627	215, 28	196, 637	411, 923	23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	15, 313, 064	1, 998, 507	17, 311, 57	1 351, 057	17, 662, 628	30.00
31.00	03100 I NTENSI VE CARE UNIT	2, 513, 455	1, 200, 001		· ·	3, 511, 431	
32. 00	03200 CORONARY CARE UNIT	0	0	(0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	O	0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34.00
40.00	04000 SUBPROVI DER - I PF	1 452 (20	125.040	1 507 444	0	1 005 407	40.00
41. 00 42. 00	04100 SUBPROVI DER	1, 452, 620	135, 040	1, 587, 660	298, 037	1, 885, 697 0	1
43. 00	04300 NURSERY	979, 270	44, 727	1, 023, 99	7 -25, 781	998, 216	
44.00	04400 SKILLED NURSING FACILITY	0	0	1	0		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	878, 271	24, 481, 140				
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	4, 244	921, 176 0	1	255, 281	1, 180, 701 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		86, 053	1	-	_	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 608, 771	572, 866	1		1, 956, 108	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	431, 867	1, 143, 145				
54. 02	05404 ULTRA SOUND	459, 667	49, 379	1			
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	603, 690 638, 453	161, 384 1, 278, 748	1			
57. 00	05700 CT SCAN	704, 783	589, 155				
	05800 MRI	287, 919	53, 432				
	05900 CARDI AC CATHETERI ZATI ON	1, 519, 863	3, 722, 001				
	06000 LABORATORY	3, 871, 860	6, 121, 142				
60. 01 62. 00	06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	346, 237	544, 633 492, 180			1, 126, 070 570, 736	
65.00	06500 RESPIRATORY THERAPY	1, 870, 192	492, 166			2, 300, 517	
66.00	06600 PHYSI CAL THERAPY	2, 255, 997	1, 824, 684		· ·	4, 051, 145	1
67. 00	06700 OCCUPATI ONAL THERAPY	399, 523	402, 360			1, 408, 364	67. 00
68.00	06800 SPEECH PATHOLOGY	432, 657	362, 831			707, 009	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	600, 349 569, 318	300, 067 117, 502			946, 746 832, 407	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	307, 310	117, 302	1	6, 738, 858		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0		6, 405, 553	6, 405, 553	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	22, 682, 389			22, 682, 389	1
74.00	07400 RENAL DI ALYSI S	0	862, 882	1		862, 882	1
76. 00	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0 195, 987	69.704		0	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	175, 767	68, 704	264, 69	1 -2, 363	262, 328	70.97
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0	89. 00
90.00	09000 CLINIC	1, 342, 143	129, 578			1, 484, 632	
90. 01 90. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH	86, 019 285, 617	67, 508 9, 539	1		153, 527 299, 738	
90. 02	09003 WOUND CENTER	581, 355	991, 402				
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	1	209, 833		
90. 05	09005 VI MCARE CLI NI C	518, 186	63, 318	1	12, 375	593, 879	90.05
90.06	09006 MEDICATION MGMT CLINIC	242, 037	2, 395				
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	4, 714, 839	1, 254, 795	5, 969, 63	2, 560, 268	8, 529, 902	91. 00 92. 00
72. UU	OTHER REIMBURSABLE COST CENTERS			1			J 7∠. UU
95.00	09500 AMBULANCE SERVICES	3, 368, 787	326, 375	3, 695, 162	2 44, 034	3, 739, 196	95.00
		•					

Health Financial Systems	COLUMBUS REGION.	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2020 o 12/31/2020	Date/Time Pre	anrod:
			'	0 12/31/2020	7/14/2021 10: 2	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
·			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
99. 10 09910 CORF	0	0	0	0	· ·	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS		. 1				
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0	0		111.00
113. 00 11300 INTEREST EXPENSE	04 547 547	1, 181, 826				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	84, 516, 547	188, 067, 195	272, 583, 742	440, 963	273, 024, 705	118.00
NONREI MBURSABLE COST CENTERS		ما	0	0	0	190. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 194. 00 07950 WELLNESS COMMUNITY	U	O O	0	256, 304	256, 304	
194.00 07950 WELLINESS COMMUNITY 194.01 07951 BUI LDI NG RENTALS	0	2, 106, 897	2, 106, 897		244, 459	
194. 02 07952 HOSPI CE		99, 093		· · ·	99, 093	
194. 03 07953 0UTREACH CLINICS		77, 073	77, 073	0		194. 02
194. 04 07954 SPEECH - HEARING AIDS		0	0	158, 427	158, 427	
194. 05 07955 NONALLOWABLE MARKETING		0	0	535, 757	535, 757	
194. 06 07956 CRH FOUNDATION	45, 957	536	46, 493	· ·	46, 493	
194. 07 07957 HEALTHY COMMUNI TI ES	0	0	.5, 170	0	•	194. 07
194. 08 07958 CRHP	1, 331, 384	1, 168, 338	2, 499, 722	470, 987	2, 970, 709	
194. 09 07959 NEUROPSYCH PART B	0	0	0	0	· · · · ·	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	85, 893, 888	191, 442, 059	277, 335, 947	0	277, 335, 947	200. 00

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10: 20 am

			7/14/2021 10:	20 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	6. 00	Allocation 7.00	-	
GENERAL SERVICE COST CENTERS	0.00	7.00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-807, 805	9, 399, 773		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-174, 457		· ·	2.00
3.00 00300 OTHER CAP REL COSTS	0	0		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-427, 512		'	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-20, 852, 551			5.00
7.00 00700 OPERATION OF PLANT	-420, 715			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0		l l	8.00
9. 00 00900 HOUSEKEEPI NG	0	_, -, ,		9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	-17, 310 -637, 052			10. 00 11. 00
13. 00 O1300 NURSING ADMINISTRATION	-037,032			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0			14.00
15. 00 01500 PHARMACY	-72, 040			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-3, 149			16.00
17. 00 01700 SOCIAL SERVICE	0			17.00
23.00 02300 PARAMED ED PRGM	0	0		23. 00
23. 01 02301 XRAY EDUCATI ON	-25, 348			23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	0	411, 923	3	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	077 400	10.000.011		00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	377, 183			30.00
32. 00 03200 CORONARY CARE UNIT	0			31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0		34.00
40. 00 04000 SUBPROVI DER - PF	0			40.00
41. 00 04100 SUBPROVI DER - I RF	0	1, 885, 697	,	41.00
42. 00 04200 SUBPROVI DER	0			42.00
43. 00 04300 NURSERY	0	998, 216		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCILLARY SERVICE COST CENTERS	0.500.011	15.0/4.004		
50. 00 05000 OPERATING ROOM	-3, 530, 311			50.00
51. 00 05100 RECOVERY ROOM	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	-8, 588	1		52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-80, 612			54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	00,012			54. 01
54. 02 05404 ULTRA SOUND	0			54.02
54. 03 05405 MAMMOGRAPHY	-1, 066			54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	-18, 247	2, 781, 981		55.00
57. 00 05700 CT SCAN	0	1, 492, 677	'	57.00
58. 00 05800 MRI	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	,		59.00
60. 00 06000 LABORATORY	0			60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	-37, 356		·	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPIRATORY THERAPY	15 462			62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	-15, 462 -24, 443			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	-24, 443			67.00
68. 00 06800 SPEECH PATHOLOGY	-859		· ·	68.00
69. 00 06900 ELECTROCARDI OLOGY	-11, 112			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 738, 858	3	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 405, 553	3	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	22, 682, 389		73.00
74. 00 07400 RENAL DI ALYSI S	0	862, 882		74.00
76. 00 03020 ACUPUNCTURE	0			76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	262, 328	3	76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	N	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1		89.00
90. 00 09000 CLINIC	0	1		90.00
90. 01 09001 DI ABETES CENTER	0			90. 01
90. 02 09002 NEUROPSYCH	-203, 440			90.02
90. 03 09003 WOUND CENTER	-24, 813	· ·		90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	-986			90. 04
90. 05 09005 VI MCARE CLI NI C	0			90. 05
90.06 09006 MEDICATION MGMT CLINIC	0	234, 247		90.06
91. 00 09100 EMERGENCY	-676, 605	7, 853, 297	/	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS	747 497	2 001 7/0		0F 00
95. 00 09500 AMBULANCE SERVICES 99. 10 09910 CORF	-747, 436 0			95. 00 99. 10
10 / / / / / / / / / / / / / / / / / /	1 0		1	1 //. 10

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

			7/14/2021 10: 20 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7.00	
101.00 10100 HOME HEALTH AGENCY	0	0	101. 00
SPECIAL PURPOSE COST CENTERS			
109.00 10900 PANCREAS ACQUISITION	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113.00 11300 I NTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-28, 442, 092	244, 582, 613	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	256, 304	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	244, 459	194. 01
194. 02 07952 HOSPI CE	0	99, 093	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	158, 427	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	535, 757	194. 05
194.06 07956 CRH FOUNDATION	0	46, 493	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	194. 07
194. 08 07958 CRHP	-354, 200	2, 616, 509	194. 08
194.09 07959 NEUROPSYCH PART B	0	o	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-28, 796, 292	248, 539, 655	200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0112

Cost Center						10	12/31/2020) Date/lime Prepared: 7/14/2021 10:20 am
Column C						1		
B. REFLASS INTEREST								
1.00			3.00	4. 00	5. 00			
2.00 2.00 2.00 2.20 0.00 2.20 0.00 0.	1 00		1 00	O	899 744			1 00
C		•						1
CAP FIT COSTS IBS A FIXT 1.00		0						
2 00 LaBORATORY 0.0 0 0 4, 760 2.0 0 4, 760 1.0 0 2.333 3.0 0 3.		C - RECLASS INSURANCE						
3.00 COUPATI ONLA THERAPY 57.00 0 2,333 3.00		•	l l	-				1
ABBILLANCE SERVICES		1	l I					1
O		1						1
1. 00 0	4.00	O	95.00					4.00
ADMIN ISTRATILY & GENERAL 5.00 851,181 136,596		D - RECLASS BILLING COST		<u> </u>	700,000			
E - RECLASS INFERRANC CYNSEN TIERAPY 90 .04 100,624 51,313 1.00	1.00		5. 00	851, 181	136, 596			1.00
MPERBARIC OXFORD THERAPY		0 — — — — —		851, 181	136, 596			
CAFETERIA EXPENSE 11.00 1.191.758 483.657 1.00 6.24 6.25 1.00 6.24 6.25 1.00 6.25 6.25 1.00 7.191.758 483.657 1.00 7.191.758 483.657 1.00 7.191.758 483.657 1.00 7.191.758 483.657 1.00 7.191.758 7.191.75								
F - RECLASS CAPELENIA & XMERINS 1.00	1. 00	HYPERBARI C OXYGEN THERAPY	90.04					1.00
1.00		U DECLASS CAFETERIA EVDENSI	<u> </u>	100, 624	51, 313			
O	1 00			1 101 759	183 657			1 00
Company Comp	1.00	0	<u> </u>					1.00
Name		G - RECLASS WELLNESS		.,,,				
H - RECLASS PHYSICIAN FEES	1.00		194. 00					1.00
1.00 ADULTS & PEDIATRICS 30.00 0 722,740 2.00 2.00 SUBPROVIDER - IRE 41.00 0 229,241 2.00 3.00 OPERATI NG ROOM 50.00 0 60.000 4.00 4.00 AMESTHESI OLOGY 53.00 0 6.00 60.000 5.00 5.00 RADI OLOGY-THERAPUTIC 54.00 0 5.00 6.00 7.00 RADI OLOGY-THERAPUTIC 55.00 0 45.000 7.00 8.0 LABORATORY-PATHOLOGICAL 60.01 0 225.000 8.00 9.00 RESPI RATORY THERAPY 66.00 0 49.750 10.00 11.00 BELECTROCARDI OLOGY 69.00 0 49.750 10.00 12.00 ELECTROCARDI OLOGY 69.00 0 53.717 11.00 13.00 WOLLAGE CLINIC 90.03 0 63.758 13.00 15.00 LECTROCARDI OLOGY 90.05 0 2.050 0 15.00		0		136, 552	36, 135			
2.00 SUBPROVIDER - IRF				_1	705 - :-1			
3.00 OPERATI NG ROOM			1	-				
4. 00 ANESTHESIOLOGY 53. 00 0 60. 000 5. 000 5. 000 6. 00 MAMMOGRAPHY 54. 03 0 2. 083 6. 00 7. 00 ADIOLOGY-DIAGNOSTIC 55. 00 0 0 45. 000 7. 00 ADIOLOGY-THERAPEUTIC 55. 00 0 0 45. 000 7. 00 ADIOLOGY-THERAPEUTIC 55. 00 0 0 45. 000 7. 00 ADIOLOGY-THERAPEY 66. 00 0 44. 550 9. 00 0 44. 550 10. 0		I	1	-1				
5. 00 ARDI OLOGY-DI AGNOSTI C 54. 00 0 50.00 45.00 6.00 7. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 2. 083 6.00 8. 00 LASROATORY-PATRIOLOGI CAL 60. 01 0 2.5000 8.00 9. 00 RESPI RATORY THERAPY 65. 00 0 48. 000 9. 00 11. 00 RESPI RATORY THERAPY 65. 00 0 48. 000 9. 00 11. 00 DELECTROCARDI GLOGY 69. 00 0 53. 717 11. 00 12. 00 ELECTROCARDI GLOGY 69. 00 0 53. 717 11. 00 13. 00 WOUND CENTER 90. 03 0 63. 758 13. 00 15. 00 WOUND CENTER 90. 05 0 2. 013 14. 00 15. 00 WI MCARE CLINYEE THERAPY 90. 05 0 2. 00 15. 00 15. 00 WI MCARE CLING 91. 00 0 2. 580. 484 16. 00 17. 00 RECLASS REMAS SERVICES 95. 00 0 13. 125		I	1		· ·			1
6.00 MAMMOGRAPHY 54.03 0 2.083 6.00 7.00 8.00 1.00 CM THERAPEUTIC 55.00 0 0 45.000 7.00 8.00 1.00 CM THERAPEUTIC 55.00 0 0 45.000 7.00 8.00 1.00 CM THERAPY 65.00 0 0 48.000 9.00 10.00 PhySI CAL THERAPY 65.00 0 0 48.000 9.00 PhySI CAL THERAPY 65.00 0 0 49.750 110.00 12.00 PhySI CAL THERAPY 70.00 0 53.717 110.00 12.00 ELECTROCARDIOLOGY 69.00 0 53.717 110.00 12.00 ELECTROCARDIOLOGY 69.00 0 6 36.25 110.00 14.00 PhyPERBARI C OXYGEN THERAPY 90.03 0 63.758 110.00 PhyPERBARI C OXYGEN THERAPY 90.04 0 2.613 14.00 PhyPERBARI C OXYGEN THERAPY 90.04 0 2.613 14.00 PhyPERBARI C OXYGEN THERAPY 90.05 0 20.000 15.00 PhySI CAL THERAPY 90.05 0 20.000 15.00 PhySI CAL THERAPY 90.05 0 20.000 17.00 PhySI CAL THERAPY 90.05 PhySI CAL THERAPY 90.05 PhySI CAL THERAPY 90.05 PhySI CAL THERAPY 95.00 PhySI Ph		I	l l		· ·			1
B. 00 LABORATORY-PATHOLOGICAL 60. 01 0 225,000 9,00 8,000 9,00				o				1
9.00 RESPIRATORY THERAPY 66.00 0 48,000 9.00 11.00 PISTO AL THERAPY 66.00 0 49,750 11.00 ELECTROCARDIOLOCY 69.00 0 53,717 11.00 12.00 ELECTROCARDIOLOCY 70.00 0 8,625 12.00 13.00 MOUND CENTER 90.03 0 63,758 13.00 14.00 PYPERBARI COXYGEN THERAPY 90.04 0 2,613 14.00 PYPERBARI COXYGEN THERAPY 90.05 0 20,000 15.00 VINCARE CLINIC 90.05 0 20,000 16.00 EMERGENCY 91.00 0 2,580,484 16.00 10.00 10.00 10.00 10.00 EMERGENCY 91.00 0 5,128,958 10.00 1	7.00	RADI OLOGY-THERAPEUTI C	55. 00	0	45, 000			7. 00
10.00 PHYSICAL THERAPY		•	l l	0	· ·			1
11. 00		•	1	0				1
12.00		1		0				1
13. 00 MOUND CENTER 90. 03 0 63. 758 13. 00 14. 00 HYPERBARI C DYYGEN THERAPY 90. 04 0 2, 613 14. 00 15. 00 TIMOARE CLINIC 90. 05 0 20, 000 15. 00 16. 00 EMERGENCY 91. 00 0 2,589. 484 16. 00 17. 00 EMERGENCY 95. 00 0 13. 125 17. 00 1 - RECLASS REHAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REHAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REMAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REMAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REMAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REHAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REHAB SERVICES 95. 00 0 13. 125 17. 00 1 - RECLASS REHAB SERVICES 95. 00 0 13. 125 17. 00 2 - 00 0 0 0 0 0 0 0 0 3 - BUBPROVI DER - I RF 41. 00 89. 301 43.3 4. 00 4 - 00 0 0 0 0 0 0 0 0 6 - 00 0 0 0 0 0 0 0 6 - 00 0 0 0 0 0 0 0 8 - 00 0 0 0 0 0 0 0 9 - 00 0 0 0 0 0 0 0 9 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 0 10 - 00 0 0 0 0 0 0 10 - 00 0		1	l I	0				1
14. 00		1	l I	o				
1.00 MBULANCE SERVICES			l I	o				
17.00	15.00	VIMCARE CLINIC	90. 05	0	20, 000			15.00
C		•	l I	0				1
- RECLASS REHAB SERVI CES	17. 00	AMBULANCE SERVICES	95.00					17.00
1.00		O DECLASS DELIAD SEDVICES		O	5, 128, 958			
2. 00	1 00		194 00	9 786	505			1 00
3.00 SUBPROVI DER - I RF		1	l I					
5. 0.0 OCCUPATI ONAL THERAPY 67. 0.0 10, 041 578 5. 0.0 6. 0.0 SPEECH PATHOLOGY 68. 0.0 11, 682 361 6. 0.0 8. 00 LECTROENCEPHALOGRAPHY 70. 00 12, 551 722 7. 0.0 8. 00 NEUROPSYCH 90. 02 5, 020 289 8. 00 J - RECLASS PHARMACY RES PROGRAM PHARMACY RESI DENCY PROG 23. 02 194, 811 1, 826 1. 00 2. 00 0 0 0 0 0 2. 00 C PHARMACY RESI DENCY PROG 23. 02 194, 811 1, 826 1. 00 2. 00 C PHARMACY RESI DENCY PROG 23. 02 194, 811 1, 826 1. 00 2. 00 C PHARMACY RESI DENCY PROG 23. 02 194, 811 1, 826 1. 00 2. 00 C PHARMACY RESI DENCY PROG 23. 02 194, 811 1, 826 1. 00 2. 00 1. 00 ADMIN IN STRATI VE & GENERAL 5. 00 196, 71 1. 00 1. 00 1.			1					
6. 00 SPECH PATHOLOGY 68. 00 11, 682 361 7.00 ELECTROENCEPHALOGRAPHY 70. 00 12, 551 7.22 7.00 7. 00 7	4.00	PHYSI CAL THERAPY	66. 00	18, 827	1, 083			4.00
7. 00 ELECTROENCEPHALOGRAPHY 70. 00 12, 551 722 7. 00 8. 00 NEUROPSYCH 90. 02 5, 020 289 8. 00 0 162, 321 4, 260 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 2. 00 0. 00								
R. 00								
1.00								
1.00	8. UU	NEURUPSICH	<u> </u>					8.00
1.00 PHARMACY RESI DENCY PROG 23.02 194,811 1,826 2.00 0 0 0 0 0 0 0 0 0		J - RECLASS PHARMACY RES PRO	GRAM	102, 321	4, 200			
2.00	1. 00			194, 811	1, 826			1.00
X - RECLASS RENT EXPENSE				0	0			
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 196, 271 1. 00 2. 00 OPERATI ON OF PLANT 7. 00 0 106, 734 2. 00 3. 00 XRAY EDUCATI ON 23. 01 0 11, 860 3. 00 4. 00 MAMMOGRAPHY 54. 03 0 101, 582 4. 00 5. 00 LABORATORY 60. 00 0 24, 663 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00		0		194, 811	1, 826			
2. 00 OPERATI ON OF PLANT 7. 00 0 106, 734 2. 00 3. 00 XRAY EDUCATI ON 23. 01 0 11, 860 3. 00 4. 00 MAMMOGRAPHY 54. 03 0 101, 582 4. 00 5. 00 LABORATORY 60. 00 0 24, 663 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 CRHP 194. 08 0 465, 689 14. 00				.1	22. 2-1			
3. 00 XRAY EDUCATION 23. 01 0 11, 860 3. 00 4. 00 MAMMOGRAPHY 54. 03 0 101, 582 4. 00 5. 00 LABORATORY 60. 00 0 24, 663 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 14. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00			l I	0				
4. 00 MAMMOGRAPHY 54. 03 0 101, 582 4. 00 5. 00 LABORATORY 60. 00 0 24, 663 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00		1		O				
5. 00 LABORATORY 60. 00 0 24, 663 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNITY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00								1
6. 00 PHYSI CAL THERAPY 66. 00 0 376, 929 6. 00 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNITY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00				ol				
7. 00 OCCUPATI ONAL THERAPY 67. 00 0 148, 144 7. 00 8. 00 SPEECH PATHOLOGY 68. 00 0 61, 333 8. 00 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00				ō				•
9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 127, 536 9. 00 10. 00 WOUND CENTER 90. 03 0 100, 379 10. 00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00	7.00	OCCUPATI ONAL THERAPY	67. 00	О	148, 144			7. 00
10. 00 WOUND CENTER 90. 03 0 100, 379 10.00 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00			l I	O				
11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 55, 283 11. 00 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNI TY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00				0				
12. 00 AMBULANCE SERVICES 95. 00 0 15, 000 12. 00 13. 00 WELLNESS COMMUNITY 194. 00 0 71, 035 13. 00 14. 00 CRHP 194. 08 0 465, 689 14. 00			l I	0				
13.00 WELLNESS COMMUNITY 194.00 0 71,035 13.00 14.00 CRHP 194.08 0 465,689 14.00				O				
14. 00 CRHP 194. 08 0 465, 689 14. 00		1		0				
				ol				

| Peri od: | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: | 7/14/2021 10:20 am Provider CCN: 15-0112

					7/14/2021 10:	20 am_
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	L - RECLASS MARKETING EXPENSE					
1. 00	NONALLOWABLE MARKETING	194. 05	•	140, 000		1. 00
	U DEGLACE DEPOSED ATLAN EVE	-NCE	0	140, 000		
1 00	M - RECLASS DEPRECIATION EXPE		ما	14 200 77/		1 00
1. 00	CAP REL COSTS-MVBLE EQUIP TOTALS		0	<u>14, 299, 7</u> 76 14, 299, 776		1. 00
	N - RECLASS MAINTENANCE EXPEN	JCE	UU	14, 299, 770		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	9, 750		1.00
2. 00	NURSING ADMINISTRATION	13. 00	ő	4, 894		2. 00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	79, 692		3.00
4. 00	PHARMACY	15. 00	o	37, 593		4. 00
5.00	OPERATING ROOM	50.00	O	333, 811		5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	O	194, 265		6.00
7.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	O	202, 737		7.00
8.00	ULTRA SOUND	54. 02	O	88, 796		8.00
9.00	MAMMOGRAPHY	54. 03	0	301, 621		9.00
10.00	RADI OLOGY-THERAPEUTI C	55. 00	0	822, 217		10.00
11. 00	CT SCAN	57. 00	0	236, 100		11.00
12.00	MRI	58. 00	0	129, 349		12.00
13.00	CARDI AC CATHETERI ZATI ON	59.00	0	172, 211		13.00
14.00	LABORATORY	60.00	0	289, 459		14.00
15.00	LABORATORY - PATHOLOGI CAL	60. 01	0	10, 200		15.00
16.00	RESPIRATORY THERAPY	65. 00	0	3, 542		16.00
17. 00	EMERGENCY	<u>91.</u> 00		32, 124		17. 00
	O - RECLASS DI RECTOR PHARMACY	/	U	2, 948, 361		
1. 00	RADI OLOGY-THERAPEUTI C	55. 00	15, 819	0		1.00
2. 00	RESPIRATORY THERAPY	65. 00	45, 198	Ö		2. 00
3. 00	CLI NI C	90.00	15, 819	Ö		3. 00
4.00	EMERGENCY	91.00	58, 757	0		4.00
5.00	AMBULANCE SERVICES	95. 00	45, 198	0		5.00
	0		180, 791	0		
	Q - RECLASS XRAY EDUCATION EX					
1. 00	XRAY EDUCATION	23. 01	353, 608	4, 430		1.00
2.00		0. 00	0	0		2. 00
3. 00		0.00	0	0		3. 00
	S - RECLASS NON ALLOW ADVERTI	SINC COSTS	353, 608	4, 430		
1. 00	NONALLOWABLE MARKETING	194. 05	0	395, 757		1. 00
1.00	0		- — "	395, 757		1.00
	U - RECLASS CHARGEABLE SUPPLY	/ COST	-1	512/121		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	6, 738, 858		1.00
	PATI ENT					
2.00	IMPL. DEV. CHARGED TO	72. 00	0	6, 405, 553		2.00
	PATI ENTS					
3. 00	SPEECH - HEARING AIDS	194. 04	0	158, 427		3. 00
4. 00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	o	o		8. 00
9. 00		0.00	o	o		9. 00
10.00		0.00	ő	Ö		10.00
11. 00		0. 00	ő	Ö		11. 00
12. 00		0. 00	o	Ö		12.00
13.00		0.00	o	O		13.00
14.00		0. 00	О	0		14.00
15.00		0.00	0_	0		15.00
	0		0	13, 302, 838		
1 00	V - RECL PTO COST FOR STD ELI		2	75 707		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	75, 787		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	7, 569		2.00
3. 00 4. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23, 335 16, 864		3. 00 4. 00
4. 00 5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	24, 287		4. 00 5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	34, 958		6. 00
7. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	6, 538		7. 00
8. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	ő	25, 742		8. 00
9. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	192, 293		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	39, 703		10.00
11.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33, 982		11.00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	23, 078		12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	13, 012		13.00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	24, 274		14.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10: 20 am Provider CCN: 15-0112

					7/14/2021 10	:20 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
15.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	418		15. 00
16.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	13, 356		16.00
17.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	2, 144		17.00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9		18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	9, 129		19. 00
20. 00		4.00	0			20.00
	EMPLOYEE BENEFITS DEPARTMENT		-1	19, 280		1
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47, 127		21.00
22.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	22, 234		22. 00
23.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 697		23.00
24.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 581		24.00
25.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	3, 428		25.00
26.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	7, 387		26.00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 465		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	2, 363		28. 00
		1	0			29. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	U	8, 854		1
30.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	727		30.00
31.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 100		31.00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 865		32.00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 185		33.00
34.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	83, 601		34.00
35.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	61, 996		35.00
				860, 368		
	X - RECLASS OT SALARIES AND	THER EXP	U ₁	300, 300		1
1. 00		67. 00	238, 393	212, 222		1.00
1.00	OCCUPATI ONAL THERAPY	— <u>67.</u> 00				1.00
	7 DECLACE LAB BLOOD CHEES	LCOD	238, 393	212, 222		-
4 00	Z - RECLASS LAB BLOOD SUPERV			-1		
1. 00	WHOLE BLOOD & PACKED RED	62. 00	78, 556	0		1.00
	BLOOD CELL					
	0		78, 556			
	WA - RECLASS CONTRACT LABOR	BENEFITS				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	400, 530		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	o	140, 054		2.00
3.00	OPERATING ROOM	50.00	o	1, 610, 382		3.00
4. 00	RECOVERY ROOM	51.00	o	250, 268		4. 00
4.00	O TREE TREE TREE TREE TREE TREE TREE TRE		— — — }	2, 401, 234		4.00
	WB - RECLASS SALARIES TO HOM	E DEDT		2,401,234		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	39, 516		1.00
	l .					1
2.00	OPERATION OF PLANT	7. 00	30, 211	0		2.00
3. 00	HOUSEKEEPI NG	9. 00	4, 997	0		3.00
4.00	DI ETARY	10. 00	1, 716	0		4. 00
5.00	CAFETERI A	11. 00	2, 472	0		5.00
6.00	NURSING ADMINISTRATION	13. 00	57, 148	0		6.00
7.00	PHARMACY	15. 00	31, 617	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16. 00	12, 664	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	35, 139	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	5, 058	Ö		10.00
11. 00	SUBPROVI DER - I RF	41.00	18, 346	ő		11.00
				-		1
12.00	OPERATING ROOM	50.00	5, 117	33, 467		12.00
13.00	RECOVERY ROOM	51. 00	0	5, 013		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	18, 725	0		14. 00
15.00	MAMMOGRAPHY	54. 03	4, 335	0		15.00
16.00	CARDIAC CATHETERIZATION	59. 00	5, 867	0		16. 00
17.00	LABORATORY	60.00	20, 025	0		17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 008	o		18. 00
19. 00	RESPIRATORY THERAPY	65.00	5, 499	o		19. 00
20. 00	ELECTROENCEPHALOGRAPHY	70.00	4, 618	0		20.00
	l .					21.00
21. 00	WOUND CENTER	90. 03	4, 916	0		1
22.00	EMERGENCY	91.00	4, 826	0		22.00
23. 00	AMBULANCE SERVICES	95. 00	4, 835	0		23. 00
24.00	WELLNESS COMMUNITY	194. 00	3, 291	0		24. 00
25.00	CRHP	194. 08	<u>5, 2</u> 98	0		25. 00
	0		287, 728	77, 996		_
	WC - RECLASS SEVERANCE PAY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	6, 899	0		1.00
2.00	DI ETARY	10.00	959	0		2.00
3. 00	CAFETERI A	11. 00	1, 380	Ö		3.00
4. 00	NURSING ADMINISTRATION	13. 00	191, 890	Ö		4. 00
5. 00	MEDICAL RECORDS & LIBRARY	16. 00	4, 176	0		5.00
						1
6. 00	OPERATING ROOM	50.00	32, 126	0		6.00
7. 00	MAMMOGRAPHY	54. 03	57, 705	0		7.00
8. 00	PHYSI CAL THERAPY	66. 00	7, 145	0		8. 00
9. 00	OCCUPATIONAL THERAPY	67. 00	1, 351	0		9. 00
10.00	CLINIC	90.00	5, 946			10.00
	0		309, 577	0		

Heal th Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0112

Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am

						// 14/2021	10:20 am_
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00			
500.00	Grand Total: Increases		4, 085, 900	44, 263, 846			500.00

1, 862, 438

	Financial Systems SIFICATIONS		COLUMBUS REGION		CCN: 15 0112 D	In Lieu of Form (Period: Worksheet	
ECLAS	SIFI CATI UNS			Provider	F	rom 01/01/2020	
		_			1	o 12/31/2020 Date/Time 7/14/2021	10: 20 am
	Cost Center	Decreases Li ne #	Sal ary	Other	 Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	B - RECLASS INTEREST						
00	INTEREST EXPENSE	113. 00	0	1, 181, 826			1.00
0			0		11		2.00
	C - RECLASS INSURANCE		U	1, 181, 826			
С	ADMI NI STRATI VE & GENERAL	5. 00	0	733, 855	5 12		1.00
)		0.00	0	C	-		2. 00
)		0.00	0	C	0		3.00
0		<u> </u>	0		0 0		4.00
	D - RECLASS BILLING COST		O ₁	733, 633	/		
)	MEDICAL RECORDS & LIBRARY	16. 00	851, 181	136, 596	0		1.00
	0		851, 181	136, 596			
	E - RECLASS HYPERBARI C THERAI		100 (04	E4 040			
)	WOUND CENTER	90.03	10 <u>0, 624</u> 100, 624	<u>51, 3</u> 13 51, 313			1.00
	F - RECLASS CAFETERIA EXPENSI	<u> </u>	100, 024	51, 513)		
)	DI ETARY	10.00	1, 191, 758	483, 657	0		1.00
	0 — — — — —		1, 191, 758	483, 657			
	G - RECLASS WELLNESS		46. ==-1				
	EMPLOYEE BENEFITS DEPARTMENT		13 <u>6, 5</u> 52 136, 552	3 <u>6, 1</u> 35 36, 135			1.00
	H - RECLASS PHYSICIAN FEES		136, 552	36, 135			
	ADMINISTRATIVE & GENERAL	5. 00	0	4, 683, 070	0		1.00
	OPERATING ROOM	50.00	ō	445, 888			2.00
		0. 00	O	C	0		3.00
		0.00	0	C	0		4.00
		0. 00 0. 00	0	C	0		5.00
		0.00	0	(6. 00 7. 00
		0.00	o	C	o o		8.00
		0.00	o	C	0		9. 00
О		0. 00	0	C	0		10.00
0		0.00	0	C	0		11.00
00		0. 00 0. 00	0				12. 00 13. 00
00		0.00	0				14. 00
00		0.00	o	C	o o		15. 00
00		0.00	О	C	0		16.00
00		0.00			<u> </u>		17. 00
	O DECLACE DELIAD CEDVICES		0	5, 128, 958	3		
)	I - RECLASS REHAB SERVICES ADMINISTRATIVE & GENERAL	5. 00	162, 321	4, 260	0		1.00
)	NOMINI STRATI VE & GENERAL	0.00	0	4, 200			2.00
)		0. 00	O	C			3.00
		0.00	0	C	0		4.00
)		0.00	0	C	-		5.00
))		0. 00 0. 00	0	C	0 0		6. 00 7. 00
)		0.00	0				8.00
			162, 321	4, 260			0.00
	J - RECLASS PHARMACY RES PRO						
)	PHARMACY	15. 00	194, 811	C	- 1		1.00
)	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 826			2. 00
	K - RECLASS RENT EXPENSE		194, 811	1, 826			
	BUILDING RENTALS	194. 01	0	1, 862, 438	8 0		1.00
		0.00	ō	C	1		2.00
)		0.00	O	C	0		3.00
)		0.00	0	C	0		4.00
)		0.00	0	C	1		5. 00
))		0. 00 0. 00	0	C			6. 00 7. 00
)		0.00	0				8.00
)		0.00	o	C	1		9.00
00		0. 00	O	C	o		10.00
00		0.00	0	C	0		11.00
00		0.00	0	C	0		12.00
00		0.00	0	C			13.00
00				1, 862, 438	 4		14.00
	IO	i l	U	1,002,430	4		1

RECLASSI FI CATI ONS

Provider CCN: 15-0112

Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/14/2021 10:20 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - RECLASS MARKETING EXPENSE 1.00 OPERATING ROOM 50.00 140,000 0 1.00 140, 000 RECLASS DEPRECIATION EXPENSE 1. 00 1.00 CAP REL COSTS-BLDG & FIXT 14, 299, 776 1.00 **TOTALS** 14, 299, 776 N - RECLASS MAINTENANCE EXPENSE OPERATION OF PLANT 1.00 7.00 2, 948, 361 0 1.00 2.00 0.00 0 0 0 2.00 3.00 0.00 0 0 0 3.00 4 00 0 00 0 0 0 4 00 0 5.00 0.00 0 0 5.00 6.00 0.00 o 0 6.00 7.00 0.00 0 0 0 7.00 0 0 8 00 0 00 8 00 9.00 0.00 0 0 9.00 10.00 0.00 o 0 10.00 0 11.00 0.00 0 0 11.00 0 0.00 0 12.00 12.00 0 13.00 0.00 0 0 13.00 o 0 14.00 0.00 14.00 0 0 0 00 15 00 0 15 00 16.00 0.00 0 0 0 16.00 17.00 0.00 0 17.00 2, 948, 361 O - RECLASS DI RECTOR PHARMACY 1.00 PHARMACY 15.00 180, 791 0 0 1.00 2.00 0 0.00 0 0 2.00 0 3.00 0.00 0 0 3.00 4 00 0.00 0 0 4 00 5.00 0.00 0 5.00 180, 791 0 Q - RECLASS XRAY EDUCATION EXPENSES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 3,896 0 1.00 2.00 RADI OLOGY-DI AGNOSTI C 54.00 353, 545 0 534 2.00 3.00 RESPIRATORY THERAPY <u>65.</u>00 0 3.00 63 0 4, 430 353, 608 S - RECLASS NON ALLOW ADVERTISING COSTS 1.00 ADMINISTRATIVE & GENERAL 5.00 395, 757 0 1.00 0 395, 757 U - RECLASS CHARGEABLE SUPPLY COST 1.00 ADULTS & PEDIATRICS 30.00 220, 931 0 1.00 INTENSIVE CARE UNIT 2.00 31.00 0 167, 380 0 2.00 SUBPROVIDER - IRF ol 5, 302 0 3.00 41.00 3.00 0 4.00 NURSERY 43.00 0 2,703 4.00 5.00 OPERATING ROOM 50.00 0 8, 934, 991 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 110, 166 0 6.00 0 MAMMOGRAPHY 0 7.00 54.03 109.359 7.00 0 8.00 CT SCAN 57.00 0 28, 232 8.00 0 9.00 CARDIAC CATHETERIZATION 59.00 0 3, 333, 998 9.00 0 RESPIRATORY THERAPY 10 00 65 00 141 883 10 00 0 0 11.00 PHYSI CAL THERAPY 66.00 23, 958 11.00 12.00 SPEECH PATHOLOGY 68.00 0 158, 427 0 12.00 13.00 VIMCARE CLINIC 90.05 0 5, 760 0 13.00 0 **IEMERGENCY** 91 00 0 32, 322 14 00 14 00 15.00 AMBULANCE SERVICES 95.00 27, 426 0 15.00 13, 302, 838 V - RECL PTO COST FOR STD ELIMINATION PD 75, 787 0 1.00 1 00 ADMINISTRATIVE & GENERAL 5 00 2.00 OPERATION OF PLANT 7.00 7,569 0 0 2.00 3.00 HOUSEKEEPI NG 9.00 23, 335 0 3.00 0 0 10.00 4.00 DI ETARY 16.864 0 4.00 11.00 0 5 00 CAFETERI A 24, 287 5 00 0 6.00 NURSING ADMINISTRATION 13.00 34, 958 0 6.00 0 7.00 PHARMACY 15.00 6,538 0 7.00 0 25, 742 8.00 MEDICAL RECORDS & LIBRARY 16, 00 0 8.00 9 00 ADULTS & PEDIATRICS 30.00 192, 293 0 9 00 10.00 INTENSIVE CARE UNIT 31.00 39, 703 0 10.00 SUBPROVIDER - IRF 0 11.00 41.00 33, 982 0 11.00 0 NURSERY 23,078 43.00 0 12.00 12.00 13.00 OPERATING ROOM 50.00 13,012 0 13.00 RADI OLOGY-DI AGNOSTI C 0 14.00 54.00 24, 274 0 14.00 NUCLEAR MEDICINE-DIAGNOSTIC 418 0 15.00 54.01 0 15.00 16.00 ULTRA SOUND 54.02 13, 356 16.00

RECLASSI FI CATI ONS

Provider CCN: 15-0112

From 01/01/2020 To 12/31/2020

Peri od:

Worksheet A-6
Date/Time Prepared:

7/14/2021 10:20 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6. 00 7.00 8.00 9.00 10.00 MAMMOGRAPHY 17.00 54.03 2, 144 0 0 17.00 18.00 RADI OLOGY-THERAPEUTI C 55.00 18.00 0 19.00 57.00 9, 129 0 19.00 CT SCAN CARDIAC CATHETERIZATION 59.00 19, 280 0 0 20.00 20.00 0 21.00 LABORATORY 60.00 47, 127 0 21.00 RESPIRATORY THERAPY 0 22.00 65.00 22, 234 0 22.00 0 23.00 PHYSICAL THERAPY 66.00 8.697 23.00 0 OCCUPATIONAL THERAPY 67.00 6, 581 24.00 0 24.00 25.00 SPEECH PATHOLOGY 68.00 3, 428 0 25.00 ELECTROCARDI OLOGY 0 26.00 69.00 7, 387 26.00 0 ELECTROENCEPHALOGRAPHY 70 00 8, 465 27 00 O 27 00 28.00 CARDIAC REHABILITATION 76.97 2, 363 28.00 29.00 CLINIC 90.00 8, 854 0 29.00 30.00 NEUROPSYCH 90.02 727 0 0 30.00 WOUND CENTER 0 90 03 31 00 1.100 31 00 0 32.00 VIMCARE CLINIC 90.05 1,865 0 32.00 33.00 MEDICATION MGMT CLINIC 90.06 10, 185 0 33.00 EMERGENCY 34.00 91.00 83.601 0 0 34.00 6<u>1, 9</u>96 35.00 AMBULANCE SERVICES 95.00 35.00 0 860, 368 ō - RECLASS OT SALARIES AND OTHER EXP 1 00 66. 00 21<u>2, 2</u>22 PHYSICAL THERAPY 23<u>8, 3</u>93 0 1.00 238, 393 212, 222 - RECLASS LAB BLOOD SUPERVISOR 1.00 <u>60.</u>00 78, 556 LABORATORY 1.00 0 0 78, 556 0 WA - RECLASS CONTRACT LABOR BENEFITS EMPLOYEE BENEFITS DEPARTMENT 0 1.00 4.00 0 2, 401, 234 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 O 0 3 00 4.00 0.00 0 4.00 ō 2, 401, 234 WB - RECLASS SALARIES TO HOME DEPT 1.00 0 ADMINISTRATIVE & GENERAL 5.00 286, 720 77, 996 1.00 2.00 LABORATORY 60.00 1,008 0 2.00 0 3.00 0.00 0 0 3.00 0 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 0 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 0 0.00 0 8.00 0 8.00 0 9.00 0.00 0 0 9.00 0 0 10.00 0.00 10.00 ol 11.00 0.00 0 11.00 0 0 12.00 0.00 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 0 0 14.00 0 0 15.00 0.00 0 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 0 18 00 0 00 18 00 0 19.00 0.00 0 19.00 20.00 0.00 0 0 20.00 0 0 21.00 0.00 0 21.00 0 0 0 00 22 00 0 22 00 23.00 0.00 0 0 0 23.00 24.00 0.00 o 0 24.00 0 25.00 25.00 0.00 77, 996 287, 728 - RECLASS SEVERANCE PAY 1.00 ADMINISTRATIVE & GENERAL 5. 00 309, 577 0 0 1.00 0 2.00 0.00 0 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 0 0 4.00 0 0 5.00 0.00 0 5.00 0 6.00 0 0.00 0 6.00 0 7.00 0.00 0 0 7.00 8.00 0.00 0 0 0 8.00 0.00 0 9.00 0 9.00 0. 00 0 10.00 10.00 309, 577 500.00 Grand Total: Decreases 500.00 4, 946, 268 43, 403, 478

Provider CCN: 15-0112

| Peri od: | Worksheet A-7 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

				l C	12/31/2020	7/14/2021 10:	
				Acqui si ti ons		,, , , , , , , , , , , , , , , , , , , ,	20 4
		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	T BALANCES					
1.00	Land	2, 010, 352	0	0	0	31, 000	1.00
2. 00	Land Improvements	20, 982, 896	37, 802	0	37, 802	0	2.00
3. 00	Buildings and Fixtures	102, 188, 281	956, 847		956, 847	302, 294	3.00
4.00	Building Improvements	106, 574, 178	315, 955	0	315, 955	· ·	4.00
5. 00	Fixed Equipment	9, 587, 449	5, 612	0	5, 612	· ·	5.00
6. 00	Movable Equipment	171, 615, 772	4, 277, 285	0	4, 277, 285	5, 025, 373	6.00
7. 00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	412, 958, 928	5, 593, 501	0	5, 593, 501	5, 434, 202	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	412, 958, 928	5, 593, 501	0	5, 593, 501	5, 434, 202	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
	DART I ANNUALO OF SUMMORS IN CARLEY ASSET	6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						4 00
1.00	Land	1, 979, 352	0				1.00
2. 00	Land Improvements	21, 020, 698	0				2.00
3.00	Buildings and Fixtures	102, 842, 834	0				3.00
4.00	Building Improvements	106, 828, 165	0				4.00
5.00	Fixed Equipment	9, 579, 494	0				5.00
6. 00	Movable Equipment	170, 867, 684	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	413, 118, 227	0				8.00
9.00	Reconciling Items	412 110 227	0				9.00
10. 00	Total (line 8 minus line 9)	413, 118, 227	0				10.00

Heal th	Health Financial Systems		NAL HOSPITAL		In Lieu of Form CMS-2552-10			
	CILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0112		Peri od: From 01/01/2020 To 12/31/2020				
					10 12/31/2020	7/14/2021 10:	20 am	
			SL	IMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9. 00	10. 00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	22, 936, 146	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	22, 936, 146	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
	·	Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			_	
1.00	CAP REL COSTS-BLDG & FLXT	0	22, 936, 146				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
2 00	Total (sum of lines 1 2)		22 026 146				2 00	

0 0

22, 936, 146

2.00

3.00 Total (sum of lines 1-2)

Heal th	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 01/01/2020 To 12/31/2020		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 (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT	242, 250, 543	0	242, 250, 54	0. 586395	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	170, 867, 684	0	170, 867, 68	4 0. 413605	0	2.00
3. 00	Total (sum of lines 1-2)	413, 118, 227		413, 118, 22			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART LLL DECONOLLLATION OF CARLTAN COOTS	6.00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		1 0		0 (51 305	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	0	1		0 8, 651, 395 0 14, 395, 095		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0			0 14, 395, 095		3.00
3.00	Total (suil of Titles 1-2)	0	·	JMMARY OF CAPI		U	3.00
			30	DIWINART OF CALL	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
	· ·		(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLTY COOTS	11.00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT		(71 4/4		0	0 200 772	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	76, 914 12, 306		1	0 0	9, 399, 773 14, 407, 401	1.00 2.00
3. 00	Total (sum of lines 1-2)	89, 220		1	0 0	23, 807, 174	
3.00	Total (Sum Of Titles 1-2)	07, 220	071,404	1 '	0	23,007,174	3.00

Provi der CCN: 15-0112

					To 12/31/2020	Date/Time Pre	pared:
				Expense Classification on		7/14/2021 10:	20 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
1. 00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-131, 065	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)	_					
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-58, 674	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-105, 828	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	Α	-143, 589	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter		, ,	A SENERALE	3. 33	J	7.00
8. 00	21) Tel evi si on and radio service	Α	-8, 846	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physi ci an	A-8-2	-6, 762, 104		0.00	0	10.00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)	A 0 1	471 202				
12. 00	Related organization transactions (chapter 10)	A-8-1	-471, 383			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-532 014	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee		0	ON ETERIA	0. 00	0	
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-3, 149	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts					0	
19. 00	Nursing and allied health education (tuition, fees,	В	-25, 348	XRAY EDUCATION	23. 01	0	19. 00
20 00	books, etc.) Vendi ng machi nes		0		0.00	0	20. 00
	Income from imposition of		0		0. 00	Ö	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24.00	limitation (chapter 14)	4.0.2	0	DUVCLOAL THEDADY	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	Ü	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
20.00	physicians' compensation		0	oost denter bereted	111.00		20.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2. 00	0	
	COSTS-MVBLE EQUIP					U	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
	1	l		ı	1	ı	ı

From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

				To	12/31/2020	Date/Time Pre	
				Expense Classification on	Worksheet A	7/14/2021 10:	20 am
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
21 00	Add water and fine an area	1.00	2.00	3.00	4. 00	5. 00	21 00
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest		_				
33.00	DEPR PAT PHONES NEW EQUIP	Α	-4, 771	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33.00
34.00	TV DEPR NEW EQUIP	Α	-8, 313	CAP REL COSTS-MVBLE EQUIP	2. 00	9	34.00
35.00	CAFETERIA VISITORS	Α	-105, 038	CAFETERI A	11. 00	0	35.00
36. 00	MEALS TO GO	Α	1	DI ETARY	10. 00	0	36.00
37. 00	OPERATING ROOM OTHER REV	В	1	OPERATING ROOM	50. 00	0	37.00
38.00	BOND AMORTI ZATI ON	A		CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
40.00	TELEPHONE SEVICES	В		ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00	LAND RENT MOB	В	1	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
42. 00 43. 00	SPEECH THERAPY OTHER REV EMPLOY BENEFITS OTHER REVENUE	B B		SPEECH PATHOLOGY EMPLOYEE BENEFITS DEPARTMENT	68. 00	0	42. 00 43. 00
44. 00	EMERGENCY ROOM OTHER REVENUE	В		EMERGENCY	4. 00 91. 00	0	44.00
44. 01	MEDICAL STAFF INCOME	В	1	ADMINISTRATIVE & GENERAL	5. 00	0	44. 01
45. 00	RADI OLOGY OTHER REVENUE	В	1	RADI OLOGY-DI AGNOSTI C	54.00	0	45. 00
45. 01	FACILITIES OTHER REVENUE	В		OPERATION OF PLANT	7. 00	0	45. 01
45. 02	RADI ATI ON ONCOLOGY OTHER	В	1	RADI OLOGY-THERAPEUTI C	55. 00	0	45. 02
	REVENUE	_				_	
45.03	CRHP OTHER REVENUE ADMIN	В	-2, 313, 406	ADMINISTRATIVE & GENERAL	5. 00	0	45. 03
45.04	CRHP OTHER REVENUE BUILDING	В	-354, 200	CRHP	194. 08	0	45.04
	RENTALS						
45.05	CRHP OTHER REVENUE EMPLOYEE	В	-385, 344	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45.05
45 07	BENEFITS			DI STADY	40.00		45 07
45. 07	FOOD OTHER REVENUE	В		DI ETARY	10.00	0	45. 07
45. 08	PROTECTIVE SERV OTHER REVENUE	В	1	OPERATION OF PLANT	7. 00	0	45. 08
45. 09 45. 10	PHARMACY OTHER REVENUE HUMAN RESOURCES OTHER REVENUE	B B	1	PHARMACY EMPLOYEE BENEFITS DEPARTMENT	15. 00 4. 00	0	45. 09 45. 10
45. 10	LACTATION AND PREPARE OTHER	В	1	ADULTS & PEDIATRICS	30. 00	0	45. 10
43.11	REVENUE	В	-100	ADDETS & TEDIATRICS	30.00	O	43.11
45. 12	VOLUNTEER OTHER REVENUE	В	-53, 266	ADMINISTRATIVE & GENERAL	5. 00	0	45. 12
45. 13	RENTAL PROPERTIES DEPRECIATION		1	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 13
45. 14	LOSS ON DISPOSAL DEMOLITION	Α	1	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 14
45. 15	UNALLOWABLE PHYS RECRUITMENT	Α		ADMINISTRATIVE & GENERAL	5. 00	0	45. 15
45. 16	DEPRECIATION RELIFED BUILDING	Α	30, 150	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 16
45. 17	DEPRECIATION RELIFED EQUIPMENT	Α	108, 403	CAP REL COSTS-MVBLE EQUIP	2. 00	9	45. 17
45. 18	PRIOR YEAR AUDIT ADJUSTMENT	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 18
45. 19	NONALLOWABLE INT EXP 1993	Α	-39, 148	CAP REL COSTS-MVBLE EQUIP	2. 00	11	45. 19
45 04	BONDS	Δ.	00.510	CAR REL COCTO MURLE FOLLS	2 22		45 04
45. 21	NONALLOWABLE INT EXP 2003/2009	А	-99, 563	CAP REL COSTS-MVBLE EQUIP	2. 00	11	45. 21
45. 22	BONDS UNALLOWABLE AHA MEMBERSHIP	А	-16 674	ADMINISTRATIVE & GENERAL	5. 00	0	45. 22
45. 22	DUES	А	-10,074	ADMINISTRATIVE & GENERAL	5.00	U	40.22
45. 23	AMBULANCE SERVICES	В	-747, 436	AMBULANCE SERVICES	95. 00	O	45. 23
45. 24	HAF ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 24
45. 25	OTHER OPERATING REVENUE - MISC			ADMINISTRATIVE & GENERAL	5. 00	0	45. 25
	SALES						
45. 27	AUDI OLOGY - OTHER REVENUE	В		SPEECH PATHOLOGY	68. 00	0	45. 27
45. 28	OUTPATIENT PT AND OT	В		PHYSI CAL THERAPY	66. 00	0	45. 28
50.00	` ′		-28, 796, 292				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)		<u> </u>	010 5 1 15 1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1. 00	2. 00	3.00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	E	J BICKEL	O.OOSI HEALTH MANAGEMENT	0.00 6.	. 00
7.00	E	D TRAPP	O.OOSI HEALTH MANAGEMENT	0.00 7.	. 00
8.00	E	Z ELLISON	O.OOSI HEALTH MANAGMENT	0. 00 8.	. 00
9.00	E	R SHEDD	O.OOSI HEALTH MANAGEMENT	0.00 9.	. 00
10.00	E	S STARK	O.OOSI HEALTH MANAGEMENT	0. 00 10.	. 00
10. 01	E	D DOUP	O.OOSI HEALTH MANAGMENT	0. 00 10.	. 01
10.02	E	D MI CHAEL	O.OOSI HEALTH MANAGMENT	0. 00 10.	. 02
100.00	G. Other (financial or			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.

STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN: 15-0112	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS							From 01/01/2020 To 12/31/2020	Date/Time Pro	epared:
									7/14/2021 10:	
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
		RED AND ADJUST	MENTS RE	QUI RED AS A RE	SULT OF TRA	NSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:									
1.00	-957, 954	0								1.00
2.00	486, 571	0								2.00
3.00	0	0								3.00
4.00	0	0								4.00
5.00	-471, 383									5.00
* The	amounts on line	es 1-4 (and sul	oscri pts	as appropriate	e) are tran	sferred i	n detail to Wo	rksheet A, column	6, lines as	
								rganization or ho		t which
has not	been posted to	o Worksheet A,	col umns	1 and/or 2, tl	he amount a	llowable :	should be indi	cated in column 4	of this part	
	Related Orga	ani zati on(s)							·	
	and/or Ho	me Office								

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

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	6. 00
7.00	MANAGEMENT COMPANY	7.	7.00
8.00	MANAGEMENT COMPANY	8	8. 00
9.00	MANAGEMENT COMPANY	9	9.00
10.00	MANAGEMENT COMPANY	10	0.00
10.01	MANAGEMENT COMPANY	10	0. 01
10.02	MANAGMENT COMPANY	10	0. 02
100.00		100	0.00

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

Health Financial Systems

In Lieu of Form CMS-2552-10
Worksheet A-8-2

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10: 20 am

							1771172021 10.	20 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	2, 221, 700	2, 035, 450	186, 250	211, 500	866	1.00
2.00	30.00	ADULTS & PEDIATRICS	722, 740	0	722, 740	211, 500	6, 033	2.00
3.00	41. 00	SUBPROVI DER - I RF	229, 241	0	229, 241	211, 500	9, 323	3.00
4.00	50.00	OPERATING ROOM	5, 876, 162	3, 528, 834	2, 347, 328	246, 400	19, 848	4.00
5.00	53. 00	ANESTHESI OLOGY	60, 000	0	60, 000	246, 400	434	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	50, 000	0	50, 000	271, 900	348	6.00
7. 00	54. 03	MAMMOGRAPHY	2, 083	0	2, 083	211, 500	10	7.00
8.00	55. 00	RADI OLOGY-THERAPEUTI C	45, 000	0	45, 000	271, 900	235	8.00
9. 00	60. 01	LABORATORY-PATHOLOGI CAL	225, 000	0	225, 000	260, 200	1, 500	9.00
10.00	65. 00	RESPIRATORY THERAPY	48, 000	0	48, 000	211, 500	320	10.00
11. 00	66. 00	PHYSI CAL THERAPY	49, 750	0	49, 750	211, 500	249	11.00
12.00	69. 00	ELECTROCARDI OLOGY	53, 717	0	53, 717	211, 500	419	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	8, 625	0	8, 625	211, 500	86	13.00
14.00	90. 02	NEUROPSYCH	203, 440	203, 440	0	211, 500	0	14.00
15.00	90. 03	WOUND CENTER	63, 758	0	63, 758	211, 500	383	15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	2, 613	0	2, 613	211, 500	16	16.00
17.00	90. 05	VIMCARE CLINIC	20, 000	0	20, 000	211, 500	416	17.00
18.00	91.00	EMERGENCY	3, 030, 484	558, 984	2, 471, 500	211, 500	23, 467	18.00
19.00	95. 00	AMBULANCE SERVICES	13, 125	0	13, 125	211, 500	180	19.00
200.00			12, 925, 438	6, 326, 708	6, 598, 730		64, 133	200.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10

Period: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am Provider CCN: 15-0112

							7/14/2021 10: 2	<u>20 am</u>
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Li mi t	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	5. 00	ADMINISTRATIVE & GENERAL	88, 057	4, 403	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	613, 452	30, 673	0	0	0	2.00
3.00	41. 00	SUBPROVI DER - I RF	947, 988	47, 399	0	0	0	3.00
4.00	50.00	OPERATING ROOM	2, 351, 225	117, 561	0	0	0	4.00
5.00	53.00	ANESTHESI OLOGY	51, 412	2, 571	0	0	0	5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	45, 491	2, 275	0	0	0	6.00
7.00	54. 03	MAMMOGRAPHY	1, 017	51	0	0	0	7.00
8.00	55. 00	RADI OLOGY-THERAPEUTI C	30, 720	1, 536	0	0	0	8.00
9. 00	60. 01	LABORATORY-PATHOLOGI CAL	187, 644	9, 382	0	0	0	9.00
10.00	65.00	RESPI RATORY THERAPY	32, 538	1, 627	0	0	0	10.00
11.00	66.00	PHYSI CAL THERAPY	25, 319	1, 266	0	0	0	11.00
12.00	69. 00	ELECTROCARDI OLOGY	42, 605	2, 130	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	8, 745	437	0	0	o	13.00
14.00	90. 02	NEUROPSYCH	O	0	0	0	o	14.00
15.00	90. 03	WOUND CENTER	38, 945	1, 947	0	0	o	15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	1, 627	81	0	0	o	16.00
17.00	90. 05	VIMCARE CLINIC	42, 300	2, 115	0	0	o	17.00
18.00	91.00	EMERGENCY	2, 386, 188	119, 309	0	0	0	18.00
19.00	95.00	AMBULANCE SERVICES	18, 303	915	0	0	0	19.00
200.00			6, 913, 576	345, 678	0	0	0 2	200. 00

Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

							7/14/2021 10:	20 am
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0	88, 057				1. 00
2.00	30.00	ADULTS & PEDIATRICS	0	613, 452	109, 288	109, 288		2. 00
3.00	41.00	SUBPROVI DER - I RF	0	947, 988	0	0		3. 00
4.00	50.00	OPERATING ROOM	0	2, 351, 225	0	3, 528, 834		4.00
5.00	53. 00	ANESTHESI OLOGY	0	51, 412	8, 588	8, 588		5. 00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	45, 491	4, 509	4, 509		6. 00
7.00	54. 03	MAMMOGRAPHY	0	1, 017	1, 066	1, 066		7. 00
8.00	55. 00	RADI OLOGY-THERAPEUTI C	0	30, 720	14, 280	14, 280		8. 00
9.00	60. 01	LABORATORY-PATHOLOGI CAL	0	187, 644	37, 356	37, 356		9. 00
10.00	65. 00	RESPI RATORY THERAPY	0	32, 538	15, 462	15, 462		10.00
11.00	66. 00	PHYSI CAL THERAPY	0	25, 319	24, 431	24, 431		11.00
12.00	69. 00	ELECTROCARDI OLOGY	0	42, 605	11, 112	11, 112		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	8, 745	0	0		13.00
14.00	90. 02	NEUROPSYCH	0	C	0	203, 440		14.00
15.00	90. 03	WOUND CENTER	0	38, 945	24, 813	24, 813		15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	0	1, 627	986	986		16. 00
17.00	90. 05	VIMCARE CLINIC	0	42, 300	0	o		17.00
18.00	91.00	EMERGENCY	0	2, 386, 188	85, 312	644, 296		18. 00
19.00	95.00	AMBULANCE SERVICES	0	18, 303	0	o		19. 00
200.00			0	6, 913, 576	435, 396	6, 762, 104		200.00

| Period: | Worksheet B | From 01/01/2020 | Part | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0112

CAPITAL RELATED DISTS							o 12/31/2020		pared:
DEMENDED SERVICE CORST CENTERS 1.00 2.00 4.					CAPI TAL REI	_ATED COSTS		771472021 10: .	20 am
DEMENDED SERVICE CORST CENTERS 1.00 2.00 4.			Coot Conton Decemintion	Not Evnences	DIDC 0 FLVT	MANDLE FOLLID	EMDLOVEE	Cubtatal	
CEMBRAL SERVICE CRIST CENTERS 1.00 2.00 4.00 4A			cost center bescription		BLDG & FIXI	MARTE EGOLA		Subtotai	
DOI: 70.00 7.00 7.00 7.00 7.00 7.00 7.00 4				Allocation					
DEBURNAL SERVICE COST_CENTERS									
1.00 1000 CAP PIEL COSIS*-BIRG & FIRTY 9,399,773 9,399,773 14,407,401 7,000 7,					1. 00	2.00	4. 00	4A	
2.00 DIODIO CAP REL DOSIS MUNIL EDUIL P 14, 407, 401 14, 407, 401 40, 0600 144, 407, 401 50, 00 144, 407, 401 50, 00 50,				0.000.770	0.000.770				
4.00 00000 DOUGNET DEPARTMENT 27, 197, 507 150, 259 6, 473 27, 303, 289 5, 42, 705 5, 500 50000 DEPART DOUGNET DEPARTMENT 4, 565, 5494 4, 625, 510 327, 027 504, 110 12, 412, 500 7, 000 10000 DEPART DOUGNET DEPARTMENT 1, 131, 798 101, 270 133, 425 132, 427 132, 431 130, 431 130, 431 130, 432 130,					9, 399, 773				
7.00 Q.07000 DERATITIO OF PLANT 6,555,943 4,225,151 327,027 904,110 17 28,055,88 8.00 9.00 Q.0000 DOROG DUSEKEEPI NG 2,046,654 60,0887 134,225 688,277 35,511,241 9.00 <		00400	EMPLOYEE BENEFITS DEPARTMENT		159, 259				
8.00 00800 LAURDRY & LI NEN SERVICE 764, 444 10, 199 0 00900 DISTREPHING 2, 646, 664 647 764, 451 9, 00 10000 DISTREPHING 2, 646, 664 764, 661, 872 139, 425 688, 275 3, 541, 241 9, 00 10000 DISTREPHING 1, 174, 773 101, 270 13, 525 270, 401 1, 566, 904 10, 00 10000 DISTREPHING 1, 174, 773 13, 174, 773 13, 174, 774 1, 366, 481 10, 00 10000 DISTREPHING 1, 174, 774 1, 366, 481 10, 00 10000 DISTREPHING 1, 174, 774 1, 366, 481 10, 00 10000 DISTREPHING 1, 174, 774 1, 366, 481 10, 00 10000 DISTREPHING 1, 174, 774 1, 175, 669 1, 174, 660 1, 175, 669 1, 174, 660 1, 175, 669 1, 174, 660 1, 175, 669 1, 174, 660 1, 175, 669 1, 175, 66		1	•						
9.00 0.0900 MUSEKEEPI NS		1	•						
11.00 0 10100 CAFETERIA 1.017.928 79.957 19.479 389.437 1.500.441 11.00 11.00 0 10100 (ENTRAL SERVICES & SUPPLY 007.322 07.832 64.170 0.466 7.485.31 13.00 10.00									
13.00 01300 RURSH NO. ADMINI STRATION 5, 674, 1177 129, 370 37, 165 1, 644, 666 7, 485, 318 13.00									
14.00 01400 CENTRAL SERVICES & SUPPLY 907, 3222 97, 882 64, 129 0 1, 069, 283 14.00		1	•						
16.00 1000 MEDI CAL RECORDS & LIBRARY 1,330,749 47.042 2,998 334,990 1,715,669 10.00 23.00 2300 PARAMED ED PREM 0 0 0 0 0 0 0 0 22.30 2300 2300 PARAMED ED PREM 0 0 0 0 0 0 0 0 0 22.30 2300 2300 PARAMED ED PREM 0 0 0 0 0 0 0 0 0 22.30 2300 2300 PARAMED ED PREM 0 0 0 0 0 0 0 0 0 0 0 0 0 22.30 2300 2300 PARAMED ED PREM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		01400	CENTRAL SERVICES & SUPPLY						
17.00 0.1700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0			•						
23.00 0300 PARAMEP FD PRCM 0 0 0 0 0 23.00				1, 330, 749					
1.00 1.00			1	0			-	- 1	
INVANT IENT ROUTINE SERVICE COST CENTERS 18,039,811 1,049,792 204,170 5,041,009 24,334,782 30,00 30.00 30300 ADURTS & PEDIDATRICS 3,511,431 141,127 68,191 824,145 4,544,994 31,00 32,00 3		1	l .	1					
31 00 03100 NTENSIVE CARE UNIT 3,511,431 141,127 68,191 824,145 4,544,894 31 00 32 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 32 00 32 00 33 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 34 00 40 00 40 00 34 00 40 00 40 00 34 00 40 00	23.02			411, 723	4, 042	7, 340	140, 073	504, 192	23.02
32 00 03200 CORROMRY CARE UNIT 0 0 0 0 0 32 00									
33.00				3, 511, 431					
40. 00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 0 0 0				0	-		o		
1.00 04100 SUBPROVI DER 1RF 1,885,697 142,750 15,221 507,453 2,551,121 41,00				0	_		0		
42 00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0				0 1 885 697	_	1	507 453	- 1	
A-1				0	0	0	0		
ANCILLARY SERVICE COST CENTERS				998, 216					
50.00	44.00			0	0		l 0	U	44.00
52.00 05200 DELLYVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00		05000	OPERATING ROOM						
53.00 05300 AMESTHESI OLOGY 137, 465 1,532 4,107 0 143, 104 53.00				1, 180, 701		1			
54-02 OS402 NUCLEAR MEDI CINE-DI AGNOSTIC 1,777, 331 42,986 72,405 143, 346 2,088, 168 54,02 54,02 05404 ULTRA SOUND 584,486 19,366 75,209 148,388 827,451 54,02 54,03 05405 MAMMOGRAPHY 1,119,831 1,301 162,357 220,627 1,504,116 54,03 55,00 05500 RADI OLOGY-THERAPEUTI C 2,781,981 101,824 1,071,848 217,526 4,173,179 55,00 05500 CADI OLOGY-THERAPEUTI C 2,781,981 101,824 122,872 231,289 4,173,179 55,00 05900 CADI AC CATHETERI ZATI ON 2,066,664 166,943 164,684 500,859 2,849,150 500,00 05000 CADI AC CATHETERI ZATI ON 2,066,664 166,943 164,684 500,859 2,849,150 050,00 05000 CADIAC CATHETERI ZATI ON 2,066,664 166,943 164,684 500,859 2,849,150 050,00 05000 LABORATORY PATHOLOGI CAL 1,088,714 15,608 11,339 115,115 1,230,776 60,010 06001 LABORATORY PATHOLOGI CAL 1,088,714 15,608 11,339 115,115 1,230,776 60,010 06000 MHOLE BLOOD & PACKED RED BLOOD CELL 570,736 5,512 1,943 26,118 604,309 62.00 06500 06500 06500 06500 07000				137, 465	_	1	-		
54. 02 05404 LITRA SOUND 584, 486 19, 368 75, 209 148, 388 827, 451 54. 02 54. 03 05405 MAMMOGRAPHY 1, 119, 831 1, 301 162, 357 220, 627 1, 504, 116 54. 03 55. 00 05500 RADI OLOCY-THERAPEUTI C 2, 781, 981 101, 824 1, 071, 848 217, 526 4, 173, 179 55. 00 57. 00 05500 RADI OLOCY-THERAPEUTI C 2, 781, 981 101, 824 1, 071, 848 217, 526 4, 173, 179 55. 00 58. 00 05800 RADI OLOCY-THERAPEUTI C 2, 781, 981 101, 824 1, 071, 848 217, 526 4, 173, 179 55. 00 59. 00 05900 CARDI ACC CATHETERI ZATI ON 2, 066, 664 116, 943 164, 684 500, 859 2, 849, 150 59. 00 60. 00 06000 LABORATORY 10, 205, 218 140, 032 223, 345 1, 251, 836 11, 820, 431 60. 00 60. 01 06001 LABORATORY-PATHOLOGI CAL 1, 088, 714 15, 608 111, 339 115, 115 1, 230, 776 60. 01 62. 00 06200 MUDILE BLOOD & PACKED RED BLOOD CELL 570, 736 5, 512 1, 943 26, 118 604, 309 62. 00 65. 00 06500 RESPI RATRORY THERAPY 4, 026, 702 7, 933 21, 458 676, 548 4, 732, 641 66. 00 66. 00 06600 PATRICAL THERAPY 4, 026, 702 7, 933 21, 458 676, 548 4, 732, 641 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 4, 026, 702 7, 933 21, 458 676, 548 4, 732, 641 66. 00 69. 00 06900 ELECTROCARDI OLOGY 706, 150 0 19, 035 146, 592 871, 777 68. 00 69. 00 06900 ELECTROCARDI OLOGY 935, 634 18, 003 273, 969 197, 146 1, 424, 752 69. 00 70. 00 70000 ELECTROCARDI OLOGY 935, 634 18, 003 273, 969 197, 146 1, 424, 752 69. 00 70. 00 70000 ELECTROCARDI OLOGY 935, 634 18, 003 273, 969 197, 146 1, 424, 752 69. 00 70. 00 07000 ELECTROCARDI OLOGY 935, 634 18, 003 273, 969 197, 146 1, 424, 752 69. 00 70. 00 07000 ELECTROCARDI OLOGY 935, 634 19, 003 19, 003 146, 592 871, 777 70. 00 70. 00 07000 ELECTROCARDI OLOGY 935, 634 19, 003 19, 003 19, 003 19, 003									
54.03 05405 MAMMOGRAPHY 1, 119, 831 1, 301 162, 357 220, 627 1, 504, 116 54.03		1	•						
57.00 05700 05700 05700 05700 05700 05700 05800 MRI									
58.00 05800 MRI 470,700 11,500 4,068 95,726 582,084 58.00 59.00 05900 CARDIAC CATHETERIZATION 2,066,664 116,943 164,684 500,859 2,849,150 59.00 60.01 06000 LABORATORY 10,205,218 140,032 223,345 1,251,836 11,820,431 60.00 60.01 06000 LABORATORY-PATHOLOGICAL 1,088,714 15,608 11,339 115,115 1,230,776 60.01 65.00 06500 RESPI RATORY THERAPY 2,285,055 101,747 74,598 631,236 3,092,636 65.00 66.00 06600 PHYSI CAL THERAPY 4,026,702 7,933 21,458 676,548 4,732,641 66.00 68.00 06600 SPEECH PATHOLOGY 706,150 0 19,035 146,592 871,777 68.00 69.00 06900 ELECTROCARDI OLOGY 735,634 18,003 273,969 197,146 1,424,752 69.00 70.00 0700 IMBLICAL SUPPLIES CHARGED TO PATIENTS 6,738,858 0 0 0 6,738,									
59.00 05900 CARDIAC CATHETERIZATION 2, 066, 664 116, 943 164, 684 500, 859 2, 849, 150 59.00 60.00 06000 LABORATORY 10, 205, 218 140, 032 223, 345 1, 251, 836 11, 820, 431 60.00									
60.01 06001 LABORATORY-PATHOLOGI CAL 1,088,714 15,608 11,339 115,115 1,230,776 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 570,736 5,512 1,943 26,118 604,309 62.00 65.00 06500 RESPIRATORY THERAPY 2,285,055 101,747 74,598 631,236 3,092,636 65.00 66.00 06600 PHYSI CAL THERAPY 4,026,702 7,933 21,458 676,548 4,732,641 66.00 67.00 06700 0CCUPATI ONAL THERAPY 1,408,364 2,846 4,127 213,692 1,629,029 67.00 68.00 06800 SPECH PATHOLOGY 706,150 0 19,035 146,592 871,777 68.00 69.00 06900 ELECTROCARDI OLOGY 935,634 18,003 273,969 197,146 1,424,752 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 832,407 0 9,985 192,179 1,034,571 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 6,405,553 0 0 0 0 6,405,553 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 22,682,389 0 0 0 0 0 6,405,553 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 22,682,389 0 0 0 0 0 22,682,389 74.00 07400 RENAL DI ALYSI S 862,882 0 31 0 862,913 74.00 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 0 76.00 03020 ACUPUNCTURE 0 0 0 0 0 76.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90.01 09000 LI ABETES CENTER 153,527 9,980 622 28,599 192,728 90.01 90.02 09002 BURDOFSYCH 96,298 1,120 146 28,750 126,314 90.02 90.03 09003 BURDOS CHIOR THERAPY 208,847 0 141 33,455 242,443 90.04 90.04 09004 HYPERBARI C OXYGEN THERAPY 208,847 0 141 33,455 77,085 330,926 90.06 90.06 09006 MEDICATION MGMT CLINIC 593,879 54,795 6,789 171,664 827,127 90.05 90.06 09006 MEDICATION MGMT CLINIC 7,853,297 232,507 208,534 1,500,915 9,855,253 91.00				2, 066, 664	116, 943	164, 684	500, 859		
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91. 00 09100 EMERGENCY 7, 853, 297 232, 507 208, 534 1, 560, 915 9, 855, 253 91. 00									
	92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00

Health Financial Systems	COLUMBUS REGIO	NAI HOSPITAI		Inlie	u of Form CMS-:	2552_10
COST ALLOCATION - GENERAL SERVICE COSTS	COLONIDOS REGIO	Provi der CC		Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I	epared:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 991, 760	103, 434	285, 57	5 1, 116, 064	4, 496, 833	
99. 10 09910 CORF	0	0		0 0	0	1
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 SLET ACQUISITION	0	O		0	0	111.00
113. 00 11300 INTEREST EXPENSE	244 502 (12	0 200 271	12 025 05	1 2/ 054 /20	242 272 100	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	244, 582, 613	9, 280, 371	12, 825, 95	1 26, 854, 628	242, 373, 100	1118.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	9, 362	18	1 0	0 E42	190.00
194. 00 07950 WELLNESS COMMUNITY	256, 304	9, 302	3, 67		308, 948	
194. 01 07951 BUI LDI NG RENTALS	244, 459	0	3,07	0 40, 700	244, 459	1
194. 02 07952 HOSPI CE	99, 093	0		0		194.01
194. 03 07953 0UTREACH CLINICS	77, 073	0		0		194. 02
194. 04 07954 SPEECH - HEARING AIDS	158, 427	0		0 0	158, 427	
194. 05 07955 NONALLOWABLE MARKETING	535, 757	0		0	535, 757	1
194. 06 07956 CRH FOUNDATION	46, 493	15, 389		0 15, 280		194.06
194. 07 07957 HEALTHY COMMUNITIES	10, 475	15, 307		0 13, 200		194. 07
194. 08 07958 CRHP	2, 616, 509	87, 749	1, 576, 69	2 444, 415	4, 725, 365	
194. 09 07959 NEUROPSYCH PART B	2,010,007	6, 902				194. 09
200.00 Cross Foot Adjustments		0, 702				200.00
201.00 Negative Cost Centers		0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	248, 539, 655	9, 399, 773	14, 407, 40	1 27, 363, 289		

7, 801 194. 09 0 200. 00 0 201. 00 248, 539, 655 202. 00

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10:20 am

						7/14/2021 10:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	E4 0/7 0F0					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	54, 267, 052 3, 467, 271	15, 879, 861				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	219, 712	41, 873				8.00
9. 00	00900 HOUSEKEEPI NG	989, 193	274, 604	0	4, 805, 038		9. 00
10.00	01000 DI ETARY	423, 750	415, 765	0	49, 462	2, 405, 971	10.00
11. 00	01100 CAFETERI A	420, 802	326, 786		69, 407	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 090, 911	531, 126	0	18, 349	0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY	298, 688	401, 649	0	63, 823	0	
16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	1, 599, 153 479, 246	253, 773 193, 132	0	39, 091	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0	Ö	o	0	17. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	195, 580	5, 287	0	798	0	23. 01
23. 02	O2302 PHARMACY RESIDENCY PROG	157, 599	19, 879	0	3, 191	0	23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4 707 470	4 200 015	244 055	1 025 415	1 044 220	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 797, 470 1, 269, 548	4, 309, 915 579, 396		1, 935, 415 273, 639	1, 844, 330 224, 550	
32. 00	03200 CORONARY CARE UNIT	1, 207, 340	377, 370	0	273,037	224, 330	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0	0	O	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	712, 617	586, 058	43, 085	205, 828	261, 629	1
42. 00	04200 SUBPROVI DER	275 540	20.022	12.745	700	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	375, 568 0	30, 823 0	12, 765 0	798 0	0	
44.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		<u> </u>		1 44.00
50.00	05000 OPERATI NG ROOM	4, 795, 313	2, 105, 631	216, 061	532, 918	11, 340	50.00
51.00	05100 RECOVERY ROOM	343, 142	168, 389	46, 701	43, 878	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	39, 974	6, 291	0	115 (70	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	707, 509 583, 298	449, 232 176, 478		115, 678 63, 025	2, 306 0	54. 00 54. 01
54. 02	05404 ULTRA SOUND	231, 136	79, 516		22, 338	0	1
54. 03	05405 MAMMOGRAPHY	420, 152	5, 340		47, 867	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 165, 715	418, 039	13, 460	77, 385	12, 454	55.00
57.00	05700 CT SCAN	522, 354	95, 059	0	12, 765	0	57.00
58.00	05800 MRI	162, 596	47, 582	0	7, 180	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	795, 867 3, 301, 860	480, 107 574, 902	62, 469 0	90, 149 98, 925	6, 400 0	59. 00 60. 00
60. 00	06001 LABORATORY-PATHOLOGI CAL	343, 799	64, 078		4, 787	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	168, 805	22, 628		3, 191	0	62.00
65.00	06500 RESPIRATORY THERAPY	863, 881	417, 721	0	119, 667	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 321, 992	32, 568	28, 942	798	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	455, 045	11, 684	11, 297	0	0	
68.00	06800 SPEECH PATHOLOGY	243, 518	72.011	0	1 50/	0	
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	397, 983 288, 992	73, 911	920	1, 596 146, 792	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 882, 399	0	920	140, 792	0	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 789, 295	0	Ö	ő	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 335, 985	0	0	0	0	73.00
	07400 RENAL DIALYSIS	241, 042	0	0	0	0	74.00
	03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	98, 461	83, 587	0	1, 596	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	ام	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90.00	09000 CLI NI C	575, 097	408, 628	43, 987	76, 587	40, 703	90.00
90. 01	09001 DI ABETES CENTER	53, 836	40, 974	0	1, 596	0	1
90. 02	09002 NEUROPSYCH	35, 284	4, 600		0	0	90. 02
90. 03	09003 WOUND CENTER	482, 831	0	1, 810	0	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	67, 723	0	76	170 501	0	90.04
90. 05 90. 06	O9005 VIMCARE CLINIC O9006 MEDICATION MGMT CLINIC	231, 046 92, 439	224, 959 48, 481		179, 501 14, 360	0	90. 05 90. 06
91.00	09100 EMERGENCY	2, 752, 917	954, 558		445, 162	2, 259	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		75 1, 550	37,270	110, 102	2,207	92.00
	OTHER REIMBURSABLE COST CENTERS]
	09500 AMBULANCE SERVICES	1, 256, 123	424, 647	0	0	0	
	09910 CORF	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

| Peri od: | Worksheet B | From 01/01/2020 | Part I | To | 12/31/2020 | Date/Time Prepared: | Part |

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Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUI SI TI ON	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					ı	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	52, 544, 517	15, 389, 656	1, 048, 140	4, 767, 542	2, 405, 971	118. 00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 666	38, 436	0	0	0	190.00
194.00 07950 WELLNESS COMMUNITY	86, 300	0	0	0	0	194. 00
194. 01 07951 BUI LDI NG RENTALS	68, 286	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	27, 680	0	0	0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	44, 254	0	0	0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	149, 656	0	0	0	0	194. 05
194. 06 07956 CRH FOUNDATION	21, 554	63, 179	0	36, 698	0	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0	194. 07
194. 08 07958 CRHP	1, 319, 960	360, 252	0	0	0	194. 08
194. 09 07959 NEUROPSYCH PART B	2, 179	28, 338	0	798	0	194. 09
200.00 Cross Foot Adjustments					l	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	54, 267, 052	15, 879, 861	1, 048, 140	4, 805, 038	2, 405, 971	202.00

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				12/31/2020	7/14/2021 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	2, 323, 436					11.00
13.00 01300 NURSING ADMINISTRATION	130, 350	10, 256, 054				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	22, 868	154, 584	2, 010, 895			14.00
15. 00 01500 PHARMACY	68, 605	459, 703	0	8, 145, 182	0 4/4 00/	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	73, 179	0	0	0	2, 461, 226	16.00
17. 00 01700 SOCIAL SERVICE 23. 00 02300 PARAMED ED PRGM	0	0	0	0	0	17. 00 23. 00
23. 01 02300 PARAMED ED PROM 23. 01 02301 XRAY EDUCATION	16, 008	0	0	0	0	23.00
23. 02 02302 PHARMACY RESI DENCY PROG	9, 147	56, 578	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	27	33, 373	<u> </u>	<u> </u>	<u> </u>	20.02
30. 00 03000 ADULTS & PEDIATRICS	562, 565	3, 722, 753	79, 675	8, 934	566, 591	30.00
31.00 03100 INTENSIVE CARE UNIT	75, 466	495, 979	2, 410	4, 858	4, 113	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	E4 004	255 045	0	308	0	40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	54, 884	355, 965 0		300	8, 226 0	41. 00 42. 00
43. 00 04300 NURSERY	27, 442	178, 208	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	ő	Ö	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	208, 103	1, 380, 803	1, 775, 752	37, 117	1, 328, 044	50.00
51. 00 05100 RECOVERY ROOM	25, 155	172, 692	0	139	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	23, 704	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	38, 876	0	13, 363	10, 632 93, 390	0	54. 00 54. 01
54. 01 05402 NUCLEAR MEDICINE-DI AGNOSTI C 54. 02 05404 ULTRA SOUND	11, 434 13, 721	0	0	93, 390 228	0	54.01
54. 03 05405 MAMMOGRAPHY	20, 582	0	3, 223	611	0	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C	18, 295	0	0	38	0	55. 00
57. 00 05700 CT SCAN	22, 868	0	0	139, 481	0	57.00
58. 00 05800 MRI	9, 147	0	О	14, 605	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	38, 876	261, 149	14, 552	47, 200	40, 104	59. 00
60. 00 06000 LABORATORY	171, 513	0	0	4, 122	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	13, 721	0	0	0	0	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY	2, 287	416, 045	1, 752	11 771	0	62.00
66. 00 06600 PHYSI CAL THERAPY	64, 032 59, 458	416, 045		11, 771 823	231, 881 0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	16, 008	0	47,780	023	0	67.00
68. 00 06800 SPEECH PATHOLOGY	11, 434	0	Ö	Ö	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	18, 295	114, 937	0	91, 420	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	18, 295	0	0	0	177, 895	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 631, 520	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 ACUPUNCTURE	0	0	0	4, 346	0	74. 00 76. 00
76. 00 03020 ACUPUNCTURE 76. 97 07697 CARDI AC REHABI LI TATI ON	6, 861	44, 893		0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0, 001	44, 073	U _I	U _I	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	Ö	0	0	89. 00
90. 00 09000 CLI NI C	48, 024	228, 689	5, 038	511	104, 372	90.00
90. 01 09001 DI ABETES CENTER	2, 287	0	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	2, 287	0	0	0	0	90. 02
90. 03 09003 WOUND CENTER	13, 721	96, 654	58, 645	2, 879	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	4, 574	23, 675	0	0	0	90.04
90. 05 09005 VI MCARE CLINI C	20, 582 4, 574	139, 636	688	1, 686	0	90.05
90.06 09006 MEDICATION MGMT CLINIC 91.00 09100 EMERGENCY	4, 574 171, 513	32, 315 939, 535	8, 011	3, 208	0	90. 06 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	171,013	737, 335	0,011	ა, ∠∪8		91.00
OTHER REIMBURSABLE COST CENTERS						, , 50
95. 00 09500 AMBULANCE SERVICES	148, 645	981, 261	0	11, 235	0	95.00
99. 10 09910 CORF	0	0	0	o	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			10	12/31/2020	7/14/2021 10:2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 1	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	110.00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 1	111. 00
113.00 11300 INTEREST EXPENSE					1	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 245, 682	10, 256, 054	2, 010, 895	8, 144, 766	2, 461, 226 1	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194. 00 07950 WELLNESS COMMUNITY	6, 861	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	416		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 1	194. 05
194.06 07956 CRH FOUNDATION	2, 287	0	0	0	0 1	194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 1	194. 07
194. 08 07958 CRHP	61, 745	0	0	0	0 1	194. 08
194. 09 07959 NEUROPSYCH PART B	6, 861	0	0	0	0 1	194. 09
200.00 Cross Foot Adjustments					2	200.00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 323, 436	10, 256, 054	2, 010, 895	8, 145, 182	2, 461, 226 2	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0112 Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				1	5 12/31/2020	Date/lime Pre 7/14/2021 10:	
	Cost Center Description	SOCIAL	PARAMED ED	XRAY	PHARMACY	Subtotal	
		SERVI CE	PRGM	EDUCATI ON	RESI DENCY PROG		
		17. 00	23. 00	23. 01	23. 02	24. 00	
1 00	GENERAL SERVICE COST CENTERS	I I		<u> </u>			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					•	5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY						15. 00 16. 00
17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0					17.00
23. 00	02300 PARAMED ED PRGM	l o	0				23.00
23. 01	02301 XRAY EDUCATION	O		917, 837			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0			810, 586		23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0	0	0	44, 529, 285	30.00
31.00	03100 NTENSIVE CARE UNIT		0		0		1
32. 00	03200 CORONARY CARE UNIT	o	0	0	0	0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	0	0	0	0	0 4, 779, 721	40. 00 41. 00
42. 00	04200 SUBPROVI DER		0	0	0	4, 777, 721	42.00
43.00	04300 NURSERY	O	0	0	0	1, 970, 112	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0	0	29, 557, 972	50.00
51.00	05100 RECOVERY ROOM		0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o o	0	Ö	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	213, 073	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	917, 837	0	4, 863, 990	1
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	0	0	0	0	3, 015, 793 1, 174, 390	1
54. 03	05405 MAMMOGRAPHY		0	0	0	2, 006, 464	1
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0	0	0	5, 878, 565	1
57.00	05700 CT SCAN	0	0	0	0	2, 662, 519	1
58.00	05800 MRI	0	0	0	0	823, 194	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0	4, 686, 023 15, 971, 753	1
60. 01	06001 LABORATORY-PATHOLOGI CAL	l ő	0	0	0	1, 657, 161	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	801, 220	1
65.00	06500 RESPI RATORY THERAPY	0	0	0	0		
	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0	0	0	0,220,000	
	06800 SPEECH PATHOLOGY		0	0	0	2, 123, 063 1, 126, 729	
	06900 ELECTROCARDI OLOGY	o o	0	Ö	0	2, 122, 894	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 667, 465	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	8, 621, 257	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0 810, 586	8, 194, 848 37, 460, 480	1
	07400 RENAL DIALYSIS		0	0	010, 300		1
	03020 ACUPUNCTURE	0	0	0	0	0	I
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	587, 880	76. 97
00 NN	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
	09000 CLINIC	o o	0	Ö	0	3, 590, 443	1
90. 01	09001 DI ABETES CENTER	0	0	0	0	291, 421	1
	09002 NEUROPSYCH	0	0	0	0	168, 485	1
	O9003 WOUND CENTER O9004 HYPERBARI C OXYGEN THERAPY	0	0	0	0	2, 385, 040 338, 491	1
	09005 VI MCARE CLINIC		0	l 0	0	1, 630, 950	
90.06			0	Ö	0	523, 095	
91.00	09100 EMERGENCY	0	0	0	0	15, 201, 714	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	0	7, 318, 744	95 00
	09910 CORF		0		0		1
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	<u> </u>						

Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			1	To 12/31/2020	Date/Time Prepared: 7/14/2021 10:20 am
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal
	SERVI CE	PRGM	EDUCATI ON	RESI DENCY	
				PROG	
	17. 00	23. 00	23. 01	23. 02	24. 00
SPECIAL PURPOSE COST CENTERS	T				
109. 00 10900 PANCREAS ACQUISITION	0	0		0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	(0	0 111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	917, 837	810, 586	<u>240, 044, 694</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0	50, 645 190. 00
194.00 07950 WELLNESS COMMUNITY	0	0		0	402, 109 194. 00
194. 01 07951 BUILDING RENTALS	0	0		0	312, 745 194. 01
194. 02 07952 HOSPI CE	0	0	(0	127, 189 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(0	0 194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	(0	202, 681 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0	685, 413 194. 05
194. 06 07956 CRH FOUNDATION	0	0	(0	200, 880 194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	(0	0 194. 07
194. 08 07958 CRHP	0	0	(0	6, 467, 322 194. 08
194. 09 07959 NEUROPSYCH PART B	0	0	(0	45, 977 194. 09
200.00 Cross Foot Adjustments		0	(0	0 200. 00
201.00 Negative Cost Centers	0	0	(0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	917, 837	810, 586	248, 539, 655 202. 00

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10:20 am

				7/14/2021 10:	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	7771472021 10.	ZO dili
		Adjustments	0/.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
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				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
	1 1				14.00
	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	01700 SOCIAL SERVICE				17. 00
	02300 PARAMED ED PRGM				23. 00
23. 01	O2301 XRAY EDUCATION DECL PENOY PROC				23. 01
23. 02	02302 PHARMACY RESIDENCY PROG		L		23. 02
20 00	O3000 ADULTS & PEDIATRICS	O	44, 529, 285		30.00
30.00	03100 INTENSIVE CARE UNIT		7, 519, 244		31.00
32. 00	03200 CORONARY CARE UNIT		7, 519, 244		32.00
	03300 BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	o o	Ö		34.00
	04000 SUBPROVI DER - I PF	0	o		40.00
	04100 SUBPROVI DER - I RF	o	4, 779, 721		41.00
42.00	04200 SUBPROVI DER	0	o		42.00
43.00	04300 NURSERY	0	1, 970, 112		43.00
44.00	04400 SKILLED NURSING FACILITY	0	o		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	29, 557, 972		50.00
	05100 RECOVERY ROOM	0	2, 028, 521		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	213, 073		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 863, 990		54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	3, 015, 793		54. 01
	05404 ULTRA SOUND	0	1, 174, 390		54.02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	0	2, 006, 464 5, 878, 565		54. 03 55. 00
57. 00	05700 CT SCAN		2, 662, 519		57.00
58. 00	05800 MRI		823, 194		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		4, 686, 023		59.00
60.00	06000 LABORATORY		15, 971, 753		60.00
	06001 LABORATORY-PATHOLOGI CAL	o o	1, 657, 161		60. 01
62. 00	1 1	0	801, 220		62.00
	06500 RESPI RATORY THERAPY	0	5, 219, 386		65.00
66.00	06600 PHYSI CAL THERAPY	0	6, 225, 008		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 123, 063		67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 126, 729		68. 00
	06900 ELECTROCARDI OLOGY	0	2, 122, 894		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 667, 465		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8, 621, 257		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 194, 848		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	37, 460, 480		73.00
	07400 RENAL DI ALYSI S	0	1, 108, 301		74.00
	03020 ACUPUNCTURE	0	0 587, 880		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	l d	587, 880		76. 97
88 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	O	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		89.00
	09000 CLINIC		3, 590, 443		90.00
	09001 DI ABETES CENTER	١	291, 421		90.01
90. 02	09002 NEUROPSYCH	O	168, 485		90. 02
	09003 WOUND CENTER	l ő	2, 385, 040		90. 03
	09004 HYPERBARI C OXYGEN THERAPY	Ö	338, 491		90.04
	09005 VI MCARE CLI NI C	0	1, 630, 950		90.05
	09006 MEDICATION MGMT CLINIC	O	523, 095		90.06
	1 1	0	15, 201, 714		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
	OTHER REIMBURSABLE COST CENTERS				
95. 00	09500 AMBULANCE SERVI CES	0	7, 318, 744		95.00

Health Financial Systems	COLUMBUS REGIONA	AL HOSPITAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 7/14/2021 10:20 am

			To 12/31/2020 Part I To 12/31/2020 Date/Time Pre	
Cook Cooker Doorwinding	1 0	Tatal	7/14/2021 10: 2	20 am
Cost Center Description	Intern &	Total		
	Residents			
	Cost & Post			
	Stepdown			
	Adjustments	04.00		
00.40 00040 0005	25. 00	26. 00		00.10
99. 10 09910 CORF	0	0		99. 10
101. 00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	T .T	. 1		
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	240, 044, 694		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	50, 645		190. 00
194. 00 07950 WELLNESS COMMUNITY	0	402, 109		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	312, 745		194. 01
194. 02 07952 HOSPI CE	0	127, 189		194. 02
194. 03 07953 OUTREACH CLINICS	0	O		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	202, 681		194. 04
194. 05 07955 NONALLOWABLE MARKETING	o	685, 413	·	194. 05
194. 06 07956 CRH FOUNDATION	ol	200, 880	·	194. 06
194. 07 07957 HEALTHY COMMUNITIES	ol	ol	·	194. 07
194. 08 07958 CRHP	o	6, 467, 322	ŀ	194. 08
194. 09 07959 NEUROPSYCH PART B		45, 977		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)		248, 539, 655		202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2020 | Part II |
| To | 12/31/2020 | Date/Time | Prepared: | 7/14/2021 | 10: 20 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

					10	12/31/2020	7/14/2021 10:	
				CAPI TAL REI	LATED COSTS			
		Cost Contor Doporintion	Directly	DIDC 0 FLVT	M/DLE FOLLID	Cubtatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
			0	1. 00	2. 00	2A	4. 00	
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT	1					1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXI						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	63, 087	159, 259	6, 473	228, 819	228, 819	4.00
5.00		ADMINISTRATIVE & GENERAL	1, 176, 201	747, 050	7, 590, 192	9, 513, 443	43, 911	5.00
7. 00	1	OPERATION OF PLANT	79, 041	4, 625, 510		5, 031, 578	7, 560	7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	2 450	10, 199 66, 887		10, 199 209, 962	100	8. 00 9. 00
10.00		DI ETARY	3, 650 5, 175	101, 270		119, 970	5, 755 2, 261	10.00
11. 00		CAFETERI A	0	79, 597		99, 076	3, 256	11. 00
13.00		NURSING ADMINISTRATION	11, 154	129, 370		177, 689	13, 752	13.00
14.00		CENTRAL SERVICES & SUPPLY	1, 514	97, 832		163, 475	0	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	4, 406 837	61, 813 47, 042		235, 082 50, 777	7, 778 2, 801	15. 00 16. 00
17. 00		SOCIAL SERVICE	000	47,042		0	2,001	17. 00
23.00	02300	PARAMED ED PRGM	0	0	0	o	0	23. 00
23. 01		XRAY EDUCATION	11, 860	1, 288		28, 225	1, 425	23. 01
23. 02		PHARMACY RESIDENCY PROG LENT ROUTINE SERVICE COST CENTERS	0	4, 842	7, 348	12, 190	1, 171	23. 02
30. 00		ADULTS & PEDIATRICS	216, 961	1, 049, 792	204, 170	1, 470, 923	42, 150	30.00
31.00		INTENSIVE CARE UNIT	12, 440	141, 127		221, 758	6, 891	31.00
32.00	1	CORONARY CARE UNIT	0	0	_	0	0	32.00
33.00		BURN INTENSIVE CARE UNIT	0	0	_	0	0	33.00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00		SUBPROVIDER - I RF	35, 557	142, 750	15, 221	193, 528	4, 243	41.00
42.00		SUBPROVI DER	0	0		0	0	42.00
43.00		NURSERY	4, 523	7, 508		32, 904	2, 658	
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00		OPERATING ROOM	448, 899	512, 881	1, 077, 888	2, 039, 668	2, 602	50.00
51.00		RECOVERY ROOM	42	41, 016		44, 688	26	51.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 8, 697	1, 532 109, 422		5, 639 250, 545	2 474	53. 00 54. 00
54. 00		NUCLEAR MEDICINE-DIAGNOSTIC	73, 356	42, 986		240, 747	3, 474 1, 199	
54. 02		ULTRA SOUND	542	19, 368		95, 119	1, 241	
54. 03		MAMMOGRAPHY	102, 851	1, 301		266, 509	1, 845	
55.00	1	RADI OLOGY-THERAPEUTI C	2, 897	101, 824		1, 176, 569	1, 819	
57. 00 58. 00	05800	CT SCAN	1, 036	23, 154 11, 590		147, 062 15, 658	1, 934 800	
59. 00		CARDI AC CATHETERI ZATI ON	6, 259	116, 943		287, 886	4, 188	59.00
60.00	06000	LABORATORY	19, 119	140, 032		382, 496	10, 467	60.00
60. 01		LABORATORY-PATHOLOGI CAL	96	15, 608		27, 043		60. 01
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY	165 8, 176	5, 512 101, 747		7, 620 184, 521	218 5, 278	62. 00 65. 00
66.00	1	PHYSI CAL THERAPY	335, 186	7, 933		364, 577	5, 657	
67. 00		OCCUPATI ONAL THERAPY	121, 540	2, 846		128, 513	1, 787	67. 00
68. 00		SPEECH PATHOLOGY	50, 825	0		69, 860	1, 226	
69.00		ELECTROCARDI OLOGY	454	18, 003		292, 426	1, 648	
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	144, 356	0	9, 985	154, 341	1, 607 0	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	l o	0	Ö	ő	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00		RENAL DIALYSIS	0	0		31	0	74.00
76. 00 76. 97		ACUPUNCTURE CARDI AC REHABI LI TATI ON	1, 015	0 20, 360	-	0 26, 794	0 538	76. 00 76. 97
70. 97		TIENT SERVICE COST CENTERS	1,015	20, 360	3, 419	20, 794	330	70.97
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	1	CLINIC	0	99, 532		123, 652	3, 767	90.00
90. 01 90. 02		DI ABETES CENTER NEUROPSYCH		9, 980 1, 120		10, 602 1, 266	239 240	90. 01 90. 02
90. 02	1	WOUND CENTER	121, 302	1, 120		124, 742	1, 347	1
90. 04	09004	HYPERBARIC OXYGEN THERAPY	40, 613	0	141	40, 754	280	90. 04
90.05	1	VI MCARE CLINIC	3, 716	54, 795		65, 300	1, 435	
90. 06 91. 00		MEDICATION MGMT CLINIC EMERGENCY	0 7, 065	11, 809 232, 507		19, 594 448, 106	645 13, 052	90. 06 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART	7,005	232, 307	200, 534	448, 100	13, 032	91.00
		· ·	. '		. '	- 1		

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Fo	orm CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Peri od: Works	heet B

ALLUCATION OF CAPITAL RELATED COSTS		Provider Co		Period: From 01/01/2020 To 12/31/2020		
		CAPI TAL REI	LATED COSTS		, , , , , , , , , , , , , , , , , , ,	
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
cost center bescription	Assigned New	DLUG & FIAI	WIVELE EQUIP	Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	21, 555	103, 434	285, 57	5 410, 564		
99. 10 09910 CORF	0	0		0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101.00
SPECIAL PURPOSE COST CENTERS		_	1			
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 111000 INTESTINAL ACQUISITION	0	0				110.00
111. 00 11100 SLET ACQUISITION 113. 00 11300 NTEREST EXPENSE	U	U	1	۷	ı	111. 00 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 146, 168	9, 280, 371	12, 825, 95 ⁻	1 25, 252, 490	224, 566	
NONREI MBURSABLE COST CENTERS	3, 140, 100	9, 200, 3/1	12, 020, 90	1] 25, 252, 490]	224, 300] 110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	9, 362	18	1 9, 543	0	190. 00
194. 00 07950 WELLNESS COMMUNITY	0	0,002	3, 678			194.00
194. 01 07951 BUI LDI NG RENTALS	58, 534	0		58, 534		194. 01
194. 02 07952 HOSPI CE	0	0				194. 02
194. 03 07953 OUTREACH CLINICS	0	0		o	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0		o	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0		o	0	194. 05
194.06 07956 CRH FOUNDATION	0	15, 389		15, 389	128	194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0		0	0	194. 07
194. 08 07958 CRHP	459, 616	87, 749	1, 576, 69	2 2, 124, 057	3, 716	194. 08
194.09 07959 NEUROPSYCH PART B	0	6, 902	899	7, 801	0	194. 09
200.00 Cross Foot Adjustments				0	I	200.00
201.00 Negative Cost Centers		0		0	-	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 664, 318	9, 399, 773	14, 407, 40	1 27, 471, 492	228, 819	202.00

					7/14/2021 10:	
Cost Center Description	ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
OFFICE AND ASSOCIATION	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVI CE COST CENTERS						1 00
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	0 557 354					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	9, 557, 354	l				5.00
7. 00 00700 OPERATION OF PLANT	610, 650	1				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	38, 695			407 (04		8.00
9. 00 00900 HOUSEKEEPI NG	174, 215	l		487, 631	240.000	9.00
10. 00 01000 DI ETARY	74, 630	1		5, 020	349, 803	10.00
11. 00 01100 CAFETERI A	74, 111	116, 265		7, 044	0	11.00
13. 00 01300 NURSING ADMINISTRATION	368, 248			1, 862	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	52, 604	142, 900		6, 477	0	14.00
15. 00 01500 PHARMACY	281, 640	l		3, 967	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	84, 404	68, 713	0	0	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00 02300 PARAMED ED PRGM	0	1 001	0	0	0	23.00
23. 01 02301 XRAY EDUCATION	34, 445	1	0	81	0	23. 01
23. 02 O2302 PHARMACY RESI DENCY PROG	27, 756	7, 073	0	324	0	23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 107 005	1 500 007	22.2/2	107 410	2/0 1/7	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 197, 095	1			268, 147	30.00
31. 00 03100 INTENSIVE CARE UNIT	223, 591	206, 139		27, 770	32, 647	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	U	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0	U	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	U	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER -	125, 505	208, 509		20, 888	38, 038	41.00
42. 00 04200 SUBPROVI DER	0	10.000	0	0	0	42.00
43. 00 04300 NURSERY	66, 144	10, 966			0	43.00
44. 00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS	044.540	7.0.1.0	10.171	54 000	4 (10	
50. 00 05000 OPERATI NG ROOM	844, 542	1		54, 082	1, 649	50.00
51. 00 05100 RECOVERY ROOM	60, 434	59, 910		4, 453	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	_	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	7, 040	l		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	124, 605	l			335	54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	102, 730			6, 396	0	54. 01
54. 02 05404 ULTRA SOUND	40, 707	28, 290		2, 267	0	54.02
54. 03 05405 MAMMOGRAPHY	73, 996	1			0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	205, 304	148, 731	820	7, 853	1, 811	55.00
57. 00 05700 CT SCAN	91, 996	l		1, 295	0	57.00
58. 00 05800 MRI	28, 636	l		729	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	140, 167	170, 814			930	59.00
60. 00 06000 LABORATORY	581, 518	l	0	10, 039	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	60, 549		0	486	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	29, 730	l	0	324	0	62.00
65. 00 06500 RESPI RATORY THERAPY	152, 145	l		12, 144	0	65.00
66. 00 06600 PHYSI CAL THERAPY	232, 827	11, 587			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	80, 142	1		0	0	67.00
68.00 O6800 SPEECH PATHOLOGY	42, 888		0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	70, 092	26, 296		162	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	50, 897	0	56	14, 897	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	331, 525		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	315, 128		0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 115, 883	l e	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	42, 452	0	0	0	0	74.00
76. 00 03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	17, 341	29, 739	0	162	0	76. 97
OUTPAȚI ENT SERVI CE COST CENTERS						
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	101, 285	145, 383	2, 681	7, 772	5, 918	90.00
90. 01 09001 DI ABETES CENTER	9, 481	14, 578	0	162	0	90. 01
90. 02 09002 NEUROPSYCH	6, 214	1, 636	0	0	0	90. 02
90. 03 09003 WOUND CENTER	85, 035	0	110	0	0	90. 03
90. 04 09004 HYPERBARIC OXYGEN THERAPY	11, 927	0	5	0	0	90. 04
90. 05 09005 VI MCARE CLI NI C	40, 691	80, 037	349	18, 216	0	90. 05
90.06 09006 MEDICATION MGMT CLINIC	16, 280		0	1, 457	0	90.06
91. 00 09100 EMERGENCY	484, 839	339, 616	4, 224	45, 177	328	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	221, 226	151, 082	0	0	0	95.00
99. 10 09910 CORF	0			0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

| Peri od: | Worksheet B | From 01/01/2020 | Part I I | To | 12/31/2020 | Date/Time Prepared: | 7/14/2021 | 10:20 | prepared | Prepa

					7/14/2021 10: 20	am
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 10	9.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 11	0.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 11	1.00
113.00 11300 INTEREST EXPENSE					11:	3.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 253, 985	5, 475, 381	63, 892	483, 826	349, 803 11	8.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	469	13, 675	0	0	0 19	0.00
194. 00 07950 WELLNESS COMMUNITY	15, 199	0	0	0	0 19	4.00
194.01 07951 BUILDING RENTALS	12, 026	0	0	0	0 19	4. 01
194. 02 07952 H0SPI CE	4, 875	0	0	0	0 19	4. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 19	4.03
194.04 07954 SPEECH - HEARING AIDS	7, 794	0	0	0	0 19	4.04
194. 05 07955 NONALLOWABLE MARKETING	26, 357	0	0	0	0 19	4. 05
194. 06 07956 CRH FOUNDATION	3, 796	22, 478	0	3, 724	0 19	4.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 19	4. 07
194. 08 07958 CRHP	232, 469	128, 172	0	0	0 19	4. 08
194. 09 07959 NEUROPSYCH PART B	384	10, 082	0	81	0 19	4. 09
200.00 Cross Foot Adjustments					20	00.00
201.00 Negative Cost Centers	0	0	0	0	0 20	1.00
202.00 TOTAL (sum lines 118 through 201)	9, 557, 354	5, 649, 788	63, 892	487, 631	349, 803 20	2.00

	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	7/14/2021 10: MEDI CAL	
	cost center bescription	CALLIERIA	ADMI NI STRATI O	SERVICES & SUPPLY	THANWACT	RECORDS & LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
4 00	GENERAL SERVI CE COST CENTERS		1				4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10. 00 11. 00	01100 CAFETERI A	299, 752					10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	16, 817	1				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 950		379, 972			14.00
15.00	01500 PHARMACY	8, 851	34, 394	0	662, 000		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 441	0	0	0	216, 136	16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM	0	_	0	0	0	17. 00 23. 00
23. 01	02301 XRAY EDUCATION	2, 065	_	Ö	ő	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	1, 180		0	0	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	72, 581		15, 055	726 395	49, 756 361	30. 00 31. 00
32.00	03200 CORONARY CARE UNIT	9, 736	1	455 0	393	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	Ö	_	Ö	Ö	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	o	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	7, 081	26, 632	0	25	722 0	41. 00 42. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	3, 540	13, 333	0	0	0	42.00
44. 00	04400 SKILLED NURSING FACILITY	0,510		Ö	Ö	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	26, 848		335, 541	3, 017	116, 624	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 245		0	11	0	51. 00 52. 00
53.00	05300 ANESTHESI OLOGY			0	1, 927	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 016	o	2, 525	864	0	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 475	1	0	7, 590	0	54. 01
54. 02	05404 ULTRA SOUND	1, 770	1	0	19	0	54.02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	2, 655 2, 360	1	609	50	0	54. 03 55. 00
57. 00	05700 CT SCAN	2, 950		0	11, 337	0	57.00
58. 00	05800 MRI	1, 180		O	1, 187	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 016		2, 750	3, 836	3, 522	59. 00
60.00	06000 LABORATORY	22, 127		0	335	0	60.00
60. 01 62. 00	06001 LABORATORY-PATHOLOGI CAL	1, 770 295		0	0	0	60. 01 62. 00
65.00	06500 RESPIRATORY THERAPY	8, 261	1	331	957	20, 363	65.00
66.00	06600 PHYSI CAL THERAPY	7, 671		9, 029	67	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 065	1	0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 475		0	7 420	0	68.00
70.00	07000 ELECTROCARDI OLOGY	2, 360 2, 360		0	7, 430 0	15, 622	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 300	ol ol	Ö	Ö	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	620, 250	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S	0		0	353	0	74. 00 76. 00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	885	1	0	0 0	0	76.00
70. 77	OUTPATIENT SERVICE COST CENTERS		0,007	<u> </u>			70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES CENTER	6, 196 295		952	42	9, 166 0	90. 00 90. 01
90.01	09001 DI ABETES CENTER 09002 NEUROPSYCH	295		0	0	0	90.01
90. 03	09003 WOUND CENTER	1, 770	1	11, 081	234	0	90.03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	590	1, 771	0	0	0	90. 04
90.05	09005 VI MCARE CLI NI C	2, 655		130	137	0	90.05
90. 06 91. 00	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY	590 22, 127		0 1, 514	0 261	0	90. 06 91. 00
91.00		22, 127	70, 294	1, 314	201	U	91.00
00	OTHER REIMBURSABLE COST CENTERS						
95.00		19, 177	1	0	913	0	95.00
99. 10		0		0	0	0	99. 10
101.00	D 10100 HOME HEALTH AGENCY	0	0	0	O	0	101. 00

			To	12/31/2020	Date/Time Prepared: 7/14/2021 10:20 am	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						_
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00	0
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00	0
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00	0
113.00 11300 INTEREST EXPENSE					113.00	0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	289, 721	767, 334	379, 972	661, 966	216, 136 118. 00	0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00	0
194. 00 07950 WELLNESS COMMUNITY	885	0	0	0	0 194. 00	0
194. 01 07951 BUILDING RENTALS	0	0	0	0	0 194. 0	1
194. 02 07952 HOSPI CE	0	0	0	34	0 194. 0	2
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 0	3
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0 194. 04	4
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 194. 0!	5
194. 06 07956 CRH FOUNDATION	295	0	0	0	0 194. 0	6
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 194. 0	7
194. 08 07958 CRHP	7, 966	0	0	0	0 194. 08	8
194. 09 07959 NEUROPSYCH PART B	885	0	0	0	0 194. 0	9
200.00 Cross Foot Adjustments					200. 00	0
201.00 Negative Cost Centers	0	o	0	ol	0 201. 00	0
202.00 TOTAL (sum lines 118 through 201)	299, 752	767, 334	379, 972	662, 000	216, 136 202. 00	0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

DEBURDAL SERVICE COST CENTERS 1.00 DOTOO] AND REL COSTS BLASE & FINANCE 1.00 DOTOO] AND RELEASE AND RELE					1	0 12/31/2020	Date/lime Pre 7/14/2021 10:	
DENESSAL SERVICE DOST CENTERS		Cost Center Description					•	
SERIORAL SERVICE DOST CENTERS			SERVICE	PRGW	EDUCATION			
0.000 CAP REL DOSTS-BLIDE & FIXT 0.00		I	17. 00	23. 00	23. 01	23. 02	24. 00	
2 00 00000 CAP REL COSTS-AMBILE FOULP	1 00				<u> </u>			1 00
4 00 00000 PURP OVER DEPART TO DEPARTMENT 5 00 000000 PURP STATUTE OF STATUTE 7 00 000000 PURP STATUTE OF STATUTE 8 00 000000 PURP STATUTE OF STATUTE 9 00 000000 PURP STATUTE OF STATUTE 10 00 10000 DETARY 10 00 10000 DETARY 11 00 01 1000 DETARY 11 00 01 1000 DETARY 11 00 01 1000 DETARY 11 10 00 11 100 0000 PURP STATUTE 12 00 000000 PURP STATUTE OF ST								
0.000 0.000 DAMIN ISTRATIVE & CENERAL		1						
0.0700 0		1						
9.00 0000 0005 0005 10005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000 0005 1000		1						
10.00 01000 DETARY	8.00	00800 LAUNDRY & LINEN SERVICE						8.00
11-10 0 11-00 CAFETERIA	9.00							9. 00
13.00 01300 MIRSING ABININ STRATION 13.00 10.00	10.00	01000 DI ETARY						10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 1	11.00	01100 CAFETERI A						11.00
15.00 10500 PHABIMACY	13.00	01300 NURSING ADMINISTRATION						13.00
16.00 16.00 IFED CAL RECORDS & LIBRARY 10.00 17.00 170.00 1	14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
17.00 30.00 1700 PARAMEDE DE PROM 0 0 68.122 32.01 23.00 23.00 2								
23.00 03000 PARAMED ED PROM 0 0 68.122 3.00 23.01 03001 SANY FERICATION 0 0 68.122 3.00 23.01		l						
23.01 0300 PARAMECY RESIDENCY PROG 0 68,122 23.01 23.02		l	-1					
23 02		1 · · · · · · · · · · · · · · · · · · ·	1	0				
IMPATT FORT BOUTH IN SERVICE COST CENTERS			l		68, 122	F0 007		
30.00	23. 02		UU			53, 927		23.02
31.00 03100 NTENSIVE CARE UNIT 0 769,557 31.00 32.00 3320 03300 BURN INTENSIVE CARE UNIT 0 033.00 33	20.00		٥				E 147 122	20.00
32.00 03200 CORDINARY CARE UNIT 0 0 33.00 33.00 33.00 03300 BURN I INTENSIVE CARE UNIT 0 0 33.00 33.00 03300 BURN I INTENSIVE CARE UNIT 0 0 33.00 33.00 03300 SURGICAL I INTENSIVE CARE UNIT 0 0 04.00 04.		1	l I					
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 034.0			l I					
34.00 03400 SURROICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0		1 · 1					-	
40. 00 40000 SUBPROVID DEF - I PF		1	1				-	
14. 00 04-100 SUBPROVI DER - I RF 0 0 04-20 05-2		1					-	
12.00 04.200 SUBPROVI DER 0 130, 044 30, 044 30, 044 30, 00 04.00 NURSERY 0 0 04.00 NURSERY 0 0 04.40 07.44 00 04.40 07.44 00 04.40 07.44 00 04.40 07.44 00 04.40 07.44 00 04.40 07.44 00 04.40 07.44			0				627, 797	
A4. 0	42.00	04200 SUBPROVI DER	О					42.00
MOLILLARY SERVICE COST CENTERS	43.00	04300 NURSERY	0				130, 404	43.00
50.00 GSDOOI OPERATING ROOM 0 18.8, 534 51.00	44.00	04400 SKILLED NURSING FACILITY	0				0	44.00
51.00 05100 RECOVERY ROOM 0 188, 534 51.00 0 0.52.00 052.								
S2.00 0S200 DELLYERY ROOM & LABOR ROOM 0 16,844 53.00		1 · · · · · · · · · · · · · · · · · · ·	1					50.00
16. 844 33. 00		1	l l					
S4-00 05400 RADIOLOGY-DI AGNOSTIC 0 422,95 54.01		1	0				-	
10 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 422 925 54 01 54 02 54 03 54 01 54 02 54 03 54 01 54 02 54 03 54 05 54 01 54 02 54 03 54 05 54 01 54 02 54 03 54 03 54 05 54 03 54 03 54 03 54 03 55 00 55 00 55 00 55 00 57 00 57 00 57 00 57 00 57 00 57 00 57 00 57 00 58 00 59		1	0					
54.02 05404 LITRA SOUND		1	0					
54.03 05405 MAMMOGRAPHY 0 0.5500 RADIOLOGY-THERAPEUTIC 0 0.551.605 59.00 0.5000 RADIOLOGY-THERAPEUTIC 0 0.551.605 59.00 0.5000 RADIOLOGY-PATHOLOGICAL 0 0.511.3609 60.01 0.5001 RADIORATORY 0 0.551.746 65.00 0.5000 RADIOLOGY-PATHOLOGICAL 0 0.551.746 65.00 0.5000 RESPIRATORY THERAPY 0 0.551.746 65.00 0.50000 0.5000 0.5000			0					
55.00 05500 RADI OLDOY-THERAPEUTIC 0 290.394 57.00 290.394								
57.00 05700 CT SCAN 0 05800 MRI 0 0 65.1 95.8 00 05800 MRI 0 0 65.1 95.8 00 05900 CARDI AC CATHETERI ZATI ON 0 0 65.1 605.8 00 060.0 0 06000 LABORATORY 0 0 1.211.523 60.0 01 60.0 0 06000 LABORATORY - PATHOLOGI CAL 0 0 1.313.609 60.0 0 06000 LABORATORY - PATHOLOGI CAL 0 0 1.211.523 60.0 01 60.0 0 06000 LABORATORY - PATHOLOGI CAL 0 0 46.238 62.0 00 65.0 06500 ESSPI RATORY + THERAPY 0 0 56.3 746 65.0 0 65.0 06500 ESSPI RATORY + THERAPY 0 0 56.3 746 65.0 0 66.0 0 0 0 0 0 0 0 0 0								
58.00 05900 05900 CARDI AC CATHETERI ZATI ON 0 0 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0								
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 06000 LABORATORY 0 0 0 06000 LABORATORY 0 0 0 06000 LABORATORY 0 0 0 0 0 0 0 0 0								
60. 00 06000 LABORATORY 0 06001 LABORATORY 0 06001 LABORATORY 0 06001 CABORATORY 0 06001 CABORATORY 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 06500 RESPI RATORY THERAPY 0 0633, 260 66. 00 06600 PHYSI CAL THERAPY 0 0633, 260 66. 00 06600 PHYSI CAL THERAPY 0 0633, 260 66. 00 06600 PHYSI CAL THERAPY 0 0633, 260 66. 00 06600 SPECH PATHOLOGY 0 070, 00 070,		l	· ·					
60.01 06001 LABORATORY-PATHOLOGICAL 0 46.238 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 46.238 62.00 65.00 06500 RESPIRATORY THERAPY 0 563, 746 66.00 06600 PHYSI CAL THERAPY 0 633, 260 66.00 06600 PHYSI CAL THERAPY 0 633, 260 67.00 06700 OCCUPATI ONAL THERAPY 0 217, 353 68.00 06800 SPEECH PATHOLOGY 0 217, 353 67.00 06900 ELECTROCARDIOLOGY 0 115, 449 69.00 06900 ELECTROCARDIOLOGY 0 409, 013 69.00 0700 OCCUPATIONAL THERAPY 0 239, 780 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 331, 525 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENT 0 331, 525 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 315, 128 72.00 74.00 07400 RENAL DIALYSIS 0 42, 836 74.00 76.00 30320 ACUPUNCTURE 0 76.00 76.97 07697 CARDI AC REHABILITATION 0 78, 818 76.97 07697 CARDI AC REHABILITATION 0 78, 818 76.97 07697 CARDI AC REHABILITATION 0 89.00 79.00 08800 RURAL HEALTH CLINIC 0 89.00 79.00 08800 RURAL HEALTH CLINIC 0 9.00 79.00 09000 LUROPSYCH 0 9.51 79.01 09001 DIABETES CENTER 0 9.651 79.02 09002 EUROPSYCH 0 9.651 79.03 09003 WOUND CENTER 0 9.651 79.04 09004 HYPERBARI C OXYGEN THERAPY 0 9.651 79.05 09005 VIMCARE CLINIC 0 58, 233 79.06 09006 MEDICATION MGMT CLINIC 0 58, 233 79.07 09000 09000 MEDICATION MGMT CLINIC 0 58, 233 79.00 09000 MEDICATION MGMT CLINIC 0 79.00 79.00 09000 09000 MEDICATION MGMT CLINIC 0 79.00 79.00 09000 MEDICATION MGMT CLINIC 0 79.00 79.00 09000 0000 0000		1 · · · · · · · · · · · · · · · · · · ·	o					
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0			o					
66.00 06600 PHYSI CAL THERAPY 0 633, 260 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 217, 353 67.00 69.00 06800 SPEECH PATHOLOGY 0 115, 449 68.00 69.00 06900 ELECTROCARDI OLOGY 0 409, 013 69.00 70.00 07000 CLECTROCARDI OLOGY 0 239, 780 70.00 07000 ELECTROCARDI OLOGY 0 239, 780 70.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 331, 525 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 315, 128 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1, 736, 133 73.00 74.00 07400 RENAL DI ALYSI S 0 42, 836 74.00 76.00 03020 ACUPUNCTURE 0 74.00 76.97 07597 CARDIA C. REHABI LITATI ON 0 78.818 76.97 07597 CARDIA C. REHABI LITATI ON 0 78.910 79.00 09000 CLI NI C 0 89.00 99.00 09000 CLI NI C 0 99.01 99.01 09001 DIABETES CENTER 0 90.02 90.02 09002 NEUROS CHERE 0 90.02 90.03 09003 WOUND CENTER 0 90.02 90.04 09004 HYPERBARI C OXYGEN THERAPY 0 90.05 90.05 09005 VIDERAC C OXYGEN THERAPY 0 90.05 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 90.05 90.00 09000 MEDI CATI ON MGMT CLI NI C 0 90.05 90.00 09000 MEDI CATI ON MGMT CLI NI C 0 90.05 90.00 09000 MERGENCY 0 90.05 90.00 09000 MERGENC	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	О					62.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 217, 353 67. 00 68. 00 06800 SPECCH PATHOLOGY 0 115, 449 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 409, 013 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 239, 780 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 331, 525 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 315, 128 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1, 736, 133 73. 00 74. 00 07400 RENAL DIALYSIS 0 42, 836 74. 00 76. 00 30200 AUPUNCTURE 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 78. 818 76. 97 0017PATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 90. 01 90. 01 90. 01 09000 CLINI C 0 35, 357 90. 01 90. 02 09002 NEUROPSYCH 0 90. 02 90. 03 09003 WOUND CENTER 0 55, 327 90. 04 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 55, 327 90. 04 90. 05 09005 VI MCARE CLINI C 0 58, 233 90. 06 90. 06 09006 MEDI CATI ON MGMT CLINI C 0 58, 233 90. 06 90. 06 09006 MEDI CATI ON MGMT CLINI C 0 58, 233 90. 06 90. 00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 00000 91. 00 09000 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 00000 95. 00 09000 ABBULANCE SERVI CES 0 0 90. 10 99. 10 09001 OP0000 CREFE 0 0 0 0 99. 10 09000 09000 09000 09000 00000 99. 10 09000 OP0000 00000 00000 00000 99. 10 09000 00000 00000 00000 99. 10 00000 000000 00000 99. 10 00000 000000 00000 99. 10 000000 000000 99. 10 000000 000000 99. 10 000000 000000 99. 10 000000 000000000 99. 10 000000000000000000000000000000000	65.00	06500 RESPIRATORY THERAPY	0				563, 746	65.00
68.00 06800 SPEECH PATHOLOGY 0 115, 449 68.00 69.00 06900 ELECTROCARDI OLOGY 0 409, 013 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 239, 780 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 331, 525 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 315, 128 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 736, 133 73.00 74.00 07400 RENAL DI ALYSIS 0 42, 836 74.00 76.00 03020 ACUPUNCTURE 0 76.00 76.97 07697 CARDI AC REHABILITATION 0 78, 818 76.97 07697 CARDI AC REHABILITATION 0 78, 818 77.90 07697 CARDI AC REHABILITATION 0 89.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89.00 08900 CLINIC 0 423, 924 90.01 09001 DI ABETES CENTER 0 90.01 90.02 09002 CLINIC 90.01 90.03 09003 WOUND CENTER 0 90.01 90.04 09004 HYPERBARIC OXYGEN THERAPY 0 55, 327 90.05 09005 VINCARE CLINIC 0 58, 233 90.06 09006 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09006 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09006 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 233 90.06 09000 MEDI CATION MGMT CLINIC 0 58, 235 90.00 09000 MEDI CATION MGMT CLINIC 0 58, 235 90.00 09000 MEDI CATION MGMT CLINIC 0 58, 235 90.00 09000 MEDI CATION MGMT CLINIC 0 58, 235 90.00 09000 MEDICATION MGMT CLINIC 0 58, 23	66.00	06600 PHYSI CAL THERAPY	0				633, 260	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 239, 780 70. 00 70.			l l					
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 239,780 70. 00 71. 00 70. 00			0					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 331, 525 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0 315, 128 72. 00 7300 O7400 IMPL. DEV. CHARGED TO PATIENTS 0 1, 736, 133 73. 00 74. 00 07400 RENAL DIALYSIS 0 1, 736, 133 73. 00 74. 00 07400 RENAL DIALYSIS 0 42, 836 74. 00 76. 00 03020 ACUPUNCTURE 0 0 76. 00 76		1	0					
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76. 00								
76. 97 07697 CARDI AC REHABILITATION 0 78,818 76. 97 00000 00000 00000			1					
SERVICE COST CENTERS SERVICE COST CENTER SERVICE COST CENTER SERVICE COST CENTER SERVICE COST CENTER SERVICE CE			1				-	
88. 00	70.77		<u> </u>				70,010	70.77
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 090.00 09000 CLINIC 0 423, 924 90. 00 90. 01 09001 DIABETES CENTER 0 35, 357 90. 01 90. 02 09002 NUND CENTER 0 90. 02 90. 03 09003 NUND CENTER 0 90. 04 09004 HYPERBARIC OXYGEN THERAPY 0 231, 550 90. 03 90. 04 09004 HYPERBARIC OXYGEN THERAPY 0 555, 327 90. 04 90. 05 09005 VI MCARE CLINIC 0 219, 397 90. 05 90. 06 09006 MEDICATION MGMT CLINIC 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 1, 429, 538 91. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART 0 09500 AMBULANCE SERVICES 0 99. 10 09910 CORF 0 99. 10 09910 CORF 0 99. 10	88. 00		0				0	88. 00
90. 01 09001 DI ABETES CENTER 0 35, 357 90. 01 90. 02 09002 NEUROPSYCH 0 9, 651 90. 02 90. 03 09003 WOUND CENTER 0 231, 550 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 55, 327 90. 04 90. 05 09005 VI MCARE CLI NI C 0 219, 397 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 1, 429, 538 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 885, 710 99. 10 09910 CORF 0 99. 10			l l				0	
90. 02 09002 NEUROPSYCH 0 9, 651 90. 02 90. 03 09003 WOUND CENTER 0 231, 550 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 55, 327 90. 04 90. 05 09005 VI MCARE CLI NI C 0 219, 397 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 1, 429, 538 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 885, 710 99. 10 09910 CORF 0 99. 10	90.00	09000 CLI NI C	0				423, 924	90.00
90. 03 09003 WOUND CENTER 0 231, 550 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 55, 327 90. 04 90. 05 09005 VI MCARE CLI NI C 0 219, 397 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 09100 EMERGENCY 0 1, 429, 538 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 885, 710 99. 10 09910 CORF 0 99. 10	90. 01	09001 DI ABETES CENTER	0				35, 357	90. 01
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 55, 327 90. 04 90. 05 09005 VI MCARE CLI NI C 0 219, 397 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 09100 EMERGENCY 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0000 92. 00 09000 OTHER REI MBURSABLE COST CENTERS 0 885, 710 99. 10 09910 CORF 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 90. 04 09000 00000 00000 00000 90. 04 00000 00000 00000 90. 05 00000 00000 00000 90. 06 00000 00000 90. 07 00000 00000 90. 08 00000 00000 90. 08 00000 00000 90. 08 00000 00000 90. 09 00000 00000 90. 00000 90. 00000 90. 00000 90. 00000 90. 00000 90. 00000	90. 02	09002 NEUROPSYCH	0				9, 651	90. 02
90. 05 09005 VI MCARE CLINI C 0 219, 397 90. 05 90. 06 09006 MEDI CATI ON MGMT CLINI C 0 58, 233 90. 06 91. 00 09100 EMERGENCY 0 09100 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 92. 00 07HER REI MBURSABLE COST CENTERS 95. 00 99500 AMBULANCE SERVI CES 0 99. 10 99. 10 09910 CORF 0 99. 10 90. 05 09000 09000 09000 09000 09000 09000 90. 05 09000 09000 09000 09000 90. 05 09000 09000 09000 09000 90. 05 09000 09000 09000 90. 05 09000 09000 90. 06 09000 90. 06 09000 90. 07 09000 90. 08 09000 90. 07 09000 90. 08 09000 90. 08 09000 90. 08 09000 90. 08 09000 90. 08 09000 90. 09000 90. 00 09000 90. 00			0					
90. 06 09006 MEDI CATI ON MGMT CLINI C 0 58, 233 90. 06 91. 00 91.00 EMERGENCY 0 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 07 07 07 07 07 07 07			0					
91. 00 09100 EMERGENCY 0 1, 429, 538 91. 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 09910 CORF 0 99. 10 09910 0 99. 10 0 99. 10 0 99. 10 0 0 0 0 0 0 0 0 0			0					
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 99. 10 09910 CORF 0 99. 10 99. 10 09910 0 99. 10 0 0 0 0 0 0 0 0 0			1					
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 885, 710 95. 00 99. 10 09910 CORF 0 0 99. 10			0				1, 429, 538	
95. 00 09500 AMBULANCE SERVI CES 0 885, 710 95. 00 99. 10 09910 CORF 0 99. 10	92. 00							92.00
99. 10 09910 CORF 0 99. 10	05.00						005 710	05.00
			l I					
101.00 101.00 101.00 0 0 0 0 0 0 0 0 0			l I					
	101.00	TO TOO THOME HEALTH ADDITION	<u> </u>		1	<u> </u>	0	1.01.00

Health Financial Systems	COLUMBUS REGIONAL H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	F	Provider CCN: 15-0112	Peri od:	Worksheet B

				From 01/01/2020 To 12/31/2020		pared: 20 am
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	
·	SERVI CE	PRGM	EDUCATI ON	RESI DENCY		
				PROG		
	17. 00	23. 00	23. 01	23. 02	24. 00	
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0					109. 00
110.00 11000 INTESTINAL ACQUISITION	0					110.00
111.00 11100 I SLET ACQUISITION	0				0	111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	24, 634, 542	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0					190.00
194. 00 07950 WELLNESS COMMUNI TY	0					194. 00
194. 01 07951 BUILDING RENTALS	0					194. 01
194. 02 07952 HOSPI CE	0				·	194. 02
194. 03 07953 OUTREACH CLINICS	0					194. 03
194. 04 07954 SPEECH - HEARING AIDS	0				·	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0				·	194. 05
194. 06 07956 CRH FOUNDATION	0					194. 06
194. 07 07957 HEALTHY COMMUNI TI ES	0					194. 07
194. 08 07958 CRHP	0				2, 496, 380	1
194.09 07959 NEUROPSYCH PART B	0				·	194. 09
200.00 Cross Foot Adjustments		0	68, 12	2 53, 927	122, 049	1
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	68, 12	2 53, 927	27, 471, 492	202.00

				10		te/lime Prepared: 14/2021 10:20 am
Cost Center Desc	ri pti on	Intern &	Total		., .,	
		Resi dents				
		Cost & Post				
		Stepdown				
		Adjustments	0/ 00			
CENEDAL SERVICE COST (PENTERS	25. 00	26. 00			
1. 00 GENERAL SERVICE COST (00100 CAP REL COSTS-BL						1.00
2. 00 00200 CAP REL COSTS-MV						2.00
4. 00 00400 EMPLOYEE BENEFIT						4.00
5. 00 00500 ADMI NI STRATI VE &						5. 00
7. 00 00700 OPERATION OF PLA						7.00
8. 00 00800 LAUNDRY & LI NEN						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSING ADMINIST	RATION					13.00
14.00 01400 CENTRAL SERVICES	& SUPPLY					14.00
15.00 01500 PHARMACY						15. 00
16.00 01600 MEDICAL RECORDS	& LI BRARY					16.00
17.00 01700 SOCIAL SERVICE						17.00
23. 00 02300 PARAMED ED PRGM						23.00
23. 01 02301 XRAY EDUCATION						23. 01
23. 02 02302 PHARMACY RESIDEN						23. 02
I NPATI ENT ROUTI NE SERV			5 1/7 122			20.00
30. 00 03000 ADULTS & PEDIATR 31. 00 03100 INTENSIVE CARE U		0	5, 147, 133 769, 557			30. 00 31. 00
32. 00 03200 CORONARY CARE UN			769, 557			32.00
33. 00 03200 CORONART CARE ON			0			33.00
34. 00 03400 SURGI CAL INTENSI		0	o			34.00
40. 00 04000 SUBPROVI DER - I P			o			40.00
41. 00 04100 SUBPROVI DER - I R		o	627, 797			41.00
42. 00 04200 SUBPROVI DER		0	0			42.00
43. 00 04300 NURSERY		O	130, 404			43.00
44.00 04400 SKILLED NURSING	FACI LI TY	0	0			44.00
ANCILLARY SERVICE COST	CENTERS					
50.00 O5000 OPERATING ROOM		0	4, 290, 200			50.00
51.00 05100 RECOVERY ROOM		0	188, 534			51.00
52.00 05200 DELIVERY ROOM &	LABOR ROOM	0	0			52.00
53. 00 05300 ANESTHESI OLOGY		0	16, 844			53.00
54. 00 05400 RADI OLOGY-DI AGNO		0	563, 548			54.00
54. 01 05402 NUCLEAR MEDI CI NE	-DI AGNOSTI C	0	422, 925			54. 01
54. 02 05404 ULTRA SOUND		0	169, 413			54. 02
54. 03 05405 MAMMOGRAPHY	FUTLC	0	352, 701			54.03
55. 00 05500 RADI OLOGY-THERAP 57. 00 05700 CT SCAN	EUTIC	0	1, 545, 270			55. 00 57. 00
58. 00 05700 CT SCAN			290, 394			58.00
59. 00 05900 CARDI AC CATHETER	I ZATLON		65, 119 651, 605			59.00
60. 00 06000 LABORATORY	IZATION		1, 211, 523			60.00
60. 01 06001 LABORATORY-PATHO	LOGLCAL		113, 609			60. 01
62. 00 06200 WHOLE BLOOD & PA		l ol	46, 238			62.00
65. 00 06500 RESPIRATORY THER		0	563, 746			65.00
66.00 06600 PHYSI CAL THERAPY		0	633, 260			66.00
67.00 06700 OCCUPATIONAL THE	RAPY	0	217, 353			67.00
68.00 06800 SPEECH PATHOLOGY		0	115, 449			68.00
69. 00 06900 ELECTROCARDI OLOG		0	409, 013			69. 00
70. 00 07000 ELECTROENCEPHALO		0	239, 780			70.00
71. 00 07100 MEDI CAL SUPPLI ES		0	331, 525			71.00
72. 00 07200 IMPL. DEV. CHARG		0	315, 128			72.00
73. 00 07300 DRUGS CHARGED TO	PATTENTS	0	1, 736, 133			73.00
74. 00 07400 RENAL DI ALYSI S		0	42, 836			74.00
76. 00 03020 ACUPUNCTURE 76. 97 07697 CARDI AC REHABI LI	TATION	0	70 010			76.00
OUTPATIENT SERVICE COS		0	78, 818			76. 97
88. 00 08800 RURAL HEALTH CLI		T ol	0			88. 00
89. 00 08900 FEDERALLY QUALIF			0			89.00
90. 00 09000 CLINIC	VENTER	ا م	423, 924			90.00
90. 01 09001 DI ABETES CENTER		l ő	35, 357			90.01
90. 02 09002 NEUROPSYCH		l ol	9, 651			90. 02
90. 03 09003 WOUND CENTER		o	231, 550			90. 03
90. 04 09004 HYPERBARI C OXYGE	N THERAPY	0	55, 327			90.04
90.05 09005 VIMCARE CLINIC		0	219, 397			90. 05
90. 06 09006 MEDICATION MGMT	CLINIC	0	58, 233			90.06
91.00 09100 EMERGENCY		0	1, 429, 538			91.00
92. 00 09200 OBSERVATION BEDS		0				92.00
OTHER REIMBURSABLE COS			005 745			
95. 00 09500 AMBULANCE SERVI C	E)	0	885, 710			95.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0112	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 7/14/2021 10:20 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	05.00	07.00			

			7/14/2021 10: 20 am
Cost Center Description	Intern &	Total	
	Resi dents		
	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	24, 634, 542	118.00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	23, 687	190.00
194. 00 07950 WELLNESS COMMUNITY	0	20, 171	194. 00
194. 01 07951 BUI LDI NG RENTALS	0	70, 560	194. 01
194. 02 07952 HOSPI CE	0	4, 909	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	7, 794	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	26, 357	194. 05
194. 06 07956 CRH FOUNDATION	0	45, 810	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	194. 07
194. 08 07958 CRHP	0	2, 496, 380	194. 08
194.09 07959 NEUROPSYCH PART B	0	19, 233	194. 09
200.00 Cross Foot Adjustments	0	122, 049	200. 00
201.00 Negative Cost Centers	o	O	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	27, 471, 492	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0112

					Т	o 12/31/2020	Date/Time Pre 7/14/2021 10:	
			CAPI TAL REI	ATED COSTS			77 147 2021 10.	20 alli
		Cook Cooker Donnel at long	DIDC 0 FLVT	MVDLE FOLLID	EMDL OVEE	D!!!-#!-	ADMINI CTDATIV	
		Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DEPR)	EMPLOYEE BENEFITS	n	ADMINISTRATIV E & GENERAL	
			(50 1221)	(BELLY)	DEPARTMENT		(ACCUM. COST)	
			1.00	0.00	(GROSS SAL)		5.00	
	GENER	AL SERVICE COST CENTERS	1. 00	2.00	4.00	5A	5. 00	
1.00		CAP REL COSTS-BLDG & FIXT	729, 925					1.00
2.00		CAP REL COSTS-MVBLE EQUIP		14, 299, 778				2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT	12, 367	6, 425			194, 272, 603	4.00
7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	58, 011 359, 187	7, 533, 492 324, 584			12, 412, 590	5. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	792				786, 555	8. 00
9.00		HOUSEKEEPI NG	5, 194	1			3, 541, 241	9.00
10. 00 11. 00		DI ETARY CAFETERI A	7, 864 6, 181	13, 424 19, 333			1, 516, 994 1, 506, 441	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	10, 046			0	7, 485, 318	
14.00		CENTRAL SERVICES & SUPPLY	7, 597	63, 650			1, 069, 283	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	4, 800	l .			5, 724, 857	15.00
17. 00		SOCIAL SERVICE	3, 653	2, 876 0	1, 007, 530 0	0	1, 715, 669 0	16. 00 17. 00
23. 00		PARAMED ED PRGM	0	0	Ö	0	0	23. 00
23. 01		XRAY EDUCATION	100				700, 164	
23. 02		PHARMACY RESIDENCY PROG IENT ROUTINE SERVICE COST CENTERS	376	7, 293	421, 322	0	564, 192	23. 02
30.00		ADULTS & PEDIATRICS	81, 520	202, 645	15, 162, 023	0	24, 334, 782	30.00
31.00	03100	INTENSIVE CARE UNIT	10, 959			0	4, 544, 894	31.00
32.00		CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00		SUBPROVI DER - I PF	0	ő	Ö	0	ő	40.00
41.00		SUBPROVI DER - I RF	11, 085	15, 107	1, 526, 286		2, 551, 121	41. 00
42.00		SUBPROVI DER	0 583	0	1	0	1 244 509	42.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	0	20, 717 0			1, 344, 508 0	43.00 44.00
	ANCI L	LARY SERVICE COST CENTERS			-			
50.00		OPERATING ROOM	39, 827	1, 069, 836				50.00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	3, 185 0	1			1, 228, 425 0	51. 00 52. 00
53.00		ANESTHESI OLOGY	119	· -		0	143, 104	
54.00		RADI OLOGY-DI AGNOSTI C	8, 497	131, 437			2, 532, 832	
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC	3, 338			0	2, 088, 168	
54. 02		ULTRA SOUND MAMMOGRAPHY	1, 504 101	74, 647 161, 144		0	827, 451 1, 504, 116	
55. 00		RADI OLOGY-THERAPEUTI C	7, 907	1, 063, 842		0	4, 173, 179	
57. 00	1	CT SCAN	1, 798	i .			1, 869, 992	
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	900 9, 081	4, 038 163, 454		0	582, 084 2, 849, 150	
60.00		LABORATORY	10, 874	l .			11, 820, 431	
60. 01		LABORATORY-PATHOLOGI CAL	1, 212		1	0	1, 230, 776	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	428	l .			604, 309	
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	7, 901 616	74, 041 21, 298			3, 092, 636 4, 732, 641	
67. 00	1	OCCUPATI ONAL THERAPY	221	4, 096			1, 629, 029	
68. 00	1	SPEECH PATHOLOGY	0			0	871, 777	68.00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 398	271, 923 9, 910			1, 424, 752 1, 034, 571	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0, 710			6, 738, 858	
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6, 405, 553	72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	22, 682, 389	
74. 00 76. 00		RENAL DI ALYSI S ACUPUNCTURE	0	31	0	0	862, 913	74. 00 76. 00
76. 97		CARDI AC REHABI LI TATI ON	1, 581	5, 379		_	352, 482	
		TIENT SERVICE COST CENTERS						
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88. 00 89. 00
90.00		CLINIC	7, 729				2, 058, 807	90.00
90. 01	09001	DI ABETES CENTER	775	617	86, 019		192, 728	90. 01
90. 02		NEUROPSYCH	87	145		0	126, 314	
90. 03 90. 04	1	WOUND CENTER HYPERBARIC OXYGEN THERAPY	0	3, 414 140		0	1, 728, 500 242, 443	
90. 05	1	VIMCARE CLINIC	4, 255	ŀ			827, 127	
90.06		MEDICATION MGMT CLINIC	917	i .		0	330, 926	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	18, 055	206, 976	4, 694, 820	0	9, 855, 253	91. 00 92. 00
,2.00	10 /200	1000 THOU INTO	T.	I	1	II	I	, ,2.00

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 ALLOCA	IION - STATISTICAL BASIS		Provi der Co		eriod: rom 01/01/2020	Worksheet B-1	
				j.		Date/Time Pre	
						7/14/2021 10:	20 am
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
		(SQ FEET)	(DEPR)	BENEFITS	n	E & GENERAL	
		, ,	, ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS SAL)			
		1. 00	2. 00	4. 00	5A	5. 00	
	REI MBURSABLE COST CENTERS				_		
	AMBULANCE SERVICES	8, 032	283, 442			.,,	
99. 10 09910		0	0	_		0	99. 10
	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	AL PURPOSE COST CENTERS			_			100 00
	PANCREAS ACQUISITION	0	0	_	_		109.00
	INTESTINAL ACQUISITION	0	0	0	0		110.00
	ISLET ACQUISITION INTEREST EXPENSE	U	U	0	U		111.00
113.00 11300	•	720, 653	10 700 141	00 771 714	E4 247 0E2		113.00
	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	720, 653	12, 730, 141	80, 771, 716	-54, 267, 052	188, 106, 048	1118.00
	GIFT FLOWER COFFEE SHOP & CANTEEN	727	180	0	0	0.542	190. 00
	WELLNESS COMMUNITY	727	3, 651		_	308, 948	
	BUILDING RENTALS		3, 031	147, 277	0	244, 459	
194. 02 07952			0	0	0	99, 093	
	OUTREACH CLINICS	0	0	0	0		194. 03
	SPEECH - HEARING AIDS	0	0	0	0	158, 427	
	NONALLOWABLE MARKETING	o	0	Ö	0	535, 757	
	CRH FOUNDATION	1, 195	0	45, 958	0	77, 162	
194. 07 07957	HEALTHY COMMUNITIES	o	0	0	0		194. 07
194. 08 07958		6, 814	1, 564, 914	1, 336, 682	0	4, 725, 365	194. 08
194. 09 07959	NEUROPSYCH PART B	536	892	0	0	7, 801	194. 09
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	9, 399, 773	14, 407, 401	27, 363, 289		54, 267, 052	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 877724	1. 007526			0. 279335	
204. 00	Cost to be allocated (per Wkst. B,			228, 819		9, 557, 354	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 002780		0. 049196	205.00
204 00	NAUE adjustment amount to be all costed						204 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	(per wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
I	i arts i i and i v)	ı	l	I	I	ı	I

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

				10	12/31/2020	Date/lime Pre 7/14/2021 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		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		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	300, 360					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	792	1, 874, 060				8.00
9. 00	00900 HOUSEKEEPI NG	5, 194	0	6, 023			9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	7, 864	0	62 87	153, 391	1, 016	10.00
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	6, 181 10, 046		23	0	1,016	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 597	Ö	80	0	10	1
15.00	01500 PHARMACY	4, 800	0	49	0	30	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 653	0	0	0	32	16.00
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM	0	0	0	0	0	17. 00 23. 00
23. 00	02301 XRAY EDUCATION	100			0	7	23. 00
	02302 PHARMACY RESIDENCY PROG	376	0	4	0	4	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	81, 520 10, 959	l		117, 584	246 33	30. 00 31. 00
32.00	03200 CORONARY CARE UNIT	10, 959	19,370		14, 316 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	Ö	Ö	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	1, ,00	0	40.00
41. 00 42. 00	04100 SUBPROVI DER	11, 085	77, 036	258 0	16, 680 0	24 0	41. 00 42. 00
43. 00	04300 NURSERY	583	22, 823		0	12	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS				700		
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	39, 827 3, 185	386, 314 83, 500		723 0	91 11	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0, 103	03,300		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, 497	135, 395		147	17	54.00
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	3, 338 1, 504	0	79 28	0	5 6	54. 01 54. 02
54. 02	05405 MAMMOGRAPHY	101	8, 177		0	9	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 907	24, 066		794	8	55.00
57. 00	05700 CT SCAN	1, 798	0		0	10	57.00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	900 9, 081	0 111, 693	9 113	0 408	4 17	58. 00 59. 00
60.00	06000 LABORATORY	10, 874	111,693	124	408	75	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	Ö	6	0	6	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	428	0	4	0	1	62.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 901	0 51, 748	150	0	28	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	616 221	20, 199		0	20 7	67.00
	06800 SPEECH PATHOLOGY	0	0		0	5	68.00
	06900 ELECTROCARDI OLOGY	1, 398	i e	2	0	8	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 645	184	0	8	70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	0	73.00
	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	03020 ACUPUNCTURE	1 501	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	1, 581	0	2	U	3	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	09000 CLINIC	7, 729	1	96	2, 595	21	90.00
90. 01 90. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH	775 87	0	0	0	1	90. 01 90. 02
	09003 WOUND CENTER	0	3, 237		0	6	90.03
	09004 HYPERBARI C OXYGEN THERAPY	0	135		0	2	90. 04
	09005 VI MCARE CLI NI C	4, 255			0	9	90.05
90. 06 91. 00	O9006 MEDICATION MGMT CLINIC O9100 EMERGENCY	917 18, 055	0 123, 904	18 558	0 144	2 75	90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 035	123, 704	550	144	75	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	8, 032	ł		0		95.00
	09910 CORF 10100 HOME HEALTH AGENCY	0	·		0		99. 10 101. 00
	1			. 9	<u> </u>		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (TIME SPT) (MEALS) (FTES) (SQ FEET) (LDRY LBS) 9.00 10.00 11.00 7 00 8 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 ol 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 Ω 0 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 291, 088 1,874,060 5, 976 153, 391 982 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190, 00 727 0 0 194. 00 07950 WELLNESS COMMUNITY 0 0 3 194.00 194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 0 194. 01 0 194. 02 07952 HOSPI CE 0 0 194. 02 0 0 0 0 194.03 194. 03 07953 OUTREACH CLINICS 0 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 194.04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 0 194.05 0 194.06 07956 CRH FOUNDATION 1 194.06 1, 195 0 46 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 0 194. 07 194. 08 07958 CRHP 6,814 0 27 194. 08 0 194. 09 07959 NEUROPSYCH PART B 3 194.09 C 0 536 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 4, 805, 038 2, 323, 436 202.00 Cost to be allocated (per Wkst. B, 15, 879, 861 1,048,140 2, 405, 971 Part I) 52. 869427 2, 286. 846457 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.559288 797. 781504 15. 685216 204.00 Cost to be allocated (per Wkst. B, 5, 649, 788 63, 892 487, 631 349, 803 299, 752 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 18.810055 0.034093 80.961481 2. 280466 295. 031496 205. 00 II)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 Peri od: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					To	12/31/2020	Date/Time Pre 7/14/2021 10:	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
			ADMI NI STRATI O N	SERVI CES & SUPPLY	(DRG COST)	RECORDS & LI BRARY	SERVICE (TIME SPT)	
			(NURS HRS)	(STER SUP)		(TIME SPT)	(TIME SIT)	
	OFNED	AL CEDITOR COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT						1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT					ļ	4.00
5. 00		ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPING						9.00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
13.00		NURSI NG ADMI NI STRATI ON	1, 411, 385	(4 250				13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	21, 273 63, 262	64, 258 0				14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	0	0	4, 787		16.00
17. 00	1	SOCIAL SERVICE	0	0	0	0	0	17. 00
23. 00	1	PARAMED ED PRGM	0	0	0	0	0	23.00
23. 01 23. 02	1	XRAY EDUCATION PHARMACY RESIDENCY PROG	7, 786	0		0	0	
25. 02		IENT ROUTINE SERVICE COST CENTERS	7,700	<u> </u>	<u> </u>	<u> </u>	- O	25.02
30.00		ADULTS & PEDIATRICS	512, 306	2, 546	26, 152	1, 102	0	30.00
31.00		INTENSIVE CARE UNIT	68, 254	77	14, 220	8	0	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		o	0	34.00
40.00	1	SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41.00	1	SUBPROVIDER - IRF	48, 986	0	903	16	0	41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY	24, 524	0	0	0	0	42. 00 43. 00
44.00	1	SKILLED NURSING FACILITY	24, 524	0		0	0	44.00
		LARY SERVICE COST CENTERS	-					
50.00		OPERATI NG ROOM	190, 019	56, 744	108, 652	2, 583	0	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	23, 765	0	406	0	0	51.00 52.00
53.00	1	ANESTHESI OLOGY		0	69, 388	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	o	427	31, 122	o	0	54.00
54. 01	1	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0	54. 01
54. 02 54. 03	1	ULTRA SOUND MAMMOGRAPHY	0	0 103		0	0	54. 02 54. 03
55. 00		RADI OLOGY-THERAPEUTI C		0	1, 788	0	0	55.00
57.00	1	CT SCAN	0	0	408, 302	0	0	57.00
58.00	05800	i e	0	0		0	0	58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	35, 938	465 0		78 0	0	59. 00 60. 00
60. 00	1	LABORATORY-PATHOLOGI CAL		0	12,003	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
		RESPI RATORY THERAPY	57, 254	56		451	0	
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	1, 527	2, 409	0	0	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY		0	0	0	0	68.00
69. 00		ELECTROCARDI OLOGY	15, 817	0	267, 613	0	0	69. 00
		ELECTROENCEPHALOGRAPHY	0	0	0	346	0	
	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	71. 00 72. 00
		DRUGS CHARGED TO PATIENTS		0	22, 339, 757	o	0	73.00
74.00		RENAL DIALYSIS	o	0	12, 723	0	0	74. 00
76.00		ACUPUNCTURE	0	0	0	0	0	76.00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	6, 178	0	0	0	0	76. 97
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90.00		CLINIC	31, 471	161	1, 497	203	0	90.00
90. 01 90. 02		DI ABETES CENTER NEUROPSYCH		0	-	0	0	90. 01 90. 02
90. 03		WOUND CENTER	13, 301	1, 874	-	ő	Ö	90.03
90. 04	1	HYPERBARIC OXYGEN THERAPY	3, 258	0	0	0	0	90. 04
90. 05 90. 06	1	VIMCARE CLINIC MEDICATION MGMT CLINIC	19, 216 4, 447	22 0		0	0	90. 05 90. 06
90.06		EMERGENCY	129, 294	256	-	0	0	90.06
	09200	OBSERVATION BEDS (NON-DISTINCT PART	,		1,270			92.00
05 00		REI MBURSABLE COST CENTERS	405 001		22.000	- I		05.00
95. 00 99. 10		AMBULANCE SERVICES	135, 036	0		0		95. 00 99. 10
	1,.0	1 * *	1 9	<u>_</u>	<u>. </u>	<u> </u>		

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

OUST REEDOMITOR STATISTICAL BROTS		Trovider o	ON: 10 0112	rom 01/01/2020	WOT ROTTED T	
				To 12/31/2020	Date/Time Pre	
					7/14/2021 10:	20 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &	(DRG COST)	RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY	(TIME SPT)	
	(NURS HRS)	(STER SUP)		(TIME SPT)		
	13. 00	14. 00	15. 00	16. 00	17. 00	
101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	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 ACQUISITION	0	0	(0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 411, 385	64, 258	23, 842, 175	4, 787	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(0		190.00
194. 00 07950 WELLNESS COMMUNITY	0	0	(0		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	(0		194. 01
194. 02 07952 HOSPI CE	0	0	1, 217	7 0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(0		194. 04
194. 05 07955 NONALLOWABLE 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						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	10, 256, 054	2, 010, 895	8, 145, 182	2, 461, 226	0	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 266659	31. 294080	0. 341612	514. 147901	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B,	767, 334	379, 972	662, 000	216, 136	0	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 543674	5. 913225	0. 027765	45. 150616	0.000000	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)						
	·					

Period: Worksheet B-1
From 01/01/2020
To 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am

COUNTY PARAMETER STATE PARAMETER COUNTY PARAMETER PARAMETER RESIDENCY PROBLEM						7/14/2021 10	
CENTRAL SERVICE DOST CENTERS 73.00 23.01 25.05		Cost Center Description					
PRINCE SPRINGE CRICT CRITTERS							
			(PERCENT)	(PERCENT)			
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2.00 0.0000 DOPO DEPART 100 SERVICE							
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13.00 1300 MIRSI NG ADMINI STRATION 14.00 1400							1
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 1	1	•					1
15.00 1500 PHARMACY							1
17.00 17.00 20CAL SERVICE							1
23.00	1	•					
23. 01 0230 PRAME LED ELOY PROG	•	1					•
23. Q2	•	1	0	100			•
INPATI ENT ROUTINE SERVICE COST CENTERS		•		100	100		1
30.00 30.00 30.00 30.00 30.00 30.00 31.00					100	<u> </u>	25.02
32.00 03200C COROMARY CARE UNIT			0	0	(30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00			0	0			31.00
34.00 03400 SURBOLAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0			1
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11. 00 04100 SUBPROVI DER 1 1 1 1 1 1 1 1 1			0	0)		
42.00 0.4200 SUBRENVI DER 0			0	0			
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0		•	o	0			
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51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00			ما	0	· · · · · · · · · · · · · · · · · · ·		
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90. 00 09000 CLINIC 0 0 0 0 0 90. 00 90. 01 09001 DI ABETES CENTER 0 0 0 0 0 90. 01 90. 02 09002 NEUROPSYCH 0 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 0 0 0 0 0 90. 03 90. 04 HYPERBARI C OXYGEN THERAPY 0 0 0 0 90. 04 90. 05 09005 VI MCARE CLINIC 0 0 0 0 90. 05 90. 06 09006 MEDI CATION MGMT CLINIC 0 0 0 0 90. 06 90. 06 90. 06 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 0700 MBULANCE SERVICES 0 0 0 0 95. 00 0 95. 00 0 0 0 0 0 0 0 0 0			-	0			1
90. 01 09001 DI ABETES CENTER 0 0 0 0 90. 01 90. 02 09002 NEUROPSYCH 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 0 0 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 90. 06 91. 00 09100 EMERGENCY 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 0000 09500 AMBULANCE SERVI CES 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 97. 01 09000 09100 09			0	0			
90. 02 09002 NEUROPSYCH 0 0 0 0 0 90.02 90.03 90.03 90.03 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.06			ő	Ö			
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 0 90. 06 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 92. 00 00500 09500 AMBULANCE SERVI CES 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 96. 04 09000 09000 09000 09000 09000 09000 09000 09000 09500 09			o	0		o	•
90. 05	1	1	O	0	(0	•
90. 06 09006 MEDI CATI ON MGMT CLINI C 0 0 0 0 90. 06 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 92. 00 07 07 07 07 07 07 07		1	0	0	(מ	•
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 0 0 0 0 0 0 0 0 0			0	0	'))	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART			0	0		ől	•
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 0 0 95. 00	1	•					1
	OT	HER REIMBURSABLE COST CENTERS					
99. 10 UP99 10 CURF U U U O 99. 10							•
	99. 10 09	A IO COKE	0	O	1	기	99. 10

| Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

				1	o 12/31/2020 Date/lime P 7/14/2021 10	
	Cost Center Description	PARAMED ED	XRAY	PHARMACY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		PRGM	EDUCATI ON	RESI DENCY		
		(PERCENT)	(PERCENT)	PROG		
				(PERCENT)		
		23. 00	23. 01	23. 02		
	HOME HEALTH AGENCY	0	0	0		101.00
	AL PURPOSE COST CENTERS					
	PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0	0		109.00
	ISLET ACQUISITION	0	0	0		110. 00 111. 00
	INTEREST EXPENSE	۷	U	U		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	٥	100	100		118.00
	IMBURSABLE COST CENTERS	<u> </u>	100	100		118.00
	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
	WELLNESS COMMUNITY		0	0		194.00
	BUILDING RENTALS	o	0	o o		194. 01
194. 02 07952		ol	0	o o		194. 02
194. 03 07953	OUTREACH CLINICS	o	0	0		194. 03
194. 04 07954	SPEECH - HEARING AIDS	o	0	0		194. 04
194. 05 07955	NONALLOWABLE MARKETING	o	0	0		194. 05
194. 06 07956	CRH FOUNDATION	o	0	0		194. 06
194. 07 07957	HEALTHY COMMUNITIES	0	0	0		194. 07
194. 08 07958		0	0	0		194. 08
	NEUROPSYCH PART B	0	0	0		194. 09
200. 00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	917, 837	810, 586		202. 00
000 00	Part I)	0.000000	0 470 070000	0 405 0/0000		000 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	9, 178. 370000			203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	U	68, 122	53, 927		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	681. 220000	539. 270000		205.00
203.00		0.000000	001. 220000	337. 270000		203.00
206. 00	NAHE adjustment amount to be allocated	0	Ω	n		206. 00
_50.00	(per Wkst. B-2)		· ·			
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000		207. 00
	Parts III and IV)					

					Го 12/31/2020	Date/Time Pre 7/14/2021 10:	pared: 20 am
			Title	Title XVIII		PPS	
Cook Contan December 1		Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	Cost Center Description	(from Wkst.	Adj.	Total Costs	Di sal I owance	TOTAL COSTS	
		B, Part I,	,				
		col . 26) 1.00	2. 00	3.00	4.00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30.00	03000 ADULTS & PEDIATRICS	44, 529, 285		44, 529, 28		44, 638, 573	30.00
31.00	03100 INTENSIVE CARE UNIT	7, 519, 244 0		7, 519, 24	4 O	7, 519, 244	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0				0	32. 00 33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			o o	0	34.00
40.00	04000 SUBPROVI DER - I PF	0		4 770 70		0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	4, 779, 721 0		4, 779, 72	1	4, 779, 721 0	41.00 42.00
43. 00	04300 NURSERY	1, 970, 112		1, 970, 11	2 0	1, 970, 112	43.00
44. 00	04400 SKILLED NURSING FACILITY	0			0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	29, 557, 972		29, 557, 97	2 0	29, 557, 972	50.00
51.00	05100 RECOVERY ROOM	2, 028, 521		2, 028, 52	1	2, 028, 521	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		010.07	0 0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	213, 073 4, 863, 990		213, 07 4, 863, 99		221, 661 4, 868, 499	53. 00 54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 015, 793		3, 015, 79		3, 015, 793	54. 01
54. 02	05404 ULTRA SOUND	1, 174, 390		1, 174, 39	I I	1, 174, 390	54. 02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	2, 006, 464 5, 878, 565		2, 006, 46 5, 878, 56		2, 007, 530 5, 892, 845	54. 03 55. 00
57. 00	05700 CT SCAN	2, 662, 519		2, 662, 51		2, 662, 519	57.00
58.00	05800 MRI	823, 194		823, 19	4 0	823, 194	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 686, 023 15, 971, 753		4, 686, 02		4, 686, 023 15, 971, 753	59. 00 60. 00
60. 00	06001 LABORATORY-PATHOLOGI CAL	1, 657, 161		15, 971, 75 1, 657, 16	I I	1, 694, 517	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	801, 220		801, 22		801, 220	62.00
65.00	06500 RESPIRATORY THERAPY	5, 219, 386	0			5, 234, 848	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 225, 008 2, 123, 063	0			6, 249, 439 2, 123, 063	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 126, 729	Ö	1, 126, 72	I I	1, 126, 729	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 122, 894		2, 122, 89		2, 134, 006	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 667, 465 8, 621, 257		1, 667, 46 8, 621, 25	1	1, 667, 465 8, 621, 257	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 194, 848		8, 194, 84	1	8, 194, 848	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	37, 460, 480		37, 460, 48	1	37, 460, 480	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	1, 108, 301 0		1, 108, 30	1 0 0 0	1, 108, 301 0	74. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	587, 880		587, 88	٥,	587, 880	76. 97
	OUTPATIENT SERVICE COST CENTERS			Γ	J		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	88. 00 89. 00
90.00	09000 CLI NI C	3, 590, 443		3, 590, 44	- 1	3, 590, 443	1
	09001 DI ABETES CENTER	291, 421		291, 42		291, 421	
90. 02 90. 03	09002 NEUROPSYCH 09003 WOUND CENTER	168, 485 2, 385, 040		168, 48 2, 385, 04		168, 485 2, 409, 853	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	338, 491		338, 49		339, 477	90.04
90. 05	09005 VI MCARE CLI NI C	1, 630, 950		1, 630, 95	I .	1, 630, 950	1
90. 06 91. 00	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY	523, 095 15, 201, 714		523, 09 15, 201, 71	I I	523, 095 15, 287, 026	90. 06 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 735, 241		4, 735, 24	I I	4, 735, 241	•
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES 09910 CORF	7, 318, 744 0		7, 318, 74	4 O	7, 318, 744 0	95. 00 99. 10
	10100 HOME HEALTH AGENCY	0					101.00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0					109. 00 110. 00
	111000 TNTESTINAL ACQUISITION 111100 ISLET ACQUISITION	0					111.00
113.00	11300 I NTEREST EXPENSE						113.00
200.00	1 ,	244, 779, 935	0			245, 117, 138	
201. 00 202. 00		4, 735, 241 240, 044, 694	0	4, 735, 24 240, 044, 69	1	4, 735, 241 240, 381, 897	
50	1					== :1 = ? ?	

Provider CCN: 15-0112 Peri od: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			'	0 12/31/2020	7/14/2021 10:	
		Title	XVIII	Hospi tal	PPS	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1 (0.04/.000	T		
30. 00 03000 ADULTS & PEDI ATRI CS	62, 866, 000		62, 866, 000			30.00
31. 00 03100 I NTENSI VE CARE UNI T	14, 669, 313		14, 669, 313			31.00
32. 00 03200 CORONARY CARE UNIT	0		0			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	7 202 077		7, 382, 977			40.00
42. 00 04200 SUBPROVI DER	7, 382, 977		1, 302, 911			41. 00 42. 00
43. 00 04300 NURSERY	2, 861, 682		2, 861, 682			43.00
44. 00 04400 SKILLED NURSING FACILITY	2,001,002		2,001,002			44.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>					1 44.00
50. 00 05000 OPERATING ROOM	22, 944, 266	63, 363, 650	86, 307, 916	0. 342471	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	1, 926, 138	4, 814, 485			0. 000000	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0 ., 0			0. 000000	
53. 00 05300 ANESTHESI OLOGY	4, 318, 224	8, 604, 954	1		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 336, 617	4, 828, 192			0. 000000	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 000, 521	11, 600, 196			0.000000	
54.02 05404 ULTRA SOUND	1, 142, 652	4, 634, 228			0.000000	
54. 03 05405 MAMMOGRAPHY	0	4, 887, 093	4, 887, 093	0. 410564	0.000000	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	336, 813	18, 403, 659	18, 740, 472	0. 313683	0.000000	55.00
57.00 05700 CT SCAN	9, 470, 908	25, 126, 825	34, 597, 733	0. 076956	0.000000	57.00
58. 00 05800 MRI	1, 477, 193	5, 414, 144	6, 891, 337	0. 119453	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 548, 830	11, 632, 242	28, 181, 072	0. 166283	0.000000	59.00
60. 00 06000 LABORATORY	20, 573, 467	41, 702, 505	62, 275, 972	0. 256467	0.000000	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	685, 668	6, 058, 850			0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 663, 796	1, 119, 357			0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	7, 137, 722	3, 212, 233			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	4, 574, 054	8, 217, 484			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 860, 569	1, 727, 530			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	808, 919	883, 890			0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 165, 136	6, 797, 831			0.000000	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	190, 875 11, 076, 901	5, 623, 661 7, 735, 412	5, 814, 536 18, 812, 313		0. 000000 0. 000000	70.00 71.00
72. 00 07100 IMPL. DEV. CHARGED TO PATIENTS	7, 154, 278	7, 733, 412			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	33, 051, 887	7, 667, 334			0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	3, 537, 595	75, 400, 100			0. 000000	
76. 00 03020 ACUPUNCTURE	3, 337, 373	0	3, 337, 373		0. 000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	11, 644	883, 009	l		0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS	,	332,331	3,555			
88. 00 08800 RURAL HEALTH CLINIC	0	0	0			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
90. 00 09000 CLI NI C	54, 461	6, 080, 041	6, 134, 502	0. 585287	0.000000	90.00
90. 01 09001 DI ABETES CENTER	372	158, 013			0.000000	90. 01
90. 02 09002 NEUROPSYCH	19, 442	145, 136			0.000000	90. 02
90. 03 09003 WOUND CENTER	239, 363	9, 400, 058			0. 000000	
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	696, 374			0. 000000	
90. 05 09005 VI MCARE CLI NI C	2, 292	995, 953			0. 000000	
90. 06 09006 MEDICATION MGMT CLINIC	3, 059	831, 984	•		0. 000000	
91. 00 09100 EMERGENCY	19, 663, 428	52, 923, 413			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12, 604, 051	12, 604, 051	0. 375692	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES	E 774	12 422 020	12, 429, 705	0. 588811	0.00000	95.00
99. 10 09910 CORF	5, 776 0	12, 423, 929	12, 429, 703	0. 300011	0. 000000	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>					101.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0			109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	o	0				110.00
111. 00 11100 SLET ACQUI SI TI ON	Ö	0	l			111.00
113.00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	265, 762, 838	426, 666, 124	692, 428, 962			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	265, 762, 838	426, 666, 124	692, 428, 962			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
From 01/01/2020
To 12/31/2020
To 12/31/2020
To 14/2021 10: 20 am

Cost Center Description					7/14/2021 10:	20 am
IMPATE BIT ROUTING SERVICE COST CENTERS	01.01	DDC 1	Title XVIII	Hospi tal	PPS	
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00	Cost Center Description					
MARTIENT ROUTHE SERVICE COST CENTERS 30 00						
30.00 3000 ABULTS & PEDIATRICS 30.00 300 3400 3400	INDATIENT DOUTINE SERVICE COST CENTERS	11.00				
31 00						20 00
32.00 03200 CORONARY CARE UNIT						•
33.00 3350 BURN INTENSIVE CARE UNIT 33.00 40.00 34000 SUBPROVIDER - I PF						1
34 - 00						1
40, 00 04000 SUBPROVIDER - I PF	l t					1
14.100 04100 SUBPROVIDER - INF	l i					•
42.00 04200 NURSERY	l i					1
43.00 04300 NURSERY	· · · · · · · · · · · · · · · · · · ·					
44. 00 ANOLELARY SERVICE COST CENTERS						
MICHILARY SERVICE COST CENTERS	l l					
50.00 05000 OFERATI NG ROOM 0.342471 50.00 51.00 551.00 551.00 65200 DELIVERY ROOM & LABOR ROOM 0.300940 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 0.500000 0.500000 0.500000 0.500000 0.5000000 0.5000000 0.5000000 0.50000000 0.50000000 0.500000000 0.50000000000						44.00
51.00 OSTOO RECOVERY ROOM ALBOR ROOM 0.300940 51.00 525.00 525.00 CHIVERY ROOM & LABOR ROOM 0.0000000 55.00 53.00 05300 DELIVERY ROOM & LABOR ROOM 0.0000000 55.00 5		0.342471				50.00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 53.00 05300 ABSTHESI DLOGY 0.171512 53.00 53.00 05400 ABSTHESI DLOGY 0.171512 53.00 53.00 05400 ABSTHESI DLOGY 0.171512 53.00 53.00 05400 ABSTHESI DLOGY 0.171512 54.00 54.01 05400 NUCLEAR MEDI CINE-DI AGNOSTI C 0.293935 54.01 54.01 05400 ULTEAR SOUND 0.203291 54.02 54.03 05450 MAMBOGRAPHY 0.410782 54.03 55.00 05500 RADI LOGY-THERAPEUTI C 0.314445 55.00 05500 RADI LOGY-THERAPEUTI C 0.314445 55.00 05500 RADI LOGY-THERAPEUTI C 0.17453 55.00 05500 C ARDI AC CATHETERI ZATI ON 0.176956 57.00 05500 C ARDI AC CATHETERI ZATI ON 0.16623 59.00 05000 C ARDI AC CATHETERI ZATI ON 0.16623 59.00 05000 C ARDI AC CATHETERI ZATI ON 0.16623 59.00 05000 C ARDI AC CATHETERI ZATI ON 0.266467 60.00 0.00	1	1 1				
53.00 05300 ANESTHESI OLOGY 0.017152 53.00 54.00 05400 ADDIOLOGY 910 ARONSTIC 0.789724 54.01 54.00 05400 ADDIOLOGY 910 ARONSTIC 0.239335 54.01 54.02 05404 ULTRA SOURD 0.020291 54.03 54.02 05404 ULTRA SOURD 0.020291 54.03 55.00 05500 ARDIOLOGY +THERAPEUTIC 0.314445 55.00 55.00 05500 CADIOLOGY +THERAPEUTIC 0.314445 55.00 55.00 05500 RADIOLOGY +THERAPEUTIC 0.314445 55.00 55.00 05500 RADIOLOGY +THERAPEUTIC 0.314445 55.00 55.00 05500 RADIOLOGY +THERAPEUTIC 0.114523 58.00 59.00 05900 CADROTAGY + 0.0000 0.0000 ADDRATORY - PATHOLOGI CAL 0.114623 59.00 59.00 05900 CARDRATORY - PATHOLOGI CAL 0.251244 60.01 60.00 06900 HADE BLOOD & PACKED RED BLOOD CELL 0.287882 62.00 65.00 06500 PHSS CAL THERAPY 0.505785 65.00 66.00 06600 PHSS CAL THERAPY 0.488560 66.00 66.00 06600 PHSS CAL THERAPY 0.488560 66.00 66.00 06600 PHSS CAL THERAPY 0.462733 67.00 67.00 06700 OCCUPATIONAL THERAPY 0.462733 67.00 68.00 06900 DELECTROCARDIOLOGY 0.194656 69.00 69.00 06900 ELECTROCARDIOLOGY 0.194656 69.00 69.00 06900 ELECTROCARDIOLOGY 0.194656 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.488277 71.00 72.00 07200 MRL DEV CHARGED TO PATIENT 0.488277 71.00 73.00 07300 RAULS CHARGED TO PATIENT 0.552890 72.00 73.00 07300 RAULS CHARGED TO PATIENT 0.585287 90.00 74.00 07400 RAULS CHARGED TO PATIENT 0.585287 90.00 74.00 07400 RAULS CHARGED TO PATIENT	l i	1 1				
54. 00 05400 RADIOLOGY-DI AGNOSTIC 0.789724 54. 00	l i	1				•
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Peri od: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/14/2021 10:20 am

					'	0 12/31/2020	7/14/2021 10:	
				Ti tl	e XIX	Hospi tal	PPS	
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst.	Adj .		Di sal I owance		
			B, Part I,					
			col. 26)					
			1. 00	2. 00	3. 00	4. 00	5. 00	
		ENT ROUTINE SERVICE COST CENTERS						
		ADULTS & PEDIATRICS	44, 529, 285		44, 529, 285		44, 638, 573	1
		INTENSIVE CARE UNIT	7, 519, 244		7, 519, 244	I I	7, 519, 244	1
		CORONARY CARE UNIT	0		0	0	0	32.00
		BURN INTENSIVE CARE UNIT	0		0	0	0	
		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		SUBPROVI DER - I PF SUBPROVI DER - I RF	4 770 701		4 770 721		0 4, 779, 721	40. 00 41. 00
		SUBPROVIDER - TRE	4, 779, 721		4, 779, 721		4, 779, 721	41.00
		NURSERY	1, 970, 112		1, 970, 112	ا ۱	1, 970, 112	ł
		SKILLED NURSING FACILITY	1, 970, 112		1, 970, 112	I I	1, 970, 112	1
		LARY SERVICE COST CENTERS				ı o	0	44.00
		OPERATING ROOM	29, 557, 972		29, 557, 972	. 0	29, 557, 972	50.00
		RECOVERY ROOM	2, 028, 521		2, 028, 521	I I	2, 028, 521	51.00
		DELIVERY ROOM & LABOR ROOM	0		2,020,021	I I	0	52.00
		ANESTHESI OLOGY	213, 073	•	213, 073	1	221, 661	53.00
		RADI OLOGY-DI AGNOSTI C	4, 863, 990		4, 863, 990		4, 868, 499	1
		NUCLEAR MEDICINE-DIAGNOSTIC	3, 015, 793		3, 015, 793		3, 015, 793	
54.02	05404	ULTRA SOUND	1, 174, 390		1, 174, 390	I I	1, 174, 390	54. 02
54.03	05405	MAMMOGRAPHY	2, 006, 464		2, 006, 464	1, 066	2, 007, 530	54.03
55.00	05500	RADI OLOGY-THERAPEUTI C	5, 878, 565		5, 878, 565	14, 280	5, 892, 845	55.00
57.00	05700	CT SCAN	2, 662, 519		2, 662, 519	0	2, 662, 519	57.00
58.00	05800	MRI	823, 194		823, 194	0	823, 194	58. 00
		CARDI AC CATHETERI ZATI ON	4, 686, 023		4, 686, 023	0	4, 686, 023	
60.00	06000	LABORATORY	15, 971, 753		15, 971, 753	0	15, 971, 753	60.00
		LABORATORY-PATHOLOGI CAL	1, 657, 161		1, 657, 161		1, 694, 517	60. 01
		WHOLE BLOOD & PACKED RED BLOOD CELL	801, 220		801, 220	I	801, 220	1
		RESPI RATORY THERAPY	5, 219, 386				5, 234, 848	1
		PHYSI CAL THERAPY	6, 225, 008				6, 249, 439	1
		OCCUPATI ONAL THERAPY	2, 123, 063		_,,	I I	2, 123, 063	1
		SPEECH PATHOLOGY	1, 126, 729		1, 126, 729	I I	1, 126, 729	1
		ELECTROCARDI OLOGY	2, 122, 894		2, 122, 894		2, 134, 006	1
		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 667, 465 8, 621, 257		1, 667, 465 8, 621, 257	I I	1, 667, 465 8, 621, 257	1
		IMPL. DEV. CHARGED TO PATIENTS	8, 194, 848		8, 194, 848	I I	8, 194, 848	1
		DRUGS CHARGED TO PATIENTS	37, 460, 480		37, 460, 480	I I	37, 460, 480	1
		RENAL DI ALYSI S	1, 108, 301		1, 108, 301	1	1, 108, 301	74.00
		ACUPUNCTURE	0		0	I I	0	76.00
		CARDI AC REHABI LI TATI ON	587, 880		587, 880	o	587, 880	•
-		TIENT SERVICE COST CENTERS	,			· · · · · · · · · · · · · · · · · · ·	,	
		RURAL HEALTH CLINIC	0		C	0	0	88. 00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	o	0	89. 00
		CLI NI C	3, 590, 443		3, 590, 443	0	3, 590, 443	
90. 01	09001	DI ABETES CENTER	291, 421		291, 421	0	291, 421	90. 01
		NEUROPSYCH	168, 485		168, 485	I I	168, 485	1
		WOUND CENTER	2, 385, 040		2, 385, 040		2, 409, 853	1
		HYPERBARIC OXYGEN THERAPY	338, 491		338, 491		339, 477	
		VI MCARE CLI NI C	1, 630, 950		1, 630, 950		1, 630, 950	1
		MEDICATION MGMT CLINIC	523, 095		523, 095		523, 095	
		EMERGENCY	15, 201, 714		15, 201, 714		15, 287, 026	•
		OBSERVATION BEDS (NON-DISTINCT PART	4, 735, 241		4, 735, 241		4, 735, 241	92.00
		REIMBURSABLE COST CENTERS	7 210 744	ı	7 210 744		7 210 744	05 00
		AMBULANCE SERVICES	7, 318, 744		7, 318, 744	I I	7, 318, 744	1
	09910	HOME HEALTH AGENCY	0				0	101.00
		AL PURPOSE COST CENTERS					0	101.00
		PANCREAS ACQUISITION	0		С		0	109. 00
		INTESTINAL ACQUISITION				I .		110.00
		ISLET ACQUISITION	0		Ö	· •		111.00
		INTEREST EXPENSE			Ĭ		Ü	113.00
200.00		Subtotal (see instructions)	244, 779, 935	0	244, 779, 935	337, 203	245, 117, 138	
201.00		Less Observation Beds	4, 735, 241		4, 735, 241		4, 735, 241	
202.00		Total (see instructions)	240, 044, 694	0		I I	240, 381, 897	
·						,		

Provider CCN: 15-0112

						7/14/2021 10:	20 am
				e XIX	Hospi tal	PPS	
			Charges	1			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6. 00	7. 00	8. 00	9. 00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30.00	03000 ADULTS & PEDIATRICS	62, 866, 000		62, 866, 000			30.00
31. 00	03100 INTENSIVE CARE UNIT	14, 669, 313		14, 669, 31			31.00
32.00	03200 CORONARY CARE UNIT	0					32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40.00	04000 SUBPROVI DER - I PF	0					40. 00
41.00	04100 SUBPROVI DER – I RF	7, 382, 977		7, 382, 97			41.00
42.00	04200 SUBPROVI DER	0 041 402					42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	2, 861, 682		2, 861, 68			43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	l o			<u>/ </u>		44.00
50.00	05000 OPERATING ROOM	22, 944, 266	63, 363, 650	86, 307, 91	0. 342471	0.000000	50.00
51. 00	05100 RECOVERY ROOM	1, 926, 138	4, 814, 485			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
53.00	05300 ANESTHESI OLOGY	4, 318, 224	8, 604, 954	12, 923, 178	0. 016488	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 336, 617	4, 828, 192		0. 788993		
54. 01	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 000, 521	11, 600, 196			0. 000000	
54. 02	05404 ULTRA SOUND	1, 142, 652	4, 634, 228			0.000000	1
54. 03	05405 MAMMOGRAPHY	0	4, 887, 093			0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	336, 813	18, 403, 659			0.000000	
57. 00 58. 00	05800 MRI	9, 470, 908 1, 477, 193	25, 126, 825 5, 414, 144			0. 000000 0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	16, 548, 830	11, 632, 242			0.000000	1
60.00	06000 LABORATORY	20, 573, 467	41, 702, 505			0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	685, 668	6, 058, 850			0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 663, 796	1, 119, 357	2, 783, 15	0. 287882	0. 000000	62.00
65.00	06500 RESPI RATORY THERAPY	7, 137, 722	3, 212, 233	10, 349, 95		0. 000000	
66.00	06600 PHYSI CAL THERAPY	4, 574, 054	8, 217, 484			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	2, 860, 569	1, 727, 530			0.000000	
68.00	06800 SPEECH PATHOLOGY	808, 919	883, 890			0.000000	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 165, 136 190, 875	6, 797, 831 5, 623, 661			0. 000000 0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 076, 901	7, 735, 412			0. 000000	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 154, 278	7, 667, 554			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 051, 887	75, 468, 188			0. 000000	
74.00	07400 RENAL DIALYSIS	3, 537, 595	0	3, 537, 59	0. 313292	0. 000000	74.00
76.00	03020 ACUPUNCTURE	0	0		0. 000000	0. 000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	11, 644	883, 009	894, 65	0. 657104	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	0	0		0.000000		
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	E4 441	0 6, 080, 041		0. 000000 0. 585287	0. 000000 0. 000000	1
90.00	09001 DI ABETES CENTER	54, 461 372	158, 013				
	09002 NEUROPSYCH	19, 442	145, 136				
	09003 WOUND CENTER	239, 363	9, 400, 058				1
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	696, 374			l e	
90.05	09005 VI MCARE CLINIC	2, 292	995, 953	998, 24	1. 633817	0. 000000	90.05
90.06	09006 MEDICATION MGMT CLINIC	3, 059	831, 984				90.06
91. 00	09100 EMERGENCY	19, 663, 428	52, 923, 413			l e	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12, 604, 051	12, 604, 05	0. 375692	0.000000	92.00
05 00	OTHER REIMBURSABLE COST CENTERS	E 77/	12 422 020	12 420 70	0 500011	0.000000	05 00
	09500 AMBULANCE SERVI CES 09910 CORF	5, 776 0	12, 423, 929 0		0. 588811	0. 000000	95. 00 99. 10
	10100 HOME HEALTH AGENCY		0				101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>					1
109.00	10900 PANCREAS ACQUISITION	0	0				109. 00
	11000 INTESTINAL ACQUISITION	0	0		D		110.00
	11100 ISLET ACQUISITION	0	0				111. 00
	11300 INTEREST EXPENSE						113.00
200.00		265, 762, 838	426, 666, 124	692, 428, 96	<u>2</u>		200.00
201.00	l l	245 742 020	104 444 104	402 420 07			201.00
202.00	Total (see instructions)	265, 762, 838	426, 666, 124	692, 428, 96	<u>4</u>	I	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
Form 01/01/2020
To 12/31/2020
To 12/31/2020
To 14/2021 10: 20 am

		Ti tle XIX	Hospi tal	7/14/2021 10: PPS	20 am
Cost Center Description	PPS Inpatient	THE XIX	nospi tui	113	
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - I PF					40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
44. 00 04400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	0. 342471				50.00
51. 00 05100 RECOVERY ROOM	0. 300940				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 017152				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 789724				54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0. 239335				54. 01
54. 02 05404 ULTRA SOUND	0. 203291				54.02
54. 03 05405 MAMMOGRAPHY	0. 410782				54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 314445				55.00
57.00 05700 CT SCAN	0. 076956				57.00
58. 00 05800 MRI	0. 119453				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 166283				59.00
60. 00 06000 LABORATORY	0. 256467				60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 251244				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 287882				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 505785				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 488560				66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 462733				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 665597				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 194656				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 286775				70.00 71.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0. 458277 0. 552890				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 345194				73.00
74. 00 07400 RENAL DI ALYSI S	0. 313292				74.00
76. 00 03020 ACUPUNCTURE	0. 000000				76.00
76. 97 07697 CARDIAC REHABILITATION	0. 657104				76. 97
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90. 00 09000 CLI NI C	0. 585287				90.00
90. 01 09001 DI ABETES CENTER	1. 839953				90. 01
90. 02 09002 NEUROPSYCH	1. 023740				90. 02
90. 03 09003 WOUND CENTER	0. 250000				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 487492				90.04
90. 05 09005 VI MCARE CLI NI C	1. 633817				90.05
90. 06 09006 MEDICATION MGMT CLINIC	0. 626429				90.06
91. 00 09100 EMERGENCY	0. 210603				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 375692				92. 00
95.00 OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	0. 588811				95.00
99. 10 09910 CORF	0. 300011				99. 10
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					1.01.00
109. 00 10900 PANCREAS ACQUISITION					109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON					110.00
111. 00 11100 SLET ACQUISITION					111.00
113. 00 11300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Peri od: Worksheet C From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 7/14/2021 10:20 am

					10 12/31/2020	7/14/2021 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
		,	ĺ	col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	29, 557, 972	4, 290, 200	25, 267, 77	2 0	0	50.00
51.00 0510	O RECOVERY ROOM	2, 028, 521	188, 534	1, 839, 98	7 0	0	51.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00 0530	O ANESTHESI OLOGY	213, 073	16, 844	196, 22	9 0	0	53.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	4, 863, 990	563, 548	4, 300, 44	2 0	0	54.00
54. 01 0540	2 NUCLEAR MEDICINE-DIAGNOSTIC	3, 015, 793	422, 925	2, 592, 86	8 0	0	54. 01
54. 02 0540	4 ULTRA SOUND	1, 174, 390	169, 413	1, 004, 97	7 0	0	54.02
54. 03 0540	5 MAMMOGRAPHY	2, 006, 464	352, 701	1, 653, 76		0	54.03
55.00 0550	O RADI OLOGY-THERAPEUTI C	5, 878, 565	1, 545, 270	4, 333, 29	5 0	0	55.00
57. 00 0570	O CT SCAN	2, 662, 519				0	57.00
	O MRI	823, 194	65, 119			0	58.00
	O CARDI AC CATHETERI ZATI ON	4, 686, 023				0	59.00
	O LABORATORY	15, 971, 753				0	60.00
	1 LABORATORY-PATHOLOGI CAL	1, 657, 161	113, 609			0	60. 01
	O WHOLE BLOOD & PACKED RED BLOOD CELL	801, 220				0	62.00
1	O RESPIRATORY THERAPY	5, 219, 386				0	65.00
	O PHYSI CAL THERAPY	6, 225, 008				0	66.00
	O OCCUPATI ONAL THERAPY	2, 123, 063				0	67.00
	O SPEECH PATHOLOGY	1, 126, 729			-	0	68.00
	O ELECTROCARDI OLOGY	2, 122, 894			-	0	69.00
	O ELECTROCARDI OLOGI O ELECTROENCEPHALOGRAPHY	1	l '			0	70.00
4	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 667, 465				0	70.00
4	OIMPL. DEV. CHARGED TO PATIENTS	8, 621, 257	331, 525			0	71.00
	O DRUGS CHARGED TO PATIENTS	8, 194, 848 37, 460, 480	l '		-	0	73.00
	O RENAL DI ALYSIS		1, 736, 133 42, 836			0	74.00
	O ACUPUNCTURE	1, 108, 301	42, 630		0 0	0	76.00
	7 CARDI AC REHABI LI TATI ON	F07 000	ı			0	
	ATIENT SERVICE COST CENTERS	587, 880	78, 818	509, 06	2 0	U	70.97
	O RURAL HEALTH CLINIC	1 0	0		0 0	0	88. 00
	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
	O CLINIC	3, 590, 443			-	0	90.00
	1 DI ABETES CENTER	291, 421	35, 357			0	90.00
	2 NEUROPSYCH	168, 485		158, 83		0	90.01
	3 WOUND CENTER	2, 385, 040				0	90.02
	4 HYPERBARI C OXYGEN THERAPY	338, 491	55, 327			0	90.03
	5 VIMCARE CLINIC	1, 630, 950				0	90.04
							90.05
	6 MEDICATION MGMT CLINIC	523, 095				0	90.06
	O EMERGENCY	15, 201, 714				0	1
	O OBSERVATION BEDS (NON-DISTINCT PART	4, 735, 241	546, 006	4, 189, 23	5 0	0	92.00
	R REIMBURSABLE COST CENTERS	7 210 744	005 710	(422 02	4	0	05 00
	O AMBULANCE SERVI CES	7, 318, 744	· ·				
99. 10 0991	l e	0	0		0	0	
	O HOME HEALTH AGENCY	0	0		0 0	0	101. 00
	I AL PURPOSE COST CENTERS	1					100 00
	O PANCREAS ACQUISITION	0	l e		0		109.00
	O I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
	O I SLET ACQUI SI TI ON	0	0	'	0		111.00
	O INTEREST EXPENSE	105 004 570	10 505 /53	1/7 475 01	,		113.00
200.00	Subtotal (sum of lines 50 thru 199)	185, 981, 573					200.00
201. 00	Less Observation Beds	4, 735, 241					201.00
202. 00	Total (line 200 minus line 201)	181, 246, 332	17, 959, 651	163, 286, 68	1 0	0	202.00

						7/14/2021 10:	20 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operating	Part I,	Charge Ratio			
		Cost	col umn 8)	(col. 6 /			
		Reducti on	001 4	col. 7)			
		6. 00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			_
F0 00		00 557 070	0/ 007 04/	0.040474	I		
50.00	05000 OPERATING ROOM	29, 557, 972					50.00
51.00	05100 RECOVERY ROOM	2, 028, 521	6, 740, 623				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52.00
53.00	05300 ANESTHESI OLOGY	213, 073	12, 923, 178	0. 016488			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 863, 990	6, 164, 809	0. 788993			54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 015, 793					54. 01
54. 02	05404 ULTRA SOUND	1, 174, 390					54. 02
54. 03	05405 MAMMOGRAPHY	2, 006, 464					54. 03
	05500 RADI OLOGY-THERAPEUTI C						
55.00		5, 878, 565		0. 313683			55.00
57. 00	05700 CT SCAN	2, 662, 519					57.00
58. 00	05800 MRI	823, 194					58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 686, 023	28, 181, 072	0. 166283			59.00
60.00	06000 LABORATORY	15, 971, 753	62, 275, 972	0. 256467			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 657, 161	6, 744, 518	0. 245705			60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	801, 220					62.00
65. 00	06500 RESPIRATORY THERAPY	5, 219, 386					65.00
							1
66. 00	06600 PHYSI CAL THERAPY	6, 225, 008					66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 123, 063					67.00
68. 00	06800 SPEECH PATHOLOGY	1, 126, 729	1, 692, 809	0. 665597			68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 122, 894	10, 962, 967	0. 193642			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 667, 465	5, 814, 536	0. 286775			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 621, 257					71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 194, 848					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	37, 460, 480					73.00
74.00	07400 RENAL DIALYSIS						74.00
		1, 108, 301	3, 537, 595				1
76. 00	03020 ACUPUNCTURE	0					76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	587, 880	894, 653	0. 657104			76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89.00
90.00	09000 CLI NI C	3, 590, 443	6, 134, 502				90.00
90. 01	09001 DI ABETES CENTER	291, 421	158, 385				90. 01
90. 02	09002 NEUROPSYCH	168, 485					90.02
90. 02	09003 WOUND CENTER	2, 385, 040		0. 247426			90.02
90. 04	09004 HYPERBARI C OXYGEN THERAPY	338, 491	696, 374				90.04
90. 05	09005 VI MCARE CLI NI C	1, 630, 950					90. 05
90.06	09006 MEDICATION MGMT CLINIC	523, 095	835, 043	0. 626429			90.06
91.00	09100 EMERGENCY	15, 201, 714	72, 586, 841	0. 209428			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 735, 241	12, 604, 051	0. 375692			92.00
	OTHER REIMBURSABLE COST CENTERS	.,	,,,,				1
95. 00	09500 AMBULANCE SERVICES	7, 318, 744	12, 429, 705	0. 588811			95. 00
99. 10	09910 CORF						99. 10
		0		1			1
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000			101.00
	SPECIAL PURPOSE COST CENTERS						1
	10900 PANCREAS ACQUISITION	0	0	0.000000			109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000			110.00
	11100 I SLET ACQUI SI TI ON	0		1			111.00
	11300 INTEREST EXPENSE		Ĭ				113.00
200.00		185, 981, 573	604, 648, 990				200.00
201.00		4, 735, 241					201.00
202.00	Total (line 200 minus line 201)	181, 246, 332	604, 648, 990	1	l		202. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Pre 7/14/2021 10:	pared: 20 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 -	Total Patient Days	Per Diem (col. 3 / col. 4)	
	col . 26) 1.00	2. 00	col . 2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
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) Cost Center Description	5, 147, 133 769, 557 0 0 0 627, 797 0 130, 404 0 6, 674, 891 I npati ent Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	769, 55 627, 79 130, 40	7 3, 186 0 0 0 0 0 0 0 0 7 3, 712 0 0 4 3, 003 0 0	176. 19 241. 54 0. 00 0. 00 0. 00 0. 00 169. 13 0. 00 43. 42 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00				
30.00 30.00 31.00 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)	10, 250 915 0 0 0 0 2, 094 0 0 0 13, 259	221, 009 0 0 0 0 354, 158 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	Provi der CCN: 15-0112	Peri od:	Worksheet D

From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 7/14/2021 10:20 am Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges Related Cost (from Wkst. Program (column 3 x (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 50.00 05000 OPERATING ROOM 4, 290, 200 86, 307, 916 0.049708 8.315.084 413, 326 05100 RECOVERY ROOM 188, 534 6, 740, 623 0.027970 51.00 51.00 711, 043 19,888 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 52.00 12, 923, 178 05300 ANESTHESI OLOGY 1, 681, 295 53.00 16,844 0.001303 2.191 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 563, 548 6, 164, 809 0.091414 651, 881 59, 591 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 422, 925 12, 600, 717 0.033564 539, 753 18, 116 54.01 05404 ULTRA SOUND 169, 413 5, 776, 880 0.029326 484, 404 54.02 14, 206 54.02 54 03 05405 MAMMOGRAPHY 352, 701 4, 887, 093 0.072170 Ω 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 545, 270 18, 740, 472 0.082456 188, 017 15, 503 55.00 57.00 05700 CT SCAN 290, 394 34, 597, 733 0.008393 4, 749, 542 39,863 57.00 58.00 05800 MRI 65, 119 6, 891, 337 0.009449 661, 284 6.248 58.00 05900 CARDI AC CATHETERI ZATI ON 141, 419 59.00 651,605 28, 181, 072 0.023122 6, 116, 229 59 00 60.00 06000 LABORATORY 1, 211, 523 62, 275, 972 0.019454 8, 459, 572 164, 573 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 113, 609 6, 744, 518 0.016845 270, 311 4, 553 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 2, 783, 153 0.016614 62.00 46, 238 874.226 14.524 62.00 65.00 06500 RESPIRATORY THERAPY 563, 746 10, 349, 955 0.054468 2, 690, 071 146, 523 65.00 06600 PHYSI CAL THERAPY 12, 791, 538 0.049506 66.00 633, 260 1, 425, 763 70, 584 66.00 06700 OCCUPATI ONAL THERAPY 217, 353 0.047373 4, 588, 099 626, 644 29,686 67.00 67.00 1, 692, 809 6, 246 68.00 06800 SPEECH PATHOLOGY 115, 449 0.068200 91, 579 68.00 69.00 06900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 1, 876, 542 70,012 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 239, 780 5, 814, 536 0.041238 87, 361 3,603 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 677, 509 71 00 331 525 0.017623 82, 432 71 00 18, 812, 313 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 315, 128 14, 821, 832 0.021261 3, 390, 314 72,081 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 736, 133 108, 520, 075 0.015998 12, 484, 067 199, 720 73.00 73.00 1, 457, 116 74.00 07400 RENAL DIALYSIS 42,836 3, 537, 595 0.012109 17,644 74.00 03020 ACUPUNCTURE 76 00 0.000000 76.00 0 76.97 07697 CARDIAC REHABILITATION 78,818 894, 653 0.088099 3, 780 333 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 0.000000 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 0 89 00 90.00 09000 CLI NI C 423, 924 6, 134, 502 0.069105 41, 126 2,842 90.00 35, 357 09001 DI ABETES CENTER 0.223235 90.01 158, 385 372 83 90.01 90.02 09002 NEUROPSYCH 9.651 164.578 0.058641 90.02 0 09003 WOUND CENTER 231, 550 0.024021 90.03 9, 639, 421 238, 262 5.723 90.03 90.04 09004 HYPERBARIC OXYGEN THERAPY 55, 327 696, 374 0.079450 90.04 0 90.05 09005 VIMCARE CLINIC 219, 397 998, 245 0.219783 199 44 90.05 09006 MEDICATION MGMT CLINIC 1.491 90.06 58, 233 835, 043 0.069737 104 90.06 180, 884 91.00 09100 EMERGENCY 1, 429, 538 72, 586, 841 0.019694 9, 184, 713 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 546,006 12, 604, 051 0.043320 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 200.00 Total (lines 50 through 199) 17, 619, 947 592, 219, 285 71, 979, 550 1, 802, 545 200. 00

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

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER				Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	School Post-Stepdown	School	Post-Stepdown Adjustments	Cost	Medical Education	
	Adjustments		Aujustillerits		Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0		1	0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0		1	0		
32. 00 03200 CORONARY CARE UNIT	0			0		
33. 00 03300 BURN INTENSIVE CARE UNIT	0		1	0	1	
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	0		1	0 0	0	
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	0 0	-	1	0 0	0	1
42. 00 04200 SUBPROVI DER - 1 RF	0		1	0 0	0	
43. 00 04300 NURSERY	0		1	0 0	0	
44. 00 04400 SKILLED NURSING FACILITY	0		1	0 0	٥	44.00
200.00 Total (lines 30 through 199)	0		1	0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpati ent	
·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
	instructions)	minus col. 4)				
INDATIONE DOUTING CERVILOR COST OFNITCHS	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	0	0	29, 21	4 0.00	10, 250	30.00
31. 00 03100 NTENSI VE CARE UNIT	0		1		915	
32. 00 03200 CORONARY CARE UNIT				0.00	0	
33. 00 03300 BURN INTENSIVE CARE UNIT			1	0.00	Ö	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			1	0.00	Ö	
40. 00 04000 SUBPROVI DER - I PF	0	0		0.00	0	1
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 71	2 0.00	2, 094	41.00
42. 00 04200 SUBPROVI DER	0	0		0.00	0	42.00
43. 00 04300 NURSERY		0	3, 00	3 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	1	0. 00		
200.00 Total (lines 30 through 199)		0	39, 11	5	13, 259	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	•				30.00
31.00 03100 INTENSIVE CARE UNIT	0	l .				31.00
32. 00 03200 CORONARY CARE UNIT	0	ł .				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	l .				33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	1				34.00
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0 0	l .				41. 00 42. 00
43. 00 04300 NURSERY	0					42.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)						200.00
		1				

7/14/2021 10:20 am Title XVIII Hospi tal Non Physician Nursi ng Allied Health Allied Health Cost Center Description Nursi ng School Post-Stepdown Anesthetist School Post-Stepdown Cost Adjustments Adjustments 1. 00 ЗА 2.00 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 50 00 0 0 0 0 51.00 05100 RECOVERY ROOM 00000000000000000000000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 917, 837 54.00 54.00 0 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 54.01 54.02 05404 ULTRA SOUND 0 0 0 54.02 05405 MAMMOGRAPHY 54.03 0 0 54.03 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MRI 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 0 0 06000 LABORATORY 60.00 C 0 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 0 62.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 0 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72 00 0 0 Ω 72 00 0 810, 586 73.00 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 74.00 03020 ACUPUNCTURE 0 0 o 76.00 0 0 76.00 07697 CARDIAC REHABILITATION 0 0 76. 97 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 00000000 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 0 Ω 89 00 0 09000 CLI NI C 90.00 0 0 90.00 90.01 09001 DI ABETES CENTER 0 0 0 0 0 0 90.01 09002 NEUROPSYCH 90.02 0 0 90.02 09003 WOUND CENTER 0 90 03 90.03 Ω 0 09004 HYPERBARIC OXYGEN THERAPY 0 90.04 0 0 90.04 90.05 09005 VIMCARE CLINIC 0 90.05 0 90.06 09006 MEDICATION MGMT CLINIC 0 0 0 0 90.06 09100 EMERGENCY 0 91.00 91 00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

1, 728, 423 200. 00

200.00

Total (lines 50 through 199)

Peri od: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared: THROUGH COSTS

Title Value Hospital Hosp				'	0 12/31/2020	7/14/2021 10:	
Medical Education Cost Cost Cost (sum of cols. Cost C			Title	XVIII	Hospi tal		
Medical Education Cost Cost Cost (sum of cols. Cost C	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4 Cost 2 3 Col 7		Medi cal	(sum of cols.	Outpati ent			
ANCILLARY SERVICE COST CENTERS		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
ANCILLARY SERVICE COST CENTERS		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
NACILLARY SERVICE COST CENTERS				and 4)		(see	
ANCI LLARY SERVICE COST CENTERS 50. 00 GOOD OPERATINE ROOM 0 0 0 0 86, 307, 916 0.000000 55. 00 51. 00 05100 OPERATINE ROOM 0 0 0 0 6, 740, 623 0.000000 55. 00 52. 00 05200 DELI LYERY PROWS & LABOR ROOM 0 0 0 0 12, 923, 178 0.000000 55. 00 53. 00 05300 OPELY PROWS PROWS & LABOR ROOM 0 0 0 12, 923, 178 0.000000 55. 00 54. 01 05400 RODI OLOGY POIL ANDSTI C 0 917, 837 917, 837 6. 164, 809 0.18883 54. 00 54. 01 05400 RODI OLOGY POIL ANDSTI C 0 917, 837 917, 837 6. 164, 809 0.18883 54. 00 54. 01 05400 RODI OLOGY POIL ANDSTI C 0 0 0 0 12, 600, 1717 0.000000 54. 01 54. 02 05404 UITRA SOUND 0 0 0 0 12, 600, 1717 0.000000 54. 01 54. 02 05404 UITRA SOUND 0 0 0 0 4, 887, 093 0.000000 55. 00 55. 00 05500 RADI DLOGY PHERAPEUTI C 0 0 0 0 0 18, 740, 472 0.000000 55. 00 57. 00 05700 CT SCAN 0 0 0 0 34, 897, 733 0.000000 57. 00 58. 00 05800 RADI DLOGY PHERAPEUTI C 0 0 0 0 34, 897, 733 0.000000 57. 00 59. 00 05900 CARDI AC CATHETER ZATI ON 0 0 0 0 28, 181, 072 0.000000 59. 00 59. 00 05900 CARDI AC CATHETER ZATI ON 0 0 0 0 28, 181, 072 0.000000 59. 00 60. 00 06000 LABORATORY PATHOLOGI CAL 0 0 0 0 0 27, 833, 153 0.000000 60. 00 60. 00 06000 HIDGE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 12, 349, 955 0.000000 60. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 12, 349, 955 0.000000 60. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 10, 48, 880, 099 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 0 12, 349, 955 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 12, 349, 955 0.000000 67. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 18, 881, 2313 0.000000 07. 00 60. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 18, 881, 2313 0.000							
SOLID CONTROL CONT		4. 00	5. 00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0							
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0							
S3.00 OSSOO AMESTHESI OLOGY 0 0 0 12, 923, 178 0.000000 53.00		0	0	0	6, 740, 623		
54.00 05400 RADIOLOGY-DI AGNOSTIC 0 917, 837 917, 837 0, 164, 809 0, 148883 54, 00 54.01 54.02 05404 ILITRA SOUND 0 0 0 0 5,776, 880 0, 000000 54, 02 54.02 05404 ILITRA SOUND 0 0 0 0 4, 887, 93 0, 000000 54, 02 57.00 0, 000000 55, 00 0, 000000 55, 00 0,		0	0	0	0		
S4-02 MUCLEAR MEDIC INF-DIAGNOSTIC 0		0	0	0			
S4 02 05404 LITRA SOUND		0	917, 837	917, 837	6, 164, 809	0. 148883	
S4.03 05405 MAMMOGRAPHY 0 0 0 0 18, 87, 093 0.000000 54, 035 50 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 18, 740, 472 0.000000 55, 00 05700 CT SCAN 0 0 0 0 0 34, 597, 733 0.000000 57, 00 058, 00 05800 MRI 0 0 0 0 0 0 6, 891, 337 0.000000 59, 00 05900 CARDI LAC CATHETERI ZATI ON 0 0 0 0 0 0 0 6, 891, 337 0.000000 59, 00 000000 000000 0000000 000000		0	0	0			
55.00 05500 RADIOLOGY-THERAPEUTIC		0	0	0			
57.00 05700 07 SCAN 0 0 0 0 34, 597, 733 0.000000 57.00		0	0	0			
58. 00 05800 MR 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	18, 740, 472	0.000000	55.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 28, 181, 072 0.000000 59, 00	57. 00 05700 CT SCAN	0	0	0	34, 597, 733	0.000000	57.00
60. 00 06000 LABORATORY 0 0 0 62, 275, 972 0. 000000 60. 01 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 0 0 67, 744, 518 0. 000000 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 2, 783, 153 0. 000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 10, 349, 955 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 12, 791, 538 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 1, 692, 809 0. 000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 1, 692, 809 0. 000000 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 1, 692, 809 0. 000000 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 5, 814, 536 0. 000000 70. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 5, 814, 536 0. 000000 70. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14, 821, 832 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 810, 586 810, 586 108, 520, 075 0. 007469 73. 00 74. 00 07400 RENALD ILALYSIS 0 0 0 3, 537, 595 0. 000000 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0. 000000 74. 00 76. 07 0767 CARDI AC REHABI LI TATI ON 0 0 0 0. 000000 76. 00 79. 01 09900 CLI NI C 0 0 0 0 0. 000000 89. 00 99. 00 09900 CLI NI C 0 0 0 0 0. 000000 99. 00 99. 01 09900 DI JABETES CENTER 0 0 0 0 0. 000000 99. 00 99. 02 09900 NURAL HEALTH CLI NI C 0 0 0 0 0 0. 000000 99. 03 09000 WURDARER CLI NI C 0 0 0 0 0. 000000 99. 00 99. 04 09900 NURAL REALTH CLI NI C 0 0 0 0 0 0. 000000 99. 05 09000 WURDARER CLI NI C 0 0 0 0 0. 000000 99. 06 09000 SERVATION MEDIS (NON-DISTINCT PART O 0 0 0 0 0 0. 000000 99. 07 09000 00000 000000 0000000000	58. 00 05800 MRI	0	0	0	6, 891, 337	0.000000	58.00
60.01 06001 LABORATORY-PATHOLOGICAL 0 0 0 0 6,744,518 0.000000 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 2,783,153 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 12,791,538 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 12,791,538 0.000000 65.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 12,791,538 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 1,692,809 0.000000 68.00 69.00 06800 SPEECH PATHOLOGY 0 0 0 10,962,967 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 10,962,967 0.000000 69.00 69.00 07.00 0.00000 0.00000 0.00000 69.00 0.00000 0.00000 0.000000 0.0	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	28, 181, 072	0.000000	59.00
62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 2, 783, 153 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 10, 349, 955 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 12, 791, 538 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 4, 588, 099 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 1, 692, 809 0.000000 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 1, 692, 809 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 5, 814, 536 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 18, 812, 313 0.000000 71. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 14, 821, 832 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 810, 586 810, 586 108, 520, 075 0.007409 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 3, 537, 595 0.000000 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0.000000 76. 00 76. 97 O7597 CARDI AC REHABI LI TATI ON 0 0 0 0 0.000000 76. 97 76. 97 07597 CARDI AC REHABI LI TATI ON 0 0 0 0 0.000000 76. 97 76. 97 07597 CARDI AC REHABI LI TATI CHITER 0 0 0 0 0.000000 89. 00 79. 01 09001 DI ABETES CENTER 0 0 0 0 0.000000 90. 00 79. 02 09002 NEUROPSYCH 0 0 0 0 6, 134, 502 0.000000 90. 01 79. 03 09003 WOUND CENTER 0 0 0 0 0 0, 639, 421 0.000000 90. 01 79. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0, 639, 421 0.000000 90. 01 79. 05 09005 VI MCARE CLI NI C 0 0 0 0 0 0, 72, 586, 841 0.000000 90. 05 79. 00 09006 MEDI LATION BEDS (MON-DISTINCT PART 0 0 0 0 0 12, 604, 051 0.000000 90. 05 79. 00 09000 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 00500 0	60. 00 06000 LABORATORY	0	0	0	62, 275, 972	0.000000	60.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 10, 349, 955 0, 000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 12, 791, 538 0, 000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 4, 588, 099 0, 000000 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 1, 692, 809 0, 000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 10, 962, 967 0, 000000 69. 00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 10, 962, 967 0, 000000 69. 00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 18, 812, 313 0, 000000 70. 00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 18, 812, 313 0, 000000 70. 00 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 18, 812, 313 0, 000000 71. 00 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 14, 821, 832 0, 000000 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 810, 586 810, 586 108, 520, 075 0, 007469 73. 00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 3, 537, 595 0, 000000 74. 00 76.00 30302 ACUPINCTURE 0 0 0 0 0 0, 000000 76. 97 000 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 88.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 0 0 90.01 09000 CLI NI C 0 0 0 0 0 0 0 0 90.02 09002 NEUROPSYCH 0 0 0 0 0 0 0 0 90.03 09003 WOUND CENTER 0 0 0 0 0 0 0 90.04 09001 DI ABETES CENTER 0 0 0 0 0 0 0 90.05 09005 VI MCARE CLI NI C 0 0 0 0 0 0 90.06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 0 0 0 90.07 09000 OSSERVATI ON MGMT CLI NI C 0 0 0 0 0 0 90.08 09000 OSSERVATI ON MGMT CLI NI C 0 0 0 0 0 0 90.00 09000 OSSERVATI ON MGMT CLI NI C 0 0 0 0 0 0 90.00 09000 OSSERVATI ON MGMT CLI NI C 0 0 0 0 0 0 90.00 09000 OSSERVATI ON MGMT CLI NI C 0 0 0	60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0	0	6, 744, 518	0.000000	60.01
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 12, 791, 538 0.000000 66. 00 67. 00 0 0 0 0 CCUPATI ONAL THERAPY 0 0 0 0 0 4, 588, 099 0.000000 67. 00 0 0 0 1, 692, 809 0.000000 68. 00 0 0 0 0 1, 692, 809 0.000000 68. 00 0 0 0 0 0 1, 692, 809 0.000000 68. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2, 783, 153	0.000000	62.00
67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 0 4,588,099 0.000000 67. 00 68. 00 0600 SPEECH PATHOLOGY 0 0 0 0 1,692,899 0.000000 68. 00 0 0 0 0 1,692,899 0.000000 69. 00 0 0 0 0 0 1,692,897 0.000000 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0	0	0	10, 349, 955	0.000000	65.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 1, 692, 809 0. 000000 68. 00 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 69. 00 0. 000000 70. 00 0. 000000 70. 00 0. 000000 70. 00 0. 000000 70. 00 0. 000000 70. 00 70. 00 0. 000000 70. 00 0. 000000 70. 00 0. 000000 70. 00 0. 000000 70. 00 70. 00 14, 821, 832 0. 000000 71. 00 72. 00 73.	66. 00 06600 PHYSI CAL THERAPY	0	0	0	12, 791, 538	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 10, 962, 967 0.000000 69. 00 70. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	4, 588, 099	0.000000	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 5, 814, 536 0.000000 70.00 71.00 71.00 71.00 70700 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 18, 812, 313 0.000000 71.00 72.00 73.00	68.00 06800 SPEECH PATHOLOGY	0	0	0	1, 692, 809	0.000000	68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 18, 812, 313 0.000000 71. 00 72. 00 72.00 1MPL DEV. CHARGED TO PATIENTS 0 0 0 14, 821, 832 0.000000 72. 00 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 810, 586 810, 586 108, 520, 075 0.000000 74. 00 74. 00 0.000000 74. 00 0.000000 74. 00 0.000000 74. 00 0.000000 74. 00 0.000000 76. 00 0 0 0.000000 76. 00 76. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0	0	10, 962, 967	0.000000	69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14, 821, 832 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 810, 586 810, 586 108, 520, 075 0.007469 73. 00 74. 00 74. 00 RENAL DI ALYSI S 0 0 0 0 0 0 0.000000 74. 00	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5, 814, 536	0.000000	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 810, 586 810, 586 108, 520, 075 0.007469 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 3, 537, 595 0.000000 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0.000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 894, 653 0.000000 76. 97 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 0.000000 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0.000000 89. 00 90. 01 09000 CLI NI C 0 0 0 0.000000 90. 01 90. 01 09001 DI ABETES CENTER 0 0 0 0 164, 578 0.000000 90. 01 90. 02 09002 NEUROPSYCH 0 0 0 0 164, 578 0.000000 90. 01 90. 03 09003 WOUND CENTER 0 0 0 0 9, 639, 421 0.000000 90. 02 90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 998, 245 0.000000 90. 03 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 0 835, 043 0.000000 90. 05 91. 00 09000 DESERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 12, 604, 051 0.000000 91. 00 00 09500 AMBULANCE SERVI CES	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18, 812, 313	0.000000	71.00
74. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14, 821, 832	0.000000	72.00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	810, 586	810, 586	108, 520, 075	0. 007469	73.00
76. 97	74. 00 07400 RENAL DI ALYSI S	0	0	0	3, 537, 595	0.000000	74.00
SE NO OBSOO RURAL HEALTH CLINIC O O O O O O O O O	76. 00 03020 ACUPUNCTURE	0	0	0	0	0.000000	76.00
88. 00		0	0	0	894, 653	0.000000	76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.000000 89. 00 90. 00 09000 CLINIC 0 0 0 0 6, 134, 502 0.000000 90. 00 90. 01 09001 DI ABETES CENTER 0 0 0 0 158, 385 0.000000 90. 01 90. 02 09002 NEUROPSYCH 0 0 0 164, 578 0.000000 90. 02 90. 03 09003 WOUND CENTER 0 0 0 0 9, 639, 421 0.000000 90. 03 90. 04 09004 HYPERBARIC OXYGEN THERAPY 0 0 0 696, 374 0.000000 90. 04 90. 05 09005 VI MCARE CLINIC 0 0 0 998, 245 0.000000 90. 05 90. 06 09006 MEDICATION MGMT CLINIC 0 0 0 835, 043 0.000000 90. 05 90. 06 09006 MEDICATION MGMT CLINIC 0 0 0 72, 586, 841 0.000000 91. 00 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0.000000 92. 00 071HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES							
90. 00 09000 CLI NI C 0 0 0 6, 134, 502 0.000000 90. 00 90. 01 90. 01 09001 DI ABETES CENTER 0 0 0 0 158, 385 0.000000 90. 01 90. 02 90. 02 90. 03 09003 NEUROPSYCH 0 0 0 0 164, 578 0.000000 90. 02 90. 03 09003 NOUND CENTER 0 0 0 0 9, 639, 421 0.000000 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 696, 374 0.000000 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0.000000 90. 05 90. 06 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 835, 043 0.000000 91. 00 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0.000000 91. 00 074, 586, 841 0.000000 92. 00 074, 586, 841 0.000000 92. 00 074, 586, 841 0.000000 92. 00 074, 586, 841 0.000000 92. 00 074, 586, 841 0.000000 92. 00 074, 586, 841 0.000000 92. 00 075, 586, 841 0.0000000 92. 00 075, 586, 841 0.000000 92. 00 075, 586, 841 0.000000 92. 00 075, 586, 841 0.000000 92. 00 075, 586, 841 0.000000 92. 00 075, 586, 841 0.0000000 92. 00 075, 586, 841 0.0000000 92. 00 075, 586, 841 0.0000000	88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88. 00
90. 01 09001 DI ABETES CENTER 0 0 0 158, 385 0.000000 90. 01 90. 02 90. 02 90. 03 09002 NEUROPSYCH 0 0 0 164, 578 0.000000 90. 02 90. 03 09003 WOUND CENTER 0 0 0 9, 639, 421 0.000000 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 696, 374 0.000000 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0.000000 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 835, 043 0.000000 91. 00 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0.000000 91. 00 00 00 00 00 00 00 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89. 00
90. 02 09002 NEUROPSYCH 0 0 0 164, 578 0.000000 90. 02 90. 03 09003 WOUND CENTER 0 0 0 0 9, 639, 421 0.000000 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 696, 374 0.000000 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0.000000 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 998, 245 0.000000 90. 05 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 12, 604, 051 0.000000 95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00	90. 00 09000 CLI NI C	0	0	0	6, 134, 502	0.000000	90.00
90. 03 09003 WOUND CENTER 0 0 0 0 9, 639, 421 0. 000000 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 696, 374 0. 000000 90. 04 90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0. 000000 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 835, 043 0. 000000 90. 06 91. 00 09100 EMERGENCY 0 0 0 0 72, 586, 841 0. 000000 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 12, 604, 051 0. 000000 95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 96. 03 09000 09000 09000 09000 09000 09000 09000 90. 04 09000 09000 09000 09000 09000 09000 09000 90. 05 09000 09000 09000 09000 090000 09000 09000 90. 05 09000 09000 09000 09000 09000 09000 09000 90. 05 09000 09000 09000 090000 090000 09000 09000 90. 05 09000 09000 090000 090000 090000 090000 09000 90. 05 09000 09000 0900000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 0900000 090000 090000 090000 0900000 0900000 090000 0900	90. 01 09001 DI ABETES CENTER	0	0	0	158, 385	0.000000	90. 01
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 696, 374 0.000000 90.04 90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0.000000 90.05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 835, 043 0.000000 90.06 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0.000000 91.00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 12, 604, 051 0.000000 95. 00 09500 AMBULANCE SERVI CES 95. 00	90. 02 09002 NEUROPSYCH	0	0	0	164, 578	0.000000	90.02
90. 05 09005 VI MCARE CLI NI C 0 0 0 998, 245 0. 000000 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 835, 043 0. 000000 90. 06 91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 12, 604, 051 0. 000000 95. 00 09500 AMBULANCE SERVI CES 95. 00	90. 03 09003 WOUND CENTER	0	0	0	9, 639, 421	0.000000	90.03
90. 06 09006 MEDI CATI ON MGMT CLINI C	90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0	0	696, 374	0.000000	90.04
91. 00 09100 EMERGENCY 0 0 0 72, 586, 841 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 12, 604, 051 0. 000000 92. 00 071HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 95. 00 95. 00 97. 00 9	90. 05 09005 VI MCARE CLI NI C	0	0	0	998, 245	0.000000	90.05
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 12, 604, 051 0. 000000 92. 00	90.06 09006 MEDICATION MGMT CLINIC	0	0	0	835, 043	0.000000	90.06
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0	0	0	72, 586, 841	0.000000	91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12, 604, 051	0.000000	92.00
200.00 Total (lines 50 through 199) 0 1,728,423 1,728,423 592,219,285 200.00							
	200.00 Total (lines 50 through 199)	0	1, 728, 423	1, 728, 423	592, 219, 285		200. 00

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:

				Т	o 12/31/2020	Date/Time Pre 7/14/2021 10:	pared:
			Title	xVIII	Hospi tal	PPS	20 aiii
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	, , , , , , , , , , , , , , , , , , ,	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	g	Costs (col. 8	g	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	<u>'</u>		•			
50.00	05000 OPERATING ROOM	0. 000000	8, 315, 084	0	15, 508, 001	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	711, 043	0	887, 507	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	1, 681, 295	0	2, 045, 526	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 148883	651, 881	97, 054	1, 544, 036	229, 881	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	539, 753	0	4, 355, 070	0	54.01
54.02	05404 ULTRA SOUND	0. 000000	484, 404	0	1, 212, 664	0	54.02
54.03	05405 MAMMOGRAPHY	0. 000000	0	0	330, 826	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	188, 017	0	7, 972, 519	0	55.00
57.00	05700 CT SCAN	0. 000000	4, 749, 542	0	6, 404, 710	0	57.00
58. 00	05800 MRI	0. 000000	661, 284	0	1, 705, 141	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 116, 229	0	3, 693, 028	0	59.00
60.00	06000 LABORATORY	0. 000000	8, 459, 572	0	4, 108, 571	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	270, 311	0	1, 458, 707	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	874, 226	0	202, 489	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	2, 690, 071	0	1, 070, 109	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 425, 763	0	29, 094	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	626, 644	0	6, 015	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	91, 579	l o	103, 107	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 876, 542	0	2, 139, 024	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	87, 361	0	1, 225, 823	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 677, 509	0	1, 950, 293	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 390, 314	0	2, 086, 979	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 007469	12, 484, 067	93, 243	30, 998, 209	231, 526	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	1, 457, 116	0	0	0	74. 00
76.00	03020 ACUPUNCTURE	0. 000000	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	3, 780	0	424, 196	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90.00	09000 CLI NI C	0. 000000	41, 126	0	2, 653, 931	0	90.00
90. 01	09001 DI ABETES CENTER	0. 000000	372	0	5, 496	0	90. 01
90. 02	09002 NEUROPSYCH	0. 000000	0	0	2, 976	0	90. 02
90. 03	09003 WOUND CENTER	0. 000000	238, 262	0	3, 970, 650	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	257, 396	0	90.04
90. 05	09005 VI MCARE CLI NI C	0. 000000	199	0	110, 848	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	1, 491	0	467, 988	0	90.06
91.00	09100 EMERGENCY	0. 000000	9, 184, 713	0	9, 237, 302	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	2, 887, 876	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		71, 979, 550	190, 297	111, 056, 107	461, 407	200.00

From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 7/14/2021 10:20 am Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 342471 15, 508, 001 5, 311, 041 50.00 05100 RECOVERY ROOM 0 887, 507 51.00 0.300940 0 51.00 267, 086 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.016488 2,045,526 0 0 33, 727 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 788993 1, 544, 036 0 0 1, 218, 234 54.00 0 0. 239335 4, 355, 070 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 1, 042, 321 54 01 0 0 54.02 05404 ULTRA SOUND 0. 203291 1, 212, 664 246, 524 54.02 54.03 05405 MAMMOGRAPHY 0. 410564 330, 826 0 135, 825 54.03 0 o 05500 RADI OLOGY-THERAPEUTI C 7, 972, 519 2, 500, 844 55.00 0.313683 55.00 0 0 05700 CT SCAN 492, 881 57.00 0.076956 6, 404, 710 57.00 58.00 05800 MRI 0.119453 1, 705, 141 0 203, 684 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.166283 3, 693, 028 0 0 614,088 59.00 06000 LABORATORY 4, 108, 571 0 11, 088 1,053,713 60 00 0 256467 60 00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 0.245705 1, 458, 707 0 358, 412 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 287882 202, 489 0 0 58, 293 62.00 62.00 06500 RESPIRATORY THERAPY 0 65.00 0.504291 1, 070, 109 0 539, 646 65.00 06600 PHYSI CAL THERAPY 0 14, 159 0 486650 0 66 00 29.094 66 00 0 67.00 06700 OCCUPATI ONAL THERAPY 0.462733 6,015 0 2, 783 67.00 06800 SPEECH PATHOLOGY 103, 107 68, 628 0.665597 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.193642 2, 139, 024 0 414, 205 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0. 286775 1, 225, 823 0 351, 535 70 00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.458277 1, 950, 293 0 893, 774 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,086,979 0 0 1, 153, 870 72.00 0.552890 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.345194 30, 998, 209 0 87, 340 10, 700, 396 73.00 07400 RENAL DIALYSIS 0 74.00 0.313292 C 0 74 00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0.657104 424, 196 0 0 278, 741 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0.585287 2, 653, 931 0 1, 553, 311 90.00 0 09001 DI ABETES CENTER 0 90.01 0 1.839953 5, 496 10, 112 90.01 90.02 09002 NEUROPSYCH 1.023740 2,976 0 3, 047 90.02 90 03 09003 WOUND CENTER 0. 247426 3, 970, 650 0 0 982, 442 90.03 257, 396 09004 HYPERBARIC OXYGEN THERAPY 0 0 125, 114 90.04 0.486076 90.04 09005 VIMCARE CLINIC 0 90.05 1.633817 110,848 0 181, 105 90.05 90.06 09006 MEDICATION MGMT CLINIC 0.626429 467, 988 0 293, 161 90.06 91.00 09100 EMERGENCY 0. 209428 9, 237, 302 0 3, 968 1, 934, 550 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1, 084, 952 92.00 0.375692 2, 887, 876 92.00 OTHER REIMBURSABLE COST CENTERS

0. 588811

111, 056, 107

111, 056, 107

0

0

0

102, 396

102, 396

34, 122, 204

34, 122, 204 202. 00

200.00

201.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

 Heal th Financial
 Systems
 COLUMBUS
 REGIO

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

Peri od: Worksheet D
From 01/01/2020 Part V
To 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am

						1/14/2021 10:	20 am
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
51. 00	05100 RECOVERY ROOM	0	_				51.00
				1			1
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	0				54.03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö				55. 00
			0				1
57. 00	05700 CT SCAN	0	_	1			57.00
58. 00	05800 MRI	0	0	1			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	2, 844				60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0				60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	Ō	1			62.00
65. 00	06500 RESPIRATORY THERAPY		0	•			65. 00
							1
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 I MPL. DEV. CHARGED TO PATIENTS	0	Ö				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		30, 149	1			73.00
		0					
74.00	07400 RENAL DI ALYSI S	0	0	•			74.00
76.00	03020 ACUPUNCTURE	0	0	•			76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						1 88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00	09000 CLINIC		0	•			90.00
		0	_	1			
90. 01	09001 DI ABETES CENTER	0	0	1			90. 01
90. 02	09002 NEUROPSYCH	0	0				90. 02
90. 03	09003 WOUND CENTER	0	0				90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0				90.04
90. 05	09005 VI MCARE CLI NI C	1	Ō				90.05
90. 06	09006 MEDICATION MGMT CLINIC		Ö	1			90.06
				1			
91.00	09100 EMERGENCY	0	831				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0			<u> </u>		95. 00
200.00		0	33, 824				200.00
201.00		1	1	1			201.00
201.00	Only Charges						[00
202. 00		0	33, 824	1			202 00
202.00	Net Charges (line 200 - line 201)	1	J 33, 824	I			202. 00

Health Financial Systems	COLUMBUS REGIO	INAL HOSPLTAL		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0112 CCN: 15-T112	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre	pared:
		Title	: XVIII	Subprovi der -	7/14/2021 10: PPS	<u>20 am</u>
Cost Center Description	Capi tal	Total Charges	Patio of Cos	t Inpatient	Capital Costs	
oust center bescription	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)	onal goo	001 4	
	col . 26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 290, 200	86, 307, 916	0. 04970	08 60, 527	3, 009	50.00
51.00 05100 RECOVERY ROOM	188, 534	6, 740, 623	0. 02797	70 12, 693	355	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.0000		0	
53. 00 05300 ANESTHESI OLOGY	16, 844		1		18	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	563, 548				2, 312	1
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	422, 925				207	
54. 02 05404 ULTRA SOUND	169, 413			·	821	1
54. 03 05405 MAMMOGRAPHY	352, 701	4, 887, 093			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 545, 270				0	
57. 00 05700 CT SCAN	290, 394				524	1
58. 00 05800 MRI	65, 119		1	·	143	
59. 00 05900 CARDI AC CATHETERI ZATI ON	651, 605				0	
60. 00 06000 LABORATORY	1, 211, 523				7, 228	
60. 01 06001 LABORATORY-PATHOLOGI CAL	113, 609				92	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 238				266	
65. 00 06500 RESPIRATORY THERAPY	563, 746			1	2, 291	1
66. 00 06600 PHYSI CAL THERAPY	633, 260		1		49, 610	1
67. 00 06700 OCCUPATI ONAL THERAPY	217, 353				42, 082	
68. 00 06800 SPEECH PATHOLOGY	115, 449				18, 996	
69. 00 06900 ELECTROCARDI OLOGY	409, 013				883	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	239, 780		1		32	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	331, 525				l	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	315, 128				11	
74. 00 07400 RENAL DI ALYSI S	1, 736, 133		1		9, 317	
76. 00 03020 ACUPUNCTURE	42, 836 0		0. 01210 0. 00000		2, 258 0	
76. 00 03020 ACOPONCTORE 76. 97 07697 CARDI AC REHABI LI TATI ON	78, 818		1		19	
OUTPATIENT SERVICE COST CENTERS	70,010	074,000	0.0000	77 210	17	70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l e	1		Ö	
90. 00 09000 CLINIC	423, 924	1				
90. 01 09001 DI ABETES CENTER	35, 357				Ö	
90. 02 09002 NEUROPSYCH	9, 651	164, 578			Ö	
90. 03 09003 WOUND CENTER	231, 550	•	1		0	
90. 04 09004 HYPERBARI C OXYGEN THERAPY	55, 327	696, 374			Ö	90.04
90. 05 09005 VI MCARE CLI NI C	219, 397				Ö	
90. 06 09006 MEDICATION MGMT CLINIC	58, 233	•			Ö	
91. 00 09100 EMERGENCY	1, 429, 538				422	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	1
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	17, 073, 941	592, 219, 285		3, 771, 109	143, 149	200. 00

	Financial Systems	COLUMBUS REGIO			_	In Lie	u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0112		eri od:	Worksheet D	
THROUG	SH COSTS		Component	CON. 1E T110		om 01/01/2020 12/31/2020	Part IV	nanad.
			Component	CCN: 15-T112	То	12/31/2020	Date/Time Pre 7/14/2021 10:	pareu: 20 am
			Title	XVIII	S	Subprovi der -	PPS	20 4111
						I RF		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist	School	School		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
		1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0		0	0	0	
51.00	05100 RECOVERY ROOM	0	0		0	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	917, 837	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0	0	54. 01
54. 02	05404 ULTRA SOUND	0	0		0	0	0	54. 02
54.03	05405 MAMMOGRAPHY	0	0		0	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58. 00	05800 MRI	0	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	810, 586	
74.00	07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0		0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS							00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90.00	09000 CLINIC	0	0		0	0	0	90.00
90. 01 90. 02	O9001 DI ABETES CENTER O9002 NEUROPSYCH	0	0		0	0	0	90. 01 90. 02
	1 1		0		0	0	0	
90. 03	09003 WOUND CENTER	0	0		0	0	_	90.03
90. 04 90. 05	09004 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	90.04
90.05	09005 VI MCARE CLINI C	0	0		0	0	0	90.05
	09006 MEDICATION MGMT CLINIC	0) 0		0	0		90.06
91. 00 92. 00	09100 EMERGENCY		0		0	U	0	91.00 92.00
9Z. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			U		U	J 9∠. UU

0

0

92.00 95.00

1, 728, 423 200. 00

APPOR1	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	COLUMBUS REGIO RVICE OTHER PAS	S Provider C	CN: 15-0112	Period: From 01/01/2020	wof Form CMS-2 Worksheet D Part IV	
			Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	epared: 20 am
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	20 4
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4. 00	5.00	6.00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50.00	05000 OPERATING ROOM	0)	0 86, 307, 916	0.000000	50.00
51.00	05100 RECOVERY ROOM	0		1	0 6, 740, 623		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1	0 0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	l c		0 12, 923, 178		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	917, 837	917, 83			1
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	C		0 12, 600, 717	0.000000	54. 01
54.02	05404 ULTRA SOUND	0	C		0 5, 776, 880	0.000000	54.02
54.03	05405 MAMMOGRAPHY	0	C		0 4, 887, 093	0. 000000	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0)	0 18, 740, 472	0. 000000	
57.00	05700 CT SCAN	0		•	0 34, 597, 733		
58. 00	05800 MRI	0		•	0 6, 891, 337	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0		l .	0 28, 181, 072	0. 000000	
60.00	06000 LABORATORY	0		1	0 62, 275, 972	0.000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0		1	0 6, 744, 518		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		1	0 2, 783, 153		
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		1	0 10, 349, 955 0 12, 791, 538		
67.00	06700 OCCUPATI ONAL THERAPY	0		1	0 4, 588, 099		1
68. 00	06800 SPEECH PATHOLOGY	0		1	0 1, 692, 809		
69.00	06900 ELECTROCARDI OLOGY	0		1	0 10, 962, 967	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	ĺ	1	0 5, 814, 536		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1	0 18, 812, 313		1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	ĺ		0 14, 821, 832	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	810, 586	810, 58			
74.00	07400 RENAL DIALYSIS	0		1	0 3, 537, 595	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	C		0 0	0. 000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C)	0 894, 653	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		l .	0 0		
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l .	l .	0 0	0.000000	1
90.00	09000 CLINIC	0		•	0 6, 134, 502		
90. 01	09001 DI ABETES CENTER	0	C	1	0 158, 385	0.000000	
90. 02	09002 NEUROPSYCH	0	C	•	0 164, 578		
90. 03 90. 04	09003 WOUND CENTER	0		•	0 9, 639, 421 0 696, 374	0.000000	
90.04	09004 HYPERBARIC OXYGEN THERAPY 09005 VIMCARE CLINIC	0		1	0 696, 374 0 998, 245	0. 000000 0. 000000	
90.05	09006 MEDICATION MGMT CLINIC		1	•	0 996, 243		
91.00	09100 EMERGENCY	0		•	0 72, 586, 841	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	0 12, 604, 051	0. 000000	
. 2. 00	OTHER REIMBURSABLE COST CENTERS				-, .2,001,001	2. 223000	1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	1, 728, 423	1, 728, 42	23 592, 219, 285		200.00
	•	•			•		

Heal th	Financial Systems	COLUMBUS REGIONA	J HOSPITAI		In lie	u of Form CMS-:	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der C	CN: 15-0112 F	Peri od:	Worksheet D	2332 10
	SH COSTS			F	rom 01/01/2020	Part IV	
			Component	CCN: 15-T112 1	To 12/31/2020 Date/Time 7/14/2021		epared:
			Title	: XVIII	Subprovi der -	77 147 2021 10. PPS	20 alli
			11110	, XVIII	IRF	113	
	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 ÷		Costs (col. 8		Costs (col. 9	
		col . 7)		x col. 10)		x col. 12)	
	ANOULLARY DERVISE COOK OFFITERS	9. 00	10. 00	11. 00	12. 00	13. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.000000	(0.507			0	
50. 00 51. 00	05000 OPERATING ROOM	0. 000000 0. 000000	60, 527	(0	
51.00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0. 000000	12, 693 0			0	
53.00	05300 ANESTHESI OLOGY	0. 000000	13, 532			0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 148883	25, 293	3, 766	-	0	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	6, 161	3, 700	1	0	
54. 02	05404 ULTRA SOUND	0. 000000	28, 011			0	
54. 03	05405 MAMMOGRAPHY	0. 000000	20, 011			0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0			0	
57. 00	05700 CT SCAN	0. 000000	62, 461			0	1
58. 00	05800 MRI	0. 000000	15, 164	1	o o	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	1
60.00	06000 LABORATORY	0. 000000	371, 519		0	0	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	5, 488		0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	15, 998		0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	42, 060	(0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 002, 105	(0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	888, 302	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	278, 533	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	23, 680	(0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	777	(0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	127, 826	(0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	510	(-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 007469	582, 383	4, 350		0	
74.00	07400 RENAL DI ALYSI S	0. 000000	186, 444	(-	0	
76.00	03020 ACUPUNCTURE	0. 000000	0	(0	
76. 97	O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 000000	210		0	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0			0	
90.00	09000 CLINIC	0. 000000	0			0	
90. 00	09001 DI ABETES CENTER	0. 000000	0	•		0	1
90. 02	09002 NEUROPSYCH	0. 000000	0			0	
90. 03	09003 WOUND CENTER	0. 000000	0			0	1
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0		1	0	
90. 05	09005 VI MCARE CLI NI C	0. 000000	0			0	
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	0			0	1
91.00	09100 EMERGENCY	0. 000000	21, 432			0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0			0	
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		3, 771, 109	8, 116	0	0	200.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narodi
				10 12/31/2020	7/14/2021 10:	pareu. 20 am
		Ti tl	e XIX	Hospi tal	PPS	20 4
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
·	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	5 447 400			00.044	17/10	
30. 00 ADULTS & PEDIATRICS	5, 147, 133	0			176. 19	
31. 00 INTENSIVE CARE UNIT	769, 557		769, 55	·	241. 54	
32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34. 00 SURGI CAL INTENSIVE CARE UNIT	0				0. 00 0. 00	
40. 00 SUBPROVIDER - I PF	0	0			0.00	
41. 00 SUBPROVIDER - TPF	627, 797	0	627, 79	~	169. 13	
42. 00 SUBPROVI DER	027,737	0	027,77	0 3, 712	0.00	
43. 00 NURSERY	130, 404	0	130, 40	4 3, 003	43. 42	
44.00 SKILLED NURSING FACILITY	0			0,000		44.00
200.00 Total (lines 30 through 199)	6, 674, 891		6, 674, 89	1 39, 115	0.00	200.00
Cost Center Description	Inpatient	Inpatient				
·	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	6, 364	1, 121, 273	•			30.00
31. 00 INTENSIVE CARE UNIT	248	59, 902	1			31.00
32. 00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT	0	0				33. 00 34. 00
40.00 SUBPROVIDER - IPF	0	0				40.00
41. 00 SUBPROVIDER - TPF	484	81, 859	1			41.00
42. 00 SUBPROVI DER	0	01,037				42.00
43. 00 NURSERY	1, 138	49, 412	1			43.00
44.00 SKILLED NURSING FACILITY	1, 130	77, 412	•			44. 00
200.00 Total (lines 30 through 199)	8, 234	ı .	1			200.00
	5, 20 .	., ,	1			, ,,,,,,

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

Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provi der C	Provider CCN: 15-0112		Worksheet D	
Cost Center Description						Part II	paradi
Capital Related Cost Content Capital Related Cost Content Capital Related Cost Content Capital Related Cost Content Capital Cap					10 12/31/2020	7/14/2021 10	20 am
Cost Center Description			Ti tl	e XIX	Hospi tal		20 0
Related Cost (from Wist. L. B. Part II col	Cost Center Description	Capi tal					
ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , ,		(from Wkst.				
B, Part II, Col. 26 Col. 2 Col. 2 Col. 2 Col. 2		(from Wkst.					
ANCILLARY SERVICE COST CENTERS						,	
ANCILLARY SERVICE COST CENTERS S. 0.00 S. 0.00 OPERATINE ROOM 4, 290, 200 86, 307, 916 0. 0.49708 2, 916, 267 144, 962 50. 0.0 S. 0.0 OSTOO OPERATINE ROOM 188, 534 6, 740, 623 0. 0.27970 256, 686 7, 180 51. 0.0 52. 0.0 OSTOO OELIVERY ROOM S. 0.00 O. 0.0 C. 0.0 O. 0.		col. 26)					
SOLID SOLID SOLI		1. 00	2. 00	3.00	4. 00	5. 00	
151.00 OS100 RECOVERY ROOM ALABOR ROOM 188, 534 6, 740, 623 0. 0.27970 256, 666 7, 180 51.00 0. 0 0. 0.000000 0. 0 52.00 52.00 0.53.00 OS300							
S2.00 OSZOO DELLYERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0							
16,00 05300 ANESTHESI OLOGY 16,844 12,923,178 0.001303 591,628 771 53,00		188, 534	6, 740, 623			7, 180	1
S4. 00 05400 RADIOLOGY-DI AGNOSTIC 563, 548 6, 164, 809 0.091414 138, 994 12, 706 54, 00 54, 01 5402 05404 IULTRA SOUND 169, 413 5, 776, 880 0.029326 150, 762 4, 421 54, 02 54, 03						1	
S4-QL MOLICEAR MEDI CINE-DI AGNOSTI C 422 925 12 600, 717 0 0 0 0 0 0 54 0 0 0 0 0 0 0 0 0				l .	· ·		
S4-02 05404 LITRA SOUND 169, 413 5,776, 880 0.029326 150, 762 4, 421 54, 02							1
54.03 0540S MARMOGRAPHY 352, 701 4, 887, 093 0.072170 0 0 54.03 55.00 05500 ROJO LOGOY-THERAPEUTIC 1, 545, 270 18, 740, 472 0.082456 17, 050 1, 406 55.00 57.00 05700 CT SCAN 290, 394 34, 597, 733 0.008393 1, 108, 093 9, 300 57.00 58.00 05900 CARDIA C CATHETERI ZATI ON 651, 605 28, 181, 072 0.0024122 1, 665, 803 38, 517 59.00 60.01 06001 LABORATORY - PATHOLOGI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.01 06001 LABORATORY - PATHOLOGI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.00 06200 MRIDERI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.00 06200 MRIDERI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.00 06200 MRIDERI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.00 06200 MRIDERI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60.01 60.00 06600 PAYSI CAL THERAPY 633, 260 12, 791, 538 0.049506 222, 547 11, 017 66.00 60.00 06600 PAYSI CAL THERAPY 633, 260 12, 791, 538 0.049506 222, 547 11, 017 66.00 60.00 06900 ELECTROCARDI OLOGY 115, 449 1, 692, 809 0.068200 8, 456 577 68.00 60.00 06900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 465, 347 17, 362 69.00 60.00 07000 ELECTROENCEPHALOGRAPHY 239, 780 5, 814, 536 0.041238 26, 418 1, 897 0.00000 60.00 07000 ELECTROENCEPHALOGRAPHY 239, 780 5, 814, 536 0.041238 26, 418 1, 897 0.00000 60.00 07000							
55. 00 05500 RADIOLOGY-THERAPEUTIC 1.545, 270 18, 740, 472 0.082456 17, 050 1, 406 55, 00 57. 00 05700 CT SCAN 290, 349 34, 579, 733 0.008393 1, 108, 093 9, 300 57. 00 58. 00 05900 CARDIA C CATHETERI ZATI ON 651, 605 291, 373 0.008499 210, 589 1, 990 58. 00 05900 CARDIA C CATHETERI ZATI ON 651, 605 28, 181, 072 0.023122 1, 665, 803 38, 517 59. 00 05900 CARDIA C CATHETERI ZATI ON 651, 605 28, 181, 072 0.023122 1, 665, 803 38, 517 59. 00 05900 CARDIA C CATHETERI ZATI ON 651, 605 28, 181, 072 0.019454 3, 236, 473 62, 962 60. 00 60. 01 60001 LABORATORY - PATHOLOGI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60. 01 60. 00 60000 MDIOLE BLOOD & PACKED RED BLOOD CELL 46, 238 2, 783, 153 0.016614 229, 169 3, 807 62. 00 66. 00 66000 PHYSI CAL THERAPY 663, 260 12, 791, 538 0.049506 222, 547 11, 017 66. 00 66000 PHYSI CAL THERAPY 217, 353 4, 588, 0.99 0.047373 184, 713 8, 750 67. 00 6700 OCCUPATI ONAL THERAPY 217, 353 4, 588, 0.99 0.047373 184, 713 8, 750 67. 00 67. 00 07000 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 465, 347 17, 362 69. 00 69000 69000 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 465, 347 17, 362 69. 00 69000 69000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 60000 600000 600000 6000000 6000000 600000000						4, 421	
57.00 05700 CT SCAN 290, 394 34, 597, 733 0.008393 1, 108, 093 9, 300 57, 00						-	
58.00 05900 05900 CARDIAC CATHETERIZATION 651,605 28,181,072 0.023122 1,665,803 38,517 59.00							1
59.00 05900 CARDI AC CATHETERI ZATI ON 651, 605 28, 181, 072 0.023122 1, 665, 803 38, 517 59, 00 06000 CABORATORY 1, 211, 523 62, 275, 972 0.019454 3, 236, 473 62, 962 60. 00 06001 LABORATORY-PATHOLOGI CAL 113, 609 6, 744, 518 0.016845 85, 119 1, 434 60. 01 65. 00 05600 RESPIRATORY THERRAPY 563, 746 10, 349, 955 0.054468 1, 121, 644 61, 095 65. 00 06500 RESPIRATORY THERRAPY 633, 260 12, 791, 538 0.049506 222, 547 11, 017 66. 00 06600 PHYSI CAL THERRAPY 217, 353 4, 588, 099 0.047373 184, 713 8, 750 67. 00 06700 0CCUPATI ONAL THERRAPY 217, 353 4, 588, 099 0.068200 8, 456 577 68. 00 06800 SPEECH PATHOLOGY 115, 449 1, 692, 809 0.068200 8, 456 577 68. 00 06800 SPEECH PATHOLOGY 115, 449 1, 692, 809 0.068200 8, 456 577 68. 00 06900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 465, 347 17, 362 69. 00 07000 07000 ELECTROCREPHALOGRAPHY 239, 780 5, 814, 536 0.041238 26, 418 1, 089 70. 00 70.						·	1
60. 00 0.000 LABORATORY 1, 211, 523 62, 275, 972 0. 019454 3, 236, 473 62, 962 60. 00 06. 01 0.0001 LABORATORY PATHOLOGI CAL 113, 609 6, 744, 518 0. 016845 85, 119 1, 434 60. 00 06. 20 0.0000 0.0000 0.00000 0. 00 0.00000 06. 00 0.0500 RESPIRATORY THERAPY 563, 746 10, 349, 955 0. 054468 1, 121, 664 61, 095 65. 00 06. 00 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 06. 00 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 06. 00 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 06. 00 0.0000 0.00000 0.00000 0.00000 0.000000 0.000000 06. 00 0.0000 0.00000 0.00000 0.00000 0.000000 0.000000 06. 00 0.0000 0.00000 0.00000 0.000000 0.000000 0.000000 06. 00 0.0000 0.00000 0.00000 0.000000 0.000000 0.0000000 06. 00 0.00000 0.000000 0.0000000 0.000000 0.0000000 0.00000000		65, 119			· ·	·	1
60. 01 06001 LABORATORY-PATHOLOGICAL 113, 609 6, 744, 518 0. 016845 85, 119 1, 434 60. 01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 46, 238 2, 783, 153 0. 016614 229, 169 3, 807 62. 00 66. 00 06500 RESPIRATORY THERAPY 563, 746 10, 349, 955 0. 054468 1, 121, 664 61, 095 65. 00 06600 PHYSI CAL THERAPY 633, 260 12, 791, 538 0. 049506 222, 547 11, 017 66. 00 0670 0CCUPATI ONAL THERAPY 217, 353 4, 588, 099 0. 047373 184, 713 8, 750 67. 00 0670 0CCUPATI ONAL THERAPY 217, 353 4, 588, 099 0. 068200 8, 456 577 68. 00 06800 SPECCH PATHOLOGY 115, 449 1, 692, 809 0. 068200 8, 456 577 68. 00 06900 ELECTROCARDI OLOGY 10, 409, 013 10, 962, 967 0. 037309 465, 347 17, 362 69. 00 0700 0CCUPATIONAL THERAPY 239, 780 5, 814, 536 0. 041238 26, 418 1, 089 70. 00 7000 ELECTROCARDI OLOGY 239, 780 5, 814, 536 0. 041238 26, 418 1, 089 70. 00 7000 ELECTROCARDI OLOGY 3315, 128 14, 821, 832 0. 021261 268, 973 5, 719 70. 00 7000 DICENTENCEPHALOGRAPHY 3315, 128 14, 821, 832 0. 021261 268, 973 5, 719 70. 00 7000 OTOO ELECTROCARDI OLOGY 315, 429, 430 0. 07300 DRUGS CHARGED TO PATI ENTS 315, 128 14, 821, 832 0. 021261 268, 973 5, 719 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 736, 133 108, 520, 075 0. 015998 4, 947, 138 79, 144 73. 00 7400 RENAL DI ALYSI S 42, 836 3, 537, 595 0. 015998 4, 947, 138 79, 144 73. 00 7400 RENAL DI ALYSI S 42, 836 3, 537, 595 0. 012109 1, 162, 620 14, 078 76. 97 0767 CARDI AC REHABIL I TATI ON 78, 818 894, 653 0. 08809 1, 050 990 1, 050 93 76. 97 0000 0000 0000 000 0000 0000 0000 0							1
62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 44, 238 2, 783, 153 0, 016614 229, 169 3, 807 62, 00 65. 00 06500 RESPI RATORY THERAPY 563, 746 10, 349, 955 0, 054468 1, 121, 664 61, 095 66. 00 66. 00 06600 PHYSI CAL THERAPY 633, 260 12, 791, 538 0, 049506 222, 547 11, 017 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 217, 353 4, 588, 099 0, 047373 184, 713 8, 750 67. 00 68. 00 08600 SPEECH PATHOLOGY 115, 449 115, 449 0, 103 10, 962, 967 0, 037309 465, 347 17, 362 69. 00 69. 00 06900 ELECTROENCEPHALOGRAPHY 239, 780 5, 814, 536 0, 041238 26, 418 1, 089 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 331, 525 18, 812, 313 0, 017623 1, 154, 797 20, 351 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 315, 128 14, 821, 832 0, 021261 268, 973 5, 719 72. 00 73. 00 07400 RENAL DI ALYSIS 42, 836 3, 537, 595 0, 012109 4, 947, 138 79, 144 73. 00 74. 00 07400 RENAL DI ALYSIS 42, 836 3, 537, 595 0, 012109 1, 162, 620 14, 078 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0, 000000 0 0 0 0, 000000 76. 97 07697 CARDI AC REHABI LI TATI ON 78, 818 894, 653 0, 088099 1, 050 93 76. 97 75. 97 0000 0000 0000 00000 00000 00000 00000 00000 000000		1, 211, 523	62, 275, 972			62, 962	60.00
65.00 06500 RESPIRATORY THERAPY 563, 746 10, 349, 955 0. 054468 1, 121, 664 61, 095 65.00 66.00 06600 PHYSI CAL THERAPY 633, 260 12, 791, 538 0. 049506 222, 547 11, 017 66.00 67.00 06700 0CCUPATI ONAL THERAPY 217, 353 4, 588, 099 0. 047373 184, 713 8, 750 67.00 68.00 06800 SPEECH PATHOLOGY 115, 449 1, 692, 809 0. 068200 8, 456 577 68.00 69.00 06900 ELECTROCARDIOLOGY 409, 013 10, 962, 967 0. 037309 465, 347 17, 362 69.00 69.00 07000 ELECTROCARDIOLOGY 409, 013 10, 962, 967 0. 037309 465, 347 17, 362 69.00 69.01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 331, 525 18, 812, 313 0. 017623 1, 154, 797 20, 351 71.00 69.00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 315, 128 14, 821, 832 0. 021261 268, 973 5, 719 72.00 69.00 07300 DRUGS CHARGED TO PATI ENTS 1, 736, 133 108, 520, 075 0. 015998 4, 947, 138 79, 144 73.00 69.00 03020 ACUPUNCTURE 0 0 0 0.000000 0 0 0 76.00 69.00 03020 ACUPUNCTURE 0 0 0.000000 0 0 0 76.00 69.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0.000000 0 0 0 89.00 69.00 09900 CLI NI C 423, 924 6, 134, 502 0. 069105 0 0 90.00 69.00 09900 MEDI CAL FERREPS 423, 924 6, 134, 502 0. 069105 0 0 90.00 69.01 09000 MEDI CAL SUPPLIES 423, 924 6, 134, 502 0. 069105 0 0 90.00 69.02 O9002 MEDI CATER 423, 924 6, 134, 502 0. 069105 0 0 90.00 69.03 09000 CLI NI C 423, 924 6, 134, 502 0. 069105 0 0 90.00 69.04 09004 MYPERBARI C OXYGEN THERAPY 55, 327 696, 374 0.079450 0 0 90.00 69.05 09005 MEDI CATI ON MGMT CLI NI C 519, 397 998, 245 0. 219783 1, 640 360 90.05 69.06 09006 MEDI CATI ON MGMT CLI NI C 58, 233 835, 043 0. 069737 0 0 90.06 69.00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART 546, 006 12, 604, 051 0.043320 0 0 90.06 69.00 09000 OSSERVATI ON BEDS (NON-DISTINCT PART 546, 006 12,		113, 609	6, 744, 518				
66. 00 06600 PHYSICAL THERAPY 633, 260 12, 791, 538 0, 049506 222, 547 11, 017 66. 00 6700 0CCUPATI ONAL THERAPY 217, 353 4, 588, 099 0, 047373 184, 713 8, 750 67. 00 6800 SPECEN PATHOLOGY 115, 449 1, 692, 809 0, 068200 8, 456 577 68. 00 6900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0, 037309 465, 347 17, 362 69. 00 7000 ELECTROENCEPHALLOGRAPHY 239, 780 5, 814, 536 0, 041238 26, 418 1, 069 70. 00 7000 ELECTROENCEPHALLOGRAPHY 331, 525 18, 812, 313 0, 017623 1, 154, 797 20, 351 71. 00 7100 MEDIC ALS SUPPLIES CHARGED TO PATI ENTS 315, 128 14, 821, 832 0, 021261 268, 973 5, 719 72. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 315, 128 14, 821, 832 0, 021261 268, 973 5, 719 72. 00 7300 DRUGS CHARGED TO PATI ENTS 1, 736, 133 108, 520, 075 0, 015098 4, 947, 138 79, 144 73. 00 7400 RFALL DI ALYSIS 42, 836 3, 537, 595 0, 012109 1, 162, 620 14, 078 74. 00 76.		46, 238					
67. 00		563, 746				61, 095	65.00
68. 00 06800 SPECH PATHOLOGY 115, 449 1, 692, 809 0. 0. 68200 8, 456 577 68. 00 69. 00 06900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0. 037309 465, 347 17, 362 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 229, 780 5, 814, 536 0. 041238 26, 418 1, 089 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 331, 525 18, 812, 313 0. 017623 1, 154, 797 20, 351 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 315, 128 14, 821, 832 0. 021261 268, 973 5, 719 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 736, 133 108, 520, 075 0. 015998 4, 947, 138 79, 144 73. 00 74. 00 07400 RENAL DI ALYSI S 42, 836 3, 537, 595 0. 012109 1, 162, 620 14, 078 74. 00 76. 97 07697 CARDI AC REHABILITATION 78, 818 894, 653 0. 088099 1, 050 93 76. 97 00000000000000000000000000000000000		633, 260	12, 791, 538	0. 04950	6 222, 547	11, 017	66.00
69. 00 06900 ELECTROCARDI OLOGY 409, 013 10, 962, 967 0.037309 465, 347 17, 362 69. 00 7000 07000 ELECTROENCEPHALOGRAPHY 239, 780 5, 814, 536 0.041238 26, 418 1, 089 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 331, 525 18, 812, 313 0.017623 1, 154, 797 20, 351 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 315, 128 14, 821, 832 0.021261 268, 973 5, 719 72. 00 7300 DRUGS CHARGED TO PATI ENTS 1, 736, 133 108, 520, 075 0.015998 4, 947, 138 79, 144 73. 00 7400 RENAL DI ALYSI S 42, 836 3, 537, 595 0.012109 1, 162, 620 14, 078 74. 00 07400 RENAL DI ALYSI S 42, 836 3, 537, 595 0.012109 1, 162, 620 14, 078 74. 00 07697 CARDI AC REHABI LI TATI ON 78, 818 894, 653 0.088099 1, 050 93 76. 97 0019ATT ENT SERVI CE COST CENTERS 88. 00 08900 FEDERALLY OUALI FI ED HEALTH CENTER 0 0 0.000000 0 0 88. 00 08900 FEDERALLY OUALI FI ED HEALTH CENTER 0 0 0.000000 0 0 89. 00 09000 CLI NI C 423, 924 6, 134, 502 0.069105 0 0 90. 00 90.		217, 353	4, 588, 099		· ·	8, 750	
70. 00 07000 ELECTROENCEPHALOGRAPHY 239, 780 5,814,536 0.041238 26,418 1,089 70.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 331,525 18,812,313 0.017623 1,154,797 20,3551 71.00 72.00 707200 MPL. DEV. CHARGED TO PATIENTS 315,128 14,821,832 0.021261 268,973 5,719 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,736,133 108,520,075 0.015998 4,947,138 79,144 73.00 74.00 07400 RENAL DIALYSIS 42,836 3,537,595 0.012109 1,162,620 14,078 74.00 76.00 000000 0 0 0.000000 0 0							
71. 00					· ·		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 315, 128 14, 821, 832 0. 021261 268, 973 5, 719 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 736, 133 108, 520, 075 0. 015998 4, 947, 138 79, 144 73. 00 74. 00 07400 RENAL DI ALYSI S 42, 836 3, 537, 595 0. 012109 1, 162, 620 14, 078 74. 00 76. 00 0. 03020 ACUPUNCTURE 0 0 0. 000000 0 0 0 0. 000000 0							
73. 00							
74. 00		315, 128					
76. 00				l .			
76. 97 O7697 CARDIAC REHABILITATION 78, 818 894, 653 0. 088099 1, 050 93 76. 97 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 0 88. 00 89. 00 09000 CLINIC 423, 924 6, 134, 502 0. 069105 0 0 0 90. 01 09001 DI ABETES CENTER 35, 357 158, 385 0. 223235 0 0 0 90. 01 09001 DI ABETES CENTER 35, 357 158, 385 0. 058641 15, 521 910 90. 02 09002 NEUROPSYCH 9, 651 164, 578 0. 058641 15, 521 910 90. 02 90. 03 09003 WOUND CENTER 231, 550 9, 639, 421 0. 024021 1, 101 26 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 55, 327 696, 374 0. 079450 0 0 0 90. 04 90. 05 09005 VI MCARE CLINIC 219, 397 998, 245 0. 219783 1, 640 360 90. 05 90. 06 09006 MEDICATION MGMT CLINIC 58, 233 835, 043 0. 069737 0 0 0 90. 06 90. 06 09100 EMERGENCY 1, 429, 538 72, 586, 841 0. 019694 2, 984, 277 58, 772 91. 00 07010 EMERGENCY 1, 429, 538 72, 586, 841 0. 019694 2, 984, 277 58, 772 91. 00 07010 EMERGENCY 550. 00 09500 AMBULANCE SERVICES 95. 00		42, 836	3, 537, 595				
SECTION SERVICE COST CENTERS SECTION			0				
88. 00		78, 818	894, 653	0. 08809	9 1, 050	93	76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0 0 89. 00 90. 00 09000 CLINIC 423, 924 6, 134, 502 0.069105 0 0 90. 00 90. 01 09001 DIABETES CENTER 35, 357 158, 385 0.223235 0 0 90. 01 90. 02 09002 NEUROPSYCH 9, 651 164, 578 0.058641 15, 521 910 90. 02 90. 03 09003 WOUND CENTER 231, 550 9, 639, 421 0.024021 1, 101 26 90. 03 90. 04 09004 HYPERBARIC OXYGEN THERAPY 55, 327 696, 374 0.079450 0 0 90. 04 90. 05 09005 VI MCARE CLINIC 219, 397 998, 245 0.219783 1, 640 360 90. 05 91. 06 09006 MEDICATION MGMT CLINIC 58, 233 835, 043 0.069737 0 0 0.090.05 91. 00 09100 EMERGENCY 1, 429, 538 72, 586, 841 0.019694 2, 984, 277 58, 772 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 546, 006 12, 604, 051 0.043320 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00		T	T .	T	-1	T	
90. 00 09000 CLI NI C 423, 924 6, 134, 502 0. 069105 0 0 90. 00 90. 01 90. 01 09001 DI ABETES CENTER 35, 357 158, 385 0. 223235 0 0 90. 01 90. 02 90. 02 09002 NEUROPSYCH 9, 651 164, 578 0. 058641 15, 521 910 90. 02 90. 03 09003 WOUND CENTER 231, 550 9, 639, 421 0. 024021 1, 101 26 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 55, 327 696, 374 0. 079450 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 219, 397 998, 245 0. 219783 1, 640 360 90. 05 90. 06 MEDI CATI ON MGMT CLI NI C 58, 233 835, 043 0. 069737 0 0 90. 06 90. 06 90. 06 MERGENCY 1, 429, 538 72, 586, 841 0. 019694 2, 984, 277 58, 772 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 546, 006 12, 604, 051 0. 043320 0 0 92. 00 071HER REI MBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00 95.							
90. 01 09001 DI ABETES CENTER 35, 357 158, 385 0. 223235 0 0 90. 01 90. 02 90. 02 90. 02 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 04 90. 04 90. 04 90. 04 90. 04 90. 04 90. 05 90. 05 90. 05 90. 05 90. 05 90. 06		1				-	
90. 02 09002 NEUROPSYCH 9, 651 164, 578 0. 058641 15, 521 910 90. 02 90. 03 09003 WOUND CENTER 231, 550 9, 639, 421 0. 024021 1, 101 26 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 55, 327 696, 374 0. 079450 0 0 0 90. 04 90. 05 09005 VI MCARE CLI NI C 219, 397 998, 245 0. 219783 1, 640 360 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 58, 233 835, 043 0. 069737 0 0 90. 06 90. 06 90. 00 90. 00 MERGENCY 1, 429, 538 72, 586, 841 0. 019694 2, 984, 277 58, 772 91. 00 92. 00 09500 MBBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00		1		•			
90. 03 09003 WOUND CENTER 231, 550 9, 639, 421 0. 024021 1, 101 26 90. 03 90. 04 90. 04 90. 04 147PERBARI C OXYGEN THERAPY 55, 327 696, 374 0. 079450 0 0 90. 04 90. 05 90. 05 90. 05 90. 05 90. 06 90							
90. 04 09004 HYPERBARI C OXYGEN THERAPY 55, 327 696, 374 0.079450 0 0 0 90.04 90. 05 09005 VI MCARE CLI NI C 219, 397 998, 245 0.219783 1, 640 360 90.05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 58, 233 835, 043 0.069737 0 0 0 90.06 91. 00 09100 EMERGENCY 1, 429, 538 72, 586, 841 0.019694 2, 984, 277 58, 772 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 546, 006 12, 604, 051 0.043320 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95. 00					· ·		
90. 05 09005 VI MCARE CLINI C 219, 397 998, 245 0. 219783 1, 640 360 90. 05 90. 06							
90. 06 09006 MEDI CATI ON MGMT CLINIC 58, 233 835, 043 0.069737 0 0 90.06 91.00 91.00 92.00 085ERVATI ON BEDS (NON-DISTINCT PART 546, 006 12, 604, 051 0.043320 0 0 92.00 09500 AMBULANCE SERVI CES 95. 00 95.00 95.00 95.00 90.06							
91. 00 09100 EMERGENCY 1, 429, 538 72, 586, 841 0. 019694 2, 984, 277 58, 772 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 546, 006 12, 604, 051 0. 043320 0 0 0 92. 00 0 0 0 0 0 0 0 0 0							1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 546, 006 12, 604, 051 0.043320 0 0 92. 00						-	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00		1 ' '					1
95. 00 09500 AMBULANCE SERVI CES 95. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	546, 006	12, 604, 051	0. 04332	0 0	0	92.00
				1			
200.00		17 /40 0:3	F00 040 005		22 242 271	F74 410	
	200.00 Total (Times 50 through 199)	17,619,947	1 392, 219, 285	I	23, 242, 874	5/1, 148	J∠UU. UU

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LANDATI ENT D	OUTLINE CERVILOE OTHER PACC TURQUOU COCTO D	O110 Deci ed Wester D

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C		Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Nursi ng School	Post-Stepdown	Allied Health Cost	All Other Medical	
	Post-Stepdown Adjustments	1.00	Adjustments		Education Cost	
LANDATI ENT. DOUTLANE, DEDIVLOE, DOOT, DENTEDO	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	_		_	_	
30. 00 03000 ADULTS & PEDI ATRI CS	0		l	0	_	
31. 00 03100 INTENSIVE CARE UNIT	0			0	_	
32. 00 03200 CORONARY CARE UNIT	0	1		0	_	
33.00 03300 BURN INTENSIVE CARE UNIT	0)	0		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0		
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0 0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0)	0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
200.00 Total (lines 30 through 199)	0			0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpatient	
· ·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
	instructions)			Í		
	4. 00	5.00	6.00	7.00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	29, 21	4 0.00	6, 364	30.00
31.00 03100 INTENSIVE CARE UNIT		0	3, 18	6 0.00	248	31.00
32.00 03200 CORONARY CARE UNIT		0)	0.00	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00		
40. 00 04000 SUBPROVI DER - PF	0			0.00		
41. 00 04100 SUBPROVI DER - RF	0		3, 71			
42. 00 04200 SUBPROVI DER		1		0.00		1
43. 00 04300 NURSERY			1			
44.00 04400 SKILLED NURSING FACILITY				0.00	·	1
200.00 Total (lines 30 through 199)			l .			200.00
Cost Center Description	Inpatient		7 37, 11	٥	0, 234	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00	†				
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	0	l .				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	l .				33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	Ö	l .				34.00
40. 00 04000 SUBPROVI DER - I PF						40.00
41. 00 04100 SUBPROVI DER - 1 PF						41.00
42. 00 04200 SUBPROVI DER 42. 00 04200 SUBPROVI DER		l .				41.00
43. 00 04300 NURSERY	0	•				43.00
44.00 04400 SKILLED NURSING FACILITY	0	l .				44.00
200.00 Total (lines 30 through 199)	0	1				200.00

				To 12/31/2020) Date/Time Pre 7/14/2021 10:	
		Ti tl	e XIX	Hospi tal	PPS	20 alli
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	+	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0 0		
51.00 05100 RECOVERY ROOM	0	0	1	0 0	1	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0		
53. 00 05300 ANESTHESI OLOGY	0	0	1	0 0	ή	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	1	54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0		0 0	ή "	1 0 0 .
54. 02 05404 ULTRA SOUND	0	0		0	0	
54. 03 05405 MAMMOGRAPHY	0	0		0 0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	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	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0			-1	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65.00 06500 RESPIRATORY THERAPY	0			0 0	ή	62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0			0 0	1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	ή	67.00
68. 00 06800 SPEECH PATHOLOGY						68.00
69. 00 06900 ELECTROCARDI OLOGY		0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			,	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	١			810, 586	
74. 00 07400 RENAL DI ALYSI S	0	0				1
76. 00 03020 ACUPUNCTURE	0	ĺ		o c	ή	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	1	0		1
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	1	70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o c	o o	89.00
90. 00 09000 CLI NI C	0	O		0 0	0	90.00
90. 01 09001 DI ABETES CENTER	0	o		0 0	0	1
90. 02 09002 NEUROPSYCH	0	o		0 0	0	90. 02
90. 03 09003 WOUND CENTER	0	0		0 0	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	90.04
90. 05 09005 VI MCARE CLI NI C	0	0		0 0	0	90.05
90.06 09006 MEDICATION MGMT CLINIC	0	0		0 0	0	90.06
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		<u> </u>	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	1	0 0	1, 728, 423	200. 00

Peri od: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared: THROUGH COSTS

						7/14/2021 10:	20 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
1	05000 OPERATING ROOM	0	0		0 86, 307, 916		
1	D5100 RECOVERY ROOM	0	0		0 6, 740, 623	0. 000000	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	•	0	0. 000000	
	D5300 ANESTHESI OLOGY	0	0		0 12, 923, 178		
	D5400 RADI OLOGY-DI AGNOSTI C	0	917, 837	917, 83		0. 148883	
	D5402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 12, 600, 717	0. 000000	
	D5404 ULTRA SOUND	0	0		0 5, 776, 880		
4	D5405 MAMMOGRAPHY	0	0		0 4, 887, 093		
	D5500 RADI OLOGY-THERAPEUTI C	0	0	1	0 18, 740, 472	0. 000000	55.00
	D5700 CT SCAN	0	0	1	0 34, 597, 733		57.00
4	05800 MRI	0	0		0 6, 891, 337	0. 000000	
4	05900 CARDI AC CATHETERI ZATI ON	0	0		0 28, 181, 072	0. 000000	
4	D6000 LABORATORY	0	0	1	0 62, 275, 972	0. 000000	
	06001 LABORATORY-PATHOLOGI CAL	0	0		0 6, 744, 518		
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 2, 783, 153		62.00
	06500 RESPI RATORY THERAPY	0	0		0 10, 349, 955		65.00
4	D6600 PHYSI CAL THERAPY	0	0	ı	0 12, 791, 538		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	i e	0 4, 588, 099		
	D6800 SPEECH PATHOLOGY	0	0		0 1, 692, 809	0. 000000	
	D6900 ELECTROCARDI OLOGY	0	0		0 10, 962, 967	0. 000000	
	D7000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 814, 536		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	•	0 18, 812, 313		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 14, 821, 832	0. 000000	
	D7300 DRUGS CHARGED TO PATIENTS	0	810, 586				73.00
1	07400 RENAL DI ALYSI S	0	0		0 3, 537, 595		
1	D3020 ACUPUNCTURE	0	0		0 0	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 894, 653	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1		0.00000	00.00
4	08800 RURAL HEALTH CLINIC	0	0		0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•	0 0	0.000000	
	D9000 CLINIC D9001 DIABETES CENTER	U O	0		0 6, 134, 502	0.000000	
		0	0	1	0 158, 385	0.000000	90. 01
4	09002 NEUROPSYCH	0	0	i e	0 164, 578		90.02
	09003 WOUND CENTER	0	0	i e	0 9, 639, 421	0.000000	
	D9004 HYPERBARIC OXYGEN THERAPY D9005 VIMCARE CLINIC	0	0		0 696, 374	0.000000	
	D9005 VINCARE CLINIC		0		0 998, 245 0 835, 043		
			0				
	09100 EMERGENCY		0	•	0 72, 586, 841 0 12, 604, 051	0.000000	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	l O	0		0 12, 604, 051	0. 000000	92.00
	D9500 AMBULANCE SERVICES			1			95.00
200.00	Total (lines 50 through 199)	o	1, 728, 423	1, 728, 42	3 592, 219, 285		200.00
200.00	Tiotal (Titles of through 199)	ᅵ	1, 128, 423	1, 128, 42	J J72, 219, 285	l	₁ ∠00.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet D
THROUGH COSTS				Patt IV

111100011 00313			To	12/31/2020	Date/Time Pre 7/14/2021 10:	pared:
		Ti tl	e XIX	Hospi tal	PPS	20 aiii
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	2, 916, 267	0	0	0	
51.00 05100 RECOVERY ROOM	0. 000000	256, 686	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	591, 628	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 148883	138, 994	20, 694	0	0	54.00
54. O1 O54O2 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	69, 979	0	0	0	54. 01
54.02 05404 ULTRA SOUND	0. 000000	150, 762	0	0	0	54.02
54. 03 05405 MAMMOGRAPHY	0. 000000	0	0	0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	17, 050	0	0	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 108, 093	0	0	0	57.00
58. 00 05800 MRI	0. 000000	210, 589	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 665, 803	0	0	0	59.00
60. 00 06000 LABORATORY	0. 000000	3, 236, 473	0	0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	85, 119	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	229, 169	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 121, 664	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	222, 547	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	184, 713	0	o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	8, 456	0	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	465, 347	0	o	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	26, 418	0	o	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 154, 797	0	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	268, 973	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 007469	4, 947, 138	36, 950	o	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 162, 620	0	o	0	74.00
76. 00 03020 ACUPUNCTURE	0. 000000	0	0	o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	1, 050	0	o	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 09001 DI ABETES CENTER	0. 000000	0	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	0. 000000	15, 521	0	0	0	90. 02
90. 03 09003 WOUND CENTER	0. 000000	1, 101	0	o	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	o	0	90.04
90. 05 09005 VI MCARE CLI NI C	0. 000000	1, 640	0	0	0	90.05
90.06 09006 MEDICATION MGMT CLINIC	0. 000000	0	0	o	0	90.06
91. 00 09100 EMERGENCY	0. 000000	2, 984, 277	0	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	О	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		23, 242, 874	57, 644	o	0	200.00

 Heal th Financial Apportionment of Apportion
 Systems
 COLUMBUS REGIO

 Apportion
 OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0112 Period: Worksheet D From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared:

					10 12/31/2020	7/14/2021 10:	
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	, and the second	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
			Services (see	Servi ces	Services Not	,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	,	Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>		•			
50.00	05000 OPERATING ROOM	0. 342471	0	8, 691, 65	6 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 300940	0	954, 87	6 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	o o	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 016488	0	1, 552, 15	4 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 788993	0	790, 96	1 0	0	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 239335	0	1, 097, 44	3 0	0	54. 01
54.02	05404 ULTRA SOUND	0. 203291	0	925, 69	o o	0	54.02
54.03	05405 MAMMOGRAPHY	0. 410564	0	339, 28	o o	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 313683	0	1, 538, 25	5 0	0	55.00
57.00	05700 CT SCAN	0. 076956	0	4, 873, 01	8 0	0	57.00
58.00	05800 MRI	0. 119453	0	763, 14	1 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 166283	0	1, 185, 61	8 0	0	59.00
60.00	06000 LABORATORY	0. 256467	0	7, 206, 97	5 0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 245705	0	702, 05	5 0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 287882	0	267, 21	6 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 504291	0	491, 93	9 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 486650	0	1, 083, 96	4 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 462733	0	15, 78	5 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 665597	0	330, 34	9 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 193642	0	668, 72	7 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 286775	0	1, 103, 40	3 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 458277	0	1, 079, 25	8 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 552890	0	619, 18	9 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 345194	0	6, 970, 49	6 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 313292	0		0 0	0	74.00
76.00	03020 ACUPUNCTURE	0. 000000	0		0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 657104	0	27, 47	6 0	0	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. 585287	0			0	90.00
90. 01	09001 DI ABETES CENTER	1. 839953	0	18, 20	6 0	0	90. 01
90. 02	09002 NEUROPSYCH	1. 023740	0	68, 71		0	90. 02
90. 03	09003 WOUND CENTER	0. 247426	0	1, 340, 56	5 0	0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 486076	0	102, 84	6 0	0	90. 04
90.05	09005 VI MCARE CLI NI C	1. 633817	0			0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	0. 626429	0			0	90.06
91.00	09100 EMERGENCY	0. 209428	0	,		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 375692	0	2, 815, 22	2 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 588811	0				95.00
200.00	1 1		0				200. 00
201.00	9				0		201. 00
000 00	Only Charges		•	/7 500 07		_	000 00
202.00	Net Charges (line 200 - line 201)	1	0	67, 592, 36	8 0	0	202. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0112	Peri od: From 01/01/2020	Worksheet D

To 12/31/2020 Date/Time Prepared: 7/14/2021 10:20 am Title XIX 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 976, 640 50.00 05100 RECOVERY ROOM 0 51.00 51.00 287, 360 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 25, 592 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 624, 063 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 262, 657 0 54.01 0 54.02 05404 ULTRA SOUND 188, 184 54.02 54.03 05405 MAMMOGRAPHY 139, 296 54.03 0 55.00 05500 RADI OLOGY-THERAPEUTI C 482, 524 55.00 05700 CT SCAN 0 57.00 375,008 57.00 58.00 05800 MRI 91, 159 0 58.00 05900 CARDIAC CATHETERIZATION 197, 148 59.00 59.00 06000 LABORATORY 1, 848, 351 60 00 60 00 60.01 06001 LABORATORY-PATHOLOGI CAL 172, 498 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 76, 927 0 62.00 06500 RESPIRATORY THERAPY 248, 080 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66 00 527.511 06700 OCCUPATIONAL THERAPY 0 67.00 7, 304 67.00 68.00 06800 SPEECH PATHOLOGY 219, 879 68.00 0 69.00 06900 ELECTROCARDI OLOGY 129, 494 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 316, 428 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 494, 599 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 342, 343 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 2, 406, 173 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 76.00 03020 ACUPUNCTURE 0 76.00 07697 CARDIAC REHABILITATION 76.97 18,055 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 325.034 90.00 90.01 09001 DI ABETES CENTER 90.01 33, 498 0 90.02 09002 NEUROPSYCH 70, 343 90.02 90.03 09003 WOUND CENTER 331, 691 0 90.03 09004 HYPERBARI C OXYGEN THERAPY 49, 991 0 90.04 90.04 09005 VIMCARE CLINIC 0 90.05 975, 745 90.05 90.06 09006 MEDICATION MGMT CLINIC 24, 417 0 90.06 91.00 09100 EMERGENCY 3, 431, 050 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,057,656 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 409, 260 95.00 200.00 Subtotal (see instructions) 20, 165, 958 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

20, 165, 958

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR THROUGH COSTS	RY SERVICE OTHER PAS	S Provi der Co	CN: 15-0112	Peri od: From 01/01/2020	Worksheet D Part IV	
Timocon 33575		Component (CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	pared: 20 am
		Ti tl	e XIX	Subprovi der – I RF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50 00 05000 OPERATING POOM	0	0		0 0	0	1 50 00

	Cost Center Description	Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursi ng School	Post-Stepdown Adjustments	Allied Health	
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00		0	1			0	50.00
51.00		0	0	0	0	0	51.00
52. 00		0	0	0	0	0	52.00
53. 00	I I	0	0	0	0	0	53.00
54.00		0	0	0	0	917, 837	54.00
54. 01	l l	0	0	0	0	0	54. 01
54. 02	l l	0	0	0	0	0	54.02
54. 03		0	0	0	0	0	54. 03
55. 00		0	0		0	0	55.00
57. 00	I I	0	0		0	0	57.00
58. 00 59. 00	I I	0	0		0	0	58. 00 59. 00
60.00		0	0	i o	0		60.00
60. 00		0	0		_	0	60.00
62. 00	ł I		0		_	0	62.00
65. 00	· · · · · · · · · · · · · · · · · · ·		0		0	0	65.00
66. 00	1 1		0		0	0	66.00
67. 00	ł l		0		0	0	67. 00
68. 00	ł l		0		0	Ö	68.00
69. 00		0	0	Ö	0	0	69.00
70.00	ł l	0	0		0	0	70.00
71. 00		0	l o		0	0	71.00
72. 00		0	0	l c	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	810, 586	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0				0	88. 00
89. 00		0	0	0	0	0	89. 00
90.00		0	0	0	0	0	90.00
90. 01		0	0	0	0	0	90. 01
90. 02	I I	0	0	0	0	0	90.02
90. 03		0	0	0	0	0	90. 03
90. 04		0	0		0	0	90.04
90.05		0	0		0	0	90.05
90.06	· · · · · · · · · · · · · · · · · · ·	0	0		0	0	90.06
91. 00 92. 00				0		0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	1 0				1 0	72.00
95. 00							95. 00
200. 0	· · · · · · · · · · · · · · · · · · ·	0	О	C	0	1, 728, 423	
		•	. '		•		

	Financial Systems TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	COLUMBUS REGIO		N. 15 0112	In Lie Period:	u of Form CMS-2 Worksheet D	∠၁5∠-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SEF SH COSTS	RVICE UTHER PAS	55 Provider C	JN: 15-0112	Perrod: From 01/01/2020	Part IV	
TTIKOOC	00010		Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	pared:
			Ti +I	e XIX	Subprovi der -	//14/2021 10:	20 am
				CAIA	I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4.00	F 00		7.00	instructions)	
	ANCILLARY CERVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS				0/ 207 01/	0.000000	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0			0 86, 307, 916 0 6, 740, 623		1
51.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 6, 740, 623 0 0	0. 000000 0. 000000	
53.00	05300 ANESTHESI OLOGY		1				1
54.00	05400 RADI OLOGY-DI AGNOSTI C		-	917, 83		0. 000000 0. 148883	
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	,				
54. 01	05404 ULTRA SOUND	0	0		0 12, 600, 717 0 5, 776, 880	0. 000000 0. 000000	
54. 02	05405 MAMMOGRAPHY	0	0		0 4, 887, 093		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 4, 667, 093	0.00000	
57. 00	05700 CT SCAN		0		0 34, 597, 733		
58.00	05800 MRI	0	0		0 6, 891, 337	0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0, 841, 337	0.000000	1
60.00	06000 LABORATORY	0	0		0 62, 275, 972	0.000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	ĺ		0 6, 744, 518		
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 2, 783, 153		
65.00	06500 RESPIRATORY THERAPY	0	0		0 10, 349, 955		
66.00	06600 PHYSI CAL THERAPY	0	l o		0 12, 791, 538		
67. 00	06700 OCCUPATI ONAL THERAPY	0	l o		0 4, 588, 099		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 692, 809		
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0 10, 962, 967	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 814, 536	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 18, 812, 313	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 14, 821, 832	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	810, 586	810, 58	6 108, 520, 075	0. 007469	73.00
74.00	07400 RENAL DI ALYSI S	0	0	(0 3, 537, 595	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	0	(0	0.000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0 894, 653	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	-		0		1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1		0	1 0.00000	
90.00	09000 CLI NI C	0			0 6, 134, 502		
90. 01	09001 DI ABETES CENTER	0	0		0 158, 385	0.000000	
90.02	09002 NEUROPSYCH	0	0		0 164, 578		
90. 03	09003 WOUND CENTER	0	0		9, 639, 421	0.000000	
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0 696, 374		
90.05	09005 VI MCARE CLI NI C	0	0		0 998, 245		
90.06	09006 MEDICATION MGMT CLINIC	0	0		0 835, 043 0 72 586 841		
a ()()	IUS IUU EMERGENU Y	. ()	. ()	1	// 586 841		1 41 (

1, 728, 423

1, 728, 423

72, 586, 841

12, 604, 051

592, 219, 285

0.000000

0.000000

91.00

92.00

95.00

200.00

91. 00 09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

92.00

200.00

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

Total (lines 50 through 199)

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	COLUMBUS REGION. RVICE OTHER PASS	Provi der C	CN: 15-0112	Peri od:	u of Form CMS-: Worksheet D	2332-10
THROUG	H COSTS		Component	CCN: 15-T112	From 01/01/2020 To 12/31/2020		pared: 20 am
			Ti tl	e XIX	Subprovi der - I RF		
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7) 9.00	10. 00	x col. 10) 11.00	12.00	x col. 12)	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13. 00	
50. 00	05000 OPERATING ROOM	0. 000000	7, 930		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	1, 343		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0,010		0 0	Ö	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	844		0 0	o o	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 148883	2, 735	4	07 0	Ō	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	0		0 0	0	
54.02	05404 ULTRA SOUND	0. 000000	2, 916		0 0	0	54. 02
54.03	05405 MAMMOGRAPHY	0. 000000	0		0 0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
57.00	05700 CT SCAN	0. 000000	11, 257		0 0	0	57.00
58.00	05800 MRI	0. 000000	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	62, 204		0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	1, 057		0 0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	139		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 000000	997		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	212, 334		0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	187, 797		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	95, 270		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 388		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0.000000	107.05(0.	0 0	0	72.00
73. 00 74. 00	07400 RENAL DI ALYSI S	0. 007469 0. 000000	107, 856 0	81	06 0 0	0	
76.00	03020 ACUPUNCTURE	0. 000000	0		0 0	0	
76. 00	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0		
70. 77	OUTPATIENT SERVICE COST CENTERS	0.000000			0 0	<u> </u>	70.77
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	o o	
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90. 01	09001 DI ABETES CENTER	0. 000000	0		0 0	Ō	
90. 02	09002 NEUROPSYCH	0. 000000	3, 921		0 0	Ō	90.02
90. 03	09003 WOUND CENTER	0. 000000	0		0 0	Ō	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	90.04
90.05	09005 VIMCARE CLINIC	0. 000000	0		0 0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	0		0 0	0	90.06
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
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Health Financial Systems	COLUMBUS REGIONAL HOSPI	TAL	In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi o	der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet D-1	
				Date/Time Prep 7/14/2021 10:2	oared: 20 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1 00	

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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44, 638, 573) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 20.00 30.00 30.00 30.00 31.00 0.00 32.	27. 00	, , ,	(line 21 minus line 26)		44, 638, 573	1
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27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,527.99 38.00 Program general inpatient routine service cost (line 9 x line 38) 15,661,898 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost di	fferential (line		1
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39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 15,661,898 39.00 40.00	38 00				1 527 00	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , ,				
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 15,661,898 41.00		, , ,	*			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		15, 661, 898	41.00

	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	44, 638, 573	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 527. 99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15, 661, 898	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 15, 661, 898	
40.00	1, , , , , , , , , , , , , , , , , , ,	- 1	
40.00	1, , , , , , , , , , , , , , , , , , ,	- 1	
40.00	1, , , , , , , , , , , , , , , , , , ,	- 1	
40.00	1, , , , , , , , , , , , , , , , , , ,	- 1	

Private CBL 15-011 Private (15-15-011 Private			COLUMBUS REGION		ON 45 0410		u of Form CMS-2	
Cost Control Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	UN: 15-0712	From 01/01/2020		
Title XVIII Blogated PPS						To 12/31/2020		
Page							PPS	
Cost		Cost Center Description						
			Cost	Days	÷ col . 2)		col. 4)	
Interest via Care Type Inpatient loop trail Unit 5.	42.00	NIIDSEDV (+i+le V & YI Y only)						12.00
44.00	42.00		<u> </u>		0.0	0		
Section Supplement Section Supplement Section Supplement Section Supplement Section Supplement Section			1					
47.00			· ·		l .		-	
Cost Center Description 1.00			O	0	0.0	0 0	0	1
1.00	47.00	. , , , , , , , , , , , , , , , , , , ,						47.00
49.00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 39,26,982 49.00 PASS THROUGH COST ADJUSTNEMTS 50.00 PASS through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and 2,026,957 50.00 1115 Pogram inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 1.00 1.		<u> </u>						
PASS THROUGH COST ADJUSTMENTS					one)			
1110 1110	49.00		41 (111 Ough 46) (see mstructri	0115)		37, 200, 702	49.00
1.00 Pass through costs applicable to Program Inpatient and Illary services (from Wkst. D. sum of Parts II and II.992, 842 51.00 and IProgram excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	50.00		atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	2, 026, 957	50.00
and IV) 17.00 17	51. 00		atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	1, 992, 842	51.00
Total Program Inpatient operating costs excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		and IV)		,				
medical education costs (line 49 minus line 52)				lated non-phy	vsician anest	netist and		1
54.00 Program discharges 0.64.00 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge 0.00 55.00 Target amount (line 54 x line 55) 0.00 55.00 Target amount (line 54 x line 55) 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00	00.00	medical education costs (line 49 minus line		ratea, non pri	ysi ci uii uiicst	icti st, una	00, 217, 100] 00.00
55.00 Target amount per discharge 0.00 55.00 50.00 50.00 Terget amount (line 54 x line 55) 0.50.00 50.00 Difference between adjusted inpatrient operating cost and target amount (line 56 minus line 53) 0.50.00 50.00	54.00						0	54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 61.00 lf line 53/54 is less than the lower of lines 55.59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 64.00 Wedicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Wedicare swing-bed SMF inpatient routine costs (line 64 plus line 65) (title XVIII only), For CAH (see instructions) (title XVIII only) 66.00 Total Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 67.00 Millowable december 31 of the cost reporting period (See instructions) (title XVIII only) 68.00 Millowable december 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Millowable V or XIX swing-bed NF inpatient routine costs (line 67 + line 28) 77.00 Millowable V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) 77.00 Millowable V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) 77.00 Millowable V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) 77.00 Millowable V or XIX swing-bed NF inpatient routine service							- 1	
58.00 Bonus payment (see instructions) 58.00 to be seed of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines \$3/54 or 55 from prior year cost report, updated by the market basket 60.01 Lines \$3/54 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 60.00 Relice payment (see instructions) 60.01 Allowable Inpatient cost plus incentive payment (see instructions) 60.02 Relice payment (see instructions) 60.03 No PROGRAM INPATIENT ROUTINE SWIN SEE OST 60.04 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (tilt le XVIII only) 60.05 Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 60.07 CAM (see instructions) 60.08 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 60.09 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Instructions) 60.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Instructions) 60.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 PART II - SKILLED NURSING FACILLITY. OTHER NURSING FACILLITY. And INCEPTIO DNIX 60.00 Program routine service cost (line 9 x line 71) 60.00 Program routine service cost (line 9 x line 71) 60.00 Program routine service cost (line 9 x line 71) 60.00 Program routine service cost (line 75 + line 2) 60.00 Program routine service cost per dien line 11 in 77) 60.00 Inpatient routine service costs								
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the another basket 0.00 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 61.00 If line 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.62.00 Relief payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.64.00 Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 0.65.00 Medicare swing-bed SMF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0.04 Kegicare swing-bed SMF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0.07 CAH (see instructions) 0.07 CAH (s								
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 for 1 ine 53/54 is less than the lower of lines 55/5 by or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions) Rel		O Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
1.1 10 10 15 15 15 15 15 1	60.00		cost report un	dated by the i	market hasket		0.00	60.00
amount (Ilne 56), otherwise enter zero (see instructions)		If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of			
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PROGRAM INPATIENT ROUTINE SWING BED COST	62.00		rnstructrons)				0	62.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see instructions) CAH (see instructions) O	63. 00		ent (see instru	ctions)			0	63.00
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70.00 71.00 72.00 73.00 74.00 75.00 75.00 76.00 76.00 77.00 77.00 77.00 77.00 78.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 70.00	69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
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83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2))				
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88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,527.99 88.00		PART IV - COMPUTATION OF OBSERVATION BED PAS:	S THROUGH COST				2.25	
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		,	•	•			· ·	1

Health Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATI	NG COST		Provi der CC		Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020		
			Title	XVIII	Hospi tal	PPS	
Cost Center Descript	i on	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line	column 2	Observati on	Bed Pass	
			21)		Bed Cost	Through Cost	
			·		(from line	(col. 3 x	
					89)	col. 4) (see	
						instructions)	
		1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION	I BED PASS THROUGH	COST					
90.00 Capital-related cost		5, 147, 133	44, 638, 573	0. 11530	7 4, 735, 241	546, 006	90.00
91.00 Nursing School cost		0	44, 638, 573	0.00000	0 4, 735, 241	0	91.00
92.00 Allied health cost		0	44, 638, 573	0.00000	0 4, 735, 241	0	92.00
93.00 All other Medical Education	on	0	44, 638, 573	0.00000	0 4, 735, 241	0	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112		Worksheet D-1
		From 01/01/2020	
	Component CCN: 15-T112	To 12/31/2020	Date/Time Prepared:
	·		7/14/2021 10:20 am
	Title XVIII	Subprovi der -	PPS
		I RF	

			I RF		
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 712	1.00
2.00	Inpatient days (including private room days, excluding swing-b			3, 712	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	s). It you have only pr	ivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation be	d days)		3, 712	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5.00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	3 / 3			
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 094	9. 00
7. 00	newborn days) (see instructions)	the regram (exercating	Jaming 200 and	2,07.	/ /
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	ions) Ly (including private r	com days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)	(gg		0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT	a through December 21 a	f the cost	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through becember 31 d	T the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			4, 779, 721	1
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5×1 ine 17)	r 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 reportin	a period (line 6	0	23. 00
	x line 18)]		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19)	1 of the cost reporting	poriod (line 0	0	25. 00
25.00	Swing-bed cost applicable to NF type services after December 3×1 ine 20)	Tot the cost reporting	perrou (Trie 6	U	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4, 779, 721	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had ab	argos)	0	28.00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	and observation bed ch	lar ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	4, 779, 721	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	CTMENTS			
20 00			ı	1 207 44	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 287. 64 2, 696, 318	
40.00	Medically necessary private room cost applicable to the Progra			2, 090, 310	40.00
	Total Program general inpatient routine service cost (line 39	,		2, 696, 318	ı
		•	'		

		COLUMBUS REGIO				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST				Peri od: From 01/01/2020		
			Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	pared: 20 am
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	O O		η	0 0		42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(1		0 0	1
45.00	BURN INTENSIVE CARE UNIT	O	(0.0	0 0	0	45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	(0.0	0 0	0	46. 00 47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 1, 594, 900	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		4, 291, 218	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	354, 158	50.00
51. 00		atient ancillar	rv services (f	rom Wkst. D. s	sum of Parts II	151, 265	51.00
	and IV)		,			·	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anestl	netist, and	505, 423 3, 785, 795	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	·	-			
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	•
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58. 00 59. 00							58. 00 59. 00
60. 00	market basket .00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00	1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)						0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
47.00	CAH (see instructions)					0	47.00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	1 December 31	or the cost re	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			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)		2 00313 (110	WOT ROTTED!	art II, corumi		
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 79. 00	Inpatient routine service cost (line 74 minu	s line 77)		do)			78. 00 79. 00
80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	arison to the d		•	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instruction	•				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					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) (se	•					88. 00 89. 00
U7. UU	Topservation bed cost (Time of X Time of) (Se	c matructions,	,			ı ⁰	1 09.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-0112	Peri od:	Worksheet D-1	
				From 01/01/2020		
		Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	
		Ti +Lo	XVIII	Subprovi der -	PPS	20 alli
		litte	AVIII		PF3	
Cook Cooker Dooreitstier	0+	D		I RF	0	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	627, 797	4, 779, 721	0. 13134	6 0	0	90.00
91.00 Nursing School cost	0	4, 779, 721	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 779, 721	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 779, 721	0. 00000	0 0	0	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet D-1	
			Date/Time Pre 7/14/2021 10:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

PART I - ALL PROVIDER COMPONENTS 1.00			Title XIX	Hospi tal	7/14/2021 10: PPS	<u> 20 am</u>
PART - ALL PROVIDER COMPONENTS		Cost Center Description				
INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 29, 214 1.00 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 29, 214 2.00 2.00 Private room days (excluding swing-bed and newborn days) 29, 214 2.00 20, 214 2.00 20, 20, 200 20, 200 20, 200 20, 200 20, 200 20, 200 20, 20, 200 20, 200 20, 200 20, 200 20, 200 20, 200 20, 20, 200 20, 200 20, 200 20, 200 20, 200 20, 200 20, 20, 200 20, 20, 200 20, 200 20, 200 20, 200 20, 200 20, 200 20, 20, 200 20, 200 20, 200 20, 200 20, 200 20, 200 20, 20, 200 2		DART I ALL DROWLDED COMPONENTS			1. 00	
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Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	1.00		s, excluding newborn)		29, 214	1.00
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (If calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 9.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 9.00 Total swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicard rate for swin						•
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9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 10.00 Nursery days (title V or XIX only) 10.00 Nursery days (title V or XIX only) 10.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 10.00 reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 10.00 reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 10.00 reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 10.00 reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 10.00 reporting period 10.00 Total general inpatient routine service cost (see instructions)	8.00		m days) after December 3	31 of the cost	0	8. 00
newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Swing-bed NF type inpatient of the Cost reporting period (if calendar year, enter 0 on this line) 19.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 10.10 Swing-bed NF type inpatient of the Cost reporting period (if calendar year, enter 0 on this line) 19.00 Nursery days (title V or XIX only) 10.00 Swing-bed NF services applicable to services through December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after December 31 of the cost 10.00 Swing-bed NF services applicable to services after	9 00		o the Program (excluding	swing_bed and	6 361	9 00
through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 20.00 Total general inpatient routine service cost (see instructions)	7. 00		o the rrogram (exeruaring	3 SWITING DEG GING	0, 304	7.00
11.00 Swing_bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 19.00 Total general inpatient routine service cost (see instructions)	10.00			room days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 19.00 Total general inpatient routine service cost (see instructions)	11 00			coom days) after	0	11 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 20.10 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 21.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 21.00 Total nursery days (title V or XIX only) 21.00 Nursery days (title V or XIX only) 21.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions)	11.00		3 \ 3 \	dom days) arter	O	11.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Total general inpatient routine service cost (see instructions) 44,638,573 21.00	12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 20.00 Total general inpatient routine service cost (see instructions)	40.00		V and C and B an art are			40.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) SWI NG BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 44,638,573 21.00	13.00				0	13.00
16.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Total general inpatient routine service cost (see instructions) 16.00 17.00 18.00 18.00 19.00 19.00 20.00 21.00 Total general inpatient routine service cost (see instructions)	14.00				0	14. 00
SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Total general inpatient routine service cost (see instructions) 44,638,573 21.00						
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Total general inpatient routine service cost (see instructions) 17.00 Total general inpatient routine services applicable to services through December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions)	16. 00				1, 138	16. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 18.00 Total general inpatient routine services applicable to services after December 31 of the cost reporting period 44,638,573 21.00	17 00		es through December 31 o	of the cost	0.00	17 00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 18.00 19.00 19.00 20.00	17.00		es till odgir becember 31 c	ine cost	0.00	17.00
19.00 Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 44,638,573 21.00	18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 20.00 44,638,573 21.00	10.00		a through Dacambar 21 of	: +ba aca+	0.00	10.00
20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 0.00 20.00 44,638,573 21.00	19.00		s through becember 31 of	the cost	0.00	19.00
21.00 Total general inpatient routine service cost (see instructions) 44,638,573 21.00	20.00		s after December 31 of t	he cost	0.00	20.00
	04.00	1			44 (00 570	04.00
22. 00 Swiring bed cost appricable to Swirtype services through becomber 51 or the cost reporting period (1114 - 0) 22.00				ing period (line		1
5 x line 17)	22.00		ci 31 di the cost report	ing period (ind	. 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	23.00		31 of the cost reportin	ng period (line 6	0	23. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	24.00		r 21 of the cost reporti	na naminal (lina	0	24.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)	24.00		i 31 of the cost reporti	ng perroa (irne	U	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00	25.00		31 of the cost reporting	period (line 8	0	25.00
x line 20)	0, 00	,				
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 44,638,573 27.00		,	(line 21 minus line 26)			1
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	27.00		(Tric 21 minds Tric 20)		44, 030, 373	27.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00	28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)		
29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00						
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0 30.00 0.000000 31.00			÷ line 28)			
32.00 Average private room per diem charge (line 29 ÷ line 3)		,	- 111le 20 <i>)</i>			1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00						1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00			, ,	ctions)		1
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 35.00 36.00		, , ,	ne 31)			1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 44,638,573 37.00		,	and private room cost di	fferential (line		1
27 minus line 36)	200	i e				
PART II - HOSPITAL AND SUBPROVIDERS ONLY			UOTHENTO.			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,527.99 38.00	38 00			I	1 527 00	38 00
39.00 Program general inpatient routine service cost per diem (see instructions) 1,527.99 38.00 9,724,128 39.00 9,724,128 39.00		, , , , , , , , , , , , , , , , , , , ,	•			•
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 9,724,128 41.00	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		9, 724, 128	41.00

36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	44, 638, 573	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 527. 99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9, 724, 128	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	9, 724, 128	41.00

		COLUMBUS REGIO		ON. 15 O110		u of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der Co	1	Period: From 01/01/2020		
					Го 12/31/2020	Date/Time Pre 7/14/2021 10:	
	Cook Cooker December 1	Takal		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 1, 970, 112	2.00	3. 00 656. 0	4. 00 5 1, 138	5. 00 746, 585	42.00
42.00	Intensive Care Type Inpatient Hospital Units	1, 970, 112	3,003	050.0	1, 130	740, 363	42.00
43.00	INTENSIVE CARE UNIT	7, 519, 244	3, 186				
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	0				44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT	o o	0				46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					6, 816, 721	48. 00
49. 00	<u> </u>	41 through 48)(see instruction	ons)		17, 872, 736	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D. sun	of Parts I and	1, 230, 587	50.00
			•				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (fi	rom Wkst. D, s	um of Parts II	628, 792	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				1, 859, 379	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anesth	etist, and	16, 013, 357	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	ı
57. 00	Difference between adjusted inpatient operat	ing cost and ta	irget amount (I	line 56 minus	line 53)	0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, i	updated and co	mpounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the r	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		.S (TITIES 54 X	60), Of 1% Of	the target		
	Relief payment (see instructions)	•				0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the (rost reporting	neriod (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line (65)(title XVII	I only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	a costs after [December 31 of	the cost reno	rting period		68.00
00.00	(line 13 x line 20)	e costs arter t	recember 51 of	the cost repo	itting period	į	00.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ı (line 14 x li	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73))			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from \	Norksheet B, F	art II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der record	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the o			us 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 (* .				83.00
84.00	Program inpatient ancillary services (see in						84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	,					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	· line 2)			3, 099 1, 527. 99	1
	Observation bed cost (line 87 x line 88) (se	•				4, 735, 241	1
					!	'	

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: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 147, 133	44, 638, 573	0. 11530	7 4, 735, 241	546, 006	90.00
91.00 Nursing School cost	0	44, 638, 573	0.00000	0 4, 735, 241	0	91.00
92.00 Allied health cost	0	44, 638, 573	0.00000	0 4, 735, 241	0	92.00
93.00 All other Medical Education	0	44, 638, 573	0.00000	0 4, 735, 241	0	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-T112	To 12/31/2020	Date/Time Prepared: 7/14/2021 10:20 am
	Title XIX	Subprovi der -	
		IRF	

		I RF		
	Cost Center Description		1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days,		3, 712	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		3, 712 0	2. 00 3. 00
3.00	do not complete this line.). It you have only private room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)	3, 712	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December 31 of the cost	0	5.00
, 00	reporting period	(a) (b) (c) (c) (c) (d) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d		
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember 31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December 31 of the cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding swing-hed and	484	9. 00
7. 00	newborn days) (see instructions)	the Frogram (exertaining swring bed and	404	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private room days)	0	10.00
44 00	through December 31 of the cost reporting period (see instructi			44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		0	12. 00
	through December 31 of the cost reporting period	, y (, , , , , , , , , , , , , , , , ,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX		0	13.00
14 00	after December 31 of the cost reporting period (if calendar year		0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed days)	_	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			16.00
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of the cost	0.00	18. 00
	reporting period		0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost	0.00	20. 00
20.00	reporting period	arter becomber of or the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)		4, 779, 721	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost reporting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting period (line 6	0	23. 00
	x line 18)	, , , , ,		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	or the cost reporting perrou (irrie o	· ·	20.00
	Total swing-bed cost (see instructions)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)	4, 779, 721	27. 00
28 00	General inpatient routine service charges (excluding swing-bed	and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	g/	0	
30. 00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)	0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00 0. 00	
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost differential (line	4, 779, 721	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see i		1, 287. 64	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 3	•	623, 218	
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,	0 623, 218	
41.00	Trotal Trogiam general impatrent routine service cost (ITHE 39 +	11110 40 <i>j</i>	023, 210	41.00

		COLUMBUS REGIO		011 45 55		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0112	Peri od: From 01/01/2020		
			Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	pared: 20 am_
			Ti tl	e XIX	Subprovi der - I RF		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		(col. 3 x col. 4)	
42.00	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	j oj		η	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		1		0 0	1
45.00	BURN INTENSIVE CARE UNIT	0	C	0.0	00	0	45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	С	0.0	00 0	0	46. 00 47. 00
	Cost Center Description				-	1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 321, 737	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		944, 955	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	81, 859	50.00
51. 00	<pre> </pre>	atient ancilla	rv services (f	rom Wkst. D.	sum of Parts II	1, 213	51.00
	and IV)		,				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	83, 072 861, 883	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)		-			
	Program di scharges					0	
55. 00 56. 00						0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996,	updated and c	ompounded by the	0.00	
60. 00	market basket	cost roport u	adated by the	markat haskat		0.00	60.00
61.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% o	f the target		
62.00	Relief payment (see instructions)	,				0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instri	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65.00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
47.00	CAH (see instructions)				•	0	67. 00
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	1 December 31	or the cost r	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	line 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Prograr	•				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 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	orovider recor	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the o		•	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction	•				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 th					86. 00
87. 00	Total observation bed days (see instructions)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•					88. 00 89. 00
_ /. 00	(30) (30) (30)		•			'	,

Health Financial Systems	COLUMBUS REGIO	ONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0112	Peri od:	Worksheet D-1	
		Component	CCN: 15-T112	From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Subprovi der -		
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	C	0	0. 00000	00	0	90.00
91.00 Nursing School cost		0	0.00000	00	0	91.00
92.00 Allied health cost		0	0. 00000	00	0	92.00
93.00 All other Medical Education	C	0	0. 00000	00 0	0	93. 00

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

INPAILE	NI ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0112	Period: From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/14/2021 10:	
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
_	03000 ADULTS & PEDIATRICS			20, 041, 310		30.00
	03100 INTENSIVE CARE UNIT			4, 769, 842		31.00
32.00 0	03200 CORONARY CARE UNIT			0		32.00
33.00 0	3300 BURN INTENSIVE CARE UNIT			0		33.00
	3400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER – I RF			0		41.00
	04200 SUBPROVI DER 04300 NURSERY			0		42. 00 43. 00
	NCI LLARY SERVI CE COST CENTERS		1			43.00
	05000 OPERATING ROOM		0. 3424	71 8, 315, 084	2, 847, 675	50.00
	D5100 RECOVERY ROOM		0. 3009		213, 981	51.00
	D5200 DELIVERY ROOM & LABOR ROOM		0.0000			52.00
1	05300 ANESTHESI OLOGY		0. 0171!		28, 838	1
1	15400 RADI OLOGY-DI AGNOSTI C 15402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 78972 0. 23933		514, 806 129, 182	1
	15404 ULTRA SOUND		0. 2393.		98, 475	1
	05405 MAMMOGRAPHY		0. 41078		0	1
	05500 RADI OLOGY-THERAPEUTI C		0. 3144		59, 121	1
	05700 CT SCAN		0. 0769		365, 506	1
	05800 MRI		0. 1194!		78, 992	58. 00
	05900 CARDI AC CATHETERI ZATI ON		0. 1662			1
1	06000 LABORATORY		0. 2564			1
	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2512 0. 2878		67, 914 251, 674	1
1	06500 RESPI RATORY THERAPY		0. 50578		1, 360, 598	1
	06600 PHYSI CAL THERAPY		0. 4885			66.00
	06700 OCCUPATI ONAL THERAPY		0. 4627		1	1
68.00 0	06800 SPEECH PATHOLOGY		0. 66559	97 91, 579	60, 955	68.00
1	06900 ELECTROCARDI OLOGY		0. 1946		365, 280	1
1	77000 ELECTROENCEPHALOGRAPHY		0. 2867		25, 053	1
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4582		1	1
	17200 IMPL. DEV. CHARGED TO PATIENTS 17300 DRUGS CHARGED TO PATIENTS		0. 5528° 0. 3451°		1, 874, 471 4, 309, 425	
	17300 BROGS CHARGED TO FATTENTS		0. 3431		1	1
	03020 ACUPUNCTURE		0. 00000		0	76.00
76. 97 0	07697 CARDI AC REHABI LI TATI ON		0. 65710	3, 780	2, 484	76. 97
	UTPATIENT SERVICE COST CENTERS					
1	08800 RURAL HEALTH CLINIC		0.0000		0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000 0. 58528		0	
	19001 DI ABETES CENTER		1. 8399			1
1	19001 DI ABETES GENTER 19002 NEUROPSYCH		1. 02374		l .	1
	19903 WOUND CENTER		0. 25000		59, 566	1
	99004 HYPERBARI C OXYGEN THERAPY		0. 4874		0	1
	19005 VIMCARE CLINIC		1. 6338		l	1
	19006 MEDICATION MGMT CLINIC		0. 62642		934	1
	19100 EMERGENCY		0. 21060			1
	19200 OBSERVATION BEDS (NON-DISTINCT PART ITHER REIMBURSABLE COST CENTERS		0. 3756	92 0	0	92.00
_	19500 AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			71, 979, 550	21, 447, 602	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)		1	71, 979, 550		202. 00

Health Financial Systems COLUMBUS REGION INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0112	Peri od:	u of Form CMS-: Worksheet D-3	
THE ATTENT AND LEARLY SERVICE COST ATTORTION WENT			From 01/01/2020		
	Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	
	Title	e XVIII	Subprovi der – I RF	PPS	
Cost Center Description	'	Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x	
			chai ges	col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS		T	0		30.00
31. 00 03100 NTENSI VE CARE UNI T				l	31.00
32. 00 03200 CORONARY CARE UNIT			Ö	l	32.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF			4, 144, 230		40.00
12. 00 04200 SUBPROVI DER			0		42.0
13. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		1			ļ
0.00 05000 OPERATING ROOM 1.00 05100 RECOVERY ROOM		0. 3424 0. 3009		20, 729 3, 820	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 0000		1	1
33. 00 05300 ANESTHESI OLOGY		0. 0171		232	•
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 7897			•
4. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2393		1, 475	•
64. 02 05404 ULTRA SOUND 64. 03 05405 MAMMOGRAPHY		0. 2032 0. 4107		5, 694 0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 3144		0	•
57. 00 05700 CT SCAN		0.0769		4, 807	
8. 00 05800 MRI		0. 1194		1, 811	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY		0. 1662 0. 2564		0 95, 282	1
io. 00 06000 LABORATORY io. 01 06001 LABORATORY-PATHOLOGI CAL		0. 2512			
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2878			
5. 00 06500 RESPIRATORY THERAPY		0. 5057			
6. 00 06600 PHYSI CAL THERAPY		0. 4885			
7. 00 O6700 OCCUPATIONAL THERAPY 8. 00 O6800 SPEECH PATHOLOGY		0. 4627 0. 6655			1
9. 00 06900 ELECTROCARDI OLOGY		0. 1946			1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2867		223	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4582			1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 5528 0. 3451			
4. 00 07400 RENAL DI ALYSI S		0. 3431			
6. 00 03020 ACUPUNCTURE		0.0000		l	1
6. 97 O7697 CARDI AC REHABI LI TATI ON		0. 6571	04 210	138	76. 9
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0] 88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLI NI C		0. 5852	87 0	0	90.00
O. 01 O9001 DI ABETES CENTER		1. 8399		1	
0. 02 09002 NEUROPSYCH 0. 03 09003 WOUND CENTER		1. 0237 0. 2500		0	
O. 03 09003 WOUND CENTER O. 04 09004 HYPERBARI C OXYGEN THERAPY		0. 2500			
0. 05 09005 VI MCARE CLI NI C		1. 6338			1
0.06 09006 MEDICATION MGMT CLINIC		0. 6264		0	
01. 00 09100 EMERGENCY		0. 2106			
2. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 3756	92 0	0	92.0
5. 00 09500 AMBULANCE SERVICES		I			95.0
00.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 771, 109	1, 594, 900	

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

Net charges (line 200 minus line 201)

202.00

1, 594, 900 200. 00 201. 00

3, 771, 109

3, 771, 109

200. 00 201. 00

202.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0112	Period: Worksheet D-3

T INI 74TI	ENT ANOTEEART SERVICE GOST ALTORITORIMENT	Trovider 6	ON. 13 0112	From 01/01/2020 To 12/31/2020		nared:
					7/14/2021 10:	20 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs (col. 1 x	
				Charges	col. 2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			14, 403, 447		30.00
31. 00	03100 I NTENSI VE CARE UNI T			2, 240, 372		31.00
32.00	03200 CORONARY CARE UNIT			0	1	32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT			0		34.00
41. 00	O4000 SUBPROVI DER			103	•	40. 00 41. 00
42. 00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY			1, 795, 878		43.00
	ANCILLARY SERVICE COST CENTERS			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
50.00	05000 OPERATING ROOM		0. 34247	2, 916, 267	998, 737	50.00
51.00	05100 RECOVERY ROOM		0. 30094		77, 247	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53.00	05300 ANESTHESI OLOGY		0. 01715			1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 78972			54.00
54. 01 54. 02	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND		0. 23933 0. 20329			1
54. 02	05404 ULTRA SOUND 05405 MAMMOGRAPHY		0. 20329	· ·	30, 649 0	54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 31444			55.00
57. 00	05700 CT SCAN		0. 07695			
58. 00	05800 MRI		0. 11945			1
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 16628			
60.00	06000 LABORATORY		0. 25646	3, 236, 473	830, 049	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL		0. 25124	4 85, 119	21, 386	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 28788			62.00
65. 00	06500 RESPI RATORY THERAPY		0. 50578			65.00
66. 00	06600 PHYSI CAL THERAPY		0. 48856			1
67.00	06700 OCCUPATIONAL THERAPY		0. 46273			1
68. 00	06800 SPEECH PATHOLOGY		0. 66559			1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0. 19465 0. 28677		90, 583 7, 576	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4582	· ·		1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 55289			1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 34519			1
74.00	07400 RENAL DI ALYSI S		0. 31329			
76.00	03020 ACUPUNCTURE		0.00000	00	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 65710	1, 050	690	76. 97
	OUTPATIENT SERVICE COST CENTERS		T		T	
88. 00	08800 RURAL HEALTH CLINIC		0.00000			88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			89.00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES CENTER		0. 58528 1. 83995			90. 00 90. 01
	09002 NEUROPSYCH		1. 02374			
	09003 WOUND CENTER		0. 25000			
90. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 48749		0	1
90. 05	09005 VI MCARE CLI NI C		1. 63381			
90.06	09006 MEDICATION MGMT CLINIC		0. 62642		0	90.06
91. 00	09100 EMERGENCY		0. 21060		628, 498	1
92. 00			0. 37569	02 0	0	92.00
0=	OTHER REIMBURSABLE COST CENTERS					
95.00				22 242 271	/ 04/ 701	95.00
200.00		(line (1)		23, 242, 874	6, 816, 721	
201. 00 202. 00		(TITIE 61)		23, 242, 874		201. 00 202. 00
202.00	p proceedings (Time 200 millios Time 201)		ı	23, 242, 074	I	202.00

	Financial Systems COLUMBUS REGI		CON. 1E 0112		u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CCN: 15-0112	Period: From 01/01/2020	Worksheet D-3	5
		Component	CCN: 15-T112	To 12/31/2020	Date/Time Pre 7/14/2021 10:	parec
		Ti t	le XIX	Subprovi der -	7, 14, 2021 10.	ZU all
	Cost Center Description		Ratio of Cos	IRF st Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
0. 00	03000 ADULTS & PEDIATRICS			0		30.
1. 00	03100 INTENSIVE CARE UNIT			0		31.
2. 00	03200 CORONARY CARE UNIT			0		32.
3. 00	03300 BURN INTENSIVE CARE UNIT			0		33.
4. 00	03400 SURGICAL INTENSIVE CARE UNIT			0		34.
0.00	04000 SUBPROVI DER - I PF			0		40.
1.00	O4100 SUBPROVI DER			913, 194		41.
2. 00 3. 00	04300 NURSERY			0		42. 43.
3. 00	ANCI LLARY SERVI CE COST CENTERS			0		43.
0. 00	05000 OPERATING ROOM		0. 3424	71 7, 930	2, 716	50.
1.00	05100 RECOVERY ROOM		0. 3009		404	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52.
3. 00	05300 ANESTHESI OLOGY		0. 0171		14	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 7897			
4. 01	05402 NUCLEAR MEDI CINE-DI AGNOSTI C		0. 2393		0	
4. 02 4. 03	05404 ULTRA SOUND 05405 MAMMOGRAPHY		0. 2032 0. 4107		593 0	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 4107		0	
7. 00	05700 CT SCAN		0. 0769		866	
3. 00	05800 MRI		0. 1194			1
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1662		0	59.
0. 00	06000 LABORATORY		0. 2564	67 62, 204	15, 953	60.
0. 01	06001 LABORATORY-PATHOLOGI CAL		0. 2512		266	
2. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2878			
5.00	06500 RESPI RATORY THERAPY		0. 5057		504	
5. 00 7. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 4885 0. 4627		103, 738 86, 900	
3. 00	06800 SPEECH PATHOLOGY		0. 4627		63, 411	68.
9. 00	06900 ELECTROCARDI OLOGY		0. 1946	· ·	03, 411	1
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 2867		ő	70.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4582			
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5528	90 0	0	
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3451			1
4.00	07400 RENAL DIALYSIS		0. 3132			
6. 00 6. 97	03020 ACUPUNCTURE		0.0000			
0. 9/	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 6571	04 0	0	76.
8. 00	08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.
9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
0. 00	09000 CLI NI C		0. 5852		0	
0. 01	09001 DI ABETES CENTER		1. 8399		_	
\sim	00003 NELIDOBSVCH		1 0227	40 2 021	1 014	l on

1.023740

0. 250000

0. 487492

1.633817

0.626429

0. 210603

0. 375692

4,014

0

704, 988

704, 988

0

0

0

0

0

0

321, 737 200. 00

90.02

90. 03 90. 04

90.05

90. 06 91. 00

92.00

95.00

201.00

202.00

90. 02 09002 NEUROPSYCH

90.04

90.05

90.06

91.00

92.00

200.00

201.00

202.00

90. 03 09003 WOUND CENTER

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09005 VIMCARE CLINIC

09004 HYPERBARI C OXYGEN THERAPY

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

Net charges (line 200 minus line 201)

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

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

09006 MEDICATION MGMT CLINIC

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 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/14/2021 10:20 am

			10 12/31/2020	7/14/2021 10:	
		Title XVIII	Hospi tal	PPS	
	DADT A LABATIENT HOODITAL CEDWINE UNDER LDDC			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring	prior to October 1 (see	20, 258, 444	1.00
	instructions)	•			
1. 02	DRG amounts other than outlier payments for discharges occurring	on or after October	1 (see	9, 937, 155	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCL for	discharges occurring	nrior to October	0	1. 03
1.00	1 (see instructions)	di schai ges occui i i ng	prior to october	O	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	s)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (se	•		402, 356	2.03
2.04	Outlier payments for discharges occurring on or after October 1			115, 612	2. 04
3.00	Managed Care Simulated Payments			9, 189, 464	3.00
4.00	Bed days available divided by number of days in the cost reporti	ng period (see instru	ctions)	220. 53	4. 00
F 00	Indirect Medical Education Adjustment			0.00	F 00
5. 00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	ecent cost reporting	period ending on	0. 00	5. 00
6.00	FTE count for allopathic and osteopathic programs that meet the	criteria for an add-c	n to the cap for	0.00	6.00
7.00	new programs in accordance with 42 CFR 413.79(e)	10.050.0110.105(6)	(4) (1) (5) (4)	0.00	7 00
7.00	MMA Section 422 reduction amount to the IME cap as specified und			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	CFR 9412. 105(1)(1)(1	V)(B)(2) II the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi	c and osteonathic pro	arams for	0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).	-, (-, (, -,,, -, -, -, -, -, -, -, -, -, -, -,	- (
8. 01	The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slots	from a closed teachi	ng hospi tal	0. 00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8 8 01 and 8 02) (see	0. 00	9. 00
7. 00	instructions)	(0) 0) 0. 4.14 0) 02)		0.00	7.00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.			0. 00	11.00
12.00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.				13.00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,	0. 00	14. 00
45.00	otherwise enter zero.			0.00	45.00
	Sum of lines 12 through 14 divided by 3.				15.00
16.00	Adjustment for residents in initial years of the program	_			16.00
	Adjustment for residents displaced by program or hospital closur	e			17.00
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00000	18.00
	Prior year resident to bed ratio (the 18 divided by time 4).			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
21.00	IME payment adjustment (see instructions)			0.000000	22.00
	IME payment adjustment - Managed Care (see instructions)			0	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 or	f the MMA		Ü	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident		FR 412. 105	0. 00	23.00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the low	er of line 23 or line	24 (see	0.00	25. 00
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	28.00
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
20.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ont days (soo instrus	tions)	4 04	20.00
30. 00 31. 00	, , ,	ent days (see instruc	LI UIIS)	4. 94	
31.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			23. 99 28. 93	
32.00	Allowable disproportionate share percentage (see instructions)			28. 93 13. 08	
	Disproportionate share adjustment (see instructions)			987, 396	
54.00	prisproportionate share aujustilient (see mistructions)		l	701, 390	34.00

	Fire and all Grand and a second a second and	I HOODITAL	1 . 12 .	. C. E OHC. (2552 40
	Financial Systems COLUMBUS REGIONA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2020 To 12/31/2020	Part A	nared:
				7/14/2021 10:	
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2. 00	
	Uncompensated Care Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 350, 599, 096 0. 000405768	8, 290, 014, 521 0. 000246488	
35. 01	, , , , , , , , , , , , , , , , , , ,	er zero on this line) (s		2, 043, 392	
05.00	instructions)		0.504.477	-1- 01-	05.00
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount of the uncompensated care (sum of columns 1 and 2 on line 35.0		2, 536, 677 3, 051, 724	515, 047	35. 03 36. 00
30.00	Additional payment for high percentage of ESRD beneficiary di				30.00
40. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6	684 and 685. (see	0		40. 00
41. 00	instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683 684 an 685 (see	0		41.00
00	instructions)	000, 001 an 000. (000			111.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652, 682, 683, 68	4 0		41. 01
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not quali	ifv for adiustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68				43.00
44. 00	instructions) Ratio of average length of stay to one week (line 43 divided	by Line 41 divided by 7	0. 000000		44. 00
44.00	days)	by Time 41 divided by 7	0.000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 47 Subtotal (see instructions)	1. 01)	0 34, 752, 687		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)	·			
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		34, 752, 687	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I am)	2, 555, 076	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	51. 00 52. 00
53. 00	Nursing and Allied Health Managed Care payment	,	,	116, 958	
54.00	Special add-on payments for new technologies			809	1
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (69)		0	54. 01 55. 00
56. 00	Cost of physicians' services in a teaching hospital (see into	ructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D. Pt. I		through 35).	100 207	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, COL. II TITIE 200)		190, 297 37, 615, 827	
60.00	Primary payer payments			47, 882	60.00
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		37, 567, 945	
63.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			3, 036, 044 20, 768	1
64.00	Allowable bad debts (see instructions)			326, 532	64.00
65.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		212, 246	
66. 00 67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ti ucti ons)		155, 815 34, 723, 379	1
68. 00	Credits received from manufacturers for replaced devices for			3, 725	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	ns)	0	1
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70. 00 70. 50
70. 87	Demonstration payment adjustment amount before sequestration	, ,	/	0	70. 87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70. 88 70. 89
70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	ti ucti ulis <i>j</i>		0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92 70. 93	Bundled Model 1 discount amount (see instructions)			0 -12, 678	70. 92 70. 93
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-12, 676 -3, 977	
70. 95	Recovery of accelerated depreciation				70. 95

leal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL		In Lie	of Form CMS-	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre	
		Ti +Lo	XVIII	Hospi tal	7/14/2021 10: PPS	20 am
		11116		(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 90
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 9
	the corresponding federal year for the period ending on or af					
0. 98	Low Volume Payment-3	,			0	70.9
0. 99	HAC adjustment amount (see instructions)				365, 931	70.9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			34, 337, 068	71.0
1. 01	Sequestration adjustment (see instructions)				226, 625	71.0
1. 02	Demonstration payment adjustment amount after sequestration				0	71.0
1. 03	Sequestration adjustment-PARHM pass-throughs					71.0
2.00	Interim payments				33, 437, 903	72.0
2. 01	Interim payments-PARHM					72.0
3. 00	Tentative settlement (for contractor use only)				0	73. C
3. 01	Tentative settlement-PARHM (for contractor use only)					73.0
4. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			672, 540	74. C
	73)					
4. 01	Balance due provider/program-PARHM (see instructions)					74.0
5.00	Protested amounts (nonallowable cost report items) in accorda	ince with			1, 095, 763	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					4
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.0
	plus 2.04 (see instructions)				_	
1. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
2. 00	1 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
4. 00	The rate used to calculate the time value of money (see instr				0.00	
5.00					0	
6.00	Time value of money for capital related expenses (see instruc	ctions)		Dust aux 45 10 /1	0 (15)	96.0
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
nn nr	HSP bonus amount (see instructions)			O	0	100.0
00. 00	HVBP Adjustment for HSP Bonus Payment			U U		1100.0
01 00	HVBP adjustment factor (see instructions)			1. 0005262539	0. 9980916793	101 0
	HVBP adjustment amount for HSP bonus payment (see instruction	ie)		1.0003202337		102.0
02.00	HRR Adjustment for HSP Bonus Payment	15)		U	0	1102.0
us uc	HRR adjustment factor (see instructions)			0. 9985	1. 0000	103 0
	HRR adjustment amount for HSP bonus payment (see instructions	:)		0. 4465		104.0
J 1. UC	Rural Community Hospital Demonstration Project (§410A Demonst		ıstment	<u> </u>		1.5 7.0
20 00	Is this the first year of the current 5-year demonstration pe					200. C
JJ. 00	Century Cures Act? Enter "Y" for yes or "N" for no.	oa anacı	2131			
	Cost Reimbursement					1
01. 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ne 49)				201. 0
	Medicare discharges (see instructions)	,				202.0
	Case-mix adjustment factor (see instructions)			1		203.0

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0	From 01/01/2020	Worksheet E Part B Date/Time Prepared: 7/14/2021 10:20 am

MART B. MEDITAL AND OTHER DEATH SERVICES 1.00			Title XVIII	Hospi tal	7/14/2021 10: PPS	20 am_
Medical and other services (sea instructions)				inespi cai		
Medical and other services (see instructions) 33,824 1,00		DADT D MEDICAL AND OTHER HEALTH SERVICES			1. 00	
	1 00				33 824	1 00
20.00 Depth payments 22, 314, Aut 3.00 Depth payment (see Instructions) 2.00 Depth payment (see Inst		,	s)			
0.011 Control Contro			,			
Internation	4.00	Outlier payment (see instructions)			270, 069	4.00
Line 2 times Time 5 0 6.00		,				
			ns)			
Transit final carridor payent (see Instructions)						
Ancil Hary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 461,407 9,00 10.00						
10.00 Organ acquisitions 33.82 11.00 Total cost (sum of lines 1 and 10) (see instructions) 33.82 11.00 Total cost (sum of lines 1 and 10) (see instructions) 33.82 11.00 12.00 12.00 12.00 13.00		, , , , , , , , , , , , , , , , , , , ,	col. 13, line 200			
COMPUTATION OF LESSER OF COST OR CHARGES	10.00				0	10.00
Reasonable charges 102.98 102.98 12.00 Ancil lary service charges 102.98 12.00 Ancil lary service charges 102.98 12.00 Ancil lary service charges 102.98 12.00 13.	11. 00				33, 824	11.00
12.00 Ancillary service charges 12.00 12.00 10.01 10.00 10.00 10.00 10.00 10.01 10.00						
13.00 Organ acquisition charges (from Wist. D-4, Pt. III. col. 4, line 69) 0.2,396 14.00 102,396 14.00 102,396 14.00 102,396 14.00 102,396 14.00 102,396 14.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0.15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0.15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0.15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0.15.00 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0.15.00 15.00	12 00				102 206	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 102,396 14.00 15.00			49)			1
Customary_charges			37)			
16.00 Amount's that would have been real ized from patients liable for payment for services on a chargebasl s had souch payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.000 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 17.000 18.00 18.00 17.000 18.00 18					·	
had such payment been made in accordance with 42 CFR §413.13(e)					0	
17.00 Ratio of Line 15 to line 16 (not to exceed 1.000000) 17.00 10.000000 17.00 17.00 17.00 18.00 17.00 17.00 17.00 17.00 18.00 17.00 17.00 17.00 17.00 18.00 17.00 1	16. 00		yment for services o	on a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 102, 396 18.00 100 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of crassonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of crassonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20.00	17 00				0.00000	17 00
19.00 Excess of customary charges over reasonable cost (complete only if file 18 exceeds line 11) (see 68.572 19.00						
instructions		,	fline 18 exceeds li	ne 11) (see		
instructions				, ,		
1.00 Lesser of cost or charges (see Instructions) 0.22.00	20. 00		fline 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00	21 00				22 024	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 27,066,116 24,00 25,00 26,		,				1
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 27,066,116 24,00		· · · · · · · · · · · · · · · · · · ·	i ons)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 25.00 26.00 2			. 6.16)			
26. 00 Deductibles and Coinsurance amounts relating to amount on line 24 (For CAH, see instructions) 2.00						
27. 00 Subtotal ([lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see 22,085,417 27.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 28.00 29.00 28.00 29.00						
Instructions						
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 0.28.00 0.00 29.0	27.00	- · · · · · · · · · · · · · · · · · · ·	the sum of lines 22	and 23] (see	22, 085, 417	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 20.0	28 00		50)		0	28 00
31.00 Subtotal (line 30 minus line 31) 22.081.197 32.00 32.0						
Subtotai (ine 30 minus line 31) 22,081,197 32.00	30.00	Subtotal (sum of lines 27 through 29)			22, 085, 417	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 33.00 0 0 0 0 0 0 0 0 0						
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 565,673 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 367,687 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 323,285 36.00 37.00 38.00 Subtotal (see instructions) 22.448,884 37.00 38.00 MSP-LCC reconciliation amount from PS&R 36 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.9	32. 00				22, 081, 197	32.00
34.00	33 00	,			0	33 00
35.00						
37.00 Subtotal (see instructions) 22, 448, 884 37.00 38.00 MSP-LCC reconciliation amount from PS&R 36 38.00 39.00 39.50 39.00 39.50 39.00 39.50 39.90 39.50 39.90 39.50 39.90 39.50 39.90					· ·	
38. 00 MSP-LCC reconciliation amount from PS&R 36 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 39. 50 39. 50 39. 50 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. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 98 22. 448, 848 40. 00 40. 01 Sequestration adjustment (see instructions) 148, 162 40. 01 40. 02 40. 03	36.00	Allowable bad debts for dual eligible beneficiaries (see instructi	i ons)		323, 285	36.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 91.000 39.50 91.0000 39.50 91.0000 39.50 91.0000 39.50 91.0000 39.50 91.0000 39.97 91.0000 39.98 92.00 93.99 92.00 93.00						
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39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 8 7 7 7 7 7 7 7 7					0	
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40. 01 Sequestration adjustment (see instructions) 148, 162 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 22, 259, 017 41. 00 41. 01 Interim payments-PARHM 41. 00 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 41, 669 43. 00 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, splits. 2 401, 157 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00	39. 99	RECOVERY OF ACCELERATED DEPRECIATION		•	0	39. 99
40. 02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Interim payments-PARHM 1 Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 401, 157 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 10 40. 02 40. 03 41. 00 42. 01 41. 01 42. 01 42. 01 43. 00 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 401, 157 44. 00 90. 00 91. 00 91. 00 92. 00 The rate used to calculate the Time Value of Money 10 90. 00 91. 00 92. 00 Time Value of Money (see instructions) 10 90. 00 93. 00						1
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1.01 Interim payments-PARHM		, ,			22 259 017	
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43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 401, 157 44.00 \$\frac{115.2}{5115.2}\$ 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 The rate used to calculate the Time Value of Money 92.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{401, 157}}{\text{515. 2}}\$ 44.00 \\ \text{9115. 2} \\ \text{TO BE COMPLETED BY CONTRACTOR} \\ 90.00 \\ \text{Original outlier amount (see instructions)} \\ 0 \\ \text{00 Utlier reconciliation adjustment amount (see instructions)} \\ 0 \\ \text{91.00} \\ \text{70 BE COMPLETED BY CONTRACTOR} \\ 0 \\ \text{00 Item and outlier amount (see instructions)} \\ 0 \\ 0 \\ 0 \\ \text{01 The rate used to calculate the Time Value of Money} \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\		, , , , , , , , , , , , , , , , , , , ,			41, 669	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00			with CMC Date 45 C	obonton 1	404 457	1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00	44.00		WITH CIVIS PUB. 15-2,	chapter I,	401, 157	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 93.00	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00	91.00	Outlier reconciliation adjustment amount (see instructions)				91.00
		l				1
94. 00 Total (Suiii of Titles 91 and 93)						
	74. UU	Tiotai (Suiii Oi Tities 71 aliu 73)			0	74. UU

| Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0112

Title XVIII					10 12/31/2020	7/14/2021 10:	
March Marc			Title	XVIII	Hospi tal		20 4111
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 3.00 1.00 2.00 3.00 4.00 3.437,90 3.437,90 2.2,259,017 1.00 2.00 1.00 1.00 2.00 3.437,90 2.2,259,017 1.00 2.00 3.437,90 3.437,90 3.437,90 3.437,90 3.00			Inpatier	it Part A	Par	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 3.00 1.00 2.00 3.00 4.00 3.437,90 3.437,90 2.2,259,017 1.00 2.00 1.00 1.00 2.00 3.437,90 2.2,259,017 1.00 2.00 3.437,90 3.437,90 3.437,90 3.437,90 3.00			//	A	/- - /	A	
1.00							
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 Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered in the cost reporting period. If none, write "NONE" or enter a zero Services rendered by a services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Services reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program Services reporting period. Also show date of each payment. Services reporting period. Services report. Servi	1 00	Total intorim nayments haid to provider	1.00				1 00
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							2.00
Services rendered in the cost reporting period. If none, write "MONE" or enter a zero.	2.00				1		2.00
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							
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 ADUSTMENTS TO PROVIDER ADUSTMENTS TO PROVIDER ADUSTMENTS TO PROVIDER BOOK ON		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3. 00						3.00
payment If none, write "NONE" or enter a zero. (1)							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 3.5 0 0 0 0 3.5 0 0 0 0 0 0 0 0 0	2 01				1		2 01
3.03 3.04 0 0 0 3.		ADJUSTIMENTS TO PROVIDER				-	
20							3. 02
Solid Soli	3. 04						3.04
ADJUSTMENTS TO PROGRAM	3. 05					-	
3.51		Provider to Program	•	•	<u>'</u>	•	ĺ
Social	3. 50	ADJUSTMENTS TO PROGRAM		()	0	3.50
3.54 0	3. 51						3. 51
3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98	3. 52					-	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						-	
Total interim payments (sum of lines 1, 2, and 3.99) 33, 437, 903 22, 259, 017 4.0	3. 99			()	0	3.99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00	,		33 437 903		22 259 017	4 00
appropriate 10 BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	4.00			33, 437, 700		22, 237, 017	7.00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 0 0 5.0 0 0 0 0 5.0 0 0 0 0 0 0 0							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 0 5.0 0 0 5.0 0 0 0 5.0 0 0 0 5.0 0 0 0	5. 00						5.00
Program to Provider TENTATIVE TO PROVIDER 0		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
TENTATI VE TO PROVIDER							ļ
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Solid		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATIVE TO PROGRAM	0.00	Provider to Program			1		0.00
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.02 Determined net settlement amount (balance due) based on the cost report. (1) Subtraction of the cost report. (1) Sub	5. 50			(0	5.50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 672,540 41,669 6.0 6.02 SETTLEMENT TO PROGRAM 0 0 22,300,686 7.0 7.00 Total Medicare program liability (see instructions) 34,110,443 22,300,686 7.0 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 51					0	5. 51
5. 50-5. 98) Determined net settlement amount (balance due) based on the cost report. (1) 5. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 52					0	5. 52
Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER 672,540 41,669 6.0 6.00 SETTLEMENT TO PROGRAM 0 0 0 6.0 0 6.0 0 0 0 0 0 0 0 0 0	5. 99			(0	5. 99
the cost report. (1) 5.01 SETTLEMENT TO PROVIDER 5.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number Number (Mo/Day/Yr) 0 1.00 2.00		1					
S.O.1 SETTLEMENT TO PROVIDER 672,540 41,669 6.00	6. 00						6.00
0 0 0 0 0 0 0 0 0 0	4 01			470 540		41 440	4 01
7.00 Total Medicare program liability (see instructions) 34,110,443 22,300,686 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		1		6/2,540			
Contractor Number Number (Mo/Day/Yr) 0 1.00 2.00				34 110 443	á		
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Tiotal modicale program reasonity (see instructions)		34, 110, 443			7.00
0 1.00 2.00							
)			
	8. 00	Name of Contractor					8.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provider CCN: 15-0112 Component CCN: 15-T112	From 01/01/2020	
•				

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 359, 30		0	1.00
2.00	Interim payments payable on individual bills, either		(O	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 3. 02	ADJUSTMENTS TO PROVIDER				0	3. 01 3. 02
3. 02						3. 02
3. 04				0		3. 04
3. 05				Ö	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM)	0	3.50
3. 51				O	0	3. 51
3. 52)	0	3.52
3. 53 3. 54					0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 54 3. 99
5. 77	3. 50-3. 98)		`		0	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 359, 30	6	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				'	
5. 01	TENTATI VE TO PROVI DER			O	0	5.01
5. 02				O	0	5.02
5. 03	Described to Describe			O	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		,		0	5. 50
5. 51	TENTATI VE TO PROGRAW			0	0	5. 51
5. 52				Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
<i>(</i> 01	the cost report. (1) SETTLEMENT TO PROVIDER		FF 07		o	/ O1
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		55, 970)		6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)		4, 415, 27	6		7. 00
7.00	1.111. man said program readility (300 more agree)		., 110, 27	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			1		8. 00

Heal th	Financial Systems COLUMBUS REGIONA	L HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0112	Peri od:	Worksheet E-	I
			From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	enared.
			10 12/01/2020	7/14/2021 10:	
	<u> </u>	Title XVIII	Hospi tal	PPS	
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COCT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1			-
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		0.14		1.00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		E 14		2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	5-12			3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	<u> </u>			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of o	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 l	ine 31) (see instruction	ns)		32.00

Heal th	Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet E-3	
		Component CCN: 15-T11			pared: 20 am
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3, 997, 428	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instru	uctions)		0. 0494	2.00
3.00	Inpatient Rehabilitation LIP Payments (see in	nstructions)		215, 461	3.00
	1 - 1 - 1			1	

	1.00	
PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00 Net Federal PPS Payment (see instructions)	3, 997, 428	1.00
2.00 Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0494	2.00
3.00 Inpatient Rehabilitation LIP Payments (see instructions)	215, 461	3.00
4.00 Outlier Payments	268, 107	4.00
5.00 Unweighted intern and resident FTE count in the most recent cost reporting period endir	ng on or prior 0.00	5.00
to November 15, 2004 (see instructions)		
5.01 Cap increases for the unweighted intern and resident FTE count for residents that were coprogram or hospital closure, that would not be counted without a temporary cap adjustment		5. 01
CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions)	0.00	4 00
	od of a "new 0.00	7.00
teaching program" (see instructions)	0.00	
8.00 Current year's unweighted I&R FTE count for residents within the new program growth peri	od of a "new 0.00	8.00
teaching program" (see instructions)	0.00	
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	
10.00 Average Daily Census (see instructions)	10. 142077	1
11.00 Teaching Adjustment Factor (see instructions)	0.000000	
12.00 Teaching Adjustment (see instructions)	0	
13.00 Total PPS Payment (see instructions)	4, 480, 996	1
14.00 Nursing and Allied Health Managed Care payments (see instruction)	0	
15.00 Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00 Cost of physicians' services in a teaching hospital (see instructions)	0	
17.00 Subtotal (see instructions)	4, 480, 996	
18.00 Primary payer payments	0	
19.00 Subtotal (line 17 less line 18).	4, 480, 996	19.00
20. 00 Deducti bl es	15, 400	20.00
21.00 Subtotal (line 19 minus line 20)	4, 465, 596	21.00
22. 00 Coi nsurance	30, 932	22.00
23.00 Subtotal (line 21 minus line 22)	4, 434, 664	23.00
24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)	2, 816	24.00
25.00 Adjusted reimbursable bad debts (see instructions)	1, 830	25.00
26.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	2, 816	26.00
27.00 Subtotal (sum of lines 23 and 25)	4, 436, 494	27.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49)	l	1
29.00 Other pass through costs (see instructions)	8, 116	29.00
30.00 Outlier payments reconciliation		
31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		
31.50 Pioneer ACO demonstration payment adjustment (see instructions)		
31.99 Demonstration payment adjustment amount before sequestration		
32.00 Total amount payable to the provider (see instructions)	4, 444, 610	
32.01 Sequestration adjustment (see instructions)	29, 334	
32.02 Demonstration payment adjustment amount after sequestration	27, 334	
33.00 Interim payments	4, 359, 306	
34. 00 Tentative settlement (for contractor use only)	4, 337, 300	1
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	55, 970	
		1
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, cha	apter 1, 22, 411	36.00
§115. 2		1
TO BE COMPLETED BY CONTRACTOR	2/0 107	F0 00
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4	268, 107	
51.00 Outlier reconciliation adjustment amount (see instructions)	0 00	
52.00 The rate used to calculate the Time Value of Money	•	52.00
53.00 Time Value of Money (see instructions)	l o	53.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	From 01/01/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/14/2021 10:20 am
	T: +1 - VIV	Hanni Ani	DDC

		'	0 12/31/2020	7/14/2021 10:	
		Title XIX	Hospi tal	PPS	
	·		Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			20, 165, 958	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	20, 165, 958	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpati ent pri mary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		o	20, 165, 958	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		'		
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		23, 242, 874	67, 592, 368	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		23, 242, 874	67, 592, 368	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable fo	1 3	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15.00
16.00	Total customary charges (see instructions)		23, 242, 874	67, 592, 368	16.00
17. 00	Excess of customary charges over reasonable cost (complete on	Ty if line 16 exceeds	23, 242, 874	47, 426, 410	17. 00
10 00	line 4) (see instructions)	ly if lime 4 avecade lime	0	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete on	Ty IT Time 4 exceeds Time	١	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		0		21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		٦	20, 103, 430	21.00
22. 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
23. 00	Outlier payments		Ö	0	23. 00
24. 00	Program capital payments			· ·	24.00
25. 00	Capital exception payments (see instructions)		o o		25. 00
26. 00	Routine and Ancillary service other pass through costs		57, 644	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		57, 644	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		57, 644	20, 165, 958	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		2.75.1		
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	57, 644	20, 165, 958	31.00
32.00	Deducti bl es		o	0	32.00
33.00	Coinsurance		o	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	57, 644	20, 165, 958	36.00
37.00	TO ZERO OUT MEDICALD		-57, 644	-20, 165, 958	37.00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41. 00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				l

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2020	Worksheet E-3
	Component CCN: 15-T112		
	Title XIX	Subprovi der -	
		IDE	

		C AIA	IRF		
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR T	TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		704, 988	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		704, 988	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services of	on a charge	0	0	13.00
	basi s				
14.00	Amounts that would have been realized from patients liable for payment for	or services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.	13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		704, 988	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 1	16 exceeds	704, 988	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if line 4	4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed f	for PPS provid			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		0	0	1
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
32.00				0	
	Coinsurance		0	0	
35.00	Allowable bad debts (see instructions)		-	U	35.00
36.00	Utilization review Subtatal (sum of lines 21, 24 and 25 minus sum of lines 22 and 22)		0	0	1
37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) TO ZERO OUT MEDICALD		0	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		o	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS	S Pub 15-2	o	0	1
.5. 55	chapter 1, §115.2			O	.5. 55
	1		1		

Health Financial Systems

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

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/14/2021 10: 20 am

oni y)				1270172020	7/14/2021 10:	20 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	63, 987, 313	0	0	0	1.00
2.00	Temporary investments	205, 344	0	0	0	2.00
3.00	Notes receivable	0		0	0	3.00
4. 00	Accounts recei vable	65, 159, 417	1 1	0	0	4.00
5.00	Other receivable	1, 493, 061	1 1	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable		1 1	0	0	6. 00 7. 00
7. 00 8. 00	Inventory Prepai d expenses	5, 146, 033 4, 791, 676	1 1	0	0	8.00
9. 00	Other current assets	2, 337, 183	1 1	0	0	9.00
10. 00	Due from other funds	2,007,100	ő	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	115, 608, 889	1	0	0	11.00
	FIXED ASSETS					
12.00	Land	1, 979, 352		0	0	
13.00	Land improvements	21, 020, 698	1 1	0	0	13.00
14.00	Accumulated depreciation	-12, 781, 806	1 1	0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	209, 670, 998 -146, 316, 121	1 1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	140, 310, 121	0	0	0	17.00
18. 00	Accumulated depreciation		Ö	0	0	18.00
19.00	Fi xed equipment	9, 579, 495	0	0	0	19.00
20.00	Accumulated depreciation	-8, 098, 184	0	0	0	20.00
21. 00	Automobiles and trucks	1, 989, 986	0	0	0	21.00
22. 00	Accumulated depreciation	-1, 622, 673	1 1	0	0	22. 00
23. 00	Major movable equipment	168, 877, 699		0	0	23.00
24. 00	Accumulated depreciation	-113, 259, 391	1	0	0	24.00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation		0	0	0	25. 00 26. 00
27. 00	HIT designated Assets		0	0	0	27.00
28. 00	Accumulated depreciation		Ö	0	Ö	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	131, 040, 053	0	0	0	30. 00
	OTHER ASSETS					
31.00	Investments	185, 118, 809	1 1	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	7, 654, 044	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	192, 772, 853	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	439, 421, 795	1 1	ő	0	36.00
	CURRENT LIABILITIES			- 1		
37. 00	Accounts payable	12, 643, 222		0	0	37.00
38. 00	Salaries, wages, and fees payable	9, 906, 906	1	0	0	38. 00
39. 00	Payroll taxes payable	2, 647, 692		0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	7, 185, 000	0	0	0	40.00
41.00	Accel erated payments	12, 186, 276		U	0	41. 00 42. 00
43. 00	Due to other funds	12, 100, 270	0	0	0	43.00
	Other current liabilities	7, 253, 772		ő	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	51, 822, 868		0	0	45.00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	35, 485, 000	1 1	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	272, 955	1 1	0	0	48. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	21, 946, 267 57, 704, 222	1 1	0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	109, 527, 090	1 1	0	0	51.00
01.00	CAPITAL ACCOUNTS	107,027,070	<u> </u>		0	01.00
52.00	General fund balance	329, 894, 705				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	_	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	329, 894, 705	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	439, 421, 795	1 1	ő	0	60.00
	59)					

STATEMENT OF CHANGES IN FUND BALANCES

EQUITY TRANSFERS TO WHOLLY OWNED SUB

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

12. 00 13. 00

14.00

15.00

16.00

17.00

18.00

Provi der CCN: 15-0112

0

0

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0

0

Peri od: Worksheet G-1 From 01/01/2020 To 12/31/2020 Date/Time Prep

12.00

13.00

14.00

15.00

16. 00 17. 00

18.00

19.00

Date/Time Prepared: 7/14/2021 10: 20 am General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3.00 4.00 5.00 1.00 Fund balances at beginning of period 316, 219, 255 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 57, 024, 370 2.00 2.00 Total (sum of line 1 and line 2) 3.00 373, 243, 625 ol 3.00 4.00 NURSING HOME CONTRIBUTIONS 7, 691, 498 4.00 0 5.00 0 5.00 0 6.00 0 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 7, 691, 498 0 10.00 Subtotal (line 3 plus line 10) 380, 935, 123 0 11.00 11.00 EQUITY TRANSFERS TO WHOLLY OWNED SUB 12.00 51, 040, 418 0 0 12.00 13.00 0 0 13.00 14.00 0 0 0 14.00 15.00 0 15.00 0 16.00 0 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 51, 040, 418 18.00 0 Fund balance at end of period per balance 19.00 329, 894, 705 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 Total (sum of line 1 and line 2) 3.00 NURSING HOME CONTRIBUTIONS 4.00 0 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00

0

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

			0 12/31/2020	Date/IIme Pre 7/14/2021 10:	
	Cost Center Description	I npati ent	Outpati ent	Total	20 (311)
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	65, 374, 236		65, 374, 236	1.00
2.00	SUBPROVI DER - I PF			0	2.00
3.00	SUBPROVI DER - I RF	7, 394, 817	1	7, 394, 817	3.00
4.00	SUBPROVI DER		I I	0	4.00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF		i i	0	6.00
7.00	SKILLED NURSING FACILITY			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)	72, 769, 053		72, 769, 053	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	15, 050, 245		15, 050, 245	11.00
12.00	CORONARY CARE UNIT			0	12.00
13.00	BURN INTENSIVE CARE UNIT	C		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT			0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	15, 050, 245		15, 050, 245	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	87, 819, 298		87, 819, 298	17.00
18.00	Ancillary services	156, 046, 207	362, 205, 790	518, 251, 997	18.00
19.00	Outpati ent servi ces	19, 691, 867	52, 959, 102	72, 650, 969	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	5, 776	12, 423, 931	12, 429, 707	23.00
24.00	CMHC				24.00
24. 10	CORF		0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27. 00	LEVEL II NURSERY	2, 861, 947	I I	2, 861, 947	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	it. 266, 425, 095	427, 588, 823	694, 013, 918	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		277, 335, 947		29. 00
30.00	PROVISION FOR BAD DEBT	3, 978, 427	I I		30.00
31.00		(31.00
32. 00					32.00
33.00		(33.00
34.00					34.00
35.00	T-1-1 - 11111 (C 11 00 05)	(1		35.00
36.00	Total additions (sum of lines 30-35)		3, 978, 427		36.00
37. 00	DEDUCT (SPECIFY)				37.00
38.00					38.00
39.00					39.00
40.00					40.00
41. 00 42. 00	Total deductions (sum of lines 37-41)				41. 00 42. 00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	cfor	281, 314, 374		42.00
43.00	to Wkst. G-3, line 4)	121 41	201, 314, 3/4		43.00
	10 mkst. 0-3, 11110 4)	I	1		

Hoal +h	Financial Systems	COLUMBUS REGIONAL	HOSDI TAI	In Lio	u of Form CMS-2	0552 10
	IENT OF REVENUES AND EXPENSES	COLUMBUS KLUTONAL	Provi der CCN: 15-0112	Peri od:	Worksheet G-3	
SIAIL	ILINI OF REVENUES AND EXPENSES		Trovider cciv. 13-0112	From 01/01/2020	WOLKSHEET 0-3	
					Date/Time Pre	
					7/14/2021 10:	20 am
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part	t L column 3 lin	e 28)		694, 013, 918	1.00
2. 00	Less contractual allowances and discounts or				401, 062, 861	1
3. 00	Net patient revenues (line 1 minus line 2)				292, 951, 057	3.00
4.00	Less total operating expenses (from Wkst. G-	-2, Part II, line	43)		281, 314, 374	4.00
5.00	Net income from service to patients (line 3		•		11, 636, 683	5.00
	OTHER I NCOME	,				
6.00	Contributions, donations, bequests, etc				610, 376	6.00
7.00	Income from investments				11, 517, 185	7.00
8.00	Revenues from telephone and other miscellane	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				58, 674	10.00
11.00	Rebates and refunds of expenses				105, 828	11.00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	ests			589, 636	14.00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical su		han patients		0	16. 00
17.00	Revenue from sale of drugs to other than pat				34, 325	17. 00
18.00	Revenue from sale of medical records and abs					18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,				25, 348	
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				139, 711	22. 00
23.00	Governmental appropriations				730, 402	23.00
24.00	UNREALIZED INVESTMENT INCOME				16, 129, 249	24.00
24. 01	JV I NCOME				87, 753	24. 01
24. 02	WELNESS REVENUE				585, 055	
24. 03	CRHP REVENUE				4, 038, 993	24. 03
24.04	OTHER OPERATING REVENUE				472, 453	
24. 50	COVI D-19 PHE Funding				10, 501, 585	
24. 51	FEMA GRANT FUNDING				552, 836	24. 51
24. 52	IGAIN ON INVESTMENT INCOME				204.051	24.52

204, 051

733, 791 27. 01

998, 922 28. 00 57, 024, 370 29. 00

46, 386, 609 58, 023, 292 265, 131 24.52

25. 00 26. 00 27. 00

GAIN ON INVESTMENT INCOME

27. 01 OTHER NON-OPERATING EXPENSES

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 LOSS ON DISPOSAL

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

	51 1 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			6.5. 010.6	
	Financial Systems COLUMBUS REGIONA ATION OF CAPITAL PAYMENT	Provider CCN: 15-0112	Peri od: From 01/01/2020 To 12/31/2020		pared:
	Hospi tal	PPS			
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT			2, 330, 481	1 00
1. 00 1. 01					1. 00 1. 01
2. 00	Capital DRG outlier payments			0 83, 834	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			03, 034	2.00
3. 00	Total inpatient days divided by number of days in the cost re	eporting period (see ins	tructions)	80. 06	3.00
4.00	Number of interns & residents (see instructions)		ĺ	0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0. 00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A p	natient days (Worksheet	F part A line	4. 94	7. 00
	30) (see instructions)		_,		
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		23. 99	8. 00
9.00	Sum of lines 7 and 8			28. 93	
10.00	Allowable disproportionate share percentage (see instructions	5)		6. 04	
11.00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)			140, 761 2, 555, 076	11. 00 12. 00
12.00	Total prospective capital payments (see mistructions)			2, 333, 076	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2. 00 3. 00
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary		x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)	,	,	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to o			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over o	capital payment (from pr	ior year	0	11.00
40.00	Worksheet L, Part III, line 14)				40.00
12.00				0	12. 00 13. 00
14. 00	3.00 Current year exception payment (if line 12 is positive, enter the amount on this line)				14.00
14.00	.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 0 14.00 (if line 12 is negative, enter the amount on this line)				14.00
15. 00		structions)		0	15. 00
	Current year operating and capital costs (see instructions)			0	16.00
17.00	Current year exception offset amount (see instructions)			0	17. 00