payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0112 Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/77/2020 10: 46 am

			/	72172020 TO. 40 alli
PART I - COST	REPORT STATUS			
Provi der use onl y	 [X] Electronically prepared cost report [] Manually prepared cost report [0] If this is an amended report enter the number [F] Medicare Utilization. Enter "F" for full or " 		Date: 7/27/2020 esubmitted this cos	
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	or this Provider CCN 12.[

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (15-0112) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	95, 423	-63, 025	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-86, 378	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	O	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	9, 045	-63, 025	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 In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/24/2020 4:05 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2400 EAST 17TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: COLUMBUS Zip Code: 47201-County: BARTHOLOMEW 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COLUMBUS REGIONAL 150112 18020 07/01/1966 Ν 0 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF COLUMBUS REGIONAL REHAB 15T112 18020 5 01/01/1984 Ν Р Ν 5.00 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital - Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 8 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas

23.00

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

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

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

yes or "N" for no.

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/24/2020 4:05 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 1, 378 685 5, 091 125 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 0 35 0 0 211 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Υ 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46,00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 57.00 57.00 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.

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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.

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	CN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 7/24/2020 4:0	pared:
				NAHE 413.8 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colulf line 60 is yes, complete columns 2 and 3 for each instructions)	85? (s umn 1. :R) NAHE ımn 2.	ee If column 1 MA payment	Y	N 23. 01	1	60. 0
0. 02	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 02	1	60. 0
	i fisti deti olis)	Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	N			0.00	0.00	61. 0
1. 02	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.0
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.0
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
1. 05	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
1. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. C
		Pro	gram Name	Program Cod	le Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1 10	06 the FTF- in Line (1 0F		1. 00	2. 00	3.00	4.00	(1.
1. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61. 1
1. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				O. OC	0.00	61. 2
						1. 00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructors the number of FTE residents that restand from	tions)					62.0
2. U I	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s	<u>ee instructio</u>		.o your nospital	0.00	62.0
2 00	Has your facility trained residents in nonprovider se			ost reporting	neriod2 Enter	N	63. (

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

Health Financial Systems	COLUMBUS	S REGIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA Provider CO		eriod: com 01/01/2019 0 12/31/2019	Worksheet S-2 Part I Date/Time Prep 7/24/2020 4:0	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00	0. 00		65 OO
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	0.000000 Ratio (col. 1/	65.00
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current	Year FTF Residents in	n Nonprovider Setting				
beginning on or after July 1, 20		3			3 1 1 1	
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te			
	1.00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program			0.00	0. 00	0. 000000	67. 00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

	"Y" for yes and "N" for no.			
	TEFRA Provi ders	<u>'</u>		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o	r "N" for no.	N	85. 00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			86. 00
	§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section		N	87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			
		V	XI X	
		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	N	Υ	90. 00
04 00	yes or "N" for no in the applicable column.			04.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	N	91. 00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see	+	N	92. 00
72.00	instructions) Enter "Y" for yes or "N" for no in the applicable column.		IV	72.00
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93. 00
70.00	"Y" for yes or "N" for no in the applicable column.			70.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
	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	N	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
98. 00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	N	Υ	98. 00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in			
98. 01	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.	N	Υ	98. 01
98.01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	IN	Y	98.01
	title XIX.			
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	N	Υ	98. 02
70.02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1		·	70.02
	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)	N	N	98. 03
	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.			
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on	N	Υ	98. 05
98. 05	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	IN	Y	98.05
	column 2 for title XIX.			
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N	Υ	98. 06
70.00	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in		·	70.00
	column 2 for title XIX.			
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105. 00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		106. 00
40	for outpatient services? (see instructions)			
107. 00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R	N		107. 00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&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)			
	Eliter 1 for yes of 14 for the fit condition 2. (See Histractions)	ļ		1

ealth Financial Systems COLUMBUS REGIONA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL HOSPITAL Provider CO	CN: 15-0112 Pa	<u>In Liε</u> eriod:	Worksheet S-	
ISSTAND THE TIME THE ELL STAND COMMENT OF THE STAND COMMENTS OF TH	l rovi dei ox		rom 01/01/2019	Part I Date/Time Pr	epared
			V	7/24/2020 4: XIX	05 pm
			1. 00	2.00	
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108. 0
join Section 3412. 113(e). Enter 1 101 yes of N 101 110.	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2.00 N	3. 00 N	4. 00 N	109. (
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IV.	IN IN	IV.	IN IN	109.1
40.000			104	1.00	110
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes or	"N" for no. If	yes,	N	110.
			1. 00	2.00	
11.00 f this facility qualifies as a CAH, did it participate in th	ne Frontier Co	ommunity	1.00 N	2. 00	111.
Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting pumn 1 is Y, of ticipating in	period? Enter enter the column 2.	·		
		1. 00	2. 00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.	oeri od? "Y", enter e	N			112.
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	l N			0115.
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	or E only) 3" percent ncludes	14			0113.
16.00 s this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	Y			116.
17.00 s this facility legally-required to carry malpractice insura	ance? Enter	Υ			117.
"Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre	,	1			118.
IT the portey is craim-made. Litter 2 if the portey is occurre	ence.	Premi ums	Losses	Insurance	
10.01		1. 00	2.00	3.00	0110
18.01 List amounts of malpractice premiums and paid losses:		828, 010		J	0 118.
			1. 00	2.00	
8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			N		118.
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA N §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)				N	119 120
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implan	ntable devices	s charged to	Υ		121
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1			N		122
the Worksheet A line number where these taxes are included. Transplant Center Information					-
5.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent	ter the certi	fication date			126
in column 1 and termination date, if applicable, in column 2.					
		ication date			127
in column 1 and termination date, if applicable, in column 2.			1	1	128
in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, ente	er the certifi	ication date			1
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certifi				
28.00 If this is a Medicare certified liver transplant center, ente	er the certifi	cation date in			129

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE	COLUMBUS REGIO X IDENTIFICATION DATA	Provider CC	:N: 15-0112	Peri od:		u of Form CMS- Worksheet S-	
SOFT THE THIS HOST THE HEALTH STILL SOME EL	N TENTITION ON ENTITION	Trovider 66		From O	1/01/2019 2/31/2019	Part I Date/Time Pro 7/24/2020 4:0	epared
					1. 00	2.00	-
31.00 f this is a Medicare certified in			erti fi cati or		1. 00	2.00	131. (
date in column 1 and termination of 32.00 If this is a Medicare certified is in column 1 and termination date,	let transplant center, en	ter the certifi	cation date	•			132. 0
3.00 Removed and reserved							133.
4.00 If this is an organ procurement or and termination date, if applicabl All Providers		he OPO number i	n column 1				134.
0.00 Ner there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If	yes, and home	office cost	:s	Υ		140.
1.00	2. (00		<u> </u>	3. 00	l	
If this facility is part of a chai home office and enter the home off				name and	l address	of the	
11. 00 Name:	Contractor's Name:	COTTE ACTOL HUMBE		tor's Nu	mber:		141.
2.00 Street:	PO Box:		7: - 0	ı			142.
3. 00 Ci ty:	State:		Zi p Coo	e:			143.
						1.00	
4.00 Are provider based physicians' cos	ts included in Worksheet	A?				Y	144.
					1. 00	2.00	
5.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in Llude Medicare utilization	column 1. If o	column 1 is		Υ		145.
6.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the previo column 1. (See CMS Pub.			f	N		146.
						1.00	
7.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N N	147.
8.00 Was there a change in the order of						N	148.
9.00 Was there a change to the simplifi	ed cost finding method? E	Part A	Part B		itle V	N Title XIX	149.
		1. 00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "							
5. 00 Hospi tal	TO THE TOT CUCH COMPON	N N	N N		N N	N	155.
6.00 Subprovi der – IPF		N	N		N	N	156.
7. 00 Subprovi der - I RF 3. 00 SUBPROVI DER		N	N		N	N	157. 158.
9. 00 SNF		N	N		N	N	159.
O. OO HOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC 1. 10 CORF			N N		N N	N N	161. 161.
			•	\ 		1.00	
Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has on	e or more campu	ıses in diff	erent CB	SAs?	N	165.
	Name	County		ip Code	CBSA	FTE/Campus	
6.00 f ine 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5.00	0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						0.0	
column 5 (see instructions)						1.00	
Health Information Technology (HIT7.00 Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or "	N" for no.			Y	167.
8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	IIT assets (see instructio	ns)					168.
3.01 f this provider is a CAH and is nexception under §413.70(a)(6)(ii)?					sni p		168.
	ıser (line 167 is "Y") and						d169

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lieu	u of Form CN	/S-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 15-0112	Peri From To	od: n 01/01/2019 12/31/2019			ared:
			Ш,		7/24/2020		
				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)						1	170. 00
				1. 00	2.00		
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported o "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru	n Wkst. S-3, Pt. I, column 1 is yes, en	line 2, col. 6? Enter	on	N		0 1	171. 00

	ı Financial Systems	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II	epared:
		· · · ·	. '	Y/N	Date	J
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Described Organization and Operation	l for all NO re	sponses. Ente	r all dates in t	he	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			
			Y/N	Date	V/I	
2.00		22 1.6	1.00	2. 00	3. 00	2.00
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
	Trorationships. (See That detrons)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 00	Financial Data and Reports		1 7			4
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. 00
5.00	Are the cost report total expenses and total revenues diffe		Y			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.)/ /hl		
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		e provider is			6. 00
7. 00 8. 00						7. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00
					Y/N 1. 00	
	Bad Debts					
12. 00 13. 00				st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		Y t B	15. 00
		Y/N	Date	Y/N	Date	
	DCOD Data	1.00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	06/09/2020	Y	06/09/2020	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	06/09/2020	Y	06/09/2020	17. 00
18. 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
19. 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 information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems COLUMBUS REGI	ONAL HOSPITAL		In Lie	u of Form CN	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S Part II Date/Time F 7/24/2020	Prepared:
		Desc	ri pti on	Y/N	Y/N	
	I. a		0	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	MGD CARE PART DAYS	A DISCH & PT	Y	N	20. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	5		N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases enter	red into durino	g this cost re	eporting period?	N	24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	orting period?	Plf yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ting period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during th	ne cost reporti	ng period? If	fyes, submit	N	27. 00
	copy. Interest Expense	<u> </u>				
28. 00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	uring the cost	reporting	N	28. 00
29. 00						
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		v debt? If yes	s, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					
22.00	Purchased Services	umul aaa Eumal ah	and through on	ntrootuol	N	22.00
32. 00 33. 00	Have changes or new agreements occurred in patient care searrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 april 1 patient care searrangements with suppliers of services?	ructions.	-		IV.	32. 00 33. 00
	no, see instructions. Provider-Based Physicians			-		
34. 00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement wit	th provider-ba	sed physicians?	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended ex lphysicians during the cost reporting period? If yes, see i		ents with the	provi der-based	Y	35. 00
	phrysicians during the cost reporting period: in yes, see i	HSTI UCTI OHS.		Y/N	Date	
	lu 055			1. 00	2. 00	
27.00	Home Office Costs			***		2, 22
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	e home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	t from that of	-		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth			5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	•	,			40. 00
	instructions.	1				127 00
		1	1.00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CATHERI NE		SI MMONS		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COLUMBUS REGI	ONAL HOSPITAL	-		42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-376-5248		CSI MMONS@CRH. O	RG	43. 00
	1. Spo. 1 p. Spor of Tri Sor anni 1 and 2, Tespectivery.	ı		ı		II

Heal th	Financial Systems COLUM	MBUS REGION	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE	Provider CCN:	1	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						7/24/2020 4:0	5 pm
		1	3.00		-		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/posheld by the cost report preparer in columns 1, 2,		MANAGER ACCOUNTIN	G			41. 00
	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 the report preparer in columns 1 and 2, respectively.						43. 00

Heal th	Financial Systems COLUMBUS REG	GLONAL HOSPITAL		Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provider CCN: 15-0112	Period: From 01/01/2019 To 12/31/2019	Date/Time Pro 7/24/2020 4:0	epared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the I stepdown adjustments on W/S B, Part I, column 25? Enter N and Y/N in column 2 for Title XIX. (see S-2, Part I, line	//N in column 1 for Title V	N	Y	1.00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N			Y	2. 00
3.00	in column 2 for Title XIX. (see S-2, Part I, line 98.01) Do Title V or XIX follow Medicare (Title XVIII) for the column 1 for Title XIX. (see S-2, Part III) for Title XIX. (see S-2, Part IIII) for Research III for Title XIX. (see S-2, Part IIII) for Research III for Research IIII for Research III for Research I			Y	3. 00
3. 01	2 for Title XIX. (see S-2, Part I, line 98.02) 3.01 Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Areimbursed 101% of cost? Enter Y or N in column 1 for ing for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical reimbursed 101% of cost? Enter Y or N in column 1 for ing for outpatient. (see S-2, Part I, lines 98.03 and 98.04)			N	5. 00
	100 00 00 00 00 00 00 00 00 00 00 00 00		Title V	Title XIX	
			1, 00	2.00	
	RCE DI SALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Dicolumn 4? Enter Y/N in column 1 for Title V and Y/N in column 5-2, Part I, line 98.05) PASS THROUGH COST		N	Y	6. 00
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (pworksheets D, parts I through IV? Enter Y/N in column 1 f 2 for Title XIX. (see S-2, Part I, line 98.06)		N	Y	7. 00
8. 00	RHC Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Title V and Y/N in column 2 for Title XIX. FOHC	? Enter Y/N in column 1 for	N	N	8. 00
9. 00	For fiscal year beginning on/after 10/01/2014, use M-seri XIX? Enter Y/N in column 1 for Title V and Y/N in column		N	N	9. 00
			Sta	ate	
			1.	00	
	STATE MEDICALD FORMS				
10. 00	Select the state when using state Medicaid forms.				1 0.00

 Heal th Financial
 Systems
 COLUMBUS

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

						To	12/31/2019	Date/Time Prep	
								7/24/2020 4: 0! I/P Days / 0/P	3 PIII
								Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V	
	55p5.115112	Line Number		o. Bous	Avai I abl e		57 II. 1.0 GI O		
		1.00		2. 00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		140	51, 10	0	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3.00
4.00	HMO IRF Subprovider								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF							0	6. 00
7. 00	Total Adults and Peds. (exclude observation			140	51, 10	0	0. 00	0	7. 00
	beds) (see instructions)							_	
8. 00	I NTENSI VE CARE UNIT	31. 00		17			0.00	0	8. 00
9. 00	CORONARY CARE UNIT	32. 00	1	0		0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	1	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		4.5		_		0	13.00
14.00	Total (see instructions)			157	57, 30	5	0. 00	0	14.00
15.00	CAH visits	40.00		0				0	15. 00
16.00	SUBPROVIDER - I PF	40.00		0		0		0	16. 00 17. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	41. 00 42. 00	1	18 0		0		0	17.00
19. 00	SKILLED NURSING FACILITY	44. 00		0		0		0	19. 00
20. 00	NURSING FACILITY	44.00		U	'	٩		U	20. 00
21. 00	OTHER LONG TERM CARE								21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00						Ŭ,	23. 00
24. 00	HOSPI CE								24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC								25. 00
25. 10	CMHC - CORF	99. 10						0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00						0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27.00	Total (sum of lines 14-26)			175					27.00
28. 00	Observation Bed Days							0	28.00
29. 00	Ambul ance Tri ps								29.00
30.00	Employee discount days (see instruction)								30.00
31. 00	Employee discount days - IRF								31. 00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33. 00
33. 01	LTCH site neutral days and discharges		l		l		l		33. 01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2019	Part	
To 12/31/2019	Date/Time Prepared:	7/24/2020 4:05 pm

						7/24/2020 4:0	5 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 048	6, 071	24, 854			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)	4, 318	0				2. 00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	544	0	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	O			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	40.040	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	12, 048	6, 071	24, 854			7. 00
8. 00	beds) (see instructions)	705	154	3, 143			8. 00
	INTENSIVE CARE UNIT		154	3, 143 C			9.00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	U	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	U	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	۷	۷	U			12.00
12.00	NURSERY		1 054	2, 961			13.00
14. 00	Total (see instructions)	12, 753	1, 054 7, 279	30, 958		1, 317. 00	14.00
15. 00	CAH visits	12, 733	7, 279	30, 930		1, 317.00	15.00
16. 00	SUBPROVIDER - IPF	0	0	0		0.00	16.00
17. 00	SUBPROVI DER - I RF	2, 021	246	3, 601			
18. 00	SUBPROVI DER	2,021	240	3, 001			18.00
19. 00	SKILLED NURSING FACILITY	o	0				
20. 00	NURSING FACILITY	Ĭ	ĭ		0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	o	0	O	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	ı .	Ĭ		0.00	0.00	23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	o	o	C	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	o	o	C	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 339. 00	27. 00
28.00	Observation Bed Days		783	3, 912			28. 00
29.00	Ambul ance Tri ps	4, 044					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	0	C			32.00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

				''	J 12/31/201 9	7/24/2020 4:0	
		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		(3, 449	1, 650	8, 565	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)			1, 038	0		2. 00
3. 00	HMO I PF Subprovi der				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	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	(3, 449	1, 650	8, 565	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	(-	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	(1	22	284	17. 00
18. 00	SUBPROVI DER	0. 00	(P	0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days			0			33. 00
33.01	LTCH site neutral days and discharges			0			33. 01

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

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | Date/Time Prepared: | Prepared: |

						0 12/31/2019	7/24/2020 4:0	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	A-6) 3.00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
1 00	SALARI ES	200. 00	04 454 204	E/1 E02	0/ 002 722	2 712 204 00	21 72	1.00
1.00	Total salaries (see instructions)	200.00	86, 654, 304					
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00		
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0.00	3. 00
4.00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 1, 282, 995	0		0. 00 5, 746. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		200, 476	0	200, 476	4, 108. 00	48. 80	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8. 00
9.00	organization personnel	44. 00	0	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		5, 514, 192	867, 294	6, 381, 486	225, 432. 00	28. 31	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		13, 783, 078	0	13, 783, 078	281, 966. 00	48. 88	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		1, 252, 930	0	1, 252, 930	27, 429. 00	45. 68	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		5, 993, 826	О	5, 993, 826	37, 799. 00	158. 57	13. 00
14. 00	Home office and/or related organization salaries and		0	o	0	0.00	0.00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A - Administrative		0 3, 889, 369 0	0 0	3, 889, 369	0. 00 47, 536. 00 0. 00	81. 82	1
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see instructions)		24, 787, 310	0	24, 787, 310			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 007, 615 0	0	2, 007, 615 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		466, 700 0 0	0	466, 700 0 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		1, 305, 566	0	1, 305, 566			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							

					Ť	o 12/31/2019		
				5 1 16 11		5 1 1 11	7/24/2020 4:0	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col . 2 ± col .	Salaries in	col. 5)	
		1.00	2.00	A-6)	3) 4.00	col . 4	/ 00	
25. 53	Hama affi as. Dhyai ai ana Dant A	1. 00	2.00	3.00	4.00	5. 00	6. 00	25. 53
25. 53	Home office: Physicians Part A - Teaching - wage-related		U	U	0			25. 53
	(core)							
	OVERHEAD COSTS - DIRECT SALARII	<u> </u>						
26. 00	Employee Benefits Department	4.00	229, 658	-213, 319	16, 339	464.00	35. 21	26. 00
27. 00	Administrative & General	5. 00	15, 561, 397	385, 436				
28. 00	Administrative & General under	0.00	5, 316, 547	0	5, 316, 547	· ·		
	contract (see inst.)		2, 2, 2, 2, 1	_				
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	2, 592, 937	-11, 923	2, 581, 014	79, 647. 00	32. 41	30. 00
31.00	Laundry & Linen Service	8. 00	36, 374	0	36, 374	2, 098. 00	17. 34	31. 00
32.00	Housekeepi ng	9. 00	1, 830, 426	-7, 772	1, 822, 654	112, 915. 00	16. 14	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	2, 130, 231	-1, 338, 399	791, 832	43, 180. 00	18. 34	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 317, 474	1, 317, 474	72, 387. 00	18. 20	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	4, 549, 813	128, 559	4, 678, 372	105, 463. 00	44. 36	38. 00
39. 00	Central Services and Supply	14. 00	825	365	1, 190	29. 00	41. 03	39. 00
40.00	Pharmacy	15. 00	3, 479, 732	-378, 491	3, 101, 241	66, 447. 00	46. 67	40.00
41.00	Medical Records & Medical	16. 00	2, 100, 690	-1, 045, 710	1, 054, 980	34, 550. 00	30. 53	41.00
	Records Library							
42.00	Social Service	17. 00	569, 639	3, 840	573, 479	· ·		42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part III | To 12/31/2019 | Date/Time Prepared:

					''	0 12/31/2019	7/24/2020 4: 0	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		90, 487, 380	-561, 582	89, 925, 798	2, 771, 574. 00	32. 45	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 514, 192	867, 294	6, 381, 486	225, 432. 00	28. 31	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		84, 973, 188	-1, 428, 876	83, 544, 312	2, 546, 142. 00	32. 81	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		24, 919, 203	0	24, 919, 203	394, 730. 00	63. 13	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 092, 876	0	26, 092, 876	0.00	31. 23	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		135, 985, 267	-1, 428, 876	134, 556, 391	2, 940, 872. 00	45. 75	6. 00
7.00	Total overhead cost (see		38, 398, 269	-1, 159, 940	37, 238, 329	1, 062, 258. 00	35. 06	7. 00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-	0112

	To 12/31/2019	Date/Time Prep 7/24/2020 4:0	
		Amount	5 piii
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	3, 864, 300	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)		1
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		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	14, 773, 353	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	422, 100	
11. 00	Life Insurance (If employee is owner or beneficiary)	57, 108	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	1, 085, 607	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	678, 796	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumul ative portion)		
47.00	TAXES	5 004 070	47.00
17. 00	FICA-Employers Portion Only	5, 994, 272	•
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unemployment Insurance	27, 424	
20.00	State or Federal Unemployment Taxes	0	20. 00
04 00	OTHER		04.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	102, 487	22. 00
23. 00	Tuition Reimbursement	256, 178	
24. 00		27, 261, 625	
24.00	Part B - Other than Core Related Cost	21,201,023	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	Total more reported additionally	1	_ 20.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	Peri od: Worksheet S-3 From 01/01/2019 Part V To 12/31/2019 Date/Time Prepared:

		To 12/31/2019	Date/Time Prep 7/24/2020 4:0	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1. 00	Total facility's contract labor and benefit cost	13, 783, 078		
2. 00	Hospi tal	13, 783, 078	27, 261, 625	
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10. 00
11. 00	Hospi tal -Based HHA	0	0	11. 00
	Separately Certified ASC			12.00
	Hospi tal -Based Hospi ce			13.00
	Hospital-Based Health Clinic RHC	0	0	14. 00
	Hospital-Based Health Clinic FQHC	0	0	15. 00
	Hospi tal -Based-CMHC			16. 00
	Hospi tal -Based-CMHC 10	0	0	
	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18. 00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CON: 15-0112 Provider CON: 15-012 Provider CON: 15-0112 Provider CON: 15-012 Provider	Heal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
Incompensated and indigent care cost computation			Provider CCN: 15-0112	Peri od:			
					Date/Time Dre	nared:	
Incompensated and indigent care cost computation 0.34757 1.00				10 12/31/2017			
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.347577 1.00					1. 00		
Medicald (See Instructions for each Line) 10,455,663 2,00 2,00 Not revenue from Medicaid 10,455,663 2,00 10 d you receive DSH or supplemental payments from Medicaid? Y 3,00 10 d you receive DSH or supplemental payments from Medicaid? Y 3,00 17 line 4 is no, then enter DSH and/or supplemental payments from Medicaid 7,151,109 5,00 0.00		Uncompensated and indigent care cost computation					
Not revenue from Medicaid 10,455,862 20,	1.00	9 .	ided by line 202 colu	ımn 8)	0. 347577	1.00	
Did you receive DSH or supplemental payments from Medicaid? Y 3.00	2 00				10 455 0/2	2 00	
1							
			al navments from Medi	cai d?		1	
Modical d charges	5. 00		. 3	cara.		1	
17,693,074 8.00 17,693,074 8.00 2.20 2.20 2.00 17,693,074 8.00 2.2	6.00	1				1	
Standard	7.00	Medicaid cost (line 1 times line 6)			35, 300, 046		
Children's Health Insurance Program (CHIP) (see instructions for each line) 0 9.00	8. 00		line 7 minus sum of I	ines 2 and 5; if	17, 693, 074	8. 00	
Net revenue from stand-al one CHIP charges		<pre>< Zero then enter zero) Children's Health Insurance Program (CHID) (see instructions for</pre>	r oach line)			-	
10.00 Stand-al one CHIP cost (line 1 times line 10) 0 10.00 0 11.00 0 0 11.00 0 0 0 0 0 0 0 0 0	9 00		i each i i ne)		0	9 00	
11.00 Stand-alone CHIP cost (line 1 times line 10) 11.00 12.00 11.00 11.00 11.00 11.00 12.00 11.00 11.00 12.00 12.00 11.00 12.00	10.00				_		
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	11. 00						
Other state or local government indigent care program ((see instructions for each line) 13.00	12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9;	if < zero then	0	12. 00	
Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)				,			
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10 col 10) State or local indigent care program cost (line 1 times line 14) 0 15.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: LF < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Cost or patients, appropriations or transfers for support of hospital operations 10.00 Charlity care (see instructions for each line) 18.00 Uncompensated Care (see instructions for each line) 19.00 Charlity care charges and uninsured discounts for the entire facility (see instructions) 20.00 Charlity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5, 793, 810 4, 448, 598 10, 242, 408 11 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 22.00 charity care (cost of charity care (line 21 minus line 22) 5, 793, 810 4, 448, 598 10, 242, 408 23.00 cost of charity care (line 21 minus line 22) 5, 793, 810 4, 448, 598 10, 242, 408 23.00 cost of charity care (line 21 minus line 22) 5, 793, 810 4, 448, 598 10, 242, 408 23.00 cost of charity care (line 21 minus line 22) 5, 793, 810 4, 448, 598 10, 242, 408 23.00 cost of charity care (line 24 minus line 25) 6, 793, 810 4, 448, 598 10, 242, 408 23.00 cost of charity care bendenced by more discounts (see instructions) 702, 123 27, 02 cost of charity care bendenced by more discounts (see instructions) 11, 402, 403 27, 01 28.00 Non-Medicare bad debt expense (see instructions) 13, 348, 269 28.00 cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5, 260, 026 30.00 cost of uncompensated care (line 23 column 3 plus line 29) 15, 15, 260, 026	12 00				0	12 00	
10) 15.00 16.00 17.00 18						1	
15.00 State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; If < zero then enter zero) Grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care	11.00		program (Not Theraac	24 111 111103 0 01	· ·	11.00	
13: if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see Instructions for each line)	15.00	,)		0	15. 00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 18. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 18. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 18. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 19. 00 Total bad debt expense for the entire hospital complex (see instructions) 10. 00 Total bad debt expense for the entire hospital complex (see instructions) 10. 00 11. 00 12. 00 12. 00 12. 00 13. 00 14. 448, 598 10. 242, 408 10	16. 00		igent care program (I	ine 15 minus line	0	16. 00	
instructions for each line) Private grants, donations, or endowment income restricted to funding charity care (according to the patients) 17. 00 18. 00 19. 00 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines) 17. 693, 074 19. 00 19. 00 Uninsured patients patients patients + col 2 10. 00							
18. 00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrel mbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 17,693,074 19.00 19			P and State/Tocal The	ingent care program	is (see		
Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 17,693,074 19.00 8, 12 and 16) Uninsured patients patients 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5,793,810 4,448,598 10,242,408 21.00 cost of patients approved for charity care and uninsured discounts (see 5,793,810 4,448,598 10,242,408 21.00 cost of patients approved for charity care and uninsured discounts (see 5,793,810 4,448,598 10,242,408 23.00 cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 cost of charity care (line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit in composed on patients covered by Medicaid or other indigent care program's length of stay limit in composed on patients covered by Medicaid or other indigent care program's length of stay limit in composed on patients covered by Medicaid or other indigent care program's length of stay limit in composed on patients covered by Medicaid or other indigent care program's length of stay limit in composed to the entire hospital complex (see instructions) 14, 428, 459 26.00 702, 123 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 14, 428, 459 26.00 702, 123 27.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00 15, 260, 026 30.00	17. 00		9		0	1	
B, 12 and 16) Uninsured patients Datients Datie	18.00			(_		
Uninsured patients previously written off as patients	19.00		indigent care progra	ams (sum of lines	17, 693, 074	19.00	
Uncompensated Care (see instructions for each line) 20.00 Uncompensated Care (see instructions for each line) 20.00 Chari ty care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 14,428,459 26.00 27.00 Medicare allowable bad debts for the entire hospital complex (see instructions) 1,080,190 27.01 28.00 Non-Medicare bad debt expense (see instructions) 13,348,269 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad debt expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad expense (line 23 column 3 plus line 29) 15,260,026 30.00 20.00 Total bad expense (line 24 line line line line			Uni nsure	d Insured			
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(see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 5,793,810 4,448,598 10,242,408 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 1.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 14,428,459 26.00 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 1,080,190 27.01 Medicare bad debt expense (see instructions) 13,348,269 28.00 Non-Medicare bad debt expense (see instructions) 5,017,618 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 15,260,026 30.00 15,	20 00		ility 16 669	141 4 448 598	21 117 739	20 00	
instructions) Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 5,793,810 1.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 70.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 70.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5,017,618 29.00 15,260,026 30.00	20.00		10,007	1, 1, 1, 1, 1, 1, 1, 1, 1	21/11///07	20.00	
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charity care 23.00 Cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 11,00 24.00 25.00 26.00 16 line 24 is yes, enter the charges for patient days beyond the indigent care program's length of or complex (see instructions) 16 line 24 is yes, enter the charges for patient days beyond a length of stay limit 17 line 24 is yes, enter the charges for patient days beyond a length of stay limit 18 line 24 is yes, enter the charges for patient days beyond a length of stay limit 19 line 24 is yes, enter the charges for patient days beyond a length of stay limit 10 line 24 is yes, enter the charges for patient days beyond a length of stay limit 19 line 24 is yes, enter the charges for patient days beyond a length of stay limit 10 line 24 is yes, enter the charges for patient days beyond the indigent care program? 10 line 24 is yes, enter the charges for patient days beyond the indigent care program? 10 line 24 is yes, enter the charges for patient days beyond a length of stay limit 10 line 24 is yes, enter the charges for patient days beyond a length of stay limit 10 line 24 is yes, enter the charges for patient days beyond the indigent care program? 10 line 24 is yes, enter the charges for patient days beyond the indigent care program? 11 line 24 is yes, enter the charges for patient days beyond the indigent care program? 11 line 24 is yes, enter the charges for patient days beyond the indigent care program? 10 line 24 is	00.00	· · · · · · · · · · · · · · · · · · ·	66			00.00	
23. 00 Cost of charity care (line 21 minus line 22) 5,793,810 4,448,598 10,242,408 23.00 1.00 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 10, 242, 408 23. 00 24. 00 25. 00 25. 00 26. 00 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5, 017, 618 29. 00 15, 260, 026 30. 00	22.00	, , , , , , , , , , , , , , , , , , , ,	orr as	0	0	22.00	
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)	23. 00		5. 793.	810 4, 448, 598	10, 242, 408	23. 00	
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)			9, 119,	., ., ., ., .,			
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 15, 260, 026 25.00 14, 428, 459 26.00 17, 080, 190 27.01 18, 348, 269 28.00 5, 017, 618 29.00 15, 260, 026 30.00							
25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 25. 00 25. 00 26. 00 27. 01 28. 01 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 01 28. 01 29. 01 29. 01 20. 02	24. 00			th of stay limit	N	24. 00	
26. 00 Total bad debt expense for the entire hospital complex (see instructions) 14, 428, 459 26. 00	25. 00					25. 00	
27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 702, 123 27. 00 Medicare allowable bad debts for the entire hospital complex (see instructions) 1,080, 190 27. 01 Medicare bad debt expense (see instructions) 13,348,269 28. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5,017,618 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 15,260,026 30. 00	0/ 00	stay limit				0, 00	
27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 1,080,190 27.01						1	
28.00 Non-Medicare bad debt expense (see instructions) 13,348,269 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5,017,618 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)		· · ·	,			•	
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 5,017,618 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 5,017,618 29.00		i i i	co matructions)			•	
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 15,260,026 30.00	29. 00		ense (see instruction	ns)		•	
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 32,953,100 32,953,100 31.00	30.00	, , , , , , , , , , , , , , , , , , , ,	•		15, 260, 026	30. 00	
	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		32, 953, 100	31.00	

Heal th	Financial Systems	COLUMBUS REGIONA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CO	CN: 15-0112	Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nared:
					10 12/31/2019	7/24/2020 4:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVI CE COST CENTERS		00 700 07/	00 700 07	44 (40 040	44 400 007	1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT		22, 732, 376				
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		14, 180, 120		2.00
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	220 450	21 252 404	21 402 24	0 2 150 021	1	3. 00 4. 00
	00500 ADMINISTRATIVE & GENERAL	229, 658	31, 253, 604				5.00
5. 00 7. 00		15, 561, 397	47, 896, 588			59, 941, 524	1
8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 592, 937 36, 374	6, 791, 911 692, 413			6, 857, 160 728, 787	8.00
9. 00	00900 HOUSEKEEPING	1, 830, 426	686, 843				
10.00	01000 DI ETARY	2, 130, 231	1, 179, 472				1
11. 00	01100 CAFETERI A	2, 130, 231	1, 177, 472	1	2, 054, 177		
13. 00	01300 NURSING ADMINISTRATION	4, 549, 813	813, 772				
14. 00	01400 CENTRAL SERVICES & SUPPLY	825	851, 720			1, 107, 016	1
15. 00	01500 PHARMACY	3, 479, 732	1, 720, 831				
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 100, 690	771, 932				
17. 00	01700 SOCIAL SERVICE	569, 639	23, 604				
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	•
23. 01	02301 XRAY EDUCATION	157, 235	3, 158	160, 39	3 364, 162	524, 555	
23. 02	02302 PHARMACY RESIDENCY PROG	172, 699	5, 676	178, 37	5 178, 733	357, 108	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	14, 646, 693	2, 555, 557	17, 202, 25	1, 213, 000	18, 415, 250	30. 00
31.00	03100 INTENSIVE CARE UNIT	2, 387, 104	1, 121, 576	3, 508, 68	-147, 583	3, 361, 097	31. 00
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	1, 347, 448	93, 896	1, 441, 34	4 370, 254	1, 811, 598	
42. 00	04200 SUBPROVI DER	0	0		0	0	
43.00	04300 NURSERY	811, 600	14, 479			1	
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	070 000	20 040 004	20.014.04	10 7/0 450	00 450 407	F0 00
50.00	05000 OPERATING ROOM	870, 939	30, 043, 321				
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	120	1, 052, 838	1, 052, 95	254, 149	1, 307, 107 0	ı
53. 00	05300 ANESTHESI OLOGY		128, 533	128, 53	3 63, 125	1	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 885, 903	592, 347				
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	393, 258	1, 555, 603				
54. 02	05404 ULTRA SOUND	446, 531	52, 278		•		ı
54. 03	05405 MAMMOGRAPHY	755, 779	192, 057				
55. 00	05500 RADI OLOGY-THERAPEUTI C	797, 486	1, 357, 334				
57.00	05700 CT SCAN	686, 121	972, 414				
58.00	05800 MRI	298, 872	112, 522	411, 39	4 131, 043	542, 437	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 731, 309	4, 476, 505	6, 207, 81	4 -3, 368, 529	2, 839, 285	59. 00
60.00	06000 LABORATORY	4, 152, 630	4, 121, 125	8, 273, 75	5 136, 173	8, 409, 928	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	353, 999	500, 002		1 237, 450	1, 091, 451	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	493, 422	493, 42	2 60, 583	554, 005	62.00
65.00	06500 RESPI RATORY THERAPY	1, 953, 689	400, 901	2, 354, 59	16, 268	2, 370, 858	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 345, 684	174, 080	4, 519, 76			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	549, 507	7, 831				
68. 00	06800 SPEECH PATHOLOGY	596, 729	193, 042				1
69. 00	06900 ELECTROCARDI OLOGY	686, 427	639, 722				
	07000 ELECTROENCEPHALOGRAPHY	698, 582	90, 478	1			•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 6, 358, 574		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		9, 658, 272		1
	07300 DRUGS CHARGED TO PATIENTS	0	22, 149, 822				1
74. 00	07400 RENAL DIALYSIS	0	813, 715				
	03020 ACUPUNCTURE	242 270	127 (14	1	0 4		
76. 97	O7697 CARDI AC REHABILITATION OUTPATIENT SERVICE COST CENTERS	262, 270	137, 614	399, 88	4] 0	399, 884	76. 97
88. 00		O	0		0 0	0	88. 00
89. 00		0	0		0 0	0	ı
90.00		1, 576, 865	148, 326		-		ı
90. 01	09001 DI ABETES CENTER	94, 274	135, 151				1
90. 02	09002 NEUROPSYCH	287, 844	10, 901				
90. 03	09003 WOUND CENTER	527, 717	894, 797				
	09004 HYPERBARI C OXYGEN THERAPY	0	0,1,7,7		227, 809		
90. 05	09005 VI MCARE CLI NI C	551, 845	125, 928	677, 77			
90.06		286, 004	2, 044			l	
91.00	09100 EMERGENCY	5, 422, 609	1, 276, 798				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
_	OTHER REIMBURSABLE COST CENTERS				-		l
95. 00	09500 AMBULANCE SERVICES	3, 765, 714	335, 549	4, 101, 26	3 107, 032	4, 208, 295	95.00

					6.5. 0110	
	COLUMBUS REGIONA	_			u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 01/01/2019	Worksheet A	
				o 12/31/2019	Date/Time Pre	nared:
			'	0 12/01/201/	7/24/2020 4:0	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
99. 10 09910 CORF	0	0	C	0	0	1 , ,
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	C	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	O	C	0		110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0		0		111. 00
113. 00 11300 I NTEREST EXPENSE		1, 897, 066				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	86, 583, 208	194, 293, 474	280, 876, 682	232, 374	281, 109, 056	118. 00
NONREI MBURSABLE COST CENTERS		_1		.1 _1	_	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00
194. 00 07950 WELLNESS COMMUNITY	0	0)	296, 804	296, 804	1
194. 01 07951 BUI LDI NG RENTALS	0	2, 286, 135	2, 286, 135		325, 843	1
194. 02 07952 HOSPI CE	0	107, 509	107, 509		107, 509	1
194. 03 07953 OUTREACH CLINICS	0	0	(0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	(186, 874		1
194. 05 07955 NONALLOWABLE MARKETING	0 447	0	0/ 505	795, 842	795, 842	1
194. 06 07956 CRH FOUNDATION	36, 417	168	36, 585		36, 585	1
194. 07 07957 HEALTHY COMMUNITIES	34, 679	3, 345	38, 024			
194. 08 07958 CRHP 194. 09 07959 NEUROPSYCH PART B		U	(460, 086		194. 08
	04 454 304	104 400 421	202 244 025		283, 344, 935	
200.00 TOTAL (SUM OF LINES 118 through 199)	86, 654, 304	196, 690, 631	283, 344, 935	기 이	203, 344, 935	₁ 200.00

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 7/24/2020 4:05 pm

				7/24/2020 4: 0!	5 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	OFNEDAL CEDIMOS COCT OFNEDO	6. 00	7.00		
1 00	GENERAL SERVICE COST CENTERS	201 252	10 021 004		1 00
1.00	00100 CAP REL COSTS BLDG & FIXT	-291, 252		1	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	-331, 204		1	2.00
3.00		245 724		1	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-365, 734		1	4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-22, 632, 958		1	5. 00 7. 00
		-401, 801			8.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG			1	9.00
10. 00		-92, 661		1	10.00
11. 00		-1, 392, 889			11.00
13. 00			1		
		C	1 ' '	1	13.00
14. 00 15. 00				1	14.00
16. 00		-54, 706 -12, 428		1	15. 00 16. 00
17. 00		-12, 420 C			17. 00
23. 00					23. 00
23. 00		-24, 553		1	23. 00
23. 01		-24, 553 C	1	1	23. 01
23.02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		337, 100		23.02
30. 00		-1, 286, 404	17, 128, 846		30.00
31. 00		-1, 200, 404		1	31.00
32. 00					32.00
33. 00				1	33. 00
34. 00					34.00
40. 00					40. 00
41. 00			•		41.00
42. 00			1 ' '		42. 00
43. 00					43. 00
44. 00			1		44. 00
11.00	ANCI LLARY SERVI CE COST CENTERS		,		11.00
50. 00		-1, 123, 454	19, 028, 653		50.00
51. 00		1, 123, 131		1	51.00
52. 00			1		52. 00
53. 00					53. 00
54. 00		-42, 576			54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1.2,375	II.		54. 01
54. 02					54. 02
54. 03		-497	1	1	54. 03
55. 00		-26, 200		1	55. 00
57. 00		20, 200	1	1	57.00
58. 00			542, 437		58. 00
59. 00		-96, 850			59. 00
60.00		-275		1	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	-37, 356		1	60. 01
62. 00	1	0.755	i e	1	62.00
65. 00	1	-8, 426	l .	1	65. 00
66. 00		-28, 952			66. 00
67. 00		0			67. 00
68. 00		-586		1	68. 00
69. 00		-35, 518		1	69.00
70. 00		C		1	70. 00
71. 00				1	71. 00
72. 00				1	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS			1	73. 00
74. 00				1	74. 00
76. 00				1	76. 00
76. 97				1	76. 97
	OUTPATIENT SERVICE COST CENTERS				
88. 00		C	0		88. 00
89. 00		C	1		89. 00
90.00		C	1, 742, 114		90.00
90. 01					90. 01
90. 02		-200, 476	1	1	90. 02
90. 03		-21, 024	1	1	90. 03
90. 04		-1, 250		1	90. 04
90. 05		0	II .	1	90. 05
90. 06			1	1	90.06
91.00		-670, 392	1	1	91.00
92.00					92.00
	OTHER REIMBURSABLE COST CENTERS	•			
95.00		-646, 846	3, 561, 449		95. 00
99. 10	09910 CORF	C	1	1	99. 10
101.0	0 10100 HOME HEALTH AGENCY	c) o		101. 00

 Health Financial
 Systems
 COLUMBUS R

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

Peri od: Worksheet A From 01/01/2019 Date/Time Prepared:

			7/24/2020 4:	05 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	or Allocation		
	6.00	7. 00		
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	О		111. 00
113.00 11300 INTEREST EXPENSE	0	О		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-29, 827, 268	251, 281, 788		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	0	296, 804		194. 00
194. 01 07951 BUILDING RENTALS	0	325, 843		194. 01
194. 02 07952 HOSPI CE	0	107, 509		194. 02
194. 03 07953 OUTREACH CLINICS	0	o		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	186, 874		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	795, 842		194. 05
194.06 07956 CRH FOUNDATION	0	36, 585		194. 06
194.07 07957 HEALTHY COMMUNITIES	-570	25, 766		194. 07
194. 08 07958 CRHP	-343, 045	117, 041		194. 08
194.09 07959 NEUROPSYCH PART B	0	O		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-30, 170, 883	253, 174, 052		200. 00

				To 12/31/2019 Date/Time Pro 7/24/2020 4:0	
	Cost Center Description		CMS Code	Standard Label For	
				Non-Standard Codes	
			1.00	2.00	
1 00	GENERAL SERVICE COST CENTERS		00100		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP		00100 00200		1.00
3.00	OTHER CAP REL COSTS		00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT		00400		4. 00
5.00	ADMI NI STRATI VE & GENERAL		00500		5. 00
7. 00 8. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE		00700 00800		7. 00 8. 00
9. 00	HOUSEKEEPI NG		00800		9.00
10. 00	DI ETARY		01000		10.00
11. 00	CAFETERI A		01100		11.00
13.00	NURSI NG ADMI NI STRATI ON		01300		13.00
14. 00 15. 00	CENTRAL SERVICES & SUPPLY PHARMACY		01400 01500		14. 00 15. 00
16. 00	MEDICAL RECORDS & LIBRARY		01600		16.00
17. 00	SOCI AL SERVI CE		01700		17. 00
23. 00	PARAMED ED PRGM-(SPECIFY)		02300		23. 00
23. 01	XRAY EDUCATION		02301		23. 01
23. 02	PHARMACY RESIDENCY PROG INPATIENT ROUTINE SERVICE COST CENTERS		02302		23. 02
30.00	ADULTS & PEDI ATRI CS		03000		30.00
31. 00	INTENSIVE CARE UNIT		03100		31.00
32. 00	CORONARY CARE UNIT		03200		32. 00
33. 00 34. 00	BURN INTENSIVE CARE UNIT		03300 03400		33.00
40. 00	SUBPROVIDER - IPF		04000		40.00
41. 00	SUBPROVIDER - IRF		04100		41. 00
42.00	SUBPROVI DER		04200		42. 00
43. 00	NURSERY		04300		43.00
44. 00	SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS		04400		44.00
50. 00	OPERATI NG ROOM		05000		50.00
51.00	RECOVERY ROOM		05100		51.00
52. 00	DELIVERY ROOM & LABOR ROOM		05200		52. 00
53. 00 54. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C		05300 05400		53. 00 54. 00
54. 00	NUCLEAR MEDICINE-DI AGNOSTI C		05400		54. 00
54. 02	ULTRA SOUND		05404		54. 02
54. 03	MAMMOGRAPHY		05405		54. 03
55. 00	RADI OLOGY-THERAPEUTI C CT SCAN		05500		55.00
57. 00 58. 00	MRI		05700 05800		57.00
59. 00	CARDI AC CATHETERI ZATI ON		05900		59.00
60.00	LABORATORY		06000		60.00
60. 01	LABORATORY-PATHOLOGI CAL		06001		60. 01
62. 00 65. 00	WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY		06200 06500		62. 00 65. 00
66. 00	PHYSI CAL THERAPY		06600		66.00
67. 00	OCCUPATI ONAL THERAPY		06700		67. 00
68. 00	SPEECH PATHOLOGY		06800		68. 00
69. 00 70. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		06900 07000		69. 00 70. 00
71. 00	MEDICAL SUPPLIES CHARGED TO PATIENT		07100		71.00
72. 00	IMPL. DEV. CHARGED TO PATIENTS		07200		72. 00
73. 00	DRUGS CHARGED TO PATIENTS		07300		73. 00
74.00	RENAL DI ALYSI S		07400	ACUPUNCTURE	74.00
76. 00 76. 97	ACUPUNCTURE CARDI AC REHABI LI TATI ON		03020 07697	CARDIAC REHABILITATION	76. 00 76. 97
. 5. 77	OUTPATIENT SERVICE COST CENTERS		3.377	TELEVISION NELVISION	1 . 5. ,,
88. 00	RURAL HEALTH CLINIC		08800		88. 00
89. 00 90. 00	FEDERALLY QUALIFIED HEALTH CENTER CLINIC		08900 09000		89. 00 90. 00
90.00	DI ABETES CENTER		09000		90.00
90. 02	NEUROPSYCH	ļ	09002		90. 02
90. 03	WOUND CENTER	ļ	09003		90. 03
90. 04	HYPERBARI C OXYGEN THERAPY		09004		90. 04
90. 05 90. 06	VIMCARE CLINIC MEDICATION MGMT CLINIC		09005 09006		90. 05 90. 06
90.06	EMERGENCY		09006		91.00
92. 00	OBSERVATION BEDS (NON-DISTINCT PART		09200		92. 00
0=	OTHER REIMBURSABLE COST CENTERS				05
95. 00	AMBULANCE SERVICES		09500		95. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
COST CENTERS USED IN COST REPORT	Provi der CCN: 15-0112	Period: Worksheet Non-CMS W
		From 01/01/2019

		To 12/31/2019 Date/Time	Propared:
		7/24/2020	
Cost Center Description	CMS Code	Standard Label For	
		Non-Standard Codes	
	1.00	2. 00	
99. 10 CORF	09910		99. 10
101.00 HOME HEALTH AGENCY	10100		101. 00
SPECIAL PURPOSE COST CENTERS			
109. 00 PANCREAS ACQUISITION	10900		109. 00
110.00 INTESTINAL ACQUISITION	11000		110. 00
111. 00 I SLET ACQUI SI TI ON	11100		111. 00
113. 00 INTEREST EXPENSE	11300		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
NONREI MBURSABLE COST CENTERS	1		
190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190. 00
194. 00 WELLNESS COMMUNITY	07950		194. 00
194. 01 BUI LDI NG RENTALS	07951		194. 01
194. 02 HOSPI CE	07952		194. 02
194. 03 OUTREACH CLINICS	07953		194. 03
194. 04 SPEECH - HEARING AIDS	07954		194. 04
194. 05 NONALLOWABLE MARKETI NG	07955		194. 05
194. 06 CRH FOUNDATION	07956		194. 06
194. 07 HEALTHY COMMUNI TI ES	07957		194. 07
194. 08 CRHP	07958		194. 08
194. 09 NEUROPSYCH PART B	07959		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)			200. 00

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

					0 12/31/20	7/24/2020 4:05 pm
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	B - RECLASS DEPREC BLDG/EQUIP					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 494, 006		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	403, 060		2. 00
	0		0	1, 897, 066		
	C - RECLASS INSURANCE					
1.00	OCCUPATI ONAL THERAPY	67. 00	0	988		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	673, 014		2. 00
3.00	AMBULANCE SERVICES	95.00	0	52, 033		3.00
4.00	LABORATORY	60.00	0	4, 088		4. 00
	0		0	730, 123		
	D - RECLASS BILLING COST					
1.00	ADMI NI STRATI VE & GENERAL	500	<u>1, 036, 4</u> 51	239, 912		1.00
	0		1, 036, 451	239, 912		
	E - RECLASS HYPERBARI C THERAP					
1.00	HYPERBARI C OXYGEN THERAPY	90. 04	108, 076	6 <u>2, 2</u> 72		1.00
	0		108, 076	62, 272		
	F - RECLASS CAFETERIA EXPENSE					
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 330, 543</u>	73 <u>6, 7</u> 03		1.00
	0		1, 330, 543	736, 703		
	G - RECLASS WELLNESS					
1. 00	WELLNESS COMMUNITY	194.00	182, 371	40, 655		1.00
	0		182, 371	40, 655		
	H - RECLASS PHYSICIAN FEES					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	50, 000		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1, 576, 921		2. 00
4.00	SUBPROVI DER - I RF	41. 00	0	231, 150		4.00
5. 00	OPERATING ROOM	50.00	0	863, 100		5. 00
6.00	ANESTHESI OLOGY	53.00	0	60, 000		6. 00
7.00	RADI OLOGY-THERAPEUTI C	55.00	0	63, 750		7. 00
9.00	LABORATORY-PATHOLOGI CAL	60. 01	0	225, 000		9. 00
10.00	RESPI RATORY THERAPY	65.00	o	25, 000		10.00
11. 00	PHYSI CAL THERAPY	66.00	o	50, 000		11.00
12.00	ELECTROCARDI OLOGY	69. 00	o	58, 600		12. 00
13. 00	ELECTROENCEPHALOGRAPHY	70.00	o	9, 750		13.00
16. 00	AMBULANCE SERVICES	95. 00	o	17, 500		16.00
17. 00	WOUND CENTER	90. 03	o	39, 632		17. 00
18. 00	HYPERBARI C OXYGEN THERAPY	90. 04	ő	2, 368		18. 00
19. 00	EMERGENCY	91.00	ő	1, 933, 172		19. 00
17.00	0		- — ŏ	5, 205, 943		17.00
	I - RECLASS REHAB SERVICES		<u> </u>	0,200,7.0		
1.00	OCCUPATI ONAL THERAPY	67.00	20, 369	6, 582		1.00
2.00	PHYSI CAL THERAPY	66.00	19, 484	5, 884		2.00
3.00	SPEECH PATHOLOGY	68. 00	17, 042	3, 405		3.00
4.00	SUBPROVI DER - I RF	41. 00	147, 418	7, 061		4.00
5. 00	ELECTROENCEPHALOGRAPHY	70. 00	9, 922	3, 531		5. 00
6. 00	SOCI AL SERVI CE	17. 00	1, 654	588		6.00
7. 00	ADULTS & PEDIATRICS	30.00	17, 040	5, 884		7.00
8. 00	NEUROPSYCH	90. 02	3, 307	1, 177		8.00
9. 00	WOUND CENTER	90. 03	0	508		9.00
10. 00	HYPERBARIC OXYGEN THERAPY	90.03	0	230		10.00
11. 00	WELLNESS COMMUNITY	194. 00	3, 307	1, 177		11. 00
11.00	0 COMMONT IY	174.00	3, 307 239, 543	$-\frac{1,177}{36,027}$		11.00
	J - RECLASS PHARMACY RES PROG	RAM	237, 343	30, 027	 	
1.00	PHARMACY RESIDENCY PROG	23. 02	174, 917	0		1.00
2. 00	PHARMACY RESIDENCY PROG	23. 02	0	2, 161		2.00
3. 00	PHARMACY RESIDENCY PROG	23. 02	0	1, 655		3.00
5.00	0		174, 917	3, 816		3.00
	K - RECLASS RENT EXPENSE		1/4, 71/	3,010		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 370		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	249, 778		2.00
3. 00	OPERATION OF PLANT	7. 00	0	125, 554		3.00
4. 00	XRAY EDUCATION	23. 01	0	11, 860		4. 00
5. 00	MAMMOGRAPHY	54. 03	0	130, 849		5. 00
	I I	60.00	0	14, 909		1
6.00	LABORATORY DUVSI CAL THEDADY	l l	- 1			6.00
7.00	PHYSICAL THERAPY	66.00	0	370, 117		7.00
8.00	OCCUPATIONAL THERAPY	67.00	0	151, 242		8.00
9.00	SPEECH PATHOLOGY	68.00	0	66, 295		9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	127, 536		10.00
11.00	WOUND CENTER	90. 03	0	99, 589		11.00
12. 00	HYPERBARI C OXYGEN THERAPY	90. 04	0	54, 863		12. 00
13.00	AMBULANCE SERVICES	95. 00	0	15, 000		13. 00
14.00	WELLNESS COMMUNITY	194. 00	0	69, 244		14. 00
15.00	CRHP	194. 08	0	<u>460, 0</u> 86		15. 00
	0		0	1, 960, 292	 	

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

					7/24/2020 4: Q5 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3.00	4. 00	5. 00	
1. 00	L - RECLASS MARKETING EXPENSE NONALLOWABLE MARKETING	194. 05	0	140, 000	1.00
1.00	O MARKETTING	194.05		140,000	1.00
	M - RECLASS DEPRECIATION EXPE	NSF	<u> </u>	140, 000	
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13, 777, 060	1.00
	0 — — — —			13, 777, 060	
	N - RECLASS MAINTENANCE EXPEN	SE			
1.00	RESPIRATORY THERAPY	65. 00	0	7, 350	1.00
2.00	ELECTROCARDI OLOGY	69.00	0	5, 280	2.00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	205, 190	3.00
4. 00 5. 00	CENTRAL SERVICES & SUPPLY OPERATING ROOM	14. 00 50. 00	0	95, 372 258, 011	4. 00 5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	682, 185	6.00
7. 00	LABORATORY	60.00	Ö	194, 254	7.00
8.00	LABORATORY-PATHOLOGI CAL	60. 01	ō	12, 450	8.00
9.00	NURSING ADMINISTRATION	13. 00	o	5, 055	9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	225, 174	10.00
11. 00	MAMMOGRAPHY	54. 03	0	273, 388	11. 00
12.00	ULTRA SOUND	54. 02	0	90, 416	12.00
13.00	CT SCAN NUCLEAR MEDICINE-DIAGNOSTIC	57. 00 54. 01	0	189, 513	13. 00 14. 00
14. 00 15. 00	MRI	58. 00	0	170, 024 132, 485	15.00
16. 00	PHARMACY	15. 00	0	46, 682	16. 00
17. 00	EMERGENCY	91.00	0	29, 922	17.00
18. 00	ADMINISTRATIVE & GENERAL	5. 00	o	15, 443	18.00
19.00	ANESTHESI OLOGY	53.00	o	3, 125	19.00
	0			2, 641, 319	
	O - RECLASS DIRECTOR PHARMACY				
1.00	EMERGENCY	91.00	101, 124	0	1.00
2.00	RESPIRATORY THERAPY	65. 00	50, 562	0	2.00
3. 00	AMBULANCE SERVICES	<u>95.</u> 00	5 <u>0, 5</u> 62 202, 248	0	3.00
	Q - RECLASS XRAY EDUCATION EX	DENSES	202, 240	U	
1.00	XRAY EDUCATION	23. 01	185	0	1.00
2.00	XRAY EDUCATION	23. 01	63	0	2.00
3.00	XRAY EDUCATION	23. 01	o	13, 367	3.00
4.00	XRAY EDUCATION	23. 01	33 <u>5, 9</u> 62	<u>2, 7</u> 25	4.00
	0	01.110 000.70	336, 210	16, 092	
1 00	S - RECLASS NON ALLOW ADVERTI		ما	/FF 040	1.00
1. 00	NONALLOWABLE MARKETING	194.05	0	65 <u>5, 842</u> 655, 842	1.00
	U - RECLASS CHARGEABLE SUPPLY	COST	<u> </u>	033, 042	
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	255, 979	1.00
	PATI ENT				
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	142, 127	2. 00
	PATI ENT				
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	4, 354	3.00
4. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	o	4, 044	4.00
4.00	PATI ENT	71.00	ď	4, 044	4.00
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	3, 863, 084	5. 00
	PATI ENT				
6.00	IMPL. DEV. CHARGED TO	72. 00	0	7, 726, 725	6. 00
0.00	PATI ENTS	74 05		4.0	
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	149, 469	8.00
10. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 125	10.00
10.00	PATI ENT	71.00	Y	1, 123	10.00
11.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	128, 748	11. 00
	PATI ENT				
12.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	29, 308	12.00
10.00	PATI ENT	74 00		47 (57	
13. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	17, 657	13.00
	IDATI ENT			1, 625, 511	15.00
15 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71 00	())		
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	., 020, 0	10.00
15. 00 16. 00	1	71. 00 72. 00	0	1, 931, 547	16.00
	MEDICAL SUPPLIES CHARGED TO PATIENT				
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO				
16. 00 17. 00	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS MEDICAL SUPPLIES CHARGED TO PATIENT	72. 00 71. 00	0	1, 931, 547 60, 085	16. 00 17. 00
16. 00	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS MEDICAL SUPPLIES CHARGED TO PATIENT MEDICAL SUPPLIES CHARGED TO	72.00	0	1, 931, 547	16.00
16. 00 17. 00 18. 00	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS MEDICAL SUPPLIES CHARGED TO PATIENT MEDICAL SUPPLIES CHARGED TO PATIENT	72. 00 71. 00 71. 00	0	1, 931, 547 60, 085 14, 420	16. 00 17. 00 18. 00
16. 00 17. 00	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS MEDICAL SUPPLIES CHARGED TO PATIENT MEDICAL SUPPLIES CHARGED TO	72. 00 71. 00	0	1, 931, 547 60, 085	16. 00 17. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: Provider CCN: 15-0112

					7/24/2020 4: Q	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
22.00	2. 00	3.00	4.00	5. 00		22.00
22. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	U	35, 496		22. 00
23. 00	MEDICAL SUPPLIES CHARGED TO	71.00	o	23, 231		23. 00
	PATIENT					
24.00	MEDICAL SUPPLIES CHARGED TO	71.00	О	2, 839		24. 00
	PATI ENT					l
	0	LULUATION DD	0	16, 203, 720		l
1 00	V - RECL PTO COST FOR STD ELI		ما	450		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	458 50, 302		1. 00 2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ő	17, 744		3. 00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	10, 041		4. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	9, 298		5. 00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	15, 469		6. 00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41, 253		7. 00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 892		8. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 622		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4.00	0	157, 438		10.00
11. 00 12. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	9, 698 11, 021		11. 00 12. 00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	8, 667		13. 00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	24, 489		14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	4, 816		15. 00
16.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	2, 841		16. 00
17.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	13, 184		17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	581		18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 682		19. 00
20.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 257		20.00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18, 779		21. 00
22. 00 23. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	29, 725 8, 266		22. 00 23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14, 001		24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	8, 584		25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	1, 784		26. 00
27.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	5, 895		27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 369		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 946		29. 00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	285		31. 00
32. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40, 675		32. 00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23, 041		33.00
34. 00 35. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	1, 069 410		34. 00 35. 00
33.00	0		— —)	561, 582		33.00
	X - RECLASS OT SALARIES AND (THER EXP	<u> </u>	001,002		l
1.00	OCCUPATI ONAL THERAPY	67.00	535, 909	48, 388		1. 00
	0		535, 909	48, 388		l
	Z - RECLASS LAB BLOOD SUPERVI		[
1. 00	WHOLE BLOOD & PACKED RED	62.00	60, 583	0		1. 00
	BLOOD CELL		60, 583	— — _ō		l
	WA - RECLASS CONTRACT LABOR E	L RENEFLTS	00, 303	<u> </u>		l
1. 00	ADMI NI STRATI VE & GENERAL	5.00	O	369, 894		1. 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	158, 734		2. 00
3.00	OPERATING ROOM	50.00	О	1, 685, 158		3. 00
4.00	RECOVERY ROOM	<u>51.</u> 00	o_	<u>252, 1</u> 01		4. 00
	TOTALS		0	2, 465, 887		l
	WB - RECLASS SALARIES TO HOME					l
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	20, 955	0		1.00
2.00	ADMINISTRATIVE & GENERAL OPERATING ROOM	5. 00 50. 00	50, 183	0		2.00
3. 00 4. 00	RECOVERY ROOM	51.00	7, 565 1, 440	0		3. 00 4. 00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	964	0		5. 00
6. 00	ADMI NI STRATI VE & GENERAL	5. 00	1, 323	Ö		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	365	Ö		7. 00
8.00	OPERATING ROOM	50.00	4, 592	0		8. 00
9.00	RECOVERY ROOM	51.00	608	0		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7	0		10.00
11.00	OPERATION OF PLANT	7.00	5, 821	0		11. 00
12.00	HOUSEKEEPI NG	9.00	1, 769	0		12.00
13. 00 14. 00	DI ETARY CAFETERI A	10. 00 11. 00	1, 067 1, 775	0		13. 00 14. 00
15. 00	NURSING ADMINISTRATION	13.00	14, 633	0		15. 00
16. 00	PHARMACY	15.00	5, 566	0		16. 00
17. 00	MEDICAL RECORDS & LIBRARY	16.00	1, 863	Ö		17. 00
	•	. '		<u> </u>	'	

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS COLUMBUS REGIONAL HOSPITAL | Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

					7/24/2020 4: Q5 pr
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5.00	
18. 00	SOCIAL SERVICE	17. 00	2, 186	0	18
19.00	ADULTS & PEDIATRICS	30.00	10, 188	0	19
20.00	INTENSIVE CARE UNIT	31. 00	1, 795	0	20
21.00	OPERATING ROOM	50.00	2, 402	0	21
22.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 425	0	22
23.00	MAMMOGRAPHY	54. 03	2, 072	0	23
24.00	RADI OLOGY-THERAPEUTI C	55.00	5, 751	0	24
25.00	CARDIAC CATHETERIZATION	59.00	2, 118	0	25
26.00	LABORATORY	60.00	8, 002	0	26
27.00	RESPI RATORY THERAPY	65.00	1, 770	0	27
28. 00	PHYSI CAL THERAPY	66.00	17, 394	0	28
29. 00	OCCUPATI ONAL THERAPY	67.00	1, 882	0	29
30. 00	ELECTROENCEPHALOGRAPHY	70.00	1, 460	0	30
31. 00	CLINIC	90.00	22, 292	0	31
32. 00	WOUND CENTER	90. 03	1, 597	0	32
33. 00	EMERGENCY	91.00	3, 995	0	33
34.00	AMBULANCE SERVICES	95.00	1, 712	0	34
35. 00	ADMINISTRATIVE & GENERAL	5. 00	11, 688	0	35
36. 00	ADMINI STRATI VE & GENERAL	5. 00	1, 000	0	36
37. 00	HOUSEKEEPI NG	9. 00	500	0	37
38. 00	DI ETARY	10.00	375	0	38
39. 00	CAFETERI A	11. 00	625	0	39
40. 00	NURSING ADMINISTRATION	13. 00	16, 005	0	40
41. 00	MEDICAL RECORDS & LIBRARY	16. 00	500	0	40
41.00	ADULTS & PEDIATRICS	30.00	16, 384	0	41
	INTENSIVE CARE UNIT	31.00		0	42
43. 00 44. 00			2, 447	0	
	RADI OLOGY-DI AGNOSTI C	54.00	250	-	44
45. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	250	0	45
46.00	LABORATORY	60.00	5, 228	0	46
47.00	ELECTROCARDI OLOGY	69. 00	250	0	47
48. 00	EMERGENCY	91.00	500	0	48
49. 00	AMBULANCE SERVICES	95. 00	250	0	49
50. 00	WELLNESS COMMUNITY	194.00		0	50
	TOTALS		267, 908	0	
	WC - RECLASS SEVERANCE PAY				
1.00	NURSING ADMINISTRATION	13. 00	139, 174	0	1
2.00	MAMMOGRAPHY	54. 03	36, 410	0	2
3.00	RADI OLOGY-THERAPEUTI C	55. 00	29, 729	0	3
4.00	AMBULANCE SERVICES	95. 00	1 <u>6, 2</u> 47	0	4
	TOTALS		221, 560	0	
500.00	Grand Total: Increases		4, 696, 319	47, 422, 699	500

Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/24/2020 4:05 pm

						7/24/2020 4:0)5 pm
	2 1 2 1	Decreases	6.1	0.11			
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
1 00	B - RECLASS DEPREC BLDG/EQUIP		ما	1 404 006	11		1 00
1.00	INTEREST EXPENSE	113.00	0	1, 494, 006	1		1.00
2.00	INTEREST EXPENSE	113.00	0	403, 060			2. 00
	C DECLASS INCUDANCE		U_	1, 897, 066			-
1. 00	C - RECLASS INSURANCE ADMINISTRATIVE & GENERAL	5. 00	0	988	0		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5.00	o	673, 014	12		2.00
3. 00	ADMINISTRATIVE & GENERAL	5.00	o	52, 033	0		3. 00
4. 00	ADMINISTRATIVE & GENERAL	5.00	o	4, 088			4. 00
4.00	O CENERAL DESCRIPTION OF THE PROPERTY OF THE P		— — — — —	730, 123			7.00
	D - RECLASS BILLING COST		<u> </u>	700, 120			
1.00	MEDI CAL RECORDS & LI BRARY	16. 00	1, 036, 451	239, 912	0		1. 00
	0		1, 036, 451	239, 912			
	E - RECLASS HYPERBARIC THERAF	PY EXPENSE		,			1
1.00	WOUND CENTER	90. 03	108, 076	62, 272	0		1. 00
	0 — — — — —		108, 076	62, 272			
	F - RECLASS CAFETERIA EXPENSE						
1.00	DI ETARY	10.00	1, 330, 543	736, 703	0		1. 00
	0		1, 330, 543	736, 703			
	G - RECLASS WELLNESS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	182, 371	4 <u>0, 6</u> 55			1. 00
	0		182, 371	40, 655			
_	H - RECLASS PHYSICIAN FEES		1				1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	50, 000	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 576, 921	0		2. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	231, 150	0		4. 00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	863, 100	0		5. 00
6.00	OPERATING ROOM	50.00	0	60, 000	0		6. 00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	63, 750	0		7. 00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	225, 000	0		9.00
10. 00 11. 00	ADMINISTRATIVE & GENERAL	5.00	0	25, 000	0		10.00
12. 00	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	50, 000 58, 600	0		11. 00 12. 00
13. 00	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00	0	9, 750	0		13. 00
16. 00	ADMINISTRATIVE & GENERAL	5.00	o	17, 500	0		16. 00
17. 00	ADMINISTRATIVE & GENERAL	5.00	0	39, 632	0		17. 00
18. 00	ADMI NI STRATI VE & GENERAL	5. 00	o	2, 368	0		18. 00
19. 00	OPERATING ROOM	50.00	o	1, 933, 172	1		19. 00
	0		— — [5, 205, 943			
	I - RECLASS REHAB SERVICES		<u>'</u>				1
1.00	ADMINISTRATIVE & GENERAL	5. 00	20, 369	6, 582	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	19, 484	5, 884	0		2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	17, 042	3, 405	0		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	147, 418	7, 061	0		4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00	9, 922	3, 531	0		5. 00
6.00	ADMINISTRATIVE & GENERAL	5. 00	1, 654	588	0		6. 00
7. 00	ADMINISTRATIVE & GENERAL	5. 00	17, 040	5, 884	0		7. 00
8. 00	ADMINISTRATIVE & GENERAL	5. 00	3, 307	1, 177	0		8. 00
9. 00	ADMINISTRATIVE & GENERAL	5. 00	0	508			9. 00
10. 00	ADMINISTRATIVE & GENERAL	5. 00	0	230			10. 00
11. 00	ADMI NI STRATI VE & GENERAL	5.00	3, 307				11. 00
	U DECLACE BUADANCE SEC. TELE	SDAM.	239, 543	36, 027			-
1 00	J - RECLASS PHARMACY RES PROG		174 017	^			1 00
1. 00 2. 00	PHARMACY ADMINISTRATIVE & GENERAL	15. 00 5. 00	174, 917 O	0 2, 161			1. 00 2. 00
			0				1
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	174, 917	<u>1, 6</u> 55 3, 816			3. 00
	U K - RECLASS RENT EXPENSE		1/4, 91/	3, 816			1
1. 00	BUILDING RENTALS	194, 01	0	13, 370	0		1.00
2.00	BUILDING RENTALS	194. 01	o	249, 778	1		2.00
3. 00	BUILDING RENTALS	194. 01	o	125, 554	o o		3. 00
4. 00	BUILDING RENTALS	194. 01	o	11, 860			4. 00
5. 00	BUILDING RENTALS	194. 01	o o	130, 849			5. 00
6. 00	BUILDING RENTALS	194. 01	ő	14, 909	ام		6. 00
7. 00	BUILDING RENTALS	194. 01	ő	370, 117	0		7. 00
8. 00	BUI LDI NG RENTALS	194. 01	ol	151, 242	0		8. 00
9. 00	BUI LDI NG RENTALS	194. 01	o	66, 295	0		9. 00
10.00	BUI LDI NG RENTALS	194. 01	ol	127, 536	0		10. 00
11. 00	BUI LDI NG RENTALS	194. 01	ol	99, 589			11. 00
12. 00	BUI LDI NG RENTALS	194. 01	ol	54, 863			12. 00
13. 00	BUI LDI NG RENTALS	194. 01	ol	15, 000			13. 00
14. 00	BUILDING RENTALS	194. 01	O	69, 244	o		14. 00
15.00	BUILDING RENTALS	194. 01	ol	460, 086	ol		15. 00
	0 — — — — —			1, 960, 292			
-	·						

Health Financial Systems RECLASSIFICATIONS

Cost Contact						10	12/31/2019 Date/lime Pr 7/24/2020 4:	
No. RECLASS WRETTINE EXPENSE								
L - SECLASS MANY ELIVE EXPENSE								
ASM INSTANTINE CREMAN 2,00				8.00	9.00	10.00		
	1.00			0	140, 000	0		1. 00
CAP PEL COSIS-BLOS & FIXE 1.00		0 — — — — —			140, 000			
Color Colo								
	1. 00	CAP REL COSTS-BLDG & FIXT				9		1.00
1.00 OPERATION OF PLANT		N _ DECLASS MALNITENANCE EXDEN	JSF	U	13, 777, 060			-
0.00 0.00	1. 00			O	7. 350	0		1.00
4.00 OPERATION OF PLANT 7.00 O 95,372 O 0.00		l control of the cont	1					1
Depart 100 OF PLANT	3.00	OPERATION OF PLANT	7.00	0		o		3. 00
0.00 0.00	4.00	l control of the cont	7. 00	0	95, 372	0		4. 00
2.00 OPERATION OF PLANT		l control of the cont		-				
8 00 0 PERATION OF PLANT 7.00 0 12,450 0 8.00 00 DEBATION OF PLANT 7.00 0 0 225,174 0 10.00 10.00 DEBATION OF PLANT 7.00 0 0 225,174 0 110.00 11.00 DEBATION OF PLANT 7.00 0 0 225,174 0 110.00 13.00 DEBATION OF PLANT 7.00 0 0 125,348 0 111.00 13.00 DEBATION OF PLANT 7.00 0 0 189,113 0 13.00 15.00 DEBATION OF PLANT 7.00 0 189,113 0 13.00 15.00 DEBATION OF PLANT 7.00 0 132,485 0 15.00 15.00 DEBATION OF PLANT 7.00 0 132,485 0 15.00 17.00 DEBATION OF PLANT 7.00 0 172,424 0 15.00 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION OF PLANT 7.00 0 124,422 0 172,024 17.00 DEBATION THERAPY 15.00 150,562 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l control of the cont	l I	-		-1		1
9.00 OPERATION OF PLANT 7.00 0 5.05S 0 9.00 11.00 OPERATION OF PLANT 7.00 0 273,388 0 111.00 11.00 OPERATION OF PLANT 7.00 0 273,388 0 111.00 12.00 OPERATION OF PLANT 7.00 0 00,416 0 12.00 13.00 OPERATION OF PLANT 7.00 0 180,014 0 13.00 14.00 OPERATION OF PLANT 7.00 0 180,014 0 13.00 15.00 OPERATION OF PLANT 7.00 0 180,014 0 13.00 16.00 OPERATION OF PLANT 7.00 0 46,682 0 16.00 17.00 OPERATION OF PLANT 7.00 0 46,682 0 16.00 18.00 OPERATION OF PLANT 7.00 0 13,448 0 18.00 18.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 18.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 18.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 18.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 19.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 19.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 19.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 17.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 0 10.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 3,125 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 0 3,125 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 0 3,125 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 0 3,125 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 0 3,50 0 0 0 2.00 10.00 OPERATION OF PLANT 7.00 0 0 336,210 0 0 0 0 0 0 0 0 10.00 OPERATION OF PLANT 7.00 0 0 0 0 0 0 0 0 0		l .	l I	-		- 1		
10.00 OPERATION OF PLANT			l I	-		- 1		
11.00 OPERATION OF PLANT		l control of the cont	1	-		-1		1
13.00		l control of the cont	l I	-		- 1		1
14.00	12.00	OPERATION OF PLANT	7.00	0	90, 416	O		12. 00
15.00 OPERATION OF PLANT		l control of the cont	1	۳		-		
16.00 OPERATION OF PLANT		1		-		- 1		
17.00 OFERATION OF PLANT			ł	0		-		1
18. 00			l I	0	·	٦		1
19.00 OPERATION OF PLANT				-		- 1		
1.00			l I	-		-		
1.00 PHARMACY		0						
PARMANCY		O - RECLASS DIRECTOR PHARMACY	(
1.00		l .	1		-			4
1.00		l .	l I		0	1		1
	3.00	PHARMACY		+				3.00
1.00		O - RECLASS XRAY EDUCATION F	(PENSES	202, 240	U _I			
3. 00 A.00 A.00 A.00 A.3. 367 O A.00 A.00	1.00			185	0	0		1.00
A. 00 RADI OLOGY-DI AGNOSTIC S4. 00 335, 962 2, 725 0 0	2.00	RESPIRATORY THERAPY	1	63	0	0		2. 00
S - RECLASS NON ALLOW ADVERTISING COSTS 1,00		l .	l I			0		1
1.00 ADMINISTRATIVE & GENERAL	4.00	RADI OLOGY-DI AGNOSTIC				0		4.00
1.00 ADMI NI STRATI VE & GENERAL 5.00 0 655, 842 0 0 0 0 0 0 0 0 0		S - RECLASS NON ALLOW ADVERTI	SING COSTS	330, 210	10, 092			
D	1.00			0	655, 842	0		1.00
1.00 ADULTS & PEDIATRICS 30.00 0 255,979 0 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 2.00 1.00 2		0		0	655, 842			_
2. 00 INTENSIVE CARE UNIT	1 00			٥	255 070			1 00
3. 00 SUBPROVI DER - I RF			1			- 1		1
4.00 NURSERY 43.00 0 4,044 0 5.00 PERATING ROOM 50.00 0 3,863,084 0 5.00 6.00 PERATING ROOM 50.00 0 7,726,725 0 6.00 6.00 PERATING ROOM 50.00 0 7,726,725 0 6.00 6.00 PERATING ROOM 50.00 0 7,726,725 0 6.00 6.00 8.00 RADIOLOGY-DIAGNOSTIC 54.00 0 149,469 0 8.00 10.00 ELECTROENCEPHALOGRAPHY 70.00 0 1,125 0 10.00 11.00 MAMMOGRAPHY 54.03 0 128,748 0 111.00 11.00 12.00 RADIOLOGY-THERAPEUTIC 55.00 0 29,308 0 12.00 CARDIAC CATHETERIZATION 59.00 0 17,657 0 13.00 CARDIAC CATHETERIZATION 59.00 0 1,625,511 0 15.00 CARDIAC CATHETERIZATION 59.00 0 1,931,547 0 16.00 17.00 PHYSICAL THERAPY 66.00 0 14,420 0 17,00 PHYSICAL THERAPY 66.00 0 14,420 0 18.00 19.00 SPEECH PATHOLOGY 68.00 0 186,874 0 19.00 19.00 SPEECH PATHOLOGY 91.00 0 1,097 0 20.00 COLOPATIONAL THERAPY 67.00 0 1,097 0 20.00 COLOPATIONAL THERAPY 67.00 0 1,097 0 20.00 22.00 EMERGENCY 91.00 0 0 16,203,720 0 10 0 22.00 AMBULANCE SERVICES 95.00 0 2,2839 0 24.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					1
6.00 OPERATI NG ROOM 50.00 0 7,726,725 0 6.00 8.00 RADI OLOGY-DI AGNOSTI C 54.00 0 149,469 0 8.00 10.00 ELECTROENCEPHALOGRAPHY 70.00 0 1,125 0 10.00 11.00 MAMMOGRAPHY 54.03 0 128,748 0 11.00 12.00 RADI OLOGY-THERAPEUTI C 55.00 0 29,308 0 12.80 13.00 CT SCAN 57.00 0 17,657 0 13.00 15.00 CARDI AC CATHETERI ZATI ON 59.00 0 1,625,511 0 15.00 16.00 CARDI AC CATHETERI ZATI ON 59.00 0 1,625,511 0 15.00 17.00 RESPIRATORY THERAPY 65.00 0 60,085 0 17.00 18.00 PHYSI CAL THERAPY 66.00 0 14,420 0 18.00 19.00 SPECH PATHOLOGY 68.00 0 18.6874 0 19.00 20.00 OCCUPATI ONAL THERAPY 67.00 0 1,097 0 20.00 22.00 EMERGENCY 91.00 0 35,496 0 22.00 23.00 AMBULANCE SERVI CES 95.00 0 2,839 0 24.00 VI MCARE CLINI C 90.05 0 2,839 0 24.00 VI MCARE CLINI C 90.05 0 2,839 0 24.00 OPERATION OF PLANT 7.00 17,744 0 0 0 3.00 3.00 OPERATION OF PLANT 7.00 17,744 0 0 0 4.00 5.00 DI ETARY 10.00 9,298 0 0 0 5.00 5.00 DI ETARY 10.00 9,298 0 0 0 6.00 CAFETERI A 11.00 15,469 0 0 0 7.00 MURSI NG ADMINI STRATI ON 13.00 41,253 0 0 0 8.00 PHARMACY 15.00 6,892 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0 9.00 MEDI CAL RECORDS & LI BRARY 16.00 11,622 0 0			1	o		Ö		1
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10. 00 ELECTROENCEPHALOGRAPHY			1	0		-		
11. 00 MAMMOGRAPHY				•				1
12. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 29, 308 0 12. 00 13. 00 CT SCAN 57. 00 0 17, 657 0 13. 00 15. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 1, 625, 511 0 15. 00 16. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 1, 625, 511 0 15. 00 17. 00 RESPI RATORY THERAPY 65. 00 0 60, 085 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 0 14, 420 0 188. 00 19. 00 SPEECH PATHOLOGY 68. 00 0 186, 874 0 19. 00 20. 00 OCCUPATI ONAL THERAPY 67. 00 0 186, 874 0 19. 00 22. 00 EMERGENCY 91. 00 0 23, 231 0 22. 00 23. 00 AMBULANCE SERVI CES 95. 00 0 23, 231 0 23. 00 24. 00 VI MCARE CLINI C 90.05 0 2, 839 0 24. 00 24. 00 VI MCARE CLINI C 90.05 0 2, 839 0 24. 00 25. 00 ADMINI STRATI VE & GENERAL 5. 00 50, 302 0 0 2. 00 26. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 3. 00 27. 00 HOUSEKEEPI NG 9. 00 10, 041 0 0 12. 00 28. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 3. 00 29. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 14. 00 20. 00 OPERATION OF DELANT 7. 00 17, 744 0 0 0 14. 00 20. 00 OPERATION OF DELANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0. 00 20. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0 0. 00 20. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0 0. 00 20. 00 20. 00 OPERATION OF PLANT 7. 00 17, 744 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-1				
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19. 00 SPEECH PATHOLOGY 68. 00 0 186, 874 0 20. 00 0CCUPATI ONAL THERAPY 67. 00 0 1, 097 0 20. 00 22. 00 EMERGENCY 91. 00 0 35, 496 0 22. 00 23. 00 AMBULANCE SERVI CES 95. 00 0 23, 231 0 23. 00 VI MCARE CLINI C 90.05 0 16, 203, 720 0 0 0 16, 203, 720 0 0 0 16, 203, 720 0 0 0 16, 203, 720 0 0 0 16, 203, 720 0 0 0 16, 203, 720 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00	RESPIRATORY THERAPY	1	0	60, 085	0		4
20.00				0				
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23. 00 AMBULANCE SERVICES 95. 00 0 23, 231 0 24. 00 24. 00 VI MCARE CLINIC 90. 05 0 16, 203, 720 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 5. 00 50, 302 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		-		4
24.00 VI MCARE CLINI C		l control of the cont		-		1		
O O 16, 203, 720 O O O O O O O O O				o		1		
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 458 0 0 1. 00 2. 00 ADMI NI STRATI VE & GENERAL 5. 00 50, 302 0 0 0 2. 00 3. 00 OPERATI ON OF PLANT 7. 00 17, 744 0 0 3. 00 4. 00 HOUSEKEEPI NG 9. 00 10, 041 0 0 4. 00 5. 00 DI ETARY 10. 00 9, 298 0 0 5. 00 6. 00 CAFETERI A 11. 00 15, 469 0 0 6. 00 7. 00 NURSI NG ADMI NI STRATI ON 13. 00 41, 253 0 0 0 8. 00 PHARMACY 15. 00 6, 892 0 0 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 0 0 9. 00		0						
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4. 00 HOUSEKEEPI NG 9. 00 10, 041 0 0 4. 00 5. 00 DI ETARY 10. 00 9, 298 0 0 0 5. 00 6. 00 CAFETERI A 11. 00 15, 469 0 0 0 6. 00 7. 00 NURSI NG ADMI NI STRATI ON 13. 00 41, 253 0 0 0 7. 00 8. 00 PHARMACY 15. 00 6, 892 0 0 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 0 0 9. 00					0	- 1		1
5. 00 DI ETARY 10. 00 9, 298 0 0 5. 00 6. 00 CAFETERI A 11. 00 15, 469 0 0 0 6. 00 7. 00 NURSI NG ADMI NI STRATI ON 13. 00 41, 253 0 0 0 7. 00 8. 00 PHARMACY 15. 00 6, 892 0 0 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 0 0 9. 00					0	-		1
6. 00 CAFETERI A 11. 00 15, 469 0 0 0 6. 00 7. 00 NURSI NG ADMI NI STRATI ON 13. 00 41, 253 0 7. 00 8. 00 PHARMACY 15. 00 6, 892 0 0 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 0 0 9. 00		l .			0	-1		
7. 00 NURSI NG ADMI NI STRATI ON 13. 00 41, 253 0 0 0 0 7. 00 8. 00 PHARMACY 15. 00 6, 892 0 0 0 8. 00 9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 0 0 9. 00			1		ő	- 1		1
9. 00 MEDI CAL RECORDS & LI BRARY 16. 00 11, 622 0 9. 00					O	o		
		1			0	-		
10.00 ADULTS & PEDIATRICS 30.00 157, 438 0 0 10.00			1		0			1
	10.00	ADULIS & PEDIATRICS	30.00	157, 438	O	U		10.00

RECLASSI FI CATIONS

Provider CCN: 15-0112

Period: Worksheet A-6 From 01/01/2019

36.00

12/31/2019 Date/Time Prepared: 7/24/2020 4:05 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 11.00 INTENSIVE CARE UNIT 31.00 9,698 0 0 11 00 12.00 SUBPROVIDER - IRF 41.00 11,021 12.00 0 13.00 NURSERY 43.00 0 13.00 8.667 RADI OLOGY-DI AGNOSTI C 0 0 14 00 14.00 54.00 24, 489 15.00 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 4,816 0 0 15.00 0 16.00 ULTRA SOUND 54.02 2,841 0 16.00 17.00 MAMMOGRAPHY 54.03 0 0 17.00 13. 184 RADI OLOGY-THERAPEUTI C 0 18.00 55.00 581 0 18.00 19.00 CT SCAN 57.00 1, 682 0 0 19.00 20.00 58.00 1, 257 0 0 20.00 CARDIAC CATHETERIZATION 59 00 0 0 21 00 18, 779 21 00 0 22.00 LABORATORY 60.00 29, 725 0 22.00 23.00 RESPIRATORY THERAPY 65.00 8, 266 0 23.00 24.00 PHYSICAL THERAPY 66.00 14,001 0 0 24.00 OCCUPATIONAL THERAPY 0 25 00 67 00 0 25 00 8.584 0 26.00 ELECTROCARDI OLOGY 69.00 1,784 0 26.00 5, 895 27.00 ELECTROENCEPHALOGRAPHY 70.00 0 27.00 28.00 CLINIC 90.00 5. 369 0 0 28.00 01 NEUROPSYCH 90.02 0 29 00 4,946 29 00 31.00 VIMCARE CLINIC 90.05 285 0 0 31.00 0 32.00 **EMERGENCY** 91.00 40, 675 0 32.00 95.00 0 AMBULANCE SERVICES 23.041 0 33.00 33.00 34.00 WELLNESS COMMUNITY 194.00 1,069 0 0 34.00 WOUND CENTER 35.00 90.03 410 0 35.00 561, 582 X - RECLASS OT SALARIES AND OTHER EXP 1.00 PHYSI CAL THERAPY 535, 909 48, 388 0 1.00 66.00 535, 909 48, 388 - RECLASS LAB BLOOD SUPERVISOR 1 00 LABORATORY 60.00 60, 583 0 1 00 60, 583 WA - RECLASS CONTRACT LABOR BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 369.894 1.00 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 158, 734 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 0 3.00 1, 685, 158 3.00 4.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 252, 101 0 4.00 TOTALS 2, 465, 887 WB - RECLASS SALARIES TO HOME DEPT 1.00 ADMINISTRATIVE & GENERAL 5. 00 20, 955 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 50, 183 0 0 2.00 7, 565 0 3.00 ADMINISTRATIVE & GENERAL 5.00 0 3.00 4.00 ADMINISTRATIVE & GENERAL 5.00 1,440 0 0 4.00 0 5.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 964 0 5.00 EMPLOYEE BENEFITS DEPARTMENT 1, 323 0 0 6.00 4.00 6.00 EMPLOYEE BENEFITS DEPARTMENT 0 0 7.00 4.00 365 7.00 8.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 4, 592 0 0 8.00 9.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 608 0 0 9.00 ADMINISTRATIVE & GENERAL 0 0 10.00 5.00 10.00 11.00 ADMINISTRATIVE & GENERAL 5.00 5,821 0 0 11.00 12.00 ADMINISTRATIVE & GENERAL 5.00 1, 769 0 0 12.00 0 ADMINISTRATIVE & GENERAL 0 13 00 5 00 1 067 13 00 0| ADMINISTRATIVE & GENERAL 0 14.00 5.00 1, 775 14.00 15.00 ADMINISTRATIVE & GENERAL 5.00 14, 633 0 0 15.00 0 16.00 ADMINISTRATIVE & GENERAL 5.00 5, 566 0 16.00 0 ADMINISTRATIVE & GENERAL 5 00 1, 863 0 17 00 17 00 18.00 ADMINISTRATIVE & GENERAL 5.00 2, 186 0 0 18.00 19.00 ADMINISTRATIVE & GENERAL 5.00 10, 188 0 0 19.00 0 20.00 ADMINISTRATIVE & GENERAL 5.00 1, 795 0 20.00 0 0 21 00 ADMINISTRATIVE & GENERAL 5 00 2.402 21 00 22.00 ADMINISTRATIVE & GENERAL 5.00 3, 425 0 0 22.00 ADMINISTRATIVE & GENERAL 0 0 23.00 5.00 2,072 23.00 ADMINISTRATIVE & GENERAL 0 0 24.00 5.00 5. 751 24.00 0 ADMINISTRATIVE & GENERAL 5.00 0 25.00 2, 118 25.00 26.00 ADMINISTRATIVE & GENERAL 5.00 8,002 0 0 26.00 0 0 27.00 ADMINISTRATIVE & GENERAL 5.00 1,770 27.00 0 28.00 ADMINISTRATIVE & GENERAL 5.00 17, 394 0 28.00 0 0 29 00 ADMINISTRATIVE & GENERAL 5.00 1, 882 29 00 1, 460 30.00 ADMINISTRATIVE & GENERAL 5.00 0 0 30.00 0 31.00 ADMINISTRATIVE & GENERAL 5.00 22, 292 0 31.00 ADMINISTRATIVE & GENERAL 0 32.00 5.00 1.597 0 32.00 0 33.00 ADMINISTRATIVE & GENERAL 5.00 3, 995 0 33.00 ADMINISTRATIVE & GENERAL 0 0 34.00 5.00 1,712 34.00 HEALTHY COMMUNITIES 0 0 35, 00 194.07 35, 00 11, 688

36.00

EMPLOYEE BENEFITS DEPARTMENT

4.00

1,000

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

		Decreases		772172020 1.0	о рііі				
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.				
	6. 00	7.00	8.00	9. 00	10.00				
37. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	500	0	0		37. 00		
38.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	375	0	0		38.00		
39.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	625	0	0		39.00		
40.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	16, 005	0	0		40.00		
41.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	500	0	0		41.00		
42.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	16, 384	0	0		42.00		
43.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 447	0	0		43.00		
44.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	250	0	0		44.00		
45.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	250	0	0		45.00		
46.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5, 228	0	0		46.00		
47.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	250	0	0		47.00		
48.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	500	0	0		48.00		
49.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	250	0	0		49.00		
50.00	ADMI NI STRATI VE & GENERAL	5.00	<u>1, 1</u> 19	0	0		50.00		
	TOTALS		267, 908	0					
	WC - RECLASS SEVERANCE PAY								
1.00	ADMINISTRATIVE & GENERAL	5. 00	139, 174	0	0		1.00		
2.00	ADMINISTRATIVE & GENERAL	5. 00	36, 410	0	0		2.00		
3.00	ADMINISTRATIVE & GENERAL	5. 00	29, 729	0	0		3.00		
4.00	ADMI NI STRATI VE & GENERAL	5. 00	1 <u>6, 2</u> 47	0	0		4.00		
	TOTALS		221, 560	0					
500.00	Grand Total: Decreases		5, 257, 901	46, 861, 117			500.00		

								7/24/2020 4:0	
	Cost Center	Incre Line #	eases Sal ary	Other	Cost Center	Decre Li ne #	sases Sal ary	Other	
	2. 00	3. 00	4.00	5.00	6. 00	7. 00	8. 00	9. 00	
1.00	B - RECLASS DEPREC BLD CAP REL COSTS-BLDG & FLXT	1. 00	0	1, 494, 006	INTEREST EXPENSE	113. 00	0	1, 494, 006	1. 00
2.00	CAP REL COSTS-MVBLE	2. 00	0	403, 060	INTEREST EXPENSE	113. 00	0	403, 060	2. 00
	0		o	1, 897, 066	0			1, 897, 066	
1. 00	C - RECLASS INSURANCE OCCUPATIONAL THERAPY	67. 00	0	988	ADMINISTRATIVE &	5. 00	0	988	1. 00
2.00	CAP REL COSTS-BLDG &	1. 00	0	673, 014	GENERAL ADMINISTRATIVE &	5. 00	0	673, 014	2. 00
3.00	AMBULANCE SERVICES	95. 00	0	52, 033	GENERAL ADMINISTRATIVE &	5. 00	0	52, 033	3. 00
4.00	LABORATORY	60. 00	0	4, 088	GENERAL ADMINISTRATIVE &	5. 00	0	4, 088	4. 00
	0 — — —		₀	730, 123	GENERAL		₀		
1. 00	D - RECLASS BILLING CO ADMINISTRATIVE &	ST 5. 00	1, 036, 451	220 012	MEDICAL RECORDS &	16.00	1, 036, 451	239, 912	1. 00
1.00	GENERAL	5.00	1, 036, 451	239, 912 	LI BRARY		1, 036, 451	239, 912 239, 912	1.00
	E - RECLASS HYPERBARIC	THERAP		239, 912	:[U		1, 036, 451	239, 912	
1.00	HYPERBARI C OXYGEN THERAPY	90. 04	108, 076	62, 272	WOUND CENTER	90. 03	108, 076	62, 272	1. 00
	0 F - RECLASS CAFETERIA	FYPENSE	108, 076	62, 272	0		108, 076	62, 272	
1. 00	CAFETERI AO	11.00		736, 703 736, 703	DI ETARY	10.00	1, 330, 543 1, 330, 543	736, 703 736, 703	1. 00
1.00	G - RECLASS WELLNESS WELLNESS COMMUNITY	194. 00	182, 371	40, 655	EMPLOYEE BENEFITS	4.00	182, 371	40, 655	1. 00
	0 — — —		182, 371	40, 655	DEPARTMENT		182, 371	40, 655	
1. 00	H - RECLASS PHYSICIAN RADI OLOGY-DI AGNOSTI C	FEES 54. 00	0	50, 000	ADMINISTRATIVE &	5.00	0	50, 000	1. 00
2. 00	ADULTS & PEDIATRICS	30. 00	0		GENERAL ADMINISTRATIVE &	5.00	0	1, 576, 921	2. 00
4.00	SUBPROVI DER - I RF	41. 00	0	231, 150	GENERAL ADMINISTRATIVE &	5. 00	0	231, 150	4. 00
5. 00	OPERATING ROOM	50. 00	0	863, 100	GENERAL ADMINISTRATIVE &	5. 00	0	863, 100	5. 00
6. 00 7. 00	ANESTHESI OLOGY RADI OLOGY-THERAPEUTI C	53. 00 55. 00	O O		GENERAL OPERATING ROOM ADMINISTRATIVE &	50. 00 5. 00	0	60, 000 63, 750	6. 00 7. 00
9. 00	LABORATORY-PATHOLOGIC	60. 01	0	225, 000	GENERAL ADMINISTRATIVE &	5. 00	0	225, 000	9. 00
10. 00	RESPI RATORY THERAPY	65. 00	0	25, 000	GENERAL ADMINISTRATIVE &	5. 00	0	25, 000	10. 00
11. 00	PHYSI CAL THERAPY	66. 00	0		GENERAL ADMINISTRATIVE &	5. 00	0	50, 000	11. 00
12. 00	ELECTROCARDI OLOGY	69. 00	0	58, 600	GENERAL ADMINISTRATIVE & GENERAL	5. 00	0	58, 600	12. 00
13. 00	ELECTROENCEPHALOGRAPH	70. 00	0	9, 750	ADMINISTRATIVE & GENERAL	5. 00	0	9, 750	13. 00
16. 00	AMBULANCE SERVICES	95. 00	0	17, 500	ADMINISTRATIVE & GENERAL	5.00	0	17, 500	16. 00
17. 00	WOUND CENTER	90. 03	0	39, 632	ADMINISTRATIVE & GENERAL	5.00	0	39, 632	17. 00
18. 00	HYPERBARI C OXYGEN THERAPY	90. 04	0		ADMINISTRATIVE & GENERAL	5. 00	0	2, 368	18. 00
19. 00	EMERGENCY	91. 00	0	<u>1, 933, 1</u> 72 5, 205, 943	OPERATING ROOM 0	50.00		<u>1, 933, 1</u> 72 5, 205, 943	19. 00
1.00	I - RECLASS REHAB SERV OCCUPATIONAL THERAPY	/I CES 67. 00	20, 369	6, 582	ADMINISTRATIVE &	5.00	20, 369	6, 582	1. 00
2. 00	PHYSI CAL THERAPY	66. 00	19, 484	5, 884	GENERAL ADMINISTRATIVE &	5.00	19, 484	5, 884	2. 00
3.00	SPEECH PATHOLOGY	68. 00	17, 042	3, 405	GENERAL ADMINISTRATIVE &	5. 00	17, 042	3, 405	3. 00
4. 00	SUBPROVI DER - I RF	41. 00	147, 418	7, 061	GENERAL ADMINISTRATIVE & GENERAL	5. 00	147, 418	7, 061	4. 00
5.00	ELECTROENCEPHALOGRAPH	70. 00	9, 922	3, 531	ADMINISTRATIVE & GENERAL	5. 00	9, 922	3, 531	5. 00
6. 00	SOCI AL SERVI CE	17. 00	1, 654	588	ADMINISTRATIVE &	5.00	1, 654	588	6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	17, 040	5, 884	ADMINISTRATIVE &	5. 00	17, 040	5, 884	7. 00
					ADMINISTRATIVE & GENERAL				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

							o 12/31/2019	Date/lime Pre 7/24/2020 4:0	
		Incre				Decre			
	Cost Center	Line #	Salary	Other 5.00	Cost Center	Li ne #	Sal ary	Other	
8. 00	2. 00 NEUROPSYCH	3. 00 90. 02	4.00	5.00	6.00 ADMINISTRATIVE &	7. 00 5. 00	8. 00 3, 307	9. 00 1, 177	8. 00
0.00	NEOROI STOIT	70.02	3, 307	1, 177	GENERAL	3.00	3, 307	1, 177	0.00
9. 00	WOUND CENTER	90. 03	0	508	ADMINISTRATIVE & GENERAL	5.00	0	508	9. 00
10. 00	HYPERBARI C OXYGEN THERAPY	90. 04	0	230	ADMINISTRATIVE & GENERAL	5.00	0	230	10. 00
11. 00	WELLNESS COMMUNITY	194. 00	3, 307	1, 177	ADMINISTRATIVE &	5. 00	3, 307	1, 177	11. 00
	0 — — —		239, 543	36, 027	GENERAL O		239, 543	36, 027	
	J - RECLASS PHARMACY R				I==				
1. 00	PHARMACY RESIDENCY PROG	23. 02	174, 917	_	PHARMACY	15. 00	174, 917	0	1. 00
2. 00	PHARMACY RESIDENCY PROG	23. 02	0	2, 161	ADMINISTRATIVE & GENERAL	5. 00	0	2, 161	2. 00
3. 00	PHARMACY RESIDENCY PROG	23. 02	0	1, 655	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 655	3. 00
	0		174, 917	3, 816			174, 917	3, 816	
1 00	K - RECLASS RENT EXPEN		0	12 270	DULL DI NO DENTAL C	104 01	٥	12 270	1 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00			BUILDING RENTALS	194. 01	0	13, 370	1. 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	249, 778	BUILDING RENTALS	194. 01	0	249, 778	2. 00
3.00	OPERATION OF PLANT	7. 00	0		BUILDING RENTALS	194. 01	0	125, 554	3. 00
4.00	XRAY EDUCATION	23. 01	0		BUILDING RENTALS	194. 01	0	11, 860	4. 00
5. 00 6. 00	MAMMOGRAPHY LABORATORY	54. 03 60. 00	0		BUILDING RENTALS BUILDING RENTALS	194. 01 194. 01	0	130, 849 14, 909	5. 00 6. 00
7. 00	PHYSI CAL THERAPY	66. 00	0		BUILDING RENTALS	194.01	0	370, 117	7. 00
8. 00	OCCUPATI ONAL THERAPY	67. 00	ő		BUILDING RENTALS	194. 01	o	151, 242	8. 00
9.00	SPEECH PATHOLOGY	68. 00	O		BUILDING RENTALS	194. 01	0	66, 295	9. 00
10. 00	ELECTROENCEPHALOGRAPH	70. 00	0	127, 536	BUILDING RENTALS	194. 01	0	127, 536	10. 00
11. 00	WOUND CENTER	90. 03	0	99, 589	BUILDING RENTALS	194. 01	o	99, 589	11. 00
12. 00	HYPERBARI C OXYGEN THERAPY	90. 04	Ō		BUILDING RENTALS	194. 01	Ō	54, 863	12. 00
13.00	AMBULANCE SERVICES	95. 00	О	15, 000	BUILDING RENTALS	194. 01	0	15, 000	13.00
14.00	WELLNESS COMMUNITY	194. 00	0	69, 244	BUILDING RENTALS	194. 01	O	69, 244	14.00
15.00	CRHP	194. 08	0		BUILDING RENTALS	194. 01	0	46 <u>0, 0</u> 86	15.00
	0		0	1, 960, 292	0		0	1, 960, 292	
1 00	L - RECLASS MARKETING			140.000	ADMINI CEDATINE O	T = 00		140,000	1 00
1. 00	NONALLOWABLE MARKETI NG	194. 05	0	140, 000	ADMINISTRATIVE & GENERAL	5. 00	0	140, 000	1. 00
	0			140, 000				140, 000	
	M - RECLASS DEPRECIATI	ON EXPE	NSE				1	·	
1.00	CAP REL COSTS-MVBLE	2. 00	0	13, 777, 060	CAP REL COSTS-BLDG &	1. 00	0	13, 777, 060	1. 00
	EQUI P			13, 777, 060	FIXT	\vdash		13, 777, 060	
	N - RECLASS MAINTENANC	E EXDEV		13, 777, 000	ĮO		U _I	13, 777, 000	
1.00	RESPIRATORY THERAPY	65. 00	0	7. 350	OPERATION OF PLANT	7.00	0	7, 350	1. 00
2.00	ELECTROCARDI OLOGY	69. 00	0	5, 280	OPERATION OF PLANT	7. 00	o	5, 280	2. 00
3.00	CARDI AC	59. 00	0	205, 190	OPERATION OF PLANT	7.00	0	205, 190	3.00
4. 00	CATHETERIZATION CENTRAL SERVICES &	14. 00	0	95, 372	OPERATION OF PLANT	7.00	0	95, 372	4. 00
5. 00	SUPPLY OPERATING ROOM	50. 00	o	258 011	OPERATION OF PLANT	7.00	o	258, 011	5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	o		OPERATION OF PLANT	7.00	0	682, 185	6. 00
7. 00	LABORATORY	60.00	-1		OPERATION OF PLANT	7. 00	0	194, 254	7. 00
8.00	LABORATORY-PATHOLOGIC	60. 01	0		OPERATION OF PLANT	7. 00	0	12, 450	8. 00
9. 00	AL NURSI NG	13. 00	0	5, 055	OPERATION OF PLANT	7.00	0	5, 055	9. 00
10. 00	ADMI NI STRATI ON RADI OLOGY-DI AGNOSTI C	54. 00			OPERATION OF PLANT	7.00	0	225, 174	10. 00
11. 00	MAMMOGRAPHY	54. 03	0		OPERATION OF PLANT	7.00	0	273, 388	11. 00
12. 00	ULTRA SOUND	54. 02	Ö		OPERATION OF PLANT	7. 00	ol	90, 416	12. 00
13.00	CT SCAN	57. 00	0	189, 513	OPERATION OF PLANT	7. 00	0	189, 513	13.00
14. 00	NUCLEAR	54. 01	0	170, 024	OPERATION OF PLANT	7. 00	o	170, 024	14. 00
15 00	MEDI CI NE-DI AGNOSTI C	FC 02		400 405	ODEDATION OF DIANT	7 00		400 405	15 00
15. 00 16. 00	MRI PHARMACY	58. 00 15. 00	0		OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	132, 485	15. 00 16. 00
16. 00 17. 00	PHARMACY EMERGENCY	91. 00	0		OPERATION OF PLANT	7.00	0	46, 682 29, 922	16. 00 17. 00
18.00	ADMINISTRATIVE &	5. 00	0		OPERATION OF PLANT	7.00	0	29, 922 15, 443	17.00
. 5. 50	GENERAL	0.00	٩	10, 440	I LANT	,	9	15, 445	. 5. 50
19. 00	ANESTHESI OLOGY	53. 00	0		OPERATION OF PLANT	7.00	<u> </u>	3, 125	19. 00
	0		0	2, 641, 319	Įυ		O	2, 641, 319	

In Lieu of Form CMS-2552-10

Period: Worksheet A-6
From 01/01/2019 Non-CMS Worksheet
To 12/31/2019 Date/Ti me Prepared:
7/24/2020 4:05 pm

							0 12/31/2019	7/24/2020 4:0	pared: 15 pm
	Cost Center	Incre Line #	eases Sal ary	Other	Cost Center	Decre Li ne #	sases Sal ary	Other	
	2.00	3.00	4. 00	5. 00	6. 00	7.00	8. 00	9. 00	
1. 00	O - RECLASS DIRECTOR P EMERGENCY	HARMAC\ 91.00			PHARMACY	15. 00	101, 124	0	1. 00
2. 00	RESPIRATORY THERAPY	65. 00			PHARMACY	15.00	50, 562	0	2. 00
3. 00	AMBULANCE SERVICES	<u>95</u> . <u>00</u>	5 <u>0, 5</u> 62 202, 248		PHARMACY	15. 00	50, 562	0	3. 00
	Q - RECLASS XRAY EDUCA	TION EX			IIO		202, 248	U	
1. 00 2. 00	XRAY EDUCATION XRAY EDUCATION	23. 01	185		MRI RESPI RATORY THERAPY	58. 00 65. 00	185	0	1. 00 2. 00
3. 00	XRAY EDUCATION	23. 01 23. 01	63 0		EMPLOYEE BENEFITS	4.00	63 0	13, 367	3. 00
4 00	VDAV EDUCATION	22 01	225 042	2 725	DEPARTMENT	E4 00	225 042	2 725	4 00
4. 00	XRAY EDUCATION	23. 01	33 <u>5, 962</u> 336, 210	<u>2, 725</u> 16, 092	RADI OLOGY-DI AGNOSTI C	54.00	33 <u>5, 9</u> 62 336, 210	<u>2, 725</u> 16, 092	4. 00
1 00	S - RECLASS NON ALLOW			/FF 042	ADMINI CTDATIVE 0			/FF 042	1 00
1. 00	NONALLOWABLE MARKETING	194. 05		055, 642	ADMINISTRATIVE & GENERAL	5.00	0	655, 842 	1. 00
	U - RECLASS CHARGEABLE	SHIDDI V	0 / COST	655, 842	0		0	655, 842	
1.00	MEDI CAL SUPPLI ES	71. 00		255, 979	ADULTS & PEDIATRICS	30.00	0	255, 979	1. 00
2. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	142, 127	INTENSIVE CARE UNIT	31.00	o	142, 127	2. 00
3. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	4 354	SUBPROVIDER - IRF	41.00	0	4, 354	3. 00
	CHARGED TO PATIENT							·	
4. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	U		NURSERY	43.00	0	4, 044	4. 00
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	3, 863, 084	OPERATING ROOM	50.00	0	3, 863, 084	5. 00
6. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	7, 726, 725	OPERATING ROOM	50.00	0	7, 726, 725	6. 00
8. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	149, 469	RADI OLOGY-DI AGNOSTI C	54.00	0	149, 469	8. 00
10. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 125	ELECTROENCEPHALOGRAPH	70.00	0	1, 125	10. 00
11. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	128, 748	MAMMOGRAPHY	54. 03	0	128, 748	11. 00
12. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	29, 308	RADI OLOGY-THERAPEUTI C	55.00	0	29, 308	12. 00
13. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	17, 657	CT SCAN	57.00	0	17, 657	13. 00
15. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 625, 511	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 625, 511	15. 00
16. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	1, 931, 547		59. 00	0	1, 931, 547	16. 00
17. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	60, 085	RESPI RATORY THERAPY	65.00	0	60, 085	17. 00
18. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	14, 420	PHYSI CAL THERAPY	66. 00	0	14, 420	18. 00
19. 00 20. 00	SPEECH - HEARING AIDS MEDICAL SUPPLIES	194. 04 71. 00			SPEECH PATHOLOGY OCCUPATIONAL THERAPY	68. 00 67. 00	0	186, 874 1, 097	
	CHARGED TO PATIENT							·	
22. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	35, 490	EMERGENCY	91.00	0	35, 496	22. 00
23. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	23, 231	AMBULANCE SERVICES	95.00	0	23, 231	23. 00
24. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	2, 839	VIMCARE CLINIC	90. 05	0	2, 839	24. 00
	0 — — — —			16, 203, 720	0			16, 203, 720	
1. 00	V - RECL PTO COST FOR EMPLOYEE BENEFITS	STD ELI 4. 00	MINATION PD O	458	EMPLOYEE BENEFITS	4.00	458	0	1. 00
2. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			DEPARTMENT ADMINISTRATIVE &	5. 00	50, 302	0	2. 00
3. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			GENERAL OPERATION OF PLANT	7.00	17, 744	0	
4. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			HOUSEKEEPI NG	9.00	10, 041	0	4. 00
5. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			DI ETARY	10.00	9, 298	0	5. 00
6. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			CAFETERI A	11.00	15, 469	0	6. 00
7. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			NURSI NG	13.00	41, 253	0	7. 00
8. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			ADMI NI STRATI ON PHARMACY	15. 00	6, 892	0	8. 00
9. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00			MEDICAL RECORDS &	16.00	11, 622	0	9. 00
	DEPARTMENT	4.00	U	11,022	LI BRARY	10.00	11,022	U	7.00

| Period: | Worksheet A-6 | From 01/01/2019 | Non-CMS Worksheet | To 12/31/2019 | Date/Time Prepared: | 7/24/2020 4:05 pm

Carper C	ther
DEPARTMENT	2. 00
11.00 EMPLOYEE BENEFITS 4.00 0 9,698 INTENSIVE CARE UNIT 31.00 9,698 DEPARTMENT 12.00 EMPLOYEE BENEFITS 4.00 0 11,021 SUBPROVIDER - IRF 41.00 11,021 13.00 EMPLOYEE BENEFITS 4.00 0 8,667 NURSERY 43.00 8,667 14.00 EMPLOYEE BENEFITS 4.00 0 24,489 RADIOLOGY-DIAGNOSTIC 54.00 24,489 EMPLOYEE BENEFITS 4.00 0 4,816 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 4,816 EMPLOYEE BENEFITS 4.00 0 2,841 ULTRA SOUND 54.02	0 10.00
12.00 EMPLOYEE BENEFITS 4.00 0 11,021 SUBPROVI DER - IRF 41.00 11,021 DEPARTMENT 13.00 EMPLOYEE BENEFITS 4.00 0 8,667 NURSERY 43.00 8,667 DEPARTMENT 14.00 EMPLOYEE BENEFITS 4.00 0 24,489 RADIOLOGY-DIAGNOSTIC 54.00 24,489 DEPARTMENT 15.00 EMPLOYEE BENEFITS 4.00 0 2,841 ULTRA SOUND 54.02 2,841 DEPARTMENT 17.00 EMPLOYEE BENEFITS 4.00 0 2,841 ULTRA SOUND 54.02 2,841 DEPARTMENT 18.00 EMPLOYEE BENEFITS 4.00 0 581 RADIOLOGY-THERAPEUTIC 55.00 581 DEPARTMENT 19.00 EMPLOYEE BENEFITS 4.00 0 581 RADIOLOGY-THERAPEUTIC 55.00 581 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 1,257 MRI 58.00 1,257 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 18,779 CARDIAC 59.00 18,779 CARDIAC 59.00 29,725 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 8,266 RESPIRATORY 60.00 29,725 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 8,584 OCCUPATIONAL THERAPY 65.00 8,266 DEPARTMENT 25.00 EMPLOYEE BENEFITS 4.00 0 8,584 OCCUPATIONAL THERAPY 66.00 1,784 DEPARTMENT 25.00 EMPLOYEE BENEFITS 4.00 0 8,584 OCCUPATIONAL THERAPY 60.00 1,784 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 5,895 ELECTROCACRIOLOGY 69.00 5,369 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 5,369 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 5,369 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.00 5,369 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.00 5,369 DEPARTMENT 20.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 EMPLOYEE BENEFITS 4.00 0 285 VI MCARE CLINIC 90.05 285 EMPLOYEE BENEFITS 4.00	0 11.00
13.00 EMPLOYEE BENEFITS 4.00 0 8,667 NURSERY 43.00 8,667 14.00 EMPLOYEE BENEFITS 4.00 0 24,489 RADIOLOGY-DIAGNOSTIC 54.00 24,489 15.00 EMPLOYEE BENEFITS 4.00 0 4,816 NUCLEAR EDICTINE-DIAGNOSTIC 16.00 EMPLOYEE BENEFITS 4.00 0 2,841 ULTRA SOUND 54.02 2,841 17.00 EMPLOYEE BENEFITS 4.00 0 31,184 MAMMOGRAPHY 54.03 13,184 18.00 EMPLOYEE BENEFITS 4.00 0 581 RADIOLOGY-THERAPEUTIC 55.00 581 19.00 EMPLOYEE BENEFITS 4.00 0 1,682 CT SCAN 57.00 1,682 20.00 EMPLOYEE BENEFITS 4.00 0 1,257 MRI 58.00 1,257 21.00 EMPLOYEE BENEFITS 4.00 0 18,779 CARDIAC 59.00 18,779 22.00 EMPLOYEE BENEFITS 4.00 0 18,779 CARDIAC CATHETRIZATION 29,725 23.00 EMPLOYEE BENEFITS 4.00 0 3,266 RESPIRATORY THERAPY 66.00 29,725 24.00 EMPLOYEE BENEFITS 4.00 0 3,584 OCCUPATIONAL THERAPY 67.00 8,584 25.00 EMPLOYEE BENEFITS 4.00 0 1,784 ELECTROCARDIOLOGY 69.00 1,784 26.00 EMPLOYEE BENEFITS 4.00 0 1,784 ELECTROCARDIOLOGY 69.00 5,369 26.00 EMPLOYEE BENEFITS 4.00 0 1,784 ELECTROCARDIOLOGY 69.00 5,369 26.00 EMPLOYEE BENEFITS 4.00 0 5,369 CLINIC 90.05 285 27.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.02 4,946 28.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 4,946 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROPSYCH 90.05 285 29.00 EMPLOYEE BENEFITS 4.00 0 4,946 NEUROP	0 12.00
DEPARTMENT	0 13.00
DEPARTMENT	0 14.00
DEPARTMENT	0 15.00
DEPARTMENT	0 16.00
DEPARTMENT	0 17.00
DEPARTMENT 20. 00 EMPLOYEE BENEFITS	0 18.00
DEPARTMENT	0 19.00
DEPARTMENT 22. 00 EMPLOYEE BENEFITS DEPARTMENT 23. 00 EMPLOYEE BENEFITS DEPARTMENT 24. 00 EMPLOYEE BENEFITS DEPARTMENT 24. 00 EMPLOYEE BENEFITS DEPARTMENT 25. 00 EMPLOYEE BENEFITS DEPARTMENT 26. 00 EMPLOYEE BENEFITS DEPARTMENT 27. 00 EMPLOYEE BENEFITS DEPARTMENT 28. 00 EMPLOYEE BENEFITS DEPARTMENT 29. 00 EMPLOYEE BENEFITS DEPARTMENT 29. 00 EMPLOYEE BENEFITS DEPARTMENT 20. 00 EMPLOYEE BENEFITS 20. 00 EMPLOYEE BENEFITS DEPARTMENT 20. 00 EMPLOYEE BENEFITS 20. 00 EMPLOYEE 20	0 20.00
DEPARTMENT 23. 00 EMPLOYEE BENEFITS 4. 00 0 8, 266 RESPIRATORY THERAPY 4. 00 0 14, 001 PHYSICAL THERAPY 55. 00 EMPLOYEE BENEFITS 4. 00 0 8, 584 OCCUPATIONAL THERAPY 55. 00 EMPLOYEE BENEFITS 4. 00 0 1, 784 ELECTROCARDIOLOGY 69. 00 1, 784 DEPARTMENT 70. 00 EMPLOYEE BENEFITS 70. 00 EMPLOYEE BENEFIT	0 21.00
DEPARTMENT 24. 00	0 22.00
DEPARTMENT 25. 00 EMPLOYEE BENEFITS	0 23.00
DEPARTMENT 26. 00 EMPLOYEE BENEFITS	0 24.00
DEPARTMENT 27. 00 EMPLOYEE BENEFITS 4. 00 0 5, 895 ELECTROENCEPHALOGRAPH 70. 00 5, 895	0 25.00
DEPARTMENT 28. 00	0 26.00
DEPARTMENT 29. 00	0 27.00
DEPARTMENT	1
	1
32. 00 EMPLOYEE BENEFITS 4. 00 0 40, 675 EMERGENCY 91. 00 40, 675	0 31.00 0 32.00
32. 00 EMPLOYEE BENEFITS 4. 00 0 23, 041 AMBULANCE SERVICES 95. 00 23, 041	0 33.00
34. 00 EMPLOYEE BENEFITS 4. 00 0 1, 069 WELLNESS COMMUNITY 194. 00 1, 069	0 34.00
35. 00 EMPLOYEE BENEFITS 4. 00 0 410 WOUND CENTER 90. 03 410	0 34.00
DEPARTMENT 0 561, 582 90. 03 410	
X - RECLASS OT SALARIES AND OTHER EXP	
1. 00 OCCUPATI ONAL THERAPY 67. 00 535, 909 48, 388 PHYSI CAL THERAPY 66. 00 535, 909 0 535, 909 535, 909	48, 388 48, 388
Z - RECLASS LAB BLOOD SUPERVI SOR	0 1.00
RED BL00D_CELL	
WA - RECLASS CONTRACT LABOR BENEFITS 1. 00 ADMINISTRATIVE & 5. 00 0 369, 894 EMPLOYEE BENEFITS 4. 00 0	369, 894 1. 00
GENERAL DEPARTMENT 2. 00 CENTRAL SERVICES & 14. 00 0 158, 734 EMPLOYEE BENEFITS 4. 00 0	158, 734 2. 00
	, 685, 158 3. 00
4.00 RECOVERY ROOM 51.00 0 252, 101 EMPLOYEE BENEFITS 4.00 0	252, 101 4. 00
	2, 465, 887
WB - RECLASS SALARIES TO HOME DEPT 1.00 EMPLOYEE BENEFITS 4.00 20,955 0 ADMINISTRATIVE & 5.00 20,955	0 1.00
DEPARTMENT 2. 00 ADMINISTRATIVE & 5. 00 50, 183 OADMINISTRATIVE & 5. 00 50, 183	0 2.00
GENERAL GENERAL	
3. 00 OPERATING ROOM 50. 00 7, 565 O ADMINISTRATIVE & 5. 00 7, 565 GENERAL	0 3.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

| In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | Non-CMS Worksheet | To 12/31/2019 | Date/Time Prepared: | 7/24/2020 4:05 pm

	In		Increases		Decreases		2505	7/24/2020 4:0	5 pm
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4.00	5. 00	6. 00	7.00	8. 00	9. 00	
4. 00	RECOVERY ROOM	51. 00	1, 440		O ADMINISTRATIVE & GENERAL	5. 00	1, 440	0	4. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	964		OEMPLOYEE BENEFITS DEPARTMENT	4. 00	964	0	5. 00
6. 00	ADMI NI STRATI VE &	5. 00	1, 323		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 323	0	6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	365		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	365	0	7. 00
8. 00	OPERATING ROOM	50. 00	4, 592		O EMPLOYEE BENEFITS DEPARTMENT	4.00	4, 592	0	8. 00
9. 00	RECOVERY ROOM	51. 00	608		O EMPLOYEE BENEFITS DEPARTMENT	4.00	608	0	9. 00
10. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	7		O ADMINISTRATIVE & GENERAL	5.00	7	0	10. 00
11. 00	OPERATION OF PLANT	7. 00	5, 821		O ADMINISTRATIVE & GENERAL	5. 00	5, 821	0	11. 00
12. 00	HOUSEKEEPI NG	9. 00	1, 769		O ADMINISTRATIVE & GENERAL	5. 00	1, 769	0	12. 00
13. 00	DI ETARY	10. 00	1, 067		O ADMINISTRATIVE & GENERAL	5. 00	1, 067	0	13. 00
14. 00	CAFETERI A	11. 00	1, 775		O ADMINISTRATIVE & GENERAL	5. 00	1, 775	0	14. 00
15. 00	NURSI NG ADMI NI STRATI ON	13. 00	14, 633		O ADMINISTRATIVE & GENERAL	5. 00	14, 633	0	15. 00
16. 00	PHARMACY	15. 00	5, 566		O ADMINISTRATIVE & GENERAL	5. 00	5, 566	0	16. 00
17. 00	MEDI CAL RECORDS & LI BRARY	16. 00	1, 863		O ADMINISTRATIVE & GENERAL	5. 00	1, 863	0	17. 00
18. 00	SOCI AL SERVI CE	17. 00	2, 186		O ADMINISTRATIVE & GENERAL	5. 00	2, 186	0	18. 00
19. 00	ADULTS & PEDIATRICS	30. 00	10, 188		O ADMINISTRATIVE & GENERAL	5. 00	10, 188	0	19. 00
20. 00	INTENSIVE CARE UNIT	31. 00	1, 795		O ADMINISTRATIVE & GENERAL	5. 00	1, 795	0	20. 00
21. 00	OPERATING ROOM	50. 00	2, 402		O ADMINISTRATIVE & GENERAL	5. 00	2, 402	0	21. 00
22. 00	RADI OLOGY-DI AGNOSTI C	54. 00	3, 425		O ADMINISTRATIVE & GENERAL	5. 00	3, 425	0	22. 00
23. 00	MAMMOGRAPHY	54. 03	2, 072		O ADMINISTRATIVE & GENERAL	5. 00	2, 072	0	23. 00
24. 00	RADI OLOGY-THERAPEUTI C	55. 00	5, 751		O ADMINISTRATIVE & GENERAL	5. 00	5, 751	0	24. 00
25. 00	CARDI AC CATHETERI ZATI ON	59. 00	2, 118		O ADMINISTRATIVE & GENERAL	5. 00	2, 118	0	25. 00
26. 00	LABORATORY	60. 00	8, 002		O ADMINISTRATIVE & GENERAL	5. 00	8, 002	0	26. 00
27. 00	RESPIRATORY THERAPY	65. 00	1, 770		O ADMINISTRATIVE & GENERAL	5. 00	1, 770	0	27. 00
28. 00	PHYSI CAL THERAPY	66. 00	17, 394		O ADMINISTRATIVE & GENERAL	5. 00	17, 394	0	28. 00
29. 00	OCCUPATI ONAL THERAPY	67. 00	1, 882		O ADMINISTRATIVE & GENERAL	5. 00	1, 882	0	29. 00
30. 00	ELECTROENCEPHALOGRAPH	70. 00	1, 460		O ADMI NI STRATI VE & GENERAL	5. 00	1, 460	0	30. 00
31. 00	CLINIC	90. 00	22, 292		O ADMINISTRATIVE & GENERAL	5. 00	22, 292	0	31. 00
32. 00	WOUND CENTER	90. 03	1, 597		O ADMI NI STRATI VE & GENERAL	5. 00	1, 597	0	32. 00
33. 00	EMERGENCY	91. 00	3, 995		O ADMINISTRATIVE & GENERAL	5. 00	3, 995	0	33. 00
34. 00	AMBULANCE SERVICES	95. 00	1, 712		O ADMI NI STRATI VE & GENERAL	5. 00	1, 712	0	34. 00
35. 00	ADMINISTRATIVE & GENERAL	5. 00	11, 688		OHEALTHY COMMUNITIES	194. 07	11, 688	0	35. 00
36. 00	ADMI NI STRATI VE & GENERAL	5. 00	1, 000		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 000	0	36. 00
37. 00	HOUSEKEEPI NG	9. 00	500		OEMPLOYEE BENEFITS DEPARTMENT	4. 00	500	0	37. 00
38. 00	DI ETARY	10. 00	375		OEMPLOYEE BENEFITS DEPARTMENT	4. 00	375	0	38. 00
39. 00	CAFETERI A	11. 00	625		OEMPLOYEE BENEFITS DEPARTMENT	4. 00	625	0	39. 00
40. 00	NURSI NG ADMI NI STRATI ON	13. 00	16, 005		OEMPLOYEE BENEFITS DEPARTMENT	4. 00	16, 005	0	40. 00
41. 00	MEDICAL RECORDS & LIBRARY	16. 00	500		O EMPLOYEE BENEFITS DEPARTMENT	4.00	500	0	41. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2019 Non-CMS Worksheet To 12/31/2019 Date/Ti me Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

								7/24/2020 4:0	5 pm
		Incre	ases			Decre	ases		
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	6. 00	7.00	8. 00	9. 00	
42.00	ADULTS & PEDIATRICS	30.00	16, 384	(EMPLOYEE BENEFITS	4.00	16, 384	0	42.00
					DEPARTMENT				
43.00	INTENSIVE CARE UNIT	31.00	2, 447	(EMPLOYEE BENEFITS	4.00	2, 447	0	43.00
					DEPARTMENT				
44.00	RADI OLOGY-DI AGNOSTI C	54.00	250	(EMPLOYEE BENEFITS	4.00	250	0	44. 00
					DEPARTMENT				
45. 00	NUCLEAR	54. 01	250	(EMPLOYEE BENEFITS	4.00	250	0	45.00
	MEDICINE-DIAGNOSTIC				DEPARTMENT				
46. 00	LABORATORY	60.00	5, 228	(EMPLOYEE BENEFITS	4.00	5, 228	0	46. 00
					DEPARTMENT				
47. 00	ELECTROCARDI OLOGY	69. 00	250	(EMPLOYEE BENEFITS	4.00	250	0	47. 00
					DEPARTMENT			_	
48. 00	EMERGENCY	91. 00	500	(DEMPLOYEE BENEFITS	4.00	500	0	48. 00
		05.00	050		DEPARTMENT		0.50		
49. 00	AMBULANCE SERVICES	95. 00	250	(DEMPLOYEE BENEFITS	4.00	250	0	49. 00
F0 00	WELL NECC COMMUNITY	404 00	1 110	,	DEPARTMENT	- 00	4 440		F0 00
50.00	WELLNESS COMMUNITY	194. 00	1, 119	(DADMINISTRATIVE &	5.00	1, 119	0	50. 00
	TOTAL C.	-		— — — ;	GENERAL	-			
	TOTALS	DAY	267, 908	(TOTALS		267, 908	0	
4 00	WC - RECLASS SEVERANCE		400 474		A DALLAL CEDATINE A	T = 00	400 474	0	4 00
1.00	NURSI NG	13. 00	139, 174	(DADMINISTRATIVE &	5.00	139, 174	0	1. 00
2 00	ADMI NI STRATI ON	F4 00	27 410	,	GENERAL	F 00	27 410	0	2 00
2. 00	MAMMOGRAPHY	54. 03	36, 410	(DADMINISTRATIVE & GENERAL	5. 00	36, 410	U	2. 00
2 00	DADLOLOGY THERADELITIC	FF 00	20. 720	,		F 00	20. 720		2 00
3.00	RADI OLOGY-THERAPEUTI C	55. 00	29, 729	(DADMINISTRATIVE & GENERAL	5. 00	29, 729	U	3. 00
4. 00	AMBULANCE SERVICES	95. 00	16, 247	,	OLADMINISTRATIVE &	5.00	16, 247	0	4. 00
4.00	AWIBULANCE SERVICES	95.00	10, 247	(GENERAL	3.00	10, 247	٩	4.00
	TOTALS — — —	-	221, 560		TOTALS	\vdash		— — <u> </u>	
500.00			4, 696, 319		9 Grand Total:	+ +		46, 861, 117	E00 00
300. 00	Increases		4, 090, 319	47, 422, 69	Decreases		5, 257, 901	40, 801, 117	300. UU
	li iici eases	1			Ineci eases	1 1	1		

				Т	o 12/31/2019	Date/Time Prep 7/24/2020 4:05	
				Acqui si ti ons		772172020 1.00	5 piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 976, 052	34, 300	0	34, 300	0	1. 00
2.00	Land Improvements	20, 873, 669	109, 227	0	109, 227	0	2. 00
3.00	Buildings and Fixtures	101, 372, 271	816, 010	0	816, 010	0	3. 00
4.00	Building Improvements	105, 874, 161	700, 017	0	700, 017	0	4. 00
5.00	Fixed Equipment	9, 493, 916	111, 628	0	111, 628	18, 095	5.00
6.00	Movable Equipment	155, 013, 732	21, 135, 795	0	21, 135, 795	4, 533, 755	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	394, 603, 801	22, 906, 977	0	22, 906, 977	4, 551, 850	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	394, 603, 801	22, 906, 977	0	22, 906, 977	4, 551, 850	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1
1.00	Land	2, 010, 352	0				1. 00
2.00	Land Improvements	20, 982, 896	0				2. 00
3.00	Buildings and Fixtures	102, 188, 281	0				3. 00
4.00	Building Improvements	106, 574, 178	0				4. 00
5.00	Fixed Equipment	9, 587, 449	0				5. 00
6.00	Movable Equipment	171, 615, 772	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	412, 958, 928	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	412, 958, 928	0				10.00

	Financial Systems	COLUMBUS REGIO				u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0112	Peri od:	Worksheet A-7	
					From 01/01/2019		
					To 12/31/2019		
						7/24/2020 4:0	5 pm
			SU	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	22, 732, 376	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	22, 732, 376	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	22, 732, 376				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
2 00	Total (our of lines 1 2)	1	22 722 274				2 00

0 0 0

22, 732, 376

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	241, 343, 156	0	241, 343, 15	6 0. 584424	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	171, 615, 772	0	171, 615, 77	2 0. 415576	0	2. 00
3.00	Total (sum of lines 1-2)	412, 958, 928		412, 958, 92			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		(00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	I O	1		0 8, 968, 255	0	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0			0 13, 675, 307		2.00
3.00	Total (sum of lines 1-2)	0	ĺ		0 22, 643, 562	Ö	3.00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11 00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13. 00	14.00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 189, 815	673, 014		ol o	10, 831, 084	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	173, 609			0 0		1
3.00	Total (sum of lines 1-2)	1, 363, 424			o o		1
			1	1	1		

Peri od: Worksheet A-8
From 01/01/2019
To 12/31/2019 Date/Time Prepared: Provi der CCN: 15-0112

					o 12/31/2019		
				Expense Classification on		7/24/2020 4: 0	o piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 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	-44, 372	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	-98, 548	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-35, 321	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	А	-143, 895	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service	А	-10, 380	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking lot (chapter 21)	В		OPERATION OF PLANT	7. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-7, 679, 078			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-746, 016			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-801, 515	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients		0				
18. 00	Sale of medical records and abstracts	В	-12, 428	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,	В	-24, 553	XRAY EDUCATION	23. 01	0	19. 00
	books, etc.)		_			_	
20. 00 21. 00	Vending machines Income from imposition of	В	0	HOUSEKEEPI NG	9. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)		_				
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	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		· ·	oost content beneficial	111.00		20.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		Λ	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20.00	limitation (chapter 14)		•	ADULTS & DEDLATRICS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
22 00	limitation (chapter 14)		0		0.00	_	22 00
32. 00	CAH HIT Adjustment for Depreciation and Interest				0.00		
33. 00	TELEPHONE SERVICES	В	-300	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

From 01/01/2019
To 12/31/2019 Date/Time Prepared:

				To	12/31/2019	Date/Time Pre 7/24/2020 4:0	
				Expense Classification on	Worksheet A	172472020 4.0	3 piii
				To/From Which the Amount is			
					j		
	0 1 0 1 5 11	D : (0 (0)				WI I A 7 D C	
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
24 00	DEDD DAT DUONEC NEW FOULD	1.00	2.00	3.00	4. 00	5. 00	24.00
34.00	DEPR PAT PHONES NEW EQUIP	A		CAP REL COSTS MYRLE EQUIP	2.00	9	
35. 00 36. 00	TV DEPR NEW EQUIP CAFETERIA VISITORS	A A		CAP REL COSTS-MVBLE EQUIP CAFETERIA	2. 00 11. 00	9	
37. 00	MEALS TO GO	A		DI ETARY	10.00	0	37. 00
38. 00	OPERATING ROOM OTHER REV	B		OPERATING ROOM	50.00	0	
41. 00	BOND AMORTI ZATI ON	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	ı
42. 00	LAND RENT MOB	B	· ·	ADMINISTRATIVE & GENERAL	5. 00	Ó	
43. 00	SPEECH THERAPY OTHER REV	В	•	SPEECH PATHOLOGY	68. 00	0	
44. 00	LABORATORY OTHER REVENUE	В		LABORATORY	60.00	0	
44. 01	EMPLOY BENEFITS OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
45. 00	EMERGENCY ROOM OTHER REV	B		EMERGENCY	91. 00	0	
45. 01	MEDICAL STAFF INCOME	B		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 02	RADI OLOGY OTHER REVENUE	B		RADI OLOGY-DI AGNOSTI C	54.00	0	
45. 03	BREAST FILM COPIES	B		MAMMOGRAPHY	54. 03	Ö	
45. 04	CARDI AC CATH LAB OTHER REVENUE			CARDIAC CATHETERIZATION	59. 00	0	
45. 05	FACILITIES OTHER REVENUE	В		OPERATION OF PLANT	7. 00	Ö	
45. 07	RADIATION ONCOLOGY OTHER	B		RADI OLOGY-THERAPEUTI C	55. 00	0	ı
10.07	REVENUE		17 100		55.55	Ĭ	10.07
45. 08	CRHP OTHER REVENUE ADMIN	В	-1, 925, 362	ADMINISTRATIVE & GENERAL	5. 00	0	45. 08
45.09	CRHP OTHER REVENUE BUILDING	В	-343, 045	CRHP	194. 08	0	45. 09
	RENTALS						
45. 10	CRHP OTHER REVENUE EMPLOYEE	В	-336, 257	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 10
	BENEFI TS						
45. 11	FOOD OTHER REVENUE	В	-1, 816	DI ETARY	10.00	0	45. 11
45. 12	WELLCONNECT OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	45. 12
45. 13	PROTECTI VE SERV OTHER REVENUE	В	-8, 670	OPERATION OF PLANT	7. 00	0	45. 13
45. 14	PHARMACY OTHER REVENUE	В	-54, 706	PHARMACY	15. 00	0	45. 14
45. 15	HUMAN RESOURCES OTHER REVENUE	В	-6, 105	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 15
45. 16	LACTATION AND PREPARE OTHER	В	-3, 408	ADULTS & PEDIATRICS	30. 00	0	45. 16
	REVENUE	_				_	
45. 17	VOLUNTEER OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 18	RENTAL PROPERTIES DEPRECIATION		-117, 232	CAP REL COSTS-BLDG & FIXT	1.00	9	45. 18
45. 19	OTHER ADJUSTMENTS (SPECIFY)	В	0		0. 00	0	45. 19
45 20	(3)		0		0.00	_	45 20
45. 20	OTHER ADJUSTMENTS (SPECIFY)		Ü		0. 00	0	45. 20
45. 21	(3) LOSS ON DISPOSAL DEMOLITION	A	11 210	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 21
45. 21	UNALLOWABLE PHYS RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 .0
45. 22	DEPRECIATION RELIFED BUILDING	A	•	CAP REL COSTS-BLDG & FLXT	1. 00	9	
45. 24	DEPRECIATION RELIFED EQUIPMENT			CAP REL COSTS-BEDG & TIXI	2. 00	9	1
45. 25	OTHER ADJUSTMENTS (SPECIFY)	B	-00, 270 O	CAI REE COSTS-WVBEE EQUIT	0.00	Ó	1
40. 20	(3)		O		0.00	0	75.25
45. 27	PRIOR YEAR AUDIT ADJUSTMENT	A	6. 711	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 27
45. 28	NONALLOWABLE INT EXP 1993	A		CAP REL COSTS-MVBLE EQUIP	2. 00		45. 28
	BONDS		,				
45. 29	NONALLOWABLE INT EXP 2003/2009	A I	-132, 845	CAP REL COSTS-MVBLE EQUIP	2. 00	11	45. 29
	BONDS		, , , , , ,				
45. 30	UNALLOWABLE AHA MEMBERSHIP	Α	-14, 494	ADMINISTRATIVE & GENERAL	5. 00	0	45. 30
	DUES						
45. 31	AMBULANCE SERVICES	В	-646, 846	AMBULANCE SERVICES	95.00	0	45. 31
45. 33	HEALTHY COMMUNITIES OTHER	В	-570	HEALTHY COMMUNITIES	194. 07	0	45. 33
	REVENUE						
45. 34	HAF ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-30, 170, 883				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) D-	comintion all chanter referen			CMC Dub 1E 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.

 			Cara Do Triar Catea Tri Coramir I		
			Related Organization(s) and/	or Home Office	
			incrated organization(3) and	or mome orrice	
Symbol (1)	Name	Percentage of	Name	Percentage of	
0320. (1)	1440		Ttalilo		
		Ownershi p		Ownershi p	
1. 00	2.00	3, 00	4. 00	5. 00	
1. 00	2.00	3.00	4. 00	5.00	
B INTERDELATIONSHIP TO DELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			1
 D. THILKKELATIONSHIT TO KELAT	LD ONGAINT ZATT ON (3) AND FOR THE	WIL OTTTCL.			

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	NONE			100.00
	non-financial) specify:				

(1) Use the following symbols to indicate interrelationship to related organizations:

Transfer column 6, line 5 to Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		COLUMBUS REGIONAL	. HOSPI TAL		In Lieu	of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FR	OM RELA	ATED ORGANIZATIONS AND HOME	Provider CCN: 15-			Worksheet A-8	3-1
OFFICE	COSTS					From 01/0 To 12/3		Date/Time Pro	epared:
								7/24/2020 4:0	05 pm
	Net	Wkst. A-7 Re	ef.						
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
			STMENTS	S REQUIRED AS A RESULT OF TRA	NSACTIONS WITH REI	LATED ORGANIZATI	ONS OR C	CLAI MED	
	HOME OFFICE CO:								
1.00	-746, 016		0						1.00
2.00	0		0						2. 00
3.00	0		0						3. 00
4.00	0		0						4. 00
5.00	-746, 016								5. 00
* The	amounts on line	es 1-4 (and	subscri	ipts as appropriate) are trans	sferred in detail	to Worksheet A,	col umn	6, lines as	
appropr	iate. Positive a	amounts incr	ease co	ost and negative amounts decre	ease cost.For rela	ited organization	or home	e office cost	whi ch
has not	been posted to	Worksheet	A, colu	umns 1 and/or 2, the amount al	I owable should be	e indicated in co	olumn 4 d	of this part.	
		()			· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)
and/or Home Office

Type of Business

6.00

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

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

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

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

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

					1	To 12/31/2019	Date/Time Pre 7/24/2020 4:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	ус рііі
		I denti fi er	Remuneration	Component	Component		ider Component	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	Hours 7. 00	
1. 00		ADMI NI STRATI VE & GENERAL	4, 359, 859		192, 650	211, 500	803	1. 00
2. 00		ADULTS & PEDIATRICS	1, 576, 921	1, 282, 996	293, 925	211, 500	3, 206	2. 00
3. 00		SUBPROVIDER - IRF	231, 150		231, 150	211, 500	9, 370	3. 00
4.00		OPERATING ROOM	2, 697, 079	125, 600	2, 571, 479	246, 400	13, 290	4.00
5. 00		LABORATORY	60, 000		60, 000	246, 400	564	5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	50, 000		50, 000	271, 900	358	6. 00
7.00		RADI OLOGY-THERAPEUTI C	63, 750		63, 750		298	7. 00
8. 00 9. 00		LABORATORY-PATHOLOGI CAL RESPI RATORY THERAPY	225, 000 25, 000		225, 000 25, 000	260, 200 211, 500	1, 500 163	8. 00 9. 00
10. 00		PHYSICAL THERAPY	50, 000		50, 000	211, 500	207	10. 00
11. 00		ELECTROCARDI OLOGY	58, 600		58, 600	211, 500	227	11. 00
12. 00		ELECTROENCEPHALOGRAPHY	9, 750		9, 750	211, 500	97	12. 00
13. 00	90. 02	NEUROPSYCH	200, 476	200, 476	0	211, 500	0	13.00
14. 00		WOUND CENTER	39, 632		39, 632	211, 500	183	14.00
15. 00		HYPERBARI C OXYGEN THERAPY	2, 368		2, 368	211, 500	11	15. 00
16. 00		EMERGENCY	2, 351, 672		2, 351, 672	211, 500	16, 891	16.00
17. 00 200. 00	95.00	AMBULANCE SERVICES	17, 500 12, 018, 757		17, 500		203 47, 371	17. 00 200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5, 776, 281 5 Percent of	6, 242, 476 Cost of		Physician Cost	200.00
	WKSt. A LINE #	I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	1.00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	81, 651 325, 995	4, 083 16, 300	0		0	1. 00 2. 00
3.00		SUBPROVIDER - IRF	952, 767	47, 638	0	0	0	3. 00
4. 00		OPERATI NG ROOM	1, 574, 354		0	0	o O	4. 00
5. 00		LABORATORY	66, 812	3, 341	0	0	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	46, 798	2, 340	0	0	0	6.00
7. 00		RADI OLOGY-THERAPEUTI C	38, 955		0	0	0	7. 00
8. 00		LABORATORY-PATHOLOGI CAL	187, 644		0	0	0	8. 00
9.00		RESPI RATORY THERAPY	16, 574		0	0	0	9. 00
10. 00 11. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY	21, 048 23, 082		0	0	0	10. 00 11. 00
12. 00		ELECTROENCEPHALOGRAPHY	9, 863		0	0	0	12. 00
13. 00		NEUROPSYCH	0	0	0	0	Ö	13. 00
14. 00	90. 03	WOUND CENTER	18, 608		0	0	0	14.00
15. 00		HYPERBARIC OXYGEN THERAPY	1, 118		0	0	0	15.00
16. 00		EMERGENCY	1, 717, 522		0	0	0	16.00
17. 00 200. 00	95. 00	AMBULANCE SERVICES	20, 642		0	0	0	17. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	5, 103, 433 Provi der	255, 172 Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Adj d3 tillott		
			Share of col.					
			14					
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0 0	,	110, 999 0			1. 00 2. 00
3.00		SUBPROVIDER - IRF			0	1, 202, 990		3. 00
4. 00		OPERATI NG ROOM	0		997, 125	1, 122, 725		4. 00
5. 00		LABORATORY	0		0	0		5. 00
6. 00	54.00	RADI OLOGY-DI AGNOSTI C	0	46, 798	3, 202	3, 202		6. 00
7. 00		RADI OLOGY-THERAPEUTI C	0		24, 795	24, 795		7. 00
8. 00		LABORATORY-PATHOLOGI CAL	0	,	37, 356	37, 356		8. 00
9.00		RESPIRATORY THERAPY	0	16, 574	8, 426	8, 426 28, 952		9. 00
10. 00 11. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY		21, 048 23, 082	28, 952 35, 518	28, 952 35, 518		10. 00 11. 00
12. 00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY			33, 318	33, 318		12. 00
13. 00		NEUROPSYCH	0	0	0	200, 476		13. 00
14. 00	90. 03	WOUND CENTER	0	18, 608	21, 024			14. 00
15. 00		HYPERBARIC OXYGEN THERAPY	0	1, 118	1, 250	1, 250		15. 00
16. 00		EMERGENCY	0		634, 150	634, 150		16. 00
17. 00	95. 00	AMBULANCE SERVICES	0 0		0 1, 902, 797	0 7, 679, 078		17. 00 200. 00
200.00		I	1	5, 103, 433	1, 902, 797	1,019,018		200.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0112

				To	12/31/2019	Date/Time Pre 7/24/2020 4:0	
			CAPI TAL REI	ATED COSTS		772472020 4.0	J piii
		N . 5	DI DO A FLYT	MADLE FOLLID	EMDL OVEE		
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A			<i>B217</i> (1111)		
		col . 7)					
	CENEDAL CEDALCE COCT CENTEDS	0	1.00	2. 00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	10, 831, 084	10, 831, 084				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	13, 848, 916		13, 848, 916			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	28, 957, 597	183, 509		29, 147, 280		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	37, 308, 566			5, 052, 590		1
7.00	00700 OPERATION OF PLANT	6, 455, 359 728, 787			889, 312	13, 250, 014	7.00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	2, 509, 497	11, 752 76, 968		12, 533 628, 012	753, 072 3, 288, 381	8. 00 9. 00
10.00	01000 DI ETARY	1, 141, 940			272, 833		1
11. 00	01100 CAFETERI A	661, 288	91, 718	27, 482	453, 948	1, 234, 436	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	5, 497, 199			1, 611, 975		1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 107, 016			410	1, 332, 731	14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	4, 814, 048 1, 574, 572	70, 751 54, 206		1, 068, 560 363, 503	6, 106, 431 1, 996, 778	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	597, 671	4, 481		197, 597	799, 827	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	500, 002	0	9, 548	170, 021	679, 571	23. 01
23. 02	02302 PHARMACY RESI DENCY PROG I NPATI ENT ROUTI NE SERVI CE COST CENTERS	357, 108	5, 579	5, 224	119, 774	487, 685	23. 02
30. 00	03000 ADULTS & PEDIATRICS	17, 128, 846	1, 139, 636	279, 886	5, 007, 430	23, 555, 798	30. 00
31. 00	03100 NTENSI VE CARE UNI T	3, 361, 097	162, 617		820, 618		1
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34.00
40. 00 41. 00	04100 SUBPROVIDER - TPF	1, 811, 598	164, 486	17, 833	511, 272	0 2, 505, 189	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	0	0	2, 303, 107	42. 00
43.00	04300 NURSERY	813, 368	8, 651	17, 974	276, 658	1, 116, 651	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
FO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATI NG ROOM	19, 028, 653	E04 27E	1, 291, 829	305, 106	21 200 0/2	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	1, 307, 107	584, 375 47, 261		303, 106 747	21, 209, 963 1, 373, 550	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	191, 658	1, 766	4, 588	0	198, 012	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 201, 878			526, 874	2, 966, 548	1
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	2, 114, 319 586, 384	49, 368 22, 317		133, 927 152, 877	2, 415, 484 834, 297	
54. 02	05405 MAMMOGRAPHY	1, 248, 126			269, 127	1, 675, 168	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 880, 146			286, 806		1
57. 00	05700 CT SCAN	1, 828, 709			235, 830		
58. 00	05800 MRI	542, 437			102, 482	668, 279	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 742, 435 8, 409, 653			590, 797 1, 404, 268		
	06001 LABORATORY-PATHOLOGI CAL	1, 054, 095			121, 974	1, 207, 590	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	554, 005		1, 612	20, 874	582, 842	
65. 00	06500 RESPI RATORY THERAPY	2, 362, 432			688, 323	3, 238, 515	1
66. 00	06600 PHYSI CAL THERAPY	4, 340, 973			1, 320, 575	5, 692, 744 1, 699, 910	1
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	1, 313, 017 689, 053	3, 279 0		378, 699 211, 480	918, 804	1
69. 00	06900 ELECTROCARDI OLOGY	1, 352, 977			235, 986	1, 880, 965	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	934, 239		9, 543	242, 593	1, 186, 375	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 358, 574	0	0	0	6, 358, 574	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 658, 272	0	0	0	9, 658, 272	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	22, 149, 822 813, 715	0	0 62	0	22, 149, 822 813, 777	73. 00 74. 00
76.00	03020 ACUPUNCTURE	013,713	0	0	0	013,777	76.00
	07697 CARDI AC REHABI LI TATI ON	399, 884	23, 460	-	90, 367	524, 469	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	1, 742, 114	0 114, 688	-	0 549, 154	0 2, 433, 289	89. 00 90. 00
90. 01	09001 DI ABETES CENTER	229, 425			32, 483	274, 028	1
90. 02	09002 NEUROPSYCH	97, 807	1, 484		29, 539	129, 062	
90. 03	09003 WOUND CENTER	1, 372, 058			145, 000	1, 519, 365	1
90.04	09004 HYPERBARI C OXYGEN THERAPY	226, 559			37, 239	263, 936	1
90. 05 90. 06	O9005 VIMCARE CLINIC O9006 MEDICATION MGMT CLINIC	674, 649 288, 048			190, 045 98, 545	934, 463 407, 967	1
	09100 EMERGENCY	8, 021, 557			1, 890, 786		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	, , , ,				92. 00

Health Financial Systems	COLUMBUS REGIO				u of Form CMS-2	2552-1
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 7/24/2020 4:0	
		CAPI TAL REL	ATED 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	<u>'</u>			<u> </u>		
95. 00 09500 AMBULANCE SERVICES	3, 561, 449	119, 184	365, 83	1, 313, 267	5, 359, 732	95.0
99. 10 09910 CORF	0	0		0 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 0
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 0
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110. 0
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111. 0
113. 00 11300 I NTEREST EXPENSE						113. 0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	251, 281, 788	10, 698, 530	12, 179, 56	29, 062, 816	249, 395, 415	118. 0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 788	35		11, 145	
194. 00 07950 WELLNESS COMMUNITY	296, 804	0	5, 98	63, 994	366, 782	
194. 01 07951 BUILDING RENTALS	325, 843	0		0 0	325, 843	
194. 02 07952 HOSPI CE	107, 509	0		0 0	107, 509	
194. 03 07953 OUTREACH CLINICS	0	0		0 0	-	194. 0
194. 04 07954 SPEECH - HEARING AIDS	186, 874	0		0 0	186, 874	
194. 05 07955 NONALLOWABLE MARKETING	795, 842	0		0	795, 842	
194. 06 07956 CRH FOUNDATION	36, 585	9, 541	65		59, 330	
194. 07 07957 HEALTHY COMMUNI TI ES	25, 766			0 7, 922	51, 420	
194. 08 07958 CRHP	117, 041	86, 732			1, 864, 915	
194. 09 07959 NEUROPSYCH PART B	0	7, 761	1, 21	6 0	8, 977	
200.00 Cross Foot Adjustments	1			1	0	200. 0

253, 174, 052

10, 831, 084

13, 848, 916

0

29, 147, 280

0 200. 00 0 201. 00 253, 174, 052 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2019	Part	
To 12/31/2019	Date/Time Prepared:	7/24/2020 4:05 pm

					12/31/2019	7/24/2020 4:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	49, 514, 375					5. 00
7. 00	00700 OPERATION OF PLANT	3, 221, 383	16, 471, 397				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	183, 089	44, 095	·			8. 00
9.00	00900 HOUSEKEEPI NG	799, 481	288, 786		4, 376, 648	2 20/ 000	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	376, 350	437, 828		34, 730	2, 396, 890 0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	300, 120 1, 773, 362	344, 127 542, 497		58, 346 20, 838	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	324, 018	423, 743		52, 789	0	14. 00
15. 00	01500 PHARMACY	1, 484, 614	265, 458		36, 119	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	485, 463	203, 381	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	194, 456	16, 814	0	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	165, 219	0	0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	118, 567	20, 934	0	2, 778	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 70/ 070	4 275 052	348, 049	1 410 114	1 007 005	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 726, 979	4, 275, 953 610, 142		, , ,	1, 827, 805 230, 132	
32. 00	03200 CORONARY CARE UNIT	1, 083, 869	010, 142	41, 600	70, 154	230, 132	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0	0	0	0	33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T		0	Ö	o	0	34.00
40.00	04000 SUBPROVI DER - I PF	O	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	609, 069	617, 158	40, 576	182, 679	263, 742	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	271, 484	32, 459	8, 782	0	0	
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS		0 100 500	100.004		7 007	
50.00	05000 OPERATING ROOM	5, 156, 630	2, 192, 593			7, 307	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	333, 942	177, 325	43, 982 0	47, 927	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	48, 141	6, 625	_	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	721, 236	478, 638		98, 633	2, 139	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	587, 260	185, 231		55, 568	2, 137	
54. 02	05404 ULTRA SOUND	202, 837	83, 735		18, 754	0	
54. 03	05405 MAMMOGRAPHY	407, 272	5, 623		43, 760	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 061, 561	440, 222	14, 093	60, 430	13, 293	55. 00
57. 00	05700 CT SCAN	538, 231	100, 104		10, 419	0	57. 00
58. 00	05800 MRI	162, 474	50, 108		6, 251	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	885, 319	597, 504		81, 962	7, 218	
60.00	06000 LABORATORY	2, 480, 009	605, 410		81, 962	0	60.00
60. 01 62. 00	06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	293, 593 141, 702	67, 478 23, 829		3, 473 2, 084	0	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	787, 357	404, 423		100, 022	0	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 384, 037	34, 296			0	66.00
67. 00	1	413, 287	12, 304			0	
68. 00	06800 SPEECH PATHOLOGY	223, 382	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	457, 306	77, 834	0	15, 281	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	288, 435	0	1, 018	669, 590	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 545, 916	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 348, 148	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 385, 131	0	0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	197, 848	0	0	6, 251	0	74.00
76.00	03020 ACUPUNCTURE	107 510	00.022	0	1 200	0	76.00
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	127, 510	88, 022	0	1, 389	U	76. 97
88. 00	08800 RURAL HEALTH CLINIC		0	0	n	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89. 00
90. 00	09000 CLI NI C	591, 589	430, 312	40, 008	60, 430	37, 724	
90. 01	09001 DI ABETES CENTER	66, 623	43, 148		695	0	90. 01
90. 02	09002 NEUROPSYCH	31, 378	5, 568	0	0	0	90. 02
90. 03	09003 WOUND CENTER	369, 393	0	1, 845	0	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	64, 169	0	0	0	0	90. 04
90. 05	09005 VI MCARE CLI NI C	227, 189	236, 897	5, 391	195, 181	0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	99, 186	51, 054		13, 197	7 520	90.06
91.00	09100 EMERGENCY	2, 547, 014	1, 005, 212	65, 263	357, 022	7, 530	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			L			92.00
95. 00		1, 303, 074	447, 182	0	ما	0	95.00
	09910 CORF	1, 303, 074	447, 102 N	0	-	0	
	10100 HOME HEALTH AGENCY	l o	0				101. 00
	•	1			1		

					7/24/2020 4:05 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7.00	8. 00	9. 00	10. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	48, 595, 702	15, 974, 052	980, 256	4, 345, 391	<u>2, 396, 890</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 710	40, 476	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	89, 173	0	0	0	0 194. 00
194. 01 07951 BUI LDI NG RENTALS	79, 220	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	26, 138	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	45, 433	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	193, 487	0	0	0	0 194. 05
194.06 07956 CRH FOUNDATION	14, 424	35, 799	0	29, 868	0 194. 06
194.07 07957 HEALTHY COMMUNITIES	12, 501	66, 532	0	1, 389	0 194. 07
194. 08 07958 CRHP	453, 404	325, 420	0	0	0 194. 08
194.09 07959 NEUROPSYCH PART B	2, 183	29, 118	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	49, 514, 375	16, 471, 397	980, 256	4, 376, 648	2, 396, 890 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: | 7/24/2020 4:05 pm

					12/31/2017	7/24/2020 4:0	5 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A	1, 937, 029					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	90, 715	1				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	23, 123		2, 156, 404			14. 00
15. 00	01500 PHARMACY	58, 698	1	0	8, 403, 139		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	64, 034	o	0	0	2, 749, 656	16. 00
17. 00	01700 SOCIAL SERVICE	14, 230	103, 889	0	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	12, 451	0	0	0	0	23. 01
23. 02	02302 PHARMACY RESI DENCY PROG	5, 336	47, 011	0	0	0	23. 02
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	400 450	0.040.400	(0.400	, 055	/45 470	00.00
30.00	03000 ADULTS & PEDIATRICS	430, 452		68, 180	6, 855	615, 472	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	58, 698	450, 522	4, 282 0	2, 690	29, 791 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT			0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	39, 132	302, 031	0	275	43, 260	41. 00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	17, 787	142, 047	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	204, 553	1, 450, 197	1, 945, 219	51, 472	1, 271, 191	50.00
51.00	05100 RECOVERY ROOM	23, 123	177, 954	0	113	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	41, 680	6, 814	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	39, 132	0	8, 947	12, 091	0	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	8, 894	0	0	105, 442	0	54. 01
54. 02	05404 ULTRA SOUND	8, 894	1	0	276	0	54. 02
54. 03	05405 MAMMOGRAPHY	19, 566	0	2, 894	728	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	17, 787	0	0	250.070	21, 393	55. 00
57. 00 58. 00	05700 CT SCAN	17, 787 7, 115	0	0	258, 879 35, 520	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	35, 574	1	14, 439	136, 526	32, 802	59. 00
60. 00	06000 LABORATORY	142, 298		14, 437	7, 001	124, 394	60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	10, 672		0	,, 001	475	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 779	1	0	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	49, 804	1	4, 104	12, 851	127, 088	65.00
66.00	06600 PHYSI CAL THERAPY	88, 936		41, 575	980	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	23, 123	0	0	0	38, 824	67. 00
68.00	06800 SPEECH PATHOLOGY	14, 230	O	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	16, 009	118, 370	0	212, 728	200, 932	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	16, 009	0	0	2	172, 884	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	이	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	이	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 486, 734	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	5, 032	0	74.00
76. 00	03020 ACUPUNCTURE	7 115	D 075	0	0	0	76.00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	7, 115	52, 975	0	10	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	ا	0	٥	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89. 00
90. 00	09000 CLINIC	42, 689	252, 525	11, 162	127	64, 336	90. 00
90. 01	09001 DI ABETES CENTER	3, 557		0	0	0 ., 000	90. 01
90. 02	09002 NEUROPSYCH	1, 779	1	0	0	0	90. 02
90. 03	09003 WOUND CENTER	10, 672	1	48, 072	1, 568	0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	3, 557		. 0	0	0	90. 04
90. 05	09005 VI MCARE CLI NI C	17, 787		827	11, 214	0	90. 05
90. 06	09006 MEDICATION MGMT CLINIC	5, 336		0	o	0	90. 06
91. 00	09100 EMERGENCY	147, 634	948, 793	6, 703	4, 301	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
0-	OTHER REIMBURSABLE COST CENTERS	1		T	1		
95.00	09500 AMBULANCE SERVICES	124, 511		0	7, 393	0	95. 00
99. 10	l l	0		0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared:

			10	12/31/2019	7/24/2020 4:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	•
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 924, 578	9, 721, 507	2, 156, 404	8, 402, 488	2, 749, 656	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	7, 115	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	651		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0	194. 07
194. 08 07958 CRHP	0	0	0	0		194. 08
194. 09 07959 NEUROPSYCH PART B	5, 336	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 937, 029	9, 721, 507	2, 156, 404	8, 403, 139	2, 749, 656	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: | 7/24/2020 4:05 pm

						7/24/2020 4:0	5 pm
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal	
			PRGM		RESIDENCY PROG		
		17. 00	23. 00	23. 01	23. 02	24.00	
G	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 0	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 0	00500 ADMINISTRATIVE & GENERAL						5. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
							10.00
	01000 DI ETARY						
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13. 00
	11400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 0	1500 PHARMACY						15. 00
16.00 0	11600 MEDICAL RECORDS & LIBRARY						16. 00
17.00 0	1700 SOCIAL SERVICE	1, 129, 216					17. 00
23. 00 0	2300 PARAMED ED PRGM-(SPECIFY)	ol	0				23. 00
1	2301 XRAY EDUCATION	o		857, 241			23. 01
1	2302 PHARMACY RESIDENCY PROG	0			682, 311		23. 02
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		ļ.	002,011		20.02
	33000 ADULTS & PEDIATRICS	346, 927	0		ol	41, 928, 267	30. 00
			-	1			
	03100 INTENSIVE CARE UNIT	96, 936	0	C	0	7, 137, 131	31.00
	03200 CORONARY CARE UNIT	0	0	1	0	0	32. 00
	3300 BURN INTENSIVE CARE UNIT	0	0	(0	0	33. 00
	3400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	34. 00
40.00 0	04000 SUBPROVI DER – I PF	0	0	C	0	0	40.00
41.00 0	04100 SUBPROVI DER – I RF	205, 776	0	C	0	4, 808, 887	41.00
42.00 0	04200 SUBPROVI DER	ol	0		0	0	42.00
	04300 NURSERY	o	0		o	1, 589, 210	43.00
	04400 SKILLED NURSING FACILITY	o	0			0	44. 00
	NCI LLARY SERVICE COST CENTERS	9			J		
	05000 OPERATI NG ROOM	0	0	C	ol	34, 232, 512	50. 00
	05100 RECOVERY ROOM		0			2, 177, 916	51.00
			0		0		
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
	05300 ANESTHESI OLOGY	0	0		0	301, 272	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	857, 241	0	5, 259, 329	54.00
54. 01 0	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	C	0	3, 357, 879	54. 01
54.02 0	05404 ULTRA SOUND	0	0	C	0	1, 148, 793	54. 02
54. 03 0	05405 MAMMOGRAPHY	0	0	C	0	2, 155, 011	54. 03
55.00 0	05500 RADI OLOGY-THERAPEUTI C	34, 013	0		0	6, 029, 146	55. 00
	05700 CT SCAN	0	0		0	3, 139, 240	57. 00
	05800 MRI		0	1	o o	929, 747	58. 00
	05900 CARDI AC CATHETERI ZATI ON		0		o o	5, 770, 637	59.00
	06000 LABORATORY	0	0			13, 641, 708	
	l e e e e e e e e e e e e e e e e e e e		0		0		
1	06001 LABORATORY-PATHOLOGI CAL	0	0		0	1, 583, 281	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	752, 236	
	06500 RESPI RATORY THERAPY	0	0	(0	5, 112, 740	65. 00
	06600 PHYSI CAL THERAPY	0	0	(0	7, 274, 146	66. 00
67. 00 0	06700 OCCUPATI ONAL THERAPY	0	0	C	0	2, 192, 934	67. 00
68.00 0	06800 SPEECH PATHOLOGY	0	0	C	0	1, 156, 416	68. 00
69.00 0	06900 ELECTROCARDI OLOGY	ol	0		0	2, 979, 425	69. 00
1	07000 ELECTROENCEPHALOGRAPHY	ol	0	1	ol	2, 334, 313	70. 00
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	7, 904, 490	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	1	o o	12, 006, 420	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0		682, 311	35, 703, 998	73.00
	07400 RENAL DIALYSIS	0	0		002, 311		
			0		0	1, 022, 908	74.00
	03020 ACUPUNCTURE	0	0		0	0	76. 00
	7697 CARDI AC REHABI LI TATI ON	0	0	<u> </u>	0	801, 490	76. 97
	UTPATIENT SERVICE COST CENTERS						
88. 00 0	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89. 00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
90.00 0	99000 CLI NI C	183, 668	0	C	0	4, 147, 859	90.00
90. 01 0	99001 DI ABETES CENTER	0	0	1	ol	388, 051	90. 01
	99002 NEUROPSYCH	0	0		0	167, 787	90. 02
	99003 WOUND CENTER		0	1	o o	2, 035, 696	90. 03
1	19004 HYPERBARI C OXYGEN THERAPY		0			355, 964	90. 04
	19004 HYPERBARIC OXYGEN THERAPY		0			1, 768, 409	90.04
1	l e e e e e e e e e e e e e e e e e e e	0	0		0		
1	09006 MEDICATION MGMT CLINIC	0	0	1	이	613, 489	90.06
1	99100 EMERGENCY	261, 896	0	C	0	15, 827, 605	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
0.	THER REIMBURSABLE COST CENTERS						
95.00 0	9500 AMBULANCE SERVICES	0	0	C	0	8, 198, 696	95. 00
99. 10 0	9910 CORF	0	0	C	0	0	99. 10
	0100 HOME HEALTH AGENCY	0	0	•			101.00
5511	1	٠ ٧	· ·		۱ ۹	· ·	

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To | 12/31/2019 | Date/Time | Prepared: |

				12/31/2019	7/24/2020 4:05 pm
Cost Center Description	SOCIAL SERVICE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal
		PRGM		RESIDENCY PROG	
	17. 00	23. 00	23. 01	23. 02	24.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 129, 216	0	857, 241	682, 311	<u>247, 935, 038</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	54, 331 190. 00
194. 00 07950 WELLNESS COMMUNITY	0	0	0	0	463, 070 194. 00
194. 01 07951 BUILDING RENTALS	0	0	0	0	405, 063 194. 01
194. 02 07952 HOSPI CE	0	0	0	0	134, 298 194. 02
194. 03 07953 0UTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	232, 307 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	989, 329 194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0	139, 421 194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	131, 842 194. 07
194. 08 07958 CRHP	0	0	0	0	2, 643, 739 194. 08
194.09 07959 NEUROPSYCH PART B	0	0	0	0	45, 614 194. 09
200.00 Cross Foot Adjustments		0	0	0	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 129, 216	0	857, 241	682, 311	253, 174, 052 202. 00

				To 12/31/2019 Date/lime Pro	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	172472020 4.1	J piii
		Adjustments			
	January of the control of the contro	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 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 CAFETERIA				11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY				13. 00 14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01	02301 XRAY EDUCATION				23. 01
23. 02	02302 PHARMACY RESIDENCY PROG				23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		41 020 277		1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	41, 928, 267 7, 137, 131		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT		7, 137, 131		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	O		34.00
40.00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00	04100 SUBPROVI DER - I RF	0	4, 808, 887		41. 00
42. 00	04200 SUBPROVI DER	0	0		42. 00
43. 00	04300 NURSERY	0	1, 589, 210		43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		44. 00
50. 00	05000 OPERATING ROOM	0	34, 232, 512		50.00
51. 00	05100 RECOVERY ROOM	o	2, 177, 916		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	301, 272		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 259, 329		54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	3, 357, 879		54. 01
54. 02 54. 03	05404 ULTRA SOUND 05405 MAMMOGRAPHY	0	1, 148, 793		54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C		2, 155, 011 6, 029, 146		55. 00
57. 00	05700 CT SCAN		3, 139, 240		57. 00
58. 00	05800 MRI	o	929, 747		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	5, 770, 637		59. 00
60.00	06000 LABORATORY	0	13, 641, 708		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	1, 583, 281		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	752, 236		62. 00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	5, 112, 740		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		7, 274, 146 2, 192, 934		67. 00
68. 00	06800 SPEECH PATHOLOGY	O	1, 156, 416		68.00
	06900 ELECTROCARDI OLOGY	0	2, 979, 425		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 334, 313		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 904, 490		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 006, 420		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	35, 703, 998		73.00
74. 00 76. 00	03020 ACUPUNCTURE	0	1, 022, 908 0		74. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON		801, 490		76. 97
70.77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0017170		7 7 7 7 7
88. 00		0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	0	4, 147, 859		90.00
90. 01	09001 DI ABETES CENTER	0	388, 051		90. 01
90. 02 90. 03	09002 NEUROPSYCH	0	167, 787		90. 02 90. 03
90. 03	09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY		2, 035, 696 355, 964		90. 03
90. 04	09005 VIMCARE CLINIC		1, 768, 409		90.04
90. 06	09006 MEDICATION MGMT CLINIC		613, 489		90.06
91. 00	09100 EMERGENCY	o	15, 827, 605		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92. 00
0=	OTHER REIMBURSABLE COST CENTERS		0.400.401		05
95. 00	09500 AMBULANCE SERVICES	0	8, 198, 696		95. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0112	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time P 7/24/2020 4	
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25. 00	26. 00				
99. 10 09910 CORF	0	0				99. 10
101. 00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS		اه ا				
109. 00 10900 PANCREAS ACQUISITION	0	0				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110. 00
111. 00 11100 SLET ACQUISITION	0	0				111.00
113. 00 11300 I NTEREST EXPENSE		0.47 005 000				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	247, 935, 038				118. 00
NONREI MBURSABLE COST CENTERS		E4 221				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54, 331				190. 00 194. 00
194.00 07950 WELLNESS COMMUNITY 194.01 07951 BUILDING RENTALS	0	463, 070				194. 00
194. 01 07951 BUILDING RENTALS 194. 02 07952 HOSPI CE	0	405, 063				194.01
194. 03 07952 H05PTCE 194. 03 07953 OUTREACH CLINICS		134, 298				194. 02
194. 04 07954 SPEECH - HEARING ALDS		222 207				194. 03
		232, 307				
194. 05 07955 NONALLOWABLE MARKETI NG 194. 06 07956 CRH FOUNDATI ON	0	989, 329				194. 05 194. 06
194. 07 07 956 CRH FOUNDATION 194. 07 07 957 HEALTHY COMMUNITIES		139, 421 131, 842				194. 06
194. 08/07958 CRHP		2, 643, 739				194. 07
194. 08 07958 CRHP 194. 09 07959 NEUROPSYCH PART B		2, 643, 739 45, 614				194. 08
200.00 Cross Foot Adjustments		40, 614				200. 00
201.00 Negative Cost Centers		0				200.00
202.00 TOTAL (sum lines 118 through 201)		253, 174, 052				201.00
202.00 TOTAL (Suil TITIES TTO LITTOUGH 201)	ı o	255, 174, 052				J202. 00

Health Financial Systems
COST ALLOCATION STATISTICS In Lieu of Form CMS-2552-10
Worksheet Non-CMS W COLUMBUS REGIONAL HOSPITAL Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 7/24/2020 4:05 pm Provider CCN: 15-0112

			1/24/2020 4.0	o piii
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1.00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQ FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DEPR	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SAL	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQ FEET	7. 00
8.00	LAUNDRY & LINEN SERVICE	9	LDRY LBS	8. 00
9.00	HOUSEKEEPI NG	10	TIME SPT	9. 00
10.00	DI ETARY	11	MEALS	10.00
11. 00	CAFETERI A	12	FTES	11. 00
13.00	NURSI NG ADMI NI STRATI ON	13	NURS HRS	13. 00
14.00	CENTRAL SERVICES & SUPPLY	14	STER SUP	14.00
15.00	PHARMACY	15	DRG COST	15. 00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPT	16. 00
17.00	SOCI AL SERVI CE	17	TIME SPT	17. 00
23.00	PARAMED ED PRGM-(SPECIFY)	18	PERCENT	23.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: | 7/24/2020 4:05 pm | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

				10	12/31/2019	7/24/2020 4:0	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oust defined beson prion	Assigned New	שבשט ע וואו	MVDLL LQOTT	Subtotui	BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
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	63, 184	183, 509		252, 867	252, 867	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	825, 723 81, 065	842, 018 5, 415, 562		7, 978, 942 5, 986, 408	43, 846 7, 715	5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	01,003	11, 752		11, 752	109	8. 00
9. 00	00900 HOUSEKEEPI NG	2, 328	76, 968		153, 200	5, 448	9. 00
10.00	01000 DI ETARY	485	116, 691	16, 518	133, 694	2, 367	10. 00
11.00	01100 CAFETERI A	0	91, 718		119, 200	3, 938	11.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	12, 539 78	144, 588 112, 937		197, 460 225, 383	13, 984 4	13. 00 14. 00
15. 00	01500 PHARMACY	4, 275	70, 751	153, 072	228, 098	9, 270	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 427	54, 206		60, 130	3, 153	16. 00
17. 00	01700 SOCIAL SERVICE	689	4, 481	78	5, 248	1, 714	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	11 0/0	0	-	0	1 475	23. 00
23. 01 23. 02	02301 XRAY EDUCATION 02302 PHARMACY RESIDENCY PROG	11, 860	5, 579	9, 548 5, 224	21, 408 10, 803	1, 475 1, 039	23. 01 23. 02
25. 02	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	3,317	5, 224	10, 005	1,037	23.02
30.00	03000 ADULTS & PEDIATRICS	222, 709	1, 139, 636	279, 886	1, 642, 231	43, 439	30. 00
31. 00	03100 INTENSIVE CARE UNIT	12, 200	162, 617	113, 777	288, 594	7, 119	31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER – I PF	o	Ö	Ö	Ö	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	24, 087	164, 486	17, 833	206, 406	4, 435	41. 00
42. 00	04200 SUBPROVI DER	0	0 (51	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	353	8, 651 0	17, 974	26, 978 0	2, 400 0	43. 00 44. 00
44. 00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	<u> </u>	<u></u>		44.00
50.00	05000 OPERATING ROOM	555, 712	584, 375	1, 291, 829	2, 431, 916	2, 647	50. 00
51.00	05100 RECOVERY ROOM	0	47, 261	18, 435	65, 696	6	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0 1, 766	0 4, 588	6, 354	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 206	127, 568		242, 002	4, 571	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	24, 560	49, 368		191, 798	1, 162	54. 01
54. 02	05404 ULTRA SOUND	1, 223	22, 317		96, 259	1, 326	54. 02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY - THERAPEUTI C	131, 588 3, 199	1, 499 117, 329		289, 503 1, 202, 601	2, 335 2, 488	54. 03 55. 00
57. 00	05700 CT SCAN	3, 199	26, 680		1, 202, 601	2, 466	57. 00
58. 00	05800 MRI	375	13, 355		23, 735	889	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	179, 699	159, 248		487, 910	5, 125	59. 00
60.00	06000 LABORATORY	25, 616	161, 355		412, 329	12, 182	60.00
60. 01 62. 00	06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	284	17, 984 6, 351		31, 805 7, 963	1, 058 181	
65. 00	06500 RESPIRATORY THERAPY	15, 145	107, 788		202, 905	5, 971	65. 00
66. 00	06600 PHYSI CAL THERAPY	331, 661	9, 141	22, 055	362, 857	11, 456	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	122, 421	3, 279		130, 615	3, 285	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	50, 427 454	20, 744	18, 271 271, 258	68, 698 292, 456	1, 835 2, 047	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	146, 956	20, 744	9, 543	156, 499	2, 104	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	0	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	0	0	62	62	0	74. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	757	23, 460	10, 758	34, 975	784	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	280	0 114, 688	0 27, 333	0 142, 301	0 4 764	89. 00 90. 00
90.00	09000 CEINIC 09001 DI ABETES CENTER	280	114, 688		142, 301	4, 764 282	90.00
90. 02	09002 NEUROPSYCH	37	1, 484		1, 753	256	90. 02
90. 03	09003 WOUND CENTER	81, 230	0	2, 307	83, 537	1, 258	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	91, 930	0	138	92, 068	323	90. 04
90. 05 90. 06	09005 VI MCARE CLINI C 09006 MEDICATION MGMT CLINI C	769	63, 138 13, 607		70, 538 21, 374	1, 649 855	90. 05 90. 06
91. 00	1 1	2, 619	267, 911		566, 513	16, 402	91.00
92. 00	1 1		•		o	•	92. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0112	
		From 01/01/2010 Dort II

ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 7/24/2020 4:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	28, 138	119, 184	365, 832	513, 154	11, 392	
99. 10 09910 CORF	0	0	(0	0	
101. 00 10100 HOME HEALTH AGENCY	0	O	() 0	0	101. 00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION		0			0	109. 00
110. 00 11000 NTESTINAL ACQUISITION	0	0				110.00
111. 00 11100 SLET ACQUISITION	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	Ī					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 062, 288	10, 698, 530	12, 179, 561	25, 940, 379	252, 134	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 788				190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	5, 984			194. 00
194. 01 07951 BUILDING RENTALS	62, 192	0	(62, 192		194. 01
194. 02 07952 HOSPI CE	0	0	(0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	(0		194. 04
194. 05 07955 NONALLOWABLE MARKETI NG 194. 06 07956 CRH_FOUNDATI ON	0	0 541	(10 107		194. 05 194. 06
194. 06 07956 CRH FOUNDATION 194. 07 07957 HEALTHY COMMUNITIES	163	9, 541 17, 732	656	10, 197 17, 895		194. 06
194. 08 07958 CRHP	446, 758	86, 732		•		194. 07
194. 09 07959 NEUROPSYCH PART B	440, 730	7, 761	1, 001, 142			194. 08
200.00 Cross Foot Adjustments		7, 701	1,210	0, 7//	ı	200. 00
201.00 Negative Cost Centers		0	(0	201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 571, 401	10, 831, 084	13, 848, 916	28, 251, 401		
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0112

					0 12/31/2017	7/24/2020 4:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
		0 000 700					1
5.00	00500 ADMINISTRATIVE & GENERAL	8, 022, 788	l e				5. 00
7.00	00700 OPERATION OF PLANT	521, 958	1				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	29, 666		1			8. 00
9.00	00900 HOUSEKEEPI NG	129, 539		1 0			9. 00
10. 00	01000 DI ETARY	60, 980	173, 205	0	3, 193	373, 439	10.00
11.00	01100 CAFETERI A	48, 628	136, 137	0	5, 365	0	11. 00
13.00	01300 NURSING ADMINISTRATION	287, 336	214, 612	2 0	1, 916	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	52, 500		1	4, 854		14. 00
15. 00	01500 PHARMACY	240, 551	105, 015	1	3, 321	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	78, 659	1	1	0, 021	Ö	16. 00
17. 00	01700 SOCIAL SERVICE	31, 508	1	1	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	31,508	l		0	0	23. 00
		_	1	1	0		1
23. 01	02301 XRAY EDUCATION	26, 770	ł	0		0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	19, 211	8, 281	0	255	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	927, 956	l	1			30. 00
31. 00	03100 INTENSIVE CARE UNIT	175, 618	241, 372	2, 515	6, 451	35, 855	31. 00
32.00	03200 CORONARY CARE UNIT	0	C	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	l c	ol o	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0			0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	98, 687	244, 147	2, 441	16, 797	41, 091	1
42. 00	04200 SUBPROVI DER	70,007	277, 177	2, 771	10, 777	0	42. 00
43. 00	04300 NURSERY	42 000	12 041	520	0	0	43. 00
		43, 988	1	1			
44. 00	04400 SKILLED NURSING FACILITY	0	C) 0	0	0	44. 00
	ANCI LLARY SERVI CE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	835, 524	1	1			
51. 00	05100 RECOVERY ROOM	54, 108	1	1		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	7, 800	2, 621	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	116, 861	189, 349	4, 495	9, 069	333	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	95, 153	73, 277	' o	5, 109	0	54. 01
54. 02	05404 ULTRA SOUND	32, 865		1	1, 724		54. 02
54. 03	05405 MAMMOGRAPHY	65, 990			4, 024		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	172, 004	174, 152	1			1
57. 00	05700 CT SCAN	87, 209		1	958		
			l	1	575		58.00
58. 00	05800 MRI	26, 326	l	1			
59. 00	05900 CARDI AC CATHETERI ZATI ON	143, 447	236, 373	1			
60. 00	06000 LABORATORY	401, 834	l	1	.,		1
60. 01	06001 LABORATORY-PATHOLOGI CAL	47, 571	26, 694				60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	22, 960		' 0	192		62. 00
65. 00	06500 RESPI RATORY THERAPY	127, 575	159, 990	0	9, 197	0	65. 00
66.00	06600 PHYSI CAL THERAPY	224, 254	13, 567	1, 900	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	66, 965	4, 868	330	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	36, 194	l	ol o	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	74, 097	30, 791	l o	1, 405		
70. 00	07000 ELECTROENCEPHALOGRAPHY	46, 735	l	61	61, 569		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	250, 483	l e			Ö	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	380, 468	l e			0	72.00
73. 00			l e	j o	0	0	
	07300 DRUGS CHARGED TO PATIENTS	872, 548			- U		73.00
74.00	07400 RENAL DI ALYSI S	32, 057			575		74.00
76. 00	03020 ACUPUNCTURE	0) 0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	20, 660	34, 822	2 0	128	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
90.00	09000 CLI NI C	95, 855	170, 231	2, 407	5, 556	5, 877	90.00
90. 01	09001 DI ABETES CENTER	10, 795	l		64		90. 01
90. 02	09002 NEUROPSYCH	5, 084	2, 203	1	n n	Ö	
90. 02	09003 WOUND CENTER	59, 852	2,200	111		0	90. 03
90. 03				(0	0	
	09004 HYPERBARI C OXYGEN THERAPY	10, 397	ł	204	17 047		
90. 05	09005 VI MCARE CLINI C	36, 811	93, 716	1			90. 05
90.06	09006 MEDICATION MGMT CLINIC	16, 071	20, 197		1, 213		90.06
91. 00	09100 EMERGENCY	412, 690	397, 662	3, 926	32, 828	1, 173	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					<u> </u>	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	211, 136	176, 905	0	0	0	95. 00
99. 10	09910 CORF	0	[c	0	0	0	99. 10
	10100 HOME HEALTH AGENCY	0	l	o	0		101.00
		•			1		

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared:

			''	0 12/31/2017	7/24/2020 4:05 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7.00	8. 00	9. 00	10. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 873, 934	6, 319, 332	58, 971	399, 557	373, 439 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	439	16, 012	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	14, 449	0	0	0	0 194. 00
194. 01 07951 BUILDING RENTALS	12, 836	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	4, 235	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	7, 362	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	31, 351	0	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	2, 337	14, 162	0	2, 746	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	2, 026	26, 320	0	128	0 194. 07
194. 08 07958 CRHP	73, 465	128, 736	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	354	11, 519	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	8, 022, 788	6, 516, 081	58, 971	402, 431	373, 439 202. 00

						7/24/2020 4:0	5 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
		11.00	10.00	SUPPLY	45.00	LI BRARY	
	GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 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	313, 268					11. 00
13.00	01300 NURSING ADMINISTRATION	14, 671	729, 979				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 740	1	454, 113			14. 00
15. 00	01500 PHARMACY	9, 493		0	629, 675		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	10, 356	1	0	0	232, 755	16. 00
17. 00	01700 SOCIAL SERVICE	2, 301	7, 801	0	0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	2, 014		0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	863	3, 530	0	0	0	23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	69, 612	248, 822	14, 358	514	52, 099	30.00
31. 00	03100 NTENSI VE CARE UNI T	9, 493		902	202	2, 522	31. 00
32. 00	03200 CORONARY CARE UNIT	7, 475	33, 02 7	0	0	2, 322	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT			0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT			0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF			0	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	6, 329	22, 679	0	21	3, 662	41. 00
42.00	04200 SUBPROVI DER	C		0	0	0	42.00
43.00	04300 NURSERY	2, 877	10, 666	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	C	o	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	33, 082	108, 894	409, 640	3, 857	107, 604	50.00
51.00	05100 RECOVERY ROOM	3,740	13, 362	0	8	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	C	0	0	3, 123	577	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 329	1	1, 884	906	0	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 438	1	0	7, 901	0	54. 01
54. 02	05404 ULTRA SOUND	1, 438	1	0	21	0	54. 02
54. 03	05405 MAMMOGRAPHY	3, 164	1	609	55	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 877	1	0	0	1, 811	55. 00
57. 00	05700 CT SCAN	2, 877	1	0	19, 399	0	57. 00
58. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	1, 151	1	2 041	2, 662	0	58. 00 59. 00
59. 00 60. 00	06000 LABORATORY	5, 753 23, 013	1	3, 041	10, 230 525	2, 777 10, 530	
60. 00	06001 LABORATORY-PATHOLOGI CAL	1, 726	1	0	0	10, 530	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	288	1	0	0	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	8, 055	1	864	963	10, 758	1
66. 00	06600 PHYSI CAL THERAPY	14, 383		8, 755	73	0,730	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 740		0,700	0	3, 286	1
68. 00	06800 SPEECH PATHOLOGY	2, 301	1	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	2, 589	1	0	15, 941	17, 009	69. 00
	07000 ELECTROENCEPHALOGRAPHY	2, 589		0	0	14, 634	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	1	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	o	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	o o	0	561, 005	0	73. 00
74.00	07400 RENAL DIALYSIS	C	o	0	377	0	74. 00
76.00	03020 ACUPUNCTURE	C	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 151	3, 978	0	1	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	C	1	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	1	0	0	0	89. 00
90.00	09000 CLINIC	6, 904	1	2, 351	9	5, 446	90.00
90. 01	09001 DI ABETES CENTER	575	1	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	288	1	10 122	117	0	90. 02
90. 03	09003 WOUND CENTER	1, 726		10, 123	117	0	90. 03
90. 04 90. 05	09004 HYPERBARI C OXYGEN THERAPY	575	1 ' 1	0 174	0	0	90.04
90.05	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	2, 877 863	1	1/4	840	0	90. 05 90. 06
90.06	09100 EMERGENCY	23, 876	1	1, 412	322	0	90.06
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	23,070	, , , , , , , , , , , , , , , , , , , ,	1,412	322		92.00
12.00	OTHER REIMBURSABLE COST CENTERS						, ,2.00
95. 00	09500 AMBULANCE SERVICES	20, 137	71, 846	0	554	0	95. 00
	09910 CORF	20, 107	1	0	0	0	
	10100 HOME HEALTH AGENCY	C	1	Ō	0		101.00
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| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared:

			10	12/31/2019	7/24/2020 4:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	311, 254	729, 979	454, 113	629, 626	232, 755	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194. 00 07950 WELLNESS COMMUNITY	1, 151	0	0	0		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	0	0	0	49	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 05
194.06 07956 CRH FOUNDATION	0	0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0	194. 07
194. 08 07958 CRHP	0	0	0	0		194. 08
194. 09 07959 NEUROPSYCH PART B	863	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	313, 268	729, 979	454, 113	629, 675	232, 755	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2019	Part II	
To 12/31/2019	Date/Time Prepared:	7/24/2020 4:05 pm

					0 12/31/2019	7/24/2020 4:0	
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED	XRAY EDUCATION		Subtotal	
		17. 00	PRGM 23. 00	23. 01	RESI DENCY PROG 23. 02	24.00	
	GENERAL SERVICE COST CENTERS	17.00	23.00	25.01	25. 02	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						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	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE	55, 224					17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	C)			23. 00
23. 01	02301 XRAY EDUCATION	0		51, 667			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0			43, 982		23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1/ 0/7				F 142 124	20.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	16, 967				5, 143, 124	30.00
31. 00 32. 00	03200 CORONARY CARE UNIT	4, 741		-		809, 213 0	31. 00 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	10, 063				656, 758	41.00
42.00	04200 SUBPROVI DER	0				0	42.00
43.00	04300 NURSERY	0				100, 278	43. 00
44.00	04400 SKILLED NURSING FACILITY	0				0	44. 00
	ANCILLARY SERVICE COST CENTERS			,			
50. 00	05000 OPERATING ROOM	0				4, 863, 724	50.00
51.00	05100 RECOVERY ROOM	0				214, 123	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0				20, 475 575, 799	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C					375, 838	54. 00 54. 01
54. 02	05404 ULTRA SOUND					166, 759	54. 02
54. 03	05405 MAMMOGRAPHY					367, 905	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 663				1, 566, 071	55. 00
57. 00	05700 CT SCAN	0				301, 371	57. 00
58.00	05800 MRI	0				75, 161	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				927, 807	59. 00
60.00	06000 LABORATORY	0				1, 107, 449	60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0				109, 213	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				41, 011	62.00
65. 00	06500 RESPIRATORY THERAPY	0				555, 456	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0				637, 245 213, 089	
	06800 SPEECH PATHOLOGY					109, 028	68.00
69. 00	06900 ELECTROCARDI OLOGY					445, 223	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY					284, 191	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o				250, 483	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0				380, 468	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0				1, 433, 553	73. 00
74.00	07400 RENAL DIALYSIS	0				33, 071	74. 00
76. 00	03020 ACUPUNCTURE	0				0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		<u> </u>		96, 499	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 90. 01	09000 CLI NI C 09001 DI ABETES CENTER	8, 982				469, 645	90.00
90. 01	09001 DI ABETES CENTER					40, 905 9, 584	90. 01 90. 02
90. 02	09003 WOUND CENTER					163, 090	90. 02
90. 04	09004 HYPERBARI C OXYGEN THERAPY					105, 188	90. 04
90. 05	09005 VI MCARE CLI NI C			1		235, 348	90. 05
90. 06	09006 MEDICATION MGMT CLINIC	O				63, 332	90.06
91. 00	09100 EMERGENCY	12, 808				1, 540, 856	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0				1, 005, 124	95. 00
	09910 CORF	0				0	99. 10
101.00	10100 HOME HEALTH AGENCY	0		1		0	101. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared:

			''	0 12/31/2019	7/24/2020 4:0	
Cost Center Description	SOCIAL SERVICE	PARAMED ED	XRAY EDUCATION	PHARMACY	Subtotal	
		PRGM		RESIDENCY PROG		
	17. 00	23.00	23. 01	23. 02	24.00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0				0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0				0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0				0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	55, 224	0	0	0	25, 493, 457	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				•	190. 00
194. 00 07950 WELLNESS COMMUNITY	0				•	194. 00
194. 01 07951 BUILDING RENTALS	0				75, 028	
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				31, 351	1
194. 06 07956 CRH FOUNDATION	0				29, 551	1
194. 07 07957 HEALTHY COMMUNITIES	0				46, 438	1
194. 08 07958 CRHP	0				2, 396, 833	1
194.09 07959 NEUROPSYCH PART B	0					194. 09
200.00 Cross Foot Adjustments		0	51, 667	43, 982	95, 649	
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	55, 224	0	51, 667	43, 982	28, 251, 401	202. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0112

			To 12/31/2019 Date/Time Prep 7/24/2020 4:0	
Cost Center Description	Intern &	Total	172472020 4.00	5 piii
	Residents Cost			
	& Post Stepdown			
	Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT				1. 00
2. 00 00200 CAP REL COSTS-BUDG & TTXT				2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL				5. 00
7. 00 00700 OPERATION OF PLANT				7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY				14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY				15. 00 16. 00
17. 00 01700 SOCIAL SERVICE				17. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01 02301 XRAY EDUCATION				23. 01
23. 02 02302 PHARMACY RESI DENCY PROG				23. 02
30.00 O3000 ADULTS & PEDIATRICS	0	5, 143, 124		30. 00
31. 00 03100 NTENSI VE CARE UNI T		809, 213		31. 00
32.00 03200 CORONARY CARE UNIT	0	o		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF	0	0		34. 00 40. 00
41. 00 04000 SUBPROVI DER - TPF 41. 00 04100 SUBPROVI DER - TRF		656, 758		40.00
42. 00 04200 SUBPROVI DER	o	0		42. 00
43. 00 04300 NURSERY	0	100, 278		43. 00
44. 00 O4400 SKILLED NURSING FACILITY	0	0		44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	4, 863, 724		50. 00
51. 00 05100 RECOVERY ROOM	O	214, 123		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	O		52. 00
53. 00 05300 ANESTHESI OLOGY	0	20, 475		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	575, 799 375, 838		54. 00 54. 01
54. 02 05404 ULTRA SOUND		166, 759		54. 02
54. 03 05405 MAMMOGRAPHY	0	367, 905		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 566, 071		55. 00
57. 00 05700 CT SCAN	0	301, 371		57. 00 58. 00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	75, 161 927, 807		58. 00 59. 00
60. 00 06000 LABORATORY	o	1, 107, 449		60. 00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	109, 213		60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	41, 011		62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	555, 456 637, 245		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		213, 089		67. 00
68.00 06800 SPEECH PATHOLOGY	O	109, 028		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	445, 223		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	284, 191		70. 00 71. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS		250, 483 380, 468		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	1, 433, 553		73. 00
74.00 07400 RENAL DIALYSIS	0	33, 071		74. 00
76. 00 03020 ACUPUNCTURE	0	0		76. 00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	96, 499		76. 97
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	o		89. 00
90. 00 09000 CLI NI C	0	469, 645		90. 00
90. 01 09001 DI ABETES CENTER	0	40, 905		90. 01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER		9, 584 163, 090		90. 02 90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY		105, 188		90. 03
90. 05 09005 VIMCARE CLINIC	0	235, 348		90. 05
90. 06 09006 MEDICATION MGMT CLINIC	0	63, 332		90.06
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	0	1, 540, 856		91.00
OTHER REIMBURSABLE COST CENTERS	ı U			92. 00
95. 00 09500 AMBULANCE SERVICES	0	1, 005, 124		95. 00

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared: 7/24/2020 4:05 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			

			1/24/2020 4:	US PIII
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
99. 10 09910 CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	25, 493, 457		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27, 596		190. 00
194.00 07950 WELLNESS COMMUNITY	0	22, 139		194. 00
194.01 07951 BUILDING RENTALS	0	75, 028		194. 01
194. 02 07952 H0SPI CE	0	4, 284		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	7, 362		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	31, 351		194. 05
194. 06 07956 CRH FOUNDATION	0	29, 551		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	46, 438		194. 07
194. 08 07958 CRHP	0	2, 396, 833		194. 08
194.09 07959 NEUROPSYCH PART B	0	21, 713		194. 09
200.00 Cross Foot Adjustments	O	95, 649		200. 00
201.00 Negative Cost Centers	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	28, 251, 401		202. 00

| Period: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0112

						o 12/31/2019	Date/Time Prep 7/24/2020 4:09	
			CAPITAL REL	ATED COSTS			772472020 4.0	5 piii
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		cost center bescription	(SQ FEET)	(DEPR)	BENEFITS	incconci i i ati on	& GENERAL	
					DEPARTMENT (GROSS SAL)		(ACCUM. COST)	
			1.00	2. 00	4. 00	5A	5. 00	
4 00		AL SERVICE COST CENTERS	700 005			T		4 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	729, 925	13, 777, 058				1. 00 2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12, 367	6, 142	84, 592, 911			4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	56, 745 364, 964	6, 278, 454 487, 240				5. 00 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	792				753, 072	8. 00
9.00	1	HOUSEKEEPI NG	5, 187	73, 521	1, 822, 654		3, 288, 381	9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	7, 864 6, 181	16, 432 27, 339	791, 832 1, 317, 474		1, 547, 982 1, 234, 436	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	9, 744	40, 124	4, 678, 372	0	7, 294, 095	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	7, 611 4, 768	111, 785 152, 278			1, 332, 731 6, 106, 431	14. 00 15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	3, 653				1, 996, 778	•
17. 00 23. 00	01700	SOCIAL SERVICE PARAMED ED PRGM-(SPECIFY)	302	78 0			799, 827 0	17.00
23. 00	02300	XRAY EDUCATION	0	9, 498		_	679, 571	23. 00 23. 01
23. 02		PHARMACY RESIDENCY PROG	376	5, 197			487, 685	23. 02
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	76, 802	278, 434	14, 532, 867	0	23, 555, 798	30. 00
31. 00	03100	INTENSIVE CARE UNIT	10, 959				4, 458, 109	31.00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00	1	SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 42. 00		SUBPROVI DER - I RF SUBPROVI DER	11, 085 0	17, 740 0	1, 483, 845	0	2, 505, 189 0	41. 00 42. 00
43.00	04300	NURSERY	583	17, 881	802, 933	0	1, 116, 651	43. 00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000	OPERATING ROOM	39, 382	1, 285, 126	885, 498	0	21, 209, 963	50. 00
51.00		RECOVERY ROOM	3, 185					
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0 119	0 4, 564	0	0	0 198, 012	52. 00 53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	8, 597	109, 656			2, 966, 548	54. 00
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	3, 327 1, 504	117, 258 72, 342			2, 415, 484 834, 297	
54. 03	1	MAMMOGRAPHY	101	155, 604			1, 675, 168	
55. 00		RADI OLOGY-THERAPEUTI C	7, 907	1, 076, 458			4, 366, 354	
57. 00 58. 00	05800	CT SCAN MRI	1, 798 900				2, 213, 820 668, 279	
59. 00		CARDI AC CATHETERI ZATI ON	10, 732	148, 190	1, 714, 648	0	3, 641, 443	59. 00
60. 00 60. 01		LABORATORY LABORATORY-PATHOLOGI CAL	10, 874 1, 212	224, 189 13, 467	4, 075, 552 353, 999		10, 200, 634 1, 207, 590	•
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	428				582, 842	62. 00
65. 00	1	RESPI RATORY THERAPY	7, 264		1, 997, 692 3, 832, 652		3, 238, 515	1
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	616 221	21, 941 4, 889			5, 692, 744 1, 699, 910	•
68. 00	1	SPEECH PATHOLOGY	0	18, 176	613, 771	0	918, 804	
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 398	269, 850 9, 493			1, 880, 965 1, 186, 375	
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6, 358, 574	
72.00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	9, 658, 272	
73. 00 74. 00	1	RENAL DIALYSIS	0	62		0	22, 149, 822 813, 777	1
76. 00		ACUPUNCTURE	0	0	0		0	76. 00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	1, 581	10, 702	262, 270	0	524, 469	76. 97
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0 27 101			2 422 200	89. 00
90. 00 90. 01	1	CLI NI C DI ABETES CENTER	7, 729 775				2, 433, 289 274, 028	90. 00 90. 01
90. 02	09002	NEUROPSYCH	100	231	85, 729	0	129, 062	90. 02
90. 03 90. 04	1	WOUND CENTER HYPERBARI C OXYGEN THERAPY	0	2, 295 137	420, 828 108, 076		1, 519, 365 263, 936	90. 03 90. 04
90. 05	09005	VIMCARE CLINIC	4, 255		551, 560	0	934, 463	90. 05
90. 06 91. 00		MEDICATION MGMT CLINIC EMERGENCY	917 18, 055	7, 727 294, 447	286, 004 5, 487, 553		407, 967 10, 476, 237	90. 06 91. 00
91.00	1	OBSERVATION BEDS (NON-DISTINCT PART	10,035	274,44/	5,467,553		10,470,237	91.00
			·	·			·	

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

From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/24/2020 4:05 pm CAPITAL RELATED COSTS **EMPLOYEE** Reconci I i ati on ADMI NI STRATI VE Cost Center Description BLDG & FIXT MVBLE EQUIP **BENEFITS** & GENERAL (SO FEET) (DFPR) DEPARTMENT (ACCUM. COST) (GROSS SAL) 1.00 2.00 4.00 5A 5.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 8.032 363, 934 3, 811, 444 5, 359, 732 95.00 99. 10 99. 10 09910 CORF 0 0 Ω 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 109, 00 109. 00 10900 PANCREAS ACQUISITION 0 n O 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 720, 992 84, 347, 775 -49, 514, 375 199, 881, 040 118. 00 118.00 12, 116, 365 NONREI MBURSABLE COST CENTERS 11, 145 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 727 355 0 0 194. 00 07950 WELLNESS COMMUNITY 0 366, 782 194. 00 5, 953 185, 728 194. 01 07951 BUI LDING RENTALS 0 325, 843 194. 01 194. 02 07952 HOSPI CE 0 0 0 0 107, 509 194. 02 194. 03 07953 OUTREACH CLINICS 0 0 0 0 0 0 0 0 194. 03 194. 04 07954 SPEECH - HEARING AIDS 0 186, 874 194. 04 Ω 194. 05 07955 NONALLOWABLE MARKETING 0 0 795, 842 194. 05 194.06 07956 CRH FOUNDATION 643 36, 417 59, 330 194. 06 653 194. 07 07957 HEALTHY COMMUNITIES 1, 195 22, 991 51, 420 194. 07 194. 08 07958 CRHP 1, 652, 522 1, 864, 915 194. 08 5.845 0 194. 09 07959 NEUROPSYCH PART B 523 1, 210 0 8, 977 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 10, 831, 084 13, 848, 916 49, 514, 375 202. 00 202.00 Cost to be allocated (per Wkst. B, 29, 147, 280 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1.005216 0. 344559 0. 243123 203. 00 14.838626 204.00 Cost to be allocated (per Wkst. B, 252, 867 8, 022, 788 204. 00 Part II) 205.00 0.002989 0. 039393 205. 00 Unit cost multiplier (Wkst. B, Part H) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D. 207.00 207. 00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0112

Peri od: Worksheet B-1 From 01/01/2019 To 12/31/2019 Date/Ti me Prepared:

7/24/2020 4:05 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE (TIME SPT) (MEALS) (FTES) (LDRY LBS) (SQ FEET) 9.00 10.00 11.00 8.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 295, 849 7.00 2, 047, 178 8.00 00800 LAUNDRY & LINEN SERVICE 792 8.00 6, 301 00900 HOUSEKEEPI NG 9.00 5.187 9 00 10.00 01000 DI ETARY 7,864 50 161, 385 10.00 11.00 01100 CAFETERI A 6, 181 84 1,089 11.00 01300 NURSING ADMINISTRATION 13.00 9.744 30 51 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 14.00 7.611 76 13 14.00 15.00 01500 PHARMACY 4,768 52 0 33 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 36 3.653 C 16.00 01700 SOCIAL SERVICE 17.00 17.00 302 0 0 8 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 C 0 0 23.00 02301 XRAY EDUCATION 0 23.01 C 23.01 02302 PHARMACY RESIDENCY PROG 376 23.02 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 76, 802 726, 868 2, 033 123, 068 242 30.00 03100 INTENSIVE CARE UNIT 31.00 10.959 87, 308 101 15, 495 33 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 C 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C 0 0 0 34.00 04000 SUBPROVI DER - I PF 40.00 C 0 40.00 41 00 04100 SUBPROVIDER - IRF 11, 085 17, 758 22 41 00 84.740 263 04200 SUBPROVI DER 42.00 0 0 42.00 43.00 04300 NURSERY 583 0 0 10 43.00 18.340 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 39, 382 415, 226 784 492 115 50.00 05100 RECOVERY ROOM 51.00 3, 185 91, 852 69 0 13 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 Ω 0 52 00 0 53.00 05300 ANESTHESI OLOGY 119 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 8, 597 156, 054 22 54.00 142 144 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 3, 327 80 0 5 54.01 05404 ULTRA SOUND 1,504 0 54 02 27 5 54 02 54.03 05405 MAMMOGRAPHY 101 63 0 11 54.03 05500 RADI OLOGY-THERAPEUTI C 7,907 55.00 29, 433 87 895 10 55.00 57.00 05700 CT SCAN 1,798 15 0 10 57.00 05800 MRI 900 58 00 0 4 58 00 59.00 05900 CARDIAC CATHETERIZATION 10, 732 122, 864 118 486 20 59.00 06000 LABORATORY 60.00 10,874 118 0 80 60.00 06001 LABORATORY-PATHOLOGI CAL 1, 212 0 60.01 60.01 5 6 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 428 C 3 62.00 65.00 06500 RESPIRATORY THERAPY 7, 264 144 0 0 0 0 28 65.00 66.00 06600 PHYSI CAL THERAPY 65, 947 50 66.00 616 C 06700 OCCUPATIONAL THERAPY 11, 457 67.00 0 13 67.00 221 06800 SPEECH PATHOLOGY 68.00 0 Ω 8 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 1, 398 22 9 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 126 0 70.00 0 964 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 0 07400 RENAL DIALYSIS 74.00 0 0 9 0 74.00 03020 ACUPUNCTURE 0 76.00 0 0 76.00 07697 CARDIAC REHABILITATION 1,581 76.97 4 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLI NI C 7.729 83, 554 87 2, 540 24 90.00 09001 DIABETES CENTER 775 2 90.01 90.01 0 09002 NEUROPSYCH 90 02 100 0 0 90.02 90.03 09003 WOUND CENTER 3,854 0 0 90.03 0 09004 HYPERBARI C OXYGEN THERAPY 90.04 0 0 0 90.04 90.05 09005 VIMCARE CLINIC 4.255 11, 259 281 0 10 90.05 09006 MEDICATION MGMT CLINIC 90.06 917 19 0 3 90.06 09100 EMERGENCY 18,055 136, 296 514 507 83 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 8,032 0 70 95.00 0 0 99. 10 09910 CORF 0 0 99. 10 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 7/24/2020 4:05 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (TIME SPT) (MEALS) (FTES) (SQ FEET) (LDRY LBS) 9.00 10.00 11.00 7.00 8.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 286, 916 2, 047, 178 6, 256 161, 385 1, 082 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 727 0 0 194. 00 07950 WELLNESS COMMUNITY 0 0 4 194.00 194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 0 194. 01 194. 02 07952 HOSPI CE 0 0 0 194. 02 0 0 0 194. 03 194. 03 07953 OUTREACH CLINICS 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 0 0 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 194. 05 194.06 07956 CRH FOUNDATION 0 194. 06 0 43 643 194. 07 07957 HEALTHY COMMUNITIES 0 194. 07 1, 195 C 2 194. 08 07958 CRHP 5,845 0 0 194. 08 194. 09 07959 NEUROPSYCH PART B 3 194. 09 523 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 16, 471, 397 980, 256 4, 376, 648 2, 396, 890 1, 937, 029 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 478833 694, 595778 14.852000 1, 778. 722681 203. 00 55 675013 313, 268 204. 00 204.00 Cost to be allocated (per Wkst. B, 6, 516, 081 58, 971 402, 431 373, 439 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 22. 025023 0.028806 63.867799 2. 313964 287. 665748 205. 00 11) 206 00 NAHE adjustment amount to be allocated 206. 00

207. 00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

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

				10	12/31/2019	Date/lime Pre 7/24/2020 4:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(DRG COST)	RECORDS & LI BRARY	(TIME SPT)	
		(NURS HRS)	(STER SUP)	45.00	(TIME SPT)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14. 00	15. 00	16. 00	17. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	1, 476, 905					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0 (41	73, 029	24 4/0 2/7			14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	68, 641	0	24, 460, 367	17, 352		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	15, 783	ő	Ö	17, 332	664	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	O	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	0	0	0	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	7, 142	0	0	0	0	23. 02
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	503, 419	2, 309	19, 954	3, 884	204	30.00
31.00	03100 INTENSIVE CARE UNIT	68, 444	2, 309	7, 830	3, 664 188	57	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	45, 885	0	801	273	121 0	41. 00 42. 00
43. 00	04300 NURSERY	21, 580	0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	Ō	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	220, 316	65, 877	149, 827	8, 022	0	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	27, 035	0	329 0	0	0 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	121, 326	43	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	303	35, 196	0	0	54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	o	306, 928	0	0	54. 01
54. 02	05404 ULTRA SOUND	0	0	803	0	0	54. 02
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	0	98	2, 120	0 135	0 20	54. 03 55. 00
57. 00	05700 CT SCAN	0	0	753, 560	133	0	57. 00
58. 00	05800 MRI	o	Ö	103, 395	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	42, 389	489	397, 408	207	0	59. 00
60.00	06000 LABORATORY	0	0	20, 379	785	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	3	0	60. 01
62. 00 65. 00	06500 RESPIRATORY THERAPY	59, 033	139	37, 408	802	0	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 408	2, 852	0	Ö	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	245	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	17, 983	0	619, 222	1, 268	0	69.00
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	/	1, 091	0	70. 00 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	Ō	21, 792, 837	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	14, 647	0	0	74. 00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97	O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	8, 048	U	29	0	0	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ō	Ō	0	0	89. 00
90.00	09000 CLI NI C	38, 364	378	369	406	108	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02 90. 03	O9002 NEUROPSYCH O9003 WOUND CENTER	12, 880	0 1, 628	0 4, 563	0	0 0	90. 02 90. 03
90. 03	09004 HYPERBARI C OXYGEN THERAPY	3, 692	1, 028 N	4, 563 N	0	0	90.03
90. 05	09005 VI MCARE CLI NI C	21, 187	28	32, 642	0	0	90.05
90. 06	09006 MEDICATION MGMT CLINIC	5, 583	O	0	0	0	90. 06
91. 00	09100 EMERGENCY	144, 142	227	12, 520	0	154	91. 00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	145, 359	ol	21, 520	0	0	95. 00
	09910 CORF	143, 339	0		0		99. 10
	ı I	<u>, </u>	٩	٦		<u>, </u>	

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0112		Worksheet B-1
		From 01/01/2019	

COST ALLOCATION - STATISTICAL BASIS			Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nared:
					10 12/31/2017	7/24/2020 4:0	
Cost Center Description		NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
· ·	AD	OMI NI STRATI ON	SERVICES &	(DRG COST)	RECORDS &		
			SUPPLY	`	LI BRARY	(TIME SPT)	
		(NURS HRS)	(STER SUP)		(TIME SPT)	, ,	
		13. 00	14.00	15. 00	16.00	17. 00	
101.00 10100 HOME HEALTH AGENCY		0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION		0	0		0 0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION		0	0		0	0	110. 00
111.00 11100 ISLET ACQUISITION		o	0		0 0	0	111. 00
113.00 11300 INTEREST EXPENSE							113. 00
118.00 SUBTOTALS (SUM OF LINES 1	through 117)	1, 476, 905	73, 029	24, 458, 47	2 17, 352	664	118. 00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0	0		0 0	0	190. 00
194.00 07950 WELLNESS COMMUNITY		О	0		0 0	0	194. 00
194. 01 07951 BUILDING RENTALS		o	0		0 0	0	194. 01
194. 02 07952 HOSPI CE		o	o	1, 89	5 0	0	194. 02
194. 03 07953 OUTREACH CLINICS		o	o		0 0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS		o	o		0 0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING		o	o		0 0	0	194. 05
194. 06 07956 CRH FOUNDATION		o	0		0 0		194, 06
194. 07 07957 HEALTHY COMMUNITIES		o	0		0 0	0	194. 07
194. 08 07958 CRHP		o	0		0 0	0	194. 08
194. 09 07959 NEUROPSYCH PART B		o	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 V	Vkst. B,	9, 721, 507	2, 156, 404	8, 403, 13	9 2, 749, 656	1, 129, 216	202. 00
Part I)	,	, , ,	,	.,,	, ,	, , ,	
203.00 Unit cost multiplier (Wkst.	B, Part I)	6. 582351	29. 528051	0. 34354	1 158. 463347	1, 700. 626506	203. 00
204.00 Cost to be allocated (per N		729, 979	454, 113	629, 67	5 232, 755		204. 00
Part II)	,	,			, , , , , ,		
205.00 Unit cost multiplier (Wkst.	B. Part	0. 494263	6. 218256	0. 02574	3 13. 413728	83. 168675	205. 00
206.00 NAHE adjustment amount to I	oe allocated						206. 00
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier	(Wkst. D,						207. 00
Parts III and IV)							

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: Provider CCN: 15-0112

				''	7/24/2020 4:0	
	Cost Center Description		XRAY EDUCATION			
		PRGM		RESI DENCY PROG		
		(PERCENT)	(PERCENT)	(PERCENT)		
		23. 00	23. 01	23. 02		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					16. 00 17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0				23. 00
23. 01	02301 XRAY EDUCATION		100			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG			100		23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	0	0		30.00
31. 00	03100 NTENSI VE CARE UNI T	0	0			31.00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0		32.00
34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0) 		33. 00 34. 00
40. 00	04000 SUBPROVIDER - I PF		0	0		40.00
41. 00	04100 SUBPROVI DER – I RF	0	Ö	Ö		41. 00
42.00	04200 SUBPROVI DER	0	0	0		42. 00
43.00	04300 NURSERY	0	0	0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0		44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0		50.00
51. 00	05100 RECOVERY ROOM		0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ō	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	100	0		54.00
54. 01 54. 02	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND	0	0	0		54. 01
54. 02	05405 MAMMOGRAPHY	0	0] 0 0		54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö	Ö		55. 00
57.00	05700 CT SCAN	0	0	0		57. 00
58. 00	05800 MRI	0	0	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		59.00
60. 00 60. 01	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL	0	0	0		60. 00 60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62. 00
65. 00	06500 RESPIRATORY THERAPY	0	l ő	Ö		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0		69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0] 0 0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	100		73. 00
74. 00	07400 RENAL DIALYSIS	0	Ö	0		74. 00
76.00	03020 ACUPUNCTURE	0	0	0		76. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0		76. 97
00.00	OUTPATIENT SERVICE COST CENTERS			_		00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		88. 00 89. 00
90.00	09000 CLINIC	0	0	0		90.00
90. 01	09001 DI ABETES CENTER		0	ا		90.00
90. 02	09002 NEUROPSYCH	0	0	0		90. 02
90. 03	09003 WOUND CENTER	0	0	0		90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	0		90. 04
90.05	09005 VI MCARE CLI NI C	0	0	0		90. 05
90. 06 91. 00	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY		0	0		90. 06 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVI CES	0	l .			95. 00
99. 10	09910 CORF	0	0	0		99. 10

| Peri od: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

				T	o 12/31/2019 Date/Time Pr 7/24/2020 4:	
	Cost Center Description	PARAMED ED	KRAY EDUCATION	PHARMACY	772472020 4.	OS piii
	, , , , , , , , , , , , , , , , , , , ,	PRGM		RESIDENCY PROG		
		(PERCENT)	(PERCENT)			
				(PERCENT)		
		23. 00	23. 01	23. 02		
	HOME HEALTH AGENCY	0	0	0		101. 00
	AL PURPOSE COST CENTERS	_1		_		
	PANCREAS ACQUISITION	0	0	0		109. 00
	INTESTINAL ACQUISITION	0	0	0		110.00
	I SLET ACQUI SI TI ON	0	0	0		111. 00
	INTEREST EXPENSE		400	400		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	U	100	100		118. 00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	WELLNESS COMMUNITY	0	0	0		194. 00
	BUILDING RENTALS	0	0	0		194. 00
194. 01 07951		0	0	0		194. 01
	OUTREACH CLINICS	0	0	0		194. 02
	SPEECH - HEARING AIDS	0	0	0		194. 04
	NONALLOWABLE MARKETING	0	0	l o		194. 05
	CRH FOUNDATION	0	0	o o		194. 06
	HEALTHY COMMUNITIES	0	0	ň		194. 07
194. 08 07958		0	0	l ő		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	857, 241	682, 311		202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	8, 572. 410000	6, 823. 110000		203. 00
204.00	Cost to be allocated (per Wkst. B,	0	51, 667	43, 982		204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	516. 670000	439. 820000		205. 00
	[11]					
206. 00	NAHE adjustment amount to be allocated	0	0	0		206. 00
	(per Wkst. B-2)		0.005			
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0.000000		207. 00
	Parts III and IV)					1

| Peri od: | Worksheet C | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0112

					1	o 12/31/2019	Date/Time Pre 7/24/2020 4:0	
				Title	XVIII	Hospi tal	PPS	<u> </u>
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst. B,	Adj .		Di sal I owance		
			Part I, col. 26)					
			1.00	2.00	3.00	4. 00	5. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	41, 928, 267		41, 928, 267		41, 928, 267	30. 00
31. 00		INTENSIVE CARE UNIT	7, 137, 131		7, 137, 131		7, 137, 131	31. 00
32.00		CORONARY CARE UNIT	0				0	32.00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0				0	33. 00 34. 00
40. 00		SUBPROVI DER - I PF	0				0	40.00
41.00		SUBPROVI DER - I RF	4, 808, 887		4, 808, 887	o	4, 808, 887	41.00
42.00		SUBPROVI DER	0		C	0	0	42. 00
43.00	1	NURSERY	1, 589, 210		1, 589, 210		1, 589, 210	
44. 00		SKILLED NURSING FACILITY	0		C	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	34, 232, 512		34, 232, 512	997, 125	35, 229, 637	50. 00
51. 00	1	RECOVERY ROOM	2, 177, 916	l e	2, 177, 916		2, 177, 916	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		C	o	0	52. 00
53. 00		ANESTHESI OLOGY	301, 272		301, 272		301, 272	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	5, 259, 329	l .	5, 259, 329		5, 262, 531	54.00
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC	3, 357, 879	l e	3, 357, 879		3, 357, 879 1, 148, 793	54. 01
54. 02	1	ULTRA SOUND MAMMOGRAPHY	1, 148, 793 2, 155, 011		1, 148, 793 2, 155, 011		2, 155, 011	
55. 00		RADI OLOGY-THERAPEUTI C	6, 029, 146		6, 029, 146		6, 053, 941	
57. 00		CT SCAN	3, 139, 240	l	3, 139, 240		3, 139, 240	
58. 00	05800		929, 747		929, 747	O	929, 747	58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	5, 770, 637		5, 770, 637		5, 770, 637	59. 00
60.00	1	LABORATORY	13, 641, 708		13, 641, 708		13, 641, 708	
60. 01 62. 00	1	LABORATORY-PATHOLOGICAL WHOLE BLOOD & PACKED RED BLOOD CELL	1, 583, 281 752, 236		1, 583, 281 752, 236		1, 620, 637 752, 236	60. 01 62. 00
65. 00		RESPIRATORY THERAPY	5, 112, 740	ł			5, 121, 166	
66. 00		PHYSI CAL THERAPY	7, 274, 146	ł			7, 303, 098	
67. 00	06700	OCCUPATIONAL THERAPY	2, 192, 934	0	2, 192, 934	0	2, 192, 934	67. 00
68. 00		SPEECH PATHOLOGY	1, 156, 416		.,	l l	1, 156, 416	
69. 00		ELECTROCARDI OLOGY	2, 979, 425	ł .	2, 979, 425		3, 014, 943	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	2, 334, 313 7, 904, 490	l e	2, 334, 313 7, 904, 490	l l	2, 334, 313 7, 904, 490	
72.00		IMPL. DEV. CHARGED TO PATIENTS	12, 006, 420	l e	12, 006, 420	l l	12, 006, 420	
73. 00		DRUGS CHARGED TO PATIENTS	35, 703, 998	l e	35, 703, 998		35, 703, 998	
74. 00		RENAL DIALYSIS	1, 022, 908		1, 022, 908		1, 022, 908	
76. 00		ACUPUNCTURE	0	l	0		0	76. 00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	801, 490		801, 490	0	801, 490	76. 97
88. 00		RURAL HEALTH CLINIC	0			ol	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0			-	0	89. 00
90.00	09000	CLINIC	4, 147, 859		4, 147, 859	o	4, 147, 859	90. 00
90. 01		DI ABETES CENTER	388, 051		388, 051		388, 051	
90. 02	1	NEUROPSYCH	167, 787	l	167, 787		167, 787	
90. 03 90. 04		WOUND CENTER HYPERBARIC OXYGEN THERAPY	2, 035, 696 355, 964		2, 035, 696 355, 964		2, 056, 720 357, 214	
90. 04		VIMCARE CLINIC	1, 768, 409	l	1, 768, 409		1, 768, 409	
90. 06		MEDICATION MGMT CLINIC	613, 489		613, 489		613, 489	
91.00	09100	EMERGENCY	15, 827, 605		15, 827, 605	634, 150	16, 461, 755	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	5, 701, 975		5, 701, 975		5, 701, 975	92. 00
05.00		REI MBURSABLE COST CENTERS	0.400.404	1	0.400.404		0.400.707	05.00
95. 00 99. 10		AMBULANCE SERVI CES	8, 198, 696 0	l	8, 198, 696		8, 198, 696 0	
		HOME HEALTH AGENCY	0				-	101. 00
		AL PURPOSE COST CENTERS						
	10900	PANCREAS ACQUISITION	0		C			109. 00
	1	INTESTINAL ACQUISITION	0		C			110.00
		ISLET ACQUISITION	0) c	'	0	111.00
200.00		INTEREST EXPENSE Subtotal (see instructions)	253, 637, 013	0	253, 637, 013	1, 791, 798	255, 428, 811	113. 00 200. 00
200.00	1	Less Observation Beds	5, 701, 975		5, 701, 975		5, 701, 975	
202.00	1	Total (see instructions)	247, 935, 038					

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
7/24/2020 4:05 pm	Provider CCN: 15-0112

			'	0 12/31/2019	7/24/2020 4:0	
			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						
30. 00 03000 ADULTS & PEDI ATRI CS	59, 406, 914		59, 406, 914			30. 00
31.00 03100 INTENSIVE CARE UNIT	13, 433, 535		13, 433, 535			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 - 1 PF	0		0			40.00
41. 00 04100 SUBPROVI DER - I RF	6, 825, 783		6, 825, 783			41.00
42. 00 04200 SUBPROVI DER	2 201 044		2 201 044			42.00
43. 00 04300 NURSERY	2, 201, 046		2, 201, 046			43.00
44. 00 04400 SKILLED NURSING FACILITY	0		0			44. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	27, 399, 316	40 420 440	05 027 074	0. 357192	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	2, 386, 005	68, 438, 660 5, 079, 734			0. 000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 360, 003	5,079,734 0	7, 405, 739		0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	5, 171, 544	9, 045, 755			0. 000000	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 305, 167	5, 208, 919			0. 000000	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	976, 213	12, 355, 644	13, 331, 857		0. 000000	54. 01
54. 02 05404 ULTRA SOUND	1, 207, 621	4, 742, 211	5, 949, 832		0. 000000	54. 02
54. 03 05405 MAMMOGRAPHY	327	4, 668, 033			0. 000000	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	306, 411	19, 224, 626			0. 000000	55.00
57. 00 05700 CT SCAN	7, 228, 645	26, 513, 713			0. 000000	57.00
58. 00 05800 MRI	1, 571, 735	6, 845, 881	8, 417, 616		0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	17, 352, 841	14, 364, 256			0. 000000	59.00
60. 00 06000 LABORATORY	15, 591, 288	40, 334, 496			0. 000000	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	701, 271	6, 126, 405			0. 000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 475, 502	885, 865	2, 361, 367		0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	7, 137, 251	3, 678, 533	10, 815, 784	0. 472711	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 205, 255	11, 229, 391	15, 434, 646	0. 471287	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 678, 130	2, 386, 670	5, 064, 800	0. 432975	0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	870, 413	736, 908	1, 607, 321	0. 719468	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 295, 623	10, 972, 121	17, 267, 744	0. 172543	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	154, 819	7, 559, 249	7, 714, 068	0. 302605	0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 455, 267	11, 046, 494	22, 501, 761	0. 351283	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 360, 863	9, 732, 874			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	27, 713, 507	71, 237, 723			0. 000000	73. 00
74. 00 07400 RENAL DI ALYSI S	1, 754, 893	0	1, 754, 893		0. 000000	74. 00
76. 00 03020 ACUPUNCTURE	0	0	0	0. 000000	0. 000000	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	37, 900	2, 036, 959	2, 074, 859	0. 386286	0. 000000	76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC						00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			88. 00 89. 00
90. 00 09000 CLINI C	71, 208	6, 053, 496	6, 124, 704	0. 677234	0. 000000	90.00
90. 01 09001 DI ABETES CENTER	178	310, 503		1. 249034	0. 000000	
90. 02 09002 NEUROPSYCH	2, 836	225, 763			0. 000000	
90. 03 09003 WOUND CENTER	99, 039	7, 249, 616			0. 000000	
90. 04 09004 HYPERBARI C OXYGEN THERAPY	2, 192	983, 660			0. 000000	90. 04
90. 05 09005 VI MCARE CLI NI C	1, 966	1, 067, 030			0. 000000	90.05
90. 06 09006 MEDICATION MGMT CLINIC	4, 089	853, 912			0. 000000	90.06
91. 00 09100 EMERGENCY	17, 384, 568	59, 102, 342			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	14, 624, 939			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	12, 630, 687	12, 630, 687	0. 649109	0.000000	95. 00
99. 10 09910 CORF	0	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0			101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0			109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	1			110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0			111.00
113.00 11300 INTEREST EXPENSE	255 774 444	457 550 010	710 004 000			113.00
200.00 Subtotal (see instructions)	255, 771, 161	457, 553, 068	713, 324, 229			200. 00 201. 00
201.00 Less Observation Beds 202.00 Total (see instructions)	255, 771, 161	457, 553, 068	713, 324, 229			201.00
202.00 Total (366 HISTI UCTI 0113)	233,771,101	401, 000, 000	1 13, 324, 229			₁ 202.00

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

Provider CCN: 15-0112 | Period: From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 7/24/2020 4:05 pm

			12,01,201,	7/24/2020 4:05 pm
0 1 0 1 0 1 1	DDC 1 11 1	Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34. 00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43. 00
44. 00 04400 SKILLED NURSING FACILITY				44. 00
ANCI LLARY SERVI CE COST CENTERS	0.047504			50.00
50. 00 05000 OPERATING ROOM	0. 367596			50.00
51. 00 05100 RECOVERY ROOM	0. 291721			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000 0. 021191			52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 021191			54.00
54. 01 05400 NADI OLOGI - DI AGNOSTI C	0. 307869			54. 00
54. 02 05404 ULTRA SOUND	0. 193080			54. 02
54. 03 05405 MAMMOGRAPHY	0. 461621			54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 309965			55. 00
57. 00 05700 CT SCAN	0. 093036			57. 00
58. 00 05800 MRI	0. 110453			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 181941			59. 00
60. 00 06000 LABORATORY	0. 243925			60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 237363			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 318560			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 473490			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 473163			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 432975			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 719468			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 174600			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 302605			70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 351283			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 569194			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0. 360824			73. 00 74. 00
74. 00 07400 RENAL DI ALTSI S 76. 00 03020 ACUPUNCTURE	0. 582889 0. 000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 386286			76. 97
OUTPATIENT SERVICE COST CENTERS	0. 300200			70. 77
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 677234			90.00
90. 01 09001 DI ABETES CENTER	1. 249034			90. 01
90. 02 09002 NEUROPSYCH	0. 733980			90. 02
90. 03 09003 WOUND CENTER	0. 279877			90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 362340			90. 04
90. 05 09005 VI MCARE CLI NI C	1. 654271			90. 05
90.06 09006 MEDICATION MGMT CLINIC	0. 715021			90. 06
91. 00 09100 EMERGENCY	0. 215223			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 389880			92. 00
OTHER REIMBURSABLE COST CENTERS	0 (40400			05.00
95. 00 09500 AMBULANCE SERVI CES	0. 649109			95. 00
99. 10 09910 CORF				99. 10
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100 SLET ACQUISITION				111.00
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	. '			•

Health Financial Systems	COLUMBUS REGIO				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part I Date/Time Pre 7/24/2020 4:0	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 143, 124	C	5, 143, 12	24 28, 766	178. 79	
31.00 INTENSIVE CARE UNIT	809, 213		809, 2	13 3, 143	257. 47	
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVI DER - I PF	0	C		0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	656, 758	C	656, 75	58 3, 601	182. 38	41.00
42. 00 SUBPROVI DER	0	C		0 0	0.00	42.00
43. 00 NURSERY	100, 278		100, 27	78 2, 961	33. 87	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	6, 709, 373		6, 709, 37	73 38, 471		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00 ADULTS & PEDIATRICS	12, 048					30. 00
31.00 INTENSIVE CARE UNIT	705					31. 00
32. 00 CORONARY CARE UNIT	0	C				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	C				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	()			34.00
40. 00 SUBPROVI DER - I PF	0	C				40. 00
41. 00 SUBPROVI DER - I RF	2, 021		1			41. 00
42. 00 SUBPROVI DER	0	1	1			42. 00
43. 00 NURSERY	0	C)			43. 00
44.00 SKILLED NURSING FACILITY	0	C)			44. 00
200.00 Total (lines 30 through 199)	14, 774	2, 704, 168	3			200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 7/24/2020 4:05 pm

AFFORTIONWENT OF THEATTENT ANGIELANT SERVICE CAPITA	AL 00313	Frovider C		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 7/24/2020 4:09	pared: 5 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	·				
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 863, 724	1			573, 085	50.00
51.00 05100 RECOVERY ROOM	214, 123	7, 465, 739			28, 516	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	20, 475			0 2, 069, 733	2, 980	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	575, 799	6, 514, 086	0. 08839	3 680, 436	60, 146	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	375, 838	13, 331, 857	0. 02819	1 689, 715	19, 444	54. 01
54. 02 05404 ULTRA SOUND	166, 759	5, 949, 832	0. 02802	8 576, 338	16, 154	54. 02
54. 03 05405 MAMMOGRAPHY	367, 905	4, 668, 360	0. 07880	8 327	26	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 566, 071	19, 531, 037	0. 08018	4 109, 868	8, 810	55. 00
57.00 05700 CT SCAN	301, 371	33, 742, 358	0.00893	2 3, 841, 374	34, 311	57.00
58. 00 05800 MRI	75, 161	8, 417, 616	0.00892	9 823, 474	7, 353	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	927, 807	31, 717, 097	0. 02925	3 6, 889, 773	201, 547	59. 00
60. 00 06000 LABORATORY	1, 107, 449	55, 925, 784	0. 01980	2 6, 579, 431	130, 286	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	109, 213	6, 827, 676	0. 01599	6 317, 781	5, 083	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41, 011	2, 361, 367			9, 757	62. 00
65. 00 06500 RESPIRATORY THERAPY	555, 456	10, 815, 784	0. 05135	6 3, 507, 208	180, 116	65. 00
66. 00 06600 PHYSI CAL THERAPY	637, 245	1		7 1, 480, 374	61, 120	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	213, 089					67. 00
68. 00 06800 SPEECH PATHOLOGY	109, 028		0.06783			68. 00
69. 00 06900 ELECTROCARDI OLOGY	445, 223	17, 267, 744				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	284, 191	7, 714, 068				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	250, 483	1	0. 01113		50, 716	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	380, 468					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 433, 553					73. 00
74. 00 07400 RENAL DI ALYSI S	33, 071	1, 754, 893	•			74. 00
76. 00 03020 ACUPUNCTURE	00,0,1	0	0. 00000		0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	96, 499	2, 074, 859	•			76. 97
OUTPATIENT SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89. 00
90. 00 09000 CLI NI C	469, 645	6, 124, 704			3, 915	90.00
90. 01 09001 DI ABETES CENTER	40, 905	310, 681	0. 13166	2 0	0	90. 01
90. 02 09002 NEUROPSYCH	9, 584	228, 599			47	90. 02
90. 03 09003 WOUND CENTER	163, 090				1, 841	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	105, 188	985, 852			234	90. 04
90. 05 09005 VI MCARE CLI NI C	235, 348					90. 05
90.06 09006 MEDICATION MGMT CLINIC	63, 332	858, 001	0. 07381		226	90. 06
91. 00 09100 EMERGENCY	1, 540, 856			-		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	699, 433				0	92.00
OTHER REIMBURSABLE COST CENTERS	2117100	, , . , . , . ,				
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	18, 478, 393	618, 826, 264		75, 594, 101	1, 971, 535	
		•	•			•

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co	CN: 15-0112 P	eri od:	Worksheet D	
			Į <u>F</u>	rom 01/01/2019	Part III	
			ļ	o 12/31/2019	Date/Time Pre 7/24/2020 4:0	parea:
		Ti +l o	xVIII	Hospi tal	PPS	5 piii
Cost Center Description	Nursing School	Nursing School			All Other	
cost center bescription	Post-Stepdown	Indi Si ilg Scriooi	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	171	1.00	271	2. 00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	0	0	0	30. 00
31. 00 03100 NTENSI VE CARE UNI T					0	31.00
32. 00 03200 CORONARY CARE UNIT		_	-	_	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0	_	0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		_		_	0	34.00
	1	_	1	_		
40. 00 04000 SUBPROVI DER - 1 PF	C	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF		0	0	0	0	41.00
42. 00 04200 SUBPROVI DER		0	0	0	0	42.00
43. 00 04300 NURSERY	C	_	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	C	0	0	0		44. 00
200.00 Total (lines 30 through 199)	C	0	0	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	,	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	,		12, 048	
31.00 03100 INTENSIVE CARE UNIT		0	3, 143		705	
32. 00 03200 CORONARY CARE UNIT		0	0		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	0	0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	C	0	0	0.00	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	C	0	3, 601	0.00	2, 021	41.00
42. 00 04200 SUBPROVI DER	C	0	0	0.00	0	42.00
43. 00 04300 NURSERY		0	2, 961	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	0	0.00	0	44. 00
200.00 Total (lines 30 through 199)		0	38, 471		14, 774	200. 00
Cost Center Description	I npati ent	PSA Adj. All	·			
	Program	Other Medical				
	Pass-Through	Education Cost				
	Cost (col. 7 x					
	col . 8)					
	9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	C	0				30.00
31.00 03100 INTENSIVE CARE UNIT	1 0	0				31.00
32. 00 03200 CORONARY CARE UNIT		0				32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T						34.00
40. 00 04000 SUBPROVI DER - PF		_				40.00
41. 00 04100 SUBPROVI DER - RF		_	1			41.00
42. 00 04200 SUBPROVI DER		_	1			42. 00
43. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			ł			43.00
44.00 04400 SKI LLED NURSING FACILITY						44.00
200.00 Total (lines 30 through 199)	1	0	Ί			200. 00

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	From 01/01/2019	Worksheet D Part IV Date/Time Prepared:

					12/31/2019	7/24/2020 4:0	
			Ti tl e	e XVIII	Hospi tal	PPS	<u></u>
	Cost Center Description	Non Physician			Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	C	0)	0	0	50. 00
51.00	05100 RECOVERY ROOM	C) C		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C) c		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	C) c		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C) c		0	857, 241	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	C) c		0	0	54. 01
54.02	05404 ULTRA SOUND	C) c		0	0	54. 02
54.03	05405 MAMMOGRAPHY	C) c		0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	C) c		0	0	55. 00
57.00	05700 CT SCAN	C	o c		o	0	57. 00
58.00	05800 MRI	C	o c		o	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	o c		o	0	59. 00
60.00	06000 LABORATORY	C	o c		o	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	C	o c		o	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	o c		o	0	62.00
65.00	06500 RESPIRATORY THERAPY	C			o	0	65. 00
66.00	06600 PHYSI CAL THERAPY	C			o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	C	o c		o	0	67. 00
68.00	06800 SPEECH PATHOLOGY	C	o c		o	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	C	o c		o	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C	o c		o	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	ol c		o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	ol c		o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	ol c		o	682, 311	73. 00
74.00	07400 RENAL DIALYSIS	C	ol c		o	0	74. 00
76.00	03020 ACUPUNCTURE	C	ol c		o	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	C	ol c		o	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			•	<u> </u>	<u> </u>	1
88.00	08800 RURAL HEALTH CLINIC	C	C) (0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C) C		0	0	89. 00
90.00	09000 CLI NI C	C) c		0	0	90.00
90. 01	09001 DI ABETES CENTER	C) C		0	0	90. 01
90. 02	09002 NEUROPSYCH	C) c		0	0	90. 02
90. 03	09003 WOUND CENTER	C) c		0	0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	C) c		0	0	90. 04
90.05	09005 VI MCARE CLI NI C	C) c		0	0	90. 05
90.06	09006 MEDICATION MGMT CLINIC	C) c		0	0	90.06
91.00	09100 EMERGENCY	C) c		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	C)			0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	C) c) (0	1, 539, 552	200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	

THROUG	H COSTS				To 12/31/2019	Date/Time Pre 7/24/2020 4:0	pared:
			Title	XVIII	Hospi tal	PPS	о р
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			ı			
50.00	05000 OPERATING ROOM	0	0	(0.000000	1
51.00	05100 RECOVERY ROOM	0	0	(.,,	0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(·	0. 000000	1
53. 00	05300 ANESTHESI OLOGY	0	0	(14, 217, 299	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	857, 241	857, 24		0. 131598	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	(0. 000000	1
54. 02	05404 ULTRA SOUND	0	0	(0, 717, 002	0. 000000	
54. 03	05405 MAMMOGRAPHY	0	0	(4, 668, 360	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(, ,	0. 000000	1
57. 00	05700 CT SCAN	0	0	(33, 742, 358	0. 000000	1
58. 00	05800 MRI	0	0		-, ,	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	01, 717, 077	0. 000000	1
60.00	06000 LABORATORY	0	0	1	00, 720, 701	0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	(0,027,070	0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		2,00.,00,	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	1	10, 101, 010	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(-,,	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0	(., 00,, 02.	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	(17, 267, 744	0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(.,,	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(22, 501, 761	0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(21,070,707	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	682, 311	682, 31		0. 006895	
74. 00	07400 RENAL DI ALYSI S	0	0	(0. 000000	
76. 00	03020 ACUPUNCTURE	0	0		-	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(2, 074, 859	0. 000000	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS					0.00000	00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		-	0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0.000000	1
90.00	09000 CLI NI C	0	0	· ·	-,,	0. 000000	1
90. 01	09001 DI ABETES CENTER	0	0	1	310, 681	0. 000000	
90. 02	09002 NEUROPSYCH	0	0	1	,	0. 000000	1
90. 03	09003 WOUND CENTER	0	0	(,,0.0,000	0. 000000	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	(985, 852	0. 000000	1
90. 05	09005 VI MCARE CLI NI C	0	0	(.,,	0. 000000	
90. 06	09006 MEDICATION MGMT CLINIC	0	0	(858, 001	0. 000000	
91.00	09100 EMERGENCY	0	0			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(14, 624, 939	0. 000000	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS				1		05.00
95.00	09500 AMBULANCE SERVICES		4 500 550	4 500 55	(40.00/.5/.		95. 00
200.00	Total (lines 50 through 199)	0	1, 539, 552	1, 539, 552	618, 826, 264		200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS			To	12/31/2019	Date/Time Prep 7/24/2020 4:09	pared:
		Title	XVIII	Hospi tal	PPS	o piii
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	0.000000	11 202 545	0	18, 764, 423	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	11, 292, 545 994, 243	0	18, 764, 423	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	994, 243 N	0	1, 112, 013	0	52.00
53. 00 05200 DELI VERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 069, 733	ا	2, 252, 736	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131598	680, 436		1, 635, 967	215, 290	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	689, 715		5, 158, 317	213, 240	54. 01
54. 02 05404 ULTRA SOUND	0. 000000	576, 338		1, 204, 484	Ö	54. 02
54. 03 05405 MAMMOGRAPHY	0. 000000	327	Ö	415, 164	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	109, 868		8, 582, 022	0	55. 00
57. 00 05700 CT SCAN	0. 000000	3, 841, 374	0	7, 569, 213	0	57. 00
58. 00 05800 MRI	0. 000000	823, 474	0	2, 212, 459	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 889, 773	O	5, 422, 802	0	59. 00
60. 00 06000 LABORATORY	0. 000000	6, 579, 431	0	4, 221, 042	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	317, 781	0	1, 591, 863	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	561, 840	0	191, 715	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 507, 208	0	1, 330, 012	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 480, 374	0	38, 090	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	619, 628	0	15, 713	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	106, 926	0	156, 621	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 257, 969	0	3, 570, 866	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	78, 030	0	1, 721, 561	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 555, 882	0	2, 516, 011	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 843, 253	0	4, 159, 913	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 006895	11, 589, 746	79, 911	31, 103, 693	214, 460	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 099, 488		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	13, 125	0	1, 032, 748	0	76. 97
OUTPATIENT SERVICE COST CENTERS				_1	_	
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0 045 7/4	0	89. 00
90. 00 09000 CLI NI C	0. 000000	51, 062	0	2, 845, 764	0	90.00
90. 01 09001 DI ABETES CENTER	0.000000	1 127	0	22, 274	0	90. 01
90. 02 09002 NEUROPSYCH	0.000000	1, 127		115, 548	0	90. 02
90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000 0. 000000	82, 969	0	3, 156, 167	0	90. 03 90. 04
90. 04 09004 HTPERBART C OXTGEN THERAPT	0. 000000	2, 192 1, 210	ا	113, 984 96, 514	0	90.04
90. 06 09006 MEDICATION MGMT CLINIC	0. 000000	3, 061	0	522, 426	0	90.06
91. 00 09100 EMERGENCY	0. 000000	8, 873, 973		11, 542, 341	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0,073,773	0	2, 664, 692	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000		١	2, 004, 072	0	, ,2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		75, 594, 101	169, 455	127, 059, 958	429, 750	
1	1	,		,	,	

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

THROUGH COSTS

THOUGH COSTS

THOUGH COSTS

THE COLUMBUS REGIONAL HOSPITAL

From 01/01/2019
To 12/31/2019

TO 12/31/2019

THE COLUMBUS REGIONAL HOSPITAL

From 01/01/2019
TO 12/31/2019

THE COLUMBUS REGIONAL HOSPITAL

THE COLUMBUS REG

Title XVIII Hospital PPS
Physician Anesthetist Education Cost Education Cost
Anesthetist Education Cost
ANCILLARY SERVICE COST CENTERS
Cost 21.00 24.00
ANCILLARY SERVICE COST CENTERS
ANCILLARY SERVICE COST CENTERS 50.00 050
50. 00 05000 OPERATI NG ROOM 0 0 50. 0 50. 0 50. 0 51. 00 51. 00 05100 RECOVERY ROOM 0 0 0 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 51. 00 52. 00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 66. 00
51. 00 05100 RECOVERY ROOM 0 0 51. 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52. 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 54. 0 54. 02 05404 ULTRA SOUND 0 0 0 54. 0 54. 03 05405 MAMMOGRAPHY 0 0 0 54. 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 0 57. 00 05700 CT SCAN 0 0 55. 0 0 55. 0 58. 00 05800 MRI 0 0 0 57. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0 60. 01 06000 LABORATORY - PATHOLOGI CAL 0 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52. 0 53. 00 05300 ANESTHESI OLOGY 0 0 53. 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 0 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 54. 02 05404 ULTRA SOUND 0 0 0 54. 03 05405 MAMMOGRAPHY 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 0 57. 00 05700 CT SCAN 0 0 0 57. 0 58. 00 05800 MRI 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0 60. 00 06000 LABORATORY 0 0 60. 0 60. 01 06000 LABORATORY-PATHOLOGI CAL 0 0 60. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 00 06600
53. 00 05300 ANESTHESI OLOGY 0 0 53. 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 0 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 54. 0 54. 02 05404 ULTRA SOUND 0 0 54. 0 54. 03 05405 MAMMOGRAPHY 0 0 54. 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55. 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MRI 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 58. 0 60. 00 06000 LABORATORY 0 0 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 60. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 0 66. 0 66. 0 66. 0 66. 0 66. 0 66. 0 66. 0 66. 0 66. 0 <t< td=""></t<>
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 55. 0 57. 0 0 0 0 55. 0 57. 0 0 0 0 55. 0 57. 0 0 0 57. 0 0 57. 0 0 0 57. 0 0 0 57. 0 0 0 57. 0 0 0 57. 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 54. 0 0 0 54. 0 0 0 54. 0 0 0 54. 0 0 54. 0 0 54. 0 0 0 54. 0 0 0 54. 0 0 0 55. 0 0 0 0 0 0 55. 0 0 0 0 0 0 0 0 55. 0 0 </td
54. 02 05404 ULTRA SOUND 0 0 54. 0 54. 03 05405 MAMMOGRAPHY 0 0 0 54. 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 0 57. 00 05700 CT SCAN 0 0 0 57. 0 58. 00 05800 MRI 0 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 58. 0 60. 01 06000 LABORATORY 0 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0
54. 03 05405 MAMMOGRAPHY 0 0 54. 0 55. 0 55. 0 55. 0 0 0 0 0 55. 0 55. 0 55. 0 0 0 0 0 55. 0 0 55. 0 0 0 0 57. 0 0 57. 0 0 0 0 57. 0 0 57. 0 0 58. 0 0 0 0 58. 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 58. 0 0 0 0 60. 0 0
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55. 0 57. 00 05700 CT SCAN 0 0 57. 0 58. 00 05800 MRI 0 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0 60. 00 06000 LABORATORY 0 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0
57. 00 05700 CT SCAN 0 0 57. 0 58. 00 05800 MRI 0 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0 60. 00 06000 LABORATORY 0 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0
58. 00 05800 MRI 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 0 60. 00 06000 LABORATORY 0 0 0 60. 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62. 0 65. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0 67. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 0 60. 00 06000 LABORATORY 0 0 0 60. 0 60. 01 06001 LABORATORY-PATHOLOGI CAL 0 0 60. 0 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62. 0 65. 00 06500 RESPI RATORY THERAPY 0 0 65. 0 66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0
60. 00 06000 LABORATORY 0 0 0 0 060. 01 060. 01 060. 01 LABORATORY - PATHOLOGI CAL 0 0 0 0 0 062. 00 062. 00 065. 00 065. 00 065. 00 065. 00 066. 00 066. 00 066. 00 067.
60. 00 06000 LABORATORY 0 0 0 0 060. 01 060. 01 060. 01 LABORATORY - PATHOLOGI CAL 0 0 0 0 0 062. 00 062. 00 065. 00 065. 00 065. 00 065. 00 066. 00 066. 00 066. 00 067.
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 65. 00 65. 00 665. 00 666. 00 666. 00 666. 00 667. 00 06700 00CCUPATI ONAL THERAPY 0 0 0 0 67. 00 00 00 00 00 00 00 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 06700 06700 06700 06700 69. 00 06700 06700 69. 00 06700 06700 60. 00 06700 06700 60. 00 60. 00 06700 60. 00 06700 60. 00 06700 60. 00 06700 60. 00 06700 60. 00 06700 60. 00 06700 60. 00 60. 00 0670
65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 666. 00 06600 PHYSI CAL THERAPY 0 0 0 667. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0
66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 0
68. 00 06800 SPEECH PATHOLOGY 0 0 68. 0
69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70. 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.0
74.00 07400 RENAL DI ALYSI S 0 0 74.0
76. 00 03020 ACUPUNCTURE 0 0 76. 0
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 9
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 0 0 88. 0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00
90. 00 09000 CLI NI C 0 0 90. 0
90. 01 09001 DI ABETES CENTER 0 0 90. 0
90. 02 09002 NEUROPSYCH 0 0 90. 0
90. 03 09003 WOUND CENTER 0 0 90. 0
90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 90. 0
90. 04 09004 HTPERBARI C OXTGEN THERAPT
90. 06 09006 MEDI CATI ON MGMT CLI NI C 0 0 0 0 0 0 0 0 0
91. 00 09100 EMERGENCY
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 92. 0
OTHER REI MBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 95. 0
200.00 Total (lines 50 through 199) 0 0 200.0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0112 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 7/24/2020 4:05 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 357192 18, 764, 423 6, 702, 502 50.00 51.00 05100 RECOVERY ROOM 0. 291721 1, 112, 813 0 0 51.00 324, 631 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.021191 2, 252, 736 47, 738 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.807378 1, 635, 967 0 1, 320, 844 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 251869 5. 158. 317 0 0 1, 299, 220 54 01 0 54.02 05404 ULTRA SOUND 0.193080 1, 204, 484 232, 562 54.02 54.03 05405 MAMMOGRAPHY 0.461621 415, 164 191, 648 54.03 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.308696 8, 582, 022 0 2, 649, 236 55.00 0 05700 CT SCAN 704, 209 57 00 0.093036 7, 569, 213 57 00 58.00 05800 MRI 0.110453 2, 212, 459 244, 373 58.00 05900 CARDIAC CATHETERIZATION 0.181941 5, 422, 802 0 986, 630 59.00 59.00 0 0 0 06000 LABORATORY 0. 243925 4, 221, 042 0 1, 029, 618 60.00 60.00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 0.231892 1, 591, 863 369, 140 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.318560 191, 715 0 61,073 62.00 06500 RESPIRATORY THERAPY 0.472711 1, 330, 012 0 628, 711 65.00 65.00 0 17, 951 06600 PHYSI CAL THERAPY 0. 471287 0 66.00 38.090 66, 00 0 06700 OCCUPATIONAL THERAPY 67 00 0.432975 15, 713 6,803 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.719468 156, 621 0 112, 684 68.00 06900 ELECTROCARDI OLOGY 3, 570, 866 0 0 69.00 0.172543 616, 128 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 520, 953 70.00 0.302605 1, 721, 561 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0.351283 2, 516, 011 883, 832 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.569194 4, 159, 913 0 0 2, 367, 798 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0.360824 31, 103, 693 0 108, 826 11, 222, 959 73.00 07400 RENAL DIALYSIS 0 74.00 0.582889 74.00 C 0 0 0 76.00 03020 ACUPUNCTURE 0.000000 0 Λ 76.00 07697 CARDIAC REHABILITATION 0.386286 398, 936 76.97 1,032,748 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.677234 2, 845, 764 0 0 1, 927, 248 90.00 09001 DI ABETES CENTER 0 1. 249034 27, 821 90.01 22, 274 0 90.01 0 90.02 09002 NEUROPSYCH 0.733980 115, 548 84, 810 90.02 0. 277016 90.03 09003 WOUND CENTER 3, 156, 167 0 0 874, 309 90.03 09004 HYPERBARI C OXYGEN THERAPY 113, 984 0 41, 156 90.04 90.04 0.361072 90.05 09005 VIMCARE CLINIC 96, 514 0 159, 660 90.05 1.654271 0 90.06 09006 MEDICATION MGMT CLINIC 0.715021 522, 426 0 373, 546 90.06 91.00 09100 EMERGENCY 0. 206932 11, 542, 341 0 2, 388, 480 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1, 038, 910 92.00 92.00 0.389880 2,664,692 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0.649109 0 95.00 0 200.00 Subtotal (see instructions) 127, 059, 958 108, 826 39, 856, 119 200.00 Less PBP Clinic Lab. Services-Program 0 201 00 201 00

127, 059, 958

0

108, 826

39, 856, 119 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Peri od: Worksheet D Part V Part V Pare V Pa

				10 12/01/201/	7/24/2020 4:05 pm	
			Title XVIII	Hospi tal	PPS	
		Costs		<u> </u>		
	Cost Center Description	Cost	Cost			
	'	Rei mbursed	Reimbursed			
			ervices Not			
			Subject To			
			ed. & Coins.			
			(see inst.)			
		6.00	7. 00			
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00			
	OO OPERATING ROOM	0	O		50.	00
	OO RECOVERY ROOM	0	ol		51.	
		0	ol		52.	
	OO DELIVERY ROOM & LABOR ROOM		-1			
	OO ANESTHESI OLOGY	0	0		53.	
	00 RADI OLOGY-DI AGNOSTI C	0	0		54.	
	02 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.	
	04 ULTRA SOUND	0	0		54.	
	05 MAMMOGRAPHY	0	0		54.	
	00 RADI OLOGY-THERAPEUTI C	0	0		55.	
	00 CT SCAN	0	0		57.	00
58. 00 0580	OO MRI	0	0		58.	00
59.00 0590	OO CARDIAC CATHETERIZATION	0	0		59.	00
60.00 0600	00 LABORATORY	0	О		60.	00
60. 01 0600	01 LABORATORY-PATHOLOGI CAL	o	o		60.	01
62.00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELL	o	o		62.	00
	00 RESPI RATORY THERAPY	o	o		65.	
1	00 PHYSI CAL THERAPY	o	o		66.	
4	OO OCCUPATI ONAL THERAPY	0	o O		67.	
	OO SPEECH PATHOLOGY	o	o		68.	
4	00 ELECTROCARDI OLOGY	l ő	ol ol		69.	
•	00 ELECTROENCEPHALOGRAPHY		ol		70.	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT		ol		71.	
-	OO IMPL. DEV. CHARGED TO PATIENTS		ol		72.	
-	OO DRUGS CHARGED TO PATIENTS	0	39, 267		73.	
-	00 RENAL DIALYSIS	0	0		74.	
			0		74.	
	20 ACUPUNCTURE	0	ol		76.	
	97 CARDI AC REHABI LI TATI ON	l ol	U		/6.	91
	PATIENT SERVICE COST CENTERS					00
	00 RURAL HEALTH CLINIC	0	0		88.	
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	O		89.	
	OO CLI NI C	0	O		90.	
	01 DI ABETES CENTER	0	0		90.	
	02 NEUROPSYCH	0	0		90.	
	03 WOUND CENTER	0	0		90.	
	04 HYPERBARIC OXYGEN THERAPY	0	0		90.	04
90. 05 0900	05 VIMCARE CLINIC	0	0		90.	05
90.06 0900	D6 MEDICATION MGMT CLINIC	0	0		90.	06
91.00 0910	DO EMERGENCY	0	О		91.	00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	o	o		92.	00
	ER REIMBURSABLE COST CENTERS		1			
	OO AMBULANCE SERVICES	0			95.	00
200.00	Subtotal (see instructions)	o	39, 267		200.	
201.00	Less PBP Clinic Lab. Services-Program	o	,		201.	
	Only Charges				201.	
202. 00	Net Charges (line 200 - line 201)	0	39, 267		202.	00
202.00	[Shar goo (200 11110 201)	9	0., 20.1		1202.	

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II	pared:
			Ti tl e	e XVIII	Subprovider -	PPS	о рііі
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50. 00	05000 OPERATING ROOM	4, 863, 724		1	· ·	3, 091	1
51. 00	05100 RECOVERY ROOM	214, 123				233	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		1 0.0000		0	
53. 00	05300 ANESTHESI OLOGY	20, 475				22	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	575, 799		1		2, 280	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	375, 838				0	
54. 02	05404 ULTRA SOUND	166, 759				326	
54. 03	05405 MAMMOGRAPHY	367, 905				0	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 566, 071	19, 531, 037	1		0	
57. 00	05700 CT SCAN	301, 371	33, 742, 358	1		279	
58. 00	05800 MRI	75, 161	8, 417, 616			61	
59. 00	05900 CARDI AC CATHETERI ZATI ON	927, 807	31, 717, 097			212	
60.00	06000 LABORATORY	1, 107, 449				5, 346	
60. 01	06001 LABORATORY-PATHOLOGI CAL	109, 213		1		89	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	41, 011	2, 361, 367			213	
65. 00	06500 RESPI RATORY THERAPY	555, 456		1		2, 169	
66.00	06600 PHYSI CAL THERAPY	637, 245	15, 434, 646	0. 04128	894, 700	36, 939	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	213, 089	5, 064, 800	0. 04207	3 811, 293	34, 134	67. 00
68. 00	06800 SPEECH PATHOLOGY	109, 028				23, 731	
69. 00	06900 ELECTROCARDI OLOGY	445, 223				563	
70.00	07000 ELECTROENCEPHALOGRAPHY	284, 191	7, 714, 068	1		28	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	250, 483			2 67, 537	752	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	380, 468				335	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 433, 553				7, 320	
74.00	07400 RENAL DIALYSIS	33, 071	1, 754, 893			1, 385	
76. 00	03020 ACUPUNCTURE	0	0	0.00000		0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	96, 499	2, 074, 859	0. 04650	9 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
90.00	09000 CLI NI C	469, 645				0	90. 00
90. 01	09001 DI ABETES CENTER	40, 905				0	90. 01
90. 02	09002 NEUROPSYCH	9, 584	228, 599	1		13	
90. 03	09003 WOUND CENTER	163, 090		1		0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	105, 188				0	90. 04
90. 05	09005 VI MCARE CLI NI C	235, 348				0	90. 05
90. 06	09006 MEDICATION MGMT CLINIC	63, 332		1		0	90. 06
91. 00	09100 EMERGENCY	1, 540, 856				159	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	14, 624, 939	0.00000	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	_					
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	17, 778, 960	618, 826, 264		3, 248, 573	119, 680	200. 00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112 Component CCN: 15-T112	Peri od: From 01/01/2019 To 12/31/2019	
		Title XVIII	Subprovi der -	PPS

		Ti tl e	e XVIII	Subprovi der -	PPS	<u> Бин</u>
		11 (1)	, AVIII	IRF	113	
Cost Center Description	Non Physician	Nursi na School	Nursi na School	Allied Health	Allied Health	
'	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0	(0	0	50. 00
51.00 05100 RECOVERY ROOM	C	0	(0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0	(0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	C	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0	(0	857, 241	54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	C	0	(0	0	54. 01
54. 02 05404 ULTRA SOUND	C	0	(0	0	54. 02
54. 03 05405 MAMMOGRAPHY	C	0	(0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	0	(0	0	55. 00
57. 00 05700 CT SCAN	C	0	(0	0	57. 00
58. 00 05800 MRI	C	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	0	(0	0	59. 00
60. 00 06000 LABORATORY	C	0	(0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	C	0	(0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0	(0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	C	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	C	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C			0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 74.00 O7400 RENAL DIALYSIS				0	682, 311	1
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 ACUPUNCTURE					0	74. 00 76. 00
76. 00 03020 ACOPONCTORE 76. 97 07697 CARDI AC_REHABI LI TATI ON		1	1	0	0	76.00
OUTPATIENT SERVICE COST CENTERS		'	1	<u> </u>	0	70.97
88. 00 08800 RURAL HEALTH CLINIC				0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		1		-	1	89.00
90. 00 09000 CLI NI C					Ö	90.00
90. 01 09001 DI ABETES CENTER					Ö	90. 01
90. 02 09002 NEUROPSYCH				0	o o	90. 02
90. 03 09003 WOUND CENTER				0	o o	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY					0	90. 04
90. 05 09005 VI MCARE CLI NI C	i c			0	0	90. 05
90.06 09006 MEDICATION MGMT CLINIC				o o	0	90.06
91. 00 09100 EMERGENCY				0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					Ō	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	C	0	(0	1, 539, 552	200.00

Real th Financial Systems		5		NAL 1100D1 TAL			6.5	
Through Costs Component CON: 15-1111 From (1701/2019) Part IV (1724/2000 Part IV (1724/2010) Part					ON 15 0110			2552-10
Cost Center Description			RVICE UTHER PASS	s Provider C	JN: 15-0112			
Title XVIII	THROUG	in C0313		Component	CCN: 15-T112		Date/Time Pre	
All Other Medical Count Cost Cost Count Cost Count Cost C				Title	XVIII	Subprovi der -		<u>5 piii </u>
Medical Education Cost 1, 2, 3, and Cost (sum of cots Co								
ANCILLARY SERVICE COST CENTERS		Cost Center Description						
ANCILLARY SERVICE COST CENTERS				`		•		
ANCILLARY SERVICE COST CENTERS			Education Cost					
ANCILLARY SERVICE COST CENTERS				4)		8)		
ANCILLARY SERVICE COST CENTERS					anu 4)			
ANCILLARY SERVICE COST CENTERS			4 00	5.00	6.00	7 00		
50.00 05000 0FEATI NG ROOM		ANCLLLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 7, 465, 739 0.000000 52.00 0520 0 0520 0 0 0 0 0 0 0 0.000000 52.00 53.00 05300 ARISTHESI OLOGY 0 0 0 0 14, 217, 299 0.000000 53.00 054.00 05400 08400	50 00		0	0		0 95 837 976	0.000000	50 00
S2.00							l e	
53.00 06300 ANESTHESI OLOGY 0 0 0 14, 217, 299 0, 000000 53. 00 54.01 05400 RADIO (LOGY—DIAGNOSTIC 0 857, 241 0, 514, 086 0, 131378 54. 00 54.01 05402 NUCLEAR MEDICINE—DIAGNOSTIC 0 0 0 13, 331, 857 0, 000000 54. 01 54.02 05404 ULTRA SOURD 0 0 0 0 5, 649, 832 0, 000000 54. 01 54.02 05404 ULTRA SOURD 0 0 0 0 4, 668, 360 0, 000000 54. 01 55.00 05500 RADIO LOGY—THERAPEUTIC 0 0 0 0 33, 742, 358 0, 000000 55. 00 55.00 05500 RADIO LOGY—THERAPEUTIC 0 0 0 0 33, 742, 358 0, 000000 57. 00 58.00 05500 RADIO LOGY—THERAPEUTIC 0 0 0 0 33, 742, 358 0, 000000 57. 00 58.00 05500 RADIO LOGY—THERAPEUTIC 0 0 0 0 31, 717, 697 0, 000000 59. 00 59.00 05500 RADIO LOGY—THERAPEUTIC 0 0 0 0 31, 717, 697 0, 000000 59. 00 59.00 05500 CARDIAC CATHETERIZATION 0 0 0 0 31, 717, 997 0, 000000 59. 00 59.00 05500 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 59.00 056000 LABORATORY—PATHOLOGICAL 0 0 0 0 0 0 0 0 59.00 056000 RESPIRATORY PATHOLOGICAL 0 0 0 0 0 0 0 0 59.00 056000 RESPIRATORY PHERAPY 0 0 0 0 0 0 0 0 0				Ö				
54. 00 05400 RADI OLOCY-DI AGNOSTIC 0 857, 241 857, 241 6, 514, 086 0, 131598 54. 00 54. 01 54. 02 05404 URLEAR MEDICI NE-DI AGNOSTIC 0 0 0 0 5, 049, 832 0, 000000 54. 02 54. 03 55. 00 05500 CS 05500			0	0		0 14, 217, 299	l e	
54 02 05402 NUCLEAR MEDICINE-DI AGNOSTIC 0 0 0 0 1, 3, 331, 857 0.000000 54, 01			0	857, 241	857, 24		l e	
54 02 05404 ILTRA SOUND	54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0				0. 000000	54. 01
55.00 05500 RADI OLOGY-THERAPEUTI C	54. 02	05404 ULTRA SOUND	0	0		0 5, 949, 832	0.000000	54. 02
57.00 05700 CT SCAN 0 0 0 0 33, 742, 358 0.000000 58.00 58.00 58.00 05800 MRI 0 0 0 0 0 0 31, 717, 097 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 31, 717, 097 0.000000 59.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	54.03	05405 MAMMOGRAPHY	0	0		0 4, 668, 360	0.000000	54. 03
S8.00 OSBOO NR O O O O B, 417, 616 O 0 0 0 0 0 0 0 0 0	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 19, 531, 037	0.000000	55.00
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 31,717,097 0.000000 59.00	57.00	05700 CT SCAN	0	0		0 33, 742, 358	0.000000	57.00
60.00 06000 LABORATORY 0 0 0 55, 925, 784 0.000000 60.00 06.00 0	58. 00		0	0		0 8, 417, 616	0.000000	58. 00
60.01			0	0			•	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 2, 361, 367 0, 000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 10, 815, 784 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 15, 434, 646 0.000000 66.00 67.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 5, 064, 800 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 1, 607, 321 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 17, 267, 744 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 7, 714, 068 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 22, 501, 761 0.000000 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 682, 311 682, 311 98, 951, 230 0.006895 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 1, 754, 893 0.000000 74.00 76.07 07697 CARDIA CREHABLI TATION 0 0 0 0 2, 074, 859 0.000000 76.00 76.97 07697 CARDIA CREHABLI TATION 0 0 0 0 0, 2, 074, 859 0.000000 76.97 76.90 07697 CARDIA CREHABLI TATION 0 0 0 0 0, 2, 074, 859 0.000000 76.97 76.90 07697 CARDIA CREHABLI TATION 0 0 0 0 0, 2, 074, 859 0.000000 76.97 76.90 07697 CARDIA CREHABLI TATION 0 0 0 0, 2, 074, 859 0.000000 76.97 76.90 07697 CARDIA CREHABLI TATION 0 0 0 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,				-				
65.00 0.500 RESPIRATORY THERAPY 0 0 0 0 0 10,815,784 0.000000 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 60.00				_		-,,	l	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 15, 434, 646 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 5, 064, 800 0.000000 67. 00 68. 00 06800 SPEECT PATHOLOGY 0 0 0 0 1, 607, 321 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 17, 267, 744 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALLOGRAPHY 0 0 0 0 22, 501, 761 0.000000 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 22, 501, 761 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 21, 093, 737 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 21, 093, 737 0.000000 72. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0, 754, 893 0.000000 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0.000000 76. 00 76. 07 07697 CARDI AC REHABI LI TATI ON 0 0 0 0.000000 76. 97 07000 DUPATI ENT SERVICE COST CENTERS 0 0 0 0 0.000000 90. 00 90. 00 09000 CLINI C 0 0 0 0 0.000000 90. 00 90. 01 09001 DI ABETES CENTER 0 0 0 0 0.000000 90. 00 90. 02 09002 NEUROPSYCH 0 0 0 0 0 0.000000 90. 00 90. 03 09003 WORARE CLINI C 0 0 0 0 0 0.000000 90. 00 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0.000000 90. 00 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 90. 05 09005 VII MCARE CLINI C 0 0 0 0 0 0 0 0 0			0	ı		2,00.,00.		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 5, 064, 800 0.000000 67. 00 68. 00 06800 OSPECCH PATHOLOGY 0 0 0 1, 607, 321 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 17, 267, 744 0.0000000 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 7, 714, 068 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 22, 501, 761 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 21, 093, 737 0.0000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0.000000 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 1, 754, 893 0.000000 76. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0.000000 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0.000000 76. 97 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0.000000 89. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0.000000 99. 00 99. 01 09900 DI ABETES CENTER 0 0 0 0 0 0.000000 99. 00 99. 02 09902 NEUROPSYCH 0 0 0 0 228, 599 0.000000 99. 01 99. 03 09003 WOUND CENTER 0 0 0 0 0 0 0.000000 99. 01 99. 04 09904 HYPERBARI C CNYGEN THERAPY 0 0 0 0 0 858, 001 0.000000 99. 05 99. 05 09005 MEDICARTION MIGHT CLINI C 0 0 0 0 0 0 0.5 99. 00 09006 DI ABERES CONTERR 0 0 0 0 0 0 0.000000 99. 05 99. 00 09006 DI BERGENCY 0 0 0 0 0 0 0 0 0			0	_			l e	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 1, 607, 321 0.000000 68. 00 69. 00 00 00 00 17, 267, 744 0.000000 69. 00 00 00 00 00 00 00 0.00000 69. 00 00 00 00 00 0.00000 69. 00 00 0.00000 00 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000			0	_			l .	1
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70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 7,714,068 0.000000 70.00 71.00 70.00 7			0	0		.,,	1	
71. 00				-				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 21,093,737 0.000000 72. 00 7300 DRUGS CHARGED TO PATIENTS 0 682,311 682,311 98,951,230 0.006895 73. 00 74. 00 74.00 ORDINARY OR				_			l	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 682, 311 682, 311 98, 951, 230 0.006895 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 1, 754, 893 0.000000 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0.000000 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0, 2, 074, 859 0.000000 76. 97 00 0 0 0 0 0, 000000 RENAL DI ALYSIS 0 0 0 0 0 0, 0000000 76. 97 00 0 0 0 0 0, 000000 RENAL DI ALYSIS 0 0.000000 RENAL			-	-			l	
74. 00				-			l e	
76. 00			-	· ·			l e	1
76. 97 O7697 CARDI AC REHABILITATION O O O 2, 074, 859 O. 000000 76. 97 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC O O O O O O. 000000 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER O O O O O O. 000000 89. 00 09000 CLINIC O O O O O. 000000 90. 00 0 0 0 0 0 0 0 0 0 0 0 0							l e	
SECTION SERVICE COST CENTERS SERVICE COST CENTER SERVICE COST CENTERS SERVICE COST CENTER SERVICE COST CENTER SERVICE COST CENTER SERVICE COST CENTERS SERVICE SERVICES							l e	
88. 00	70. 77					2,014,037	0.000000	70.77
89. 00	88. 00		0	0		0 0	0.000000	88. 00
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90. 01	90.00			0			l e	
90. 03	90. 01	09001 DI ABETES CENTER	0	0			i e	
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 0 0 0 985, 852 0.000000 90. 04 90. 05 09005 VI MCARE CLINI C 0 0 0 1,068,996 0.000000 90. 05 90. 06 09006 MEDI CATION MGMT CLINI C 0 0 0 858,001 0.000000 90. 06 91. 00 09100 EMERGENCY 0 0 0 0 76,486,910 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 14,624,939 0.000000 92. 00 09500 AMBULANCE SERVI CES 95. 00	90. 02	09002 NEUROPSYCH	0	0		0 228, 599	0.000000	90. 02
90. 05	90. 03	09003 WOUND CENTER	0	0		0 7, 348, 655	0.000000	90. 03
90. 06 09006 MEDI CATION MGMT CLINI C 0 0 0 858, 001 0.000000 90. 06 91. 00 09100 EMERGENCY 0 0 0 0 14, 624, 939 0.000000 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 14, 624, 939 0.000000 92. 00 0000000 0000000000000000000000	90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0 985, 852	0. 000000	90. 04
91. 00			0	0		.,,		
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OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES 95. 00								
95. 00 09500 AMBULANCE SERVI CES 95. 00	92. 00		0	0		0 14, 624, 939	0.000000	92.00
200.00 Total (Tines 50 through 199) 0 1,539,552 1,539,552 618,826,264 200.00				1 520 550	1 500 5	(10 00/ 0/4		
	200. OC	Tiotal (Tines 50 through 199)	0	1, 539, 552	1, 539, 5	02 018,826,264	I	1200.00

APPORTIONIENT OF IMPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Title VIII Support of the Control of th		Financial Systems	COLUMBUS REGIONA	_	ON 45 0440		u of Form CMS-	2552-10
Cost Center Description			RVICE OTHER PASS				Date/Time Pre	pared:
Cost Center Description				Title	: XVIII			
To Charges Charges Charges Charges Costs (col. 8 x col. 10) Costs (col. 8 x col. 12) Costs (col. 9 x col. 12) Costs (col. 12)		Cost Center Description	Outpati ent	I npati ent	I npati ent		Outpati ent	
NOTE			Ratio of Cost	Program				
ANCILLARY SERVICE COST CENTERS			to Charges	Charges	Pass-Through	n Charges		
NCLLARY SERVICE COST CENTERS			(col. 6 ÷ col.			8		
MICLILARY SERVICE COST CENTERS							x col. 12)	
50.00			9. 00	10. 00	11. 00	12. 00	13. 00	
51.00 05100 RECOVERY ROON 0 0 0 0 0 0 0 52.00 52.00 05200 DELIVERY ROON & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ARISTHESI OLOGY 0.000000 15,280 0 0 0 53.00 54.01 05402 ARISTHESI OLOGY 0.000000 13,1958 25,799 3,395 0 0 54.00 54.01 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.00 54.01 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 54.03 05405 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 54.03 05405 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 54.03 05405 NUCLEAR MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 55.00 05500 RADIO CONTROL MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 55.00 05500 RADIO CONTROL MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 54.02 55.00 05500 RADIO CONTROL MEDI CINE-DI AGNOSTI C 0.000000 0 0 0 0 0 0 0								
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 0 53.00 53.00 53.00 63.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 053.00 054.01 055.00 055.00 055.00 057.								
53. 00 05300 ANESTHESI OLOGY			1					
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54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 0 0 0 54. 02 54. 02 05404 ULTRA SQUIND 0.000000 0 0 0 0 0 54. 02 54. 03 05405 MAMMOGRAPHY 0.000000 0 0 0 0 0 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTIC 0.000000 0 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 0 55. 00 58. 00 05800 IRI 0.000000 0 0 0 0 0 0 0			1			-1		
54. Q2 05404 ULTRA SOUND 0.000000 11,632 0 0 0 54. Q2 4. Q2 05405 MMM0CRAPHY 0.000000 0 0 0 0 0 55. Q0 55. Q0 05500 RADI OLGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 57. Q0 05700 CT SCAN 0.000000 31,191 0 0 0 55. Q0 59. Q0 05900 CARDI AC CATHETERI ZATI ON 0.000000 6,810 0 0 0 58. Q0 59. Q0 05900 CARDI AC CATHETERI ZATI ON 0.000000 269,983 0 0 0 0 0 0 60. Q1 06000 LABORATORY 0.000000 269,983 0 0 0 0 0 0 60. Q1 06000 LABORATORY 0.000000 25,557 0 0 0 0 0 60. Q1 06000 LABORATORY DO WHOLE BLOOD & PLACKED RED BLOOD CELL 0.000000 12,276 0 0 0 0 0 60. Q0 06000 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 22,226 0 0 0 0 0 60. Q0 06000 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 394,700 0 0 0 0 60. Q0 06000 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 394,700 0 0 0 0 0 60. Q0 06000 PRIVISI CAL THERAPY 0.000000 394,700 0 0 0 0 0 60. Q0 06600 PRIVISI CAL THERAPY 0.000000 314,851 0 0 0 0 0 60. Q0 06600 PRIVISI CAL THERAPY 0.000000 314,851 0 0 0 0 0 60. Q0 06600 SEECH PATHOLOGY 0.000000 318,573 0 0 0 0 0 60. Q0 07000 ELECTROCARDEPIALOGRAPHY 0.000000 75,80 0 0 0 0 0 60. Q0 07000 ELECTROCARDEPIALOGRAPHY 0.000000 75,80 0 0 0 0 0 60. Q0 07000 DRUGS CHARGED TO PATI ENTS 0.000000 75,80 0 0 0 0 0 60. Q0 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 07000 0.00000 0 0 0 0 0 60. Q0 070000 0.000000 0 0 0 0 60. Q0 070000 0.0				25, 799	3, 39	95 0		
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55 00 0 05500 RADIOLOGY-THERAPEUTI C 0 000000 0 0 0 55.00 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 57.00 0 0 0 57.00 0 0 57.00 0 0 59.00 0 <td< td=""><td>54. 02</td><td>05404 ULTRA SOUND</td><td>0. 000000</td><td>11, 632</td><td></td><td>0 0</td><td>0</td><td>54. 02</td></td<>	54. 02	05404 ULTRA SOUND	0. 000000	11, 632		0 0	0	54. 02
57, 00	54. 03		0. 000000	0		0 0		
58. 00 0S800 MRI 0.000000 6,810 0 0 58,00 59,00 0S900 CARDIAC CATHETERIZATION 0.000000 7,262 0 0 0 59,00 0 0 59,00 0 0 59,00 0 0 0 59,00 0 <t< td=""><td></td><td></td><td></td><td></td><td>l .</td><td>-</td><td>0</td><td></td></t<>					l .	-	0	
59,00 05900 CARDIAC CATHETERIZATION 0,000000 7,262 0 0 0 59,00 60.00 06000 LABORATORY 0,000000 269,983 0	57.00		0. 000000	31, 191		0 0	0	
60.00 06000 LABORATORY 0.000000 269, 983 0 0 0 60.00 60.01 06000 LABORATORY - PATHOLOGICAL 0.000000 5, 557 0 0 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 12, 276 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.000000 42, 226 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 42, 226 0 0 0 0 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 811, 293 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 349, 851 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 349, 851 0 0 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0.000000 758 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 758 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18, 573 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 18, 573 0 0 0 0 0 74.00 07400 REDIA LO ILAYSIS 0.000000 0 0 0 0 0 76.00 076.97 0797 CARDIA CREHABILITATI ON 0.000000 0 0 0 0 0 76.97 0797 CARDIA CREHABILITATI ON 0.000000 0 0 0 0 0 70.00 07900 LIRES ENVICE COST CENTERS 0.000000 0 0 0 0 0 70.00 09000 LINI C 0.000000 0 0 0 0 0 70.00 09000 DI JABETES CENTER 0.000000 0 0 0 0 0 70.01 09001 DIABETES CENTER 0.000000 0 0 0 0 0 70.02 09002 MEUROPSYCH 0.000000 0 0 0 0 0 70.03 09003 WUND CENTER 0.000000 0 0 0 0 0 70.04 09005 VIMCARE CLINIC 0.000000 0 0 0 0 0 70.05 09006 MEDILANGE SERVICES 0.000000 0 0 0 0 70.00 09500 MBULANCE SERVICES 0.000000 0 0 0 70.00 09500 MBULANCE SERVICES 0.000000 0 0 70.00 09500 MBULANCE SERVICES 0.000000 0 0 70.00 09500 MBULANCE SERVICES 0.000000 0 0 0 70.00 09500 MBULANCE SERVICES 0.000000 0 0 0 70.00 09500 MBULANCE	58.00	05800 MRI	0. 000000	6, 810		0	0	58. 00
60.01 66.001 66.001 66.001 62.0000 62.000 62.000 62.000 62.000 62.000 62.000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.00000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.0000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000 62.0000000000 62.0000000 62.000000000000000000000000000000000000	59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	7, 262		0 0	0	59. 00
62.00 06200 whole Blood & Packed Red Blood Cell 0.000000 12, 276 0 0 0 62.00	60.00		0. 000000	269, 983		0 0	0	60. 00
65. 00 06500 RESPIRATORY THERAPY 0.000000 42, 226 0 0 0 0 65. 00 66. 00 06600 06600 06600 06600 06600 0	60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	5, 557		0 0	0	60. 01
66. 00 06600 PHYSI CAL THERAPY 0.000000 894, 700 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 811, 293 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 349, 851 0 0 0 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 21, 831 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 758 0 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 67, 537 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18, 573 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 18, 573 0 0 0 0 74. 00 07400 ELECTROCARDI DIALYSIS 0.000000 73, 500 0 0 0 76. 00 03020 ACUPUNCTURE 0.000000 0 0 0 0 76. 90 07697 (CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76. 97 07697 (CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 79. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 79. 01 09001 DIABETES CENTER 0.000000 0 0 0 0 79. 01 09001 DIABETES CENTER 0.000000 0 0 0 0 79. 02 09002 RUROPSYCH 0.000000 0 0 0 0 79. 03 09003 WOUND CENTER 0.000000 0 0 0 0 79. 04 09004 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 79. 05 09005 VINCARE CLINIC 0.000000 0 0 0 0 79. 06 09006 MEDICATION MGMT CLINIC 0.000000 0 0 0 0 79. 07 09005 VINCARE CLINIC 0.000000 0 0 0 0 79. 07 09000 09000 09000 09000 000000 0	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	12, 276		0 0	0	62. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 811, 293 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 349, 851 0 0 0 0 68. 00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 21, 831 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALLOGRAPHY 0.000000 758 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 67, 537 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 18, 573 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 18, 573 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 76. 00 03020 ACUPUNCTURE 0.000000 0 0 0 0 76. 07 07697 CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76. 97 0000000000000000000000000000000000	65.00	06500 RESPI RATORY THERAPY	0. 000000	42, 226		0	0	65. 00
68. 00 06800 SPEECH PATHOLOGY 0.000000 349, 851 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 21, 831 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0.000000 758 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 67, 537 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18, 573 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 18, 573 0 0 0 74. 00 07400 RENAL DI ALYSI S 0.000895 505, 279 3, 484 0 0 73. 00 76. 00 03020 ACUPUNCTURE 0.000000 73, 500 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76. 97 07697 0	66.00	06600 PHYSI CAL THERAPY	0. 000000	894, 700		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 21,831 0 0 0 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 758 0 0 0 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 67,537 0 0 0 70.00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0.000000 18,573 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 18,573 0 0 0 72.00 74. 00 07400 RENAL DI ALYSI S 0.000000 73,500 0 0 0 0 76. 00 03020 ACUPUNCTURE 0.000000 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 76. 97 0017PATI ENT SERVI CE COST CENTERS 88. 00 08900 RURAL HEALTH CLINI C 0.000000 0 0 0 0 89. 00 08900 EDERALLY QUALI FI ED HEALTH CENTER 0.000000 0 0 0 0 90. 01 09000 CLI NI C 0.000000 0 0 0 0 0 90. 02 09002 ALUROPSYCH 0.000000 0 0 0 0 90. 03 09003 WOUND CENTER 0.000000 0 0 0 0 0 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 0 90. 05 09005 VIMCARE CLI NI C 0.000000 0 0 0 0 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0.000000 0 0 0 0 90. 07 09000 DISERVATI ON BEDS (NON-DISTI NCT PART 0.000000 0 0 0 0 0 90. 00 09500 BABULANCE SERVI CES 95.00	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	811, 293		0 0	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 758 0 0 0 70. 00 71. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 67, 537 0 0 0 71. 00 72. 00 72. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 67, 537 0 0 0 0 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 0	68.00	06800 SPEECH PATHOLOGY	0. 000000	349, 851		0 0	0	68. 00
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0. 000000	21, 831		0 0	0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18,573 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.006895 505,279 3,484 0 0 0 73.00 74. 00 07400 RENAL DI ALYSIS 0.000000 73,500 0 0 0 0 0 0 74.00 76. 00 03020 ACUPUNCTURE 0.000000 0 0 0 0 0 0 0 0 76.00 0 0 0 0 76.00 0 76.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 76.00 0 76.00 0 </td <td>70.00</td> <td>07000 ELECTROENCEPHALOGRAPHY</td> <td>0. 000000</td> <td>758</td> <td></td> <td>0 0</td> <td>0</td> <td>70. 00</td>	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	758		0 0	0	70. 00
73. 00	71.00		0. 000000	67, 537		0 0	0	71. 00
74. 00 07400 RENAL DI ALYSI S 0.000000 73,500 0 0 74.00 76.00 76.00 0 0 0 0 76.00 76.00 76.00 0 0 0 0 0 76.00 76.00 76.00 76.00 0 0 0 0 0 76.00 76.00 76.00 0 0 0 0 76.00 76.00 76.00 76.00 76.00 0 0 0 0 76.00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	18, 573		0 0	0	72. 00
76. 00 03020 ACUPUNCTURE	73.00		0. 006895	505, 279	3, 48	34 0	0	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 0. 000000 0 0 0 0 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0. 0.000000 0 0 0 0 0 88. 00 89. 00 0 0 0 0 0 0 0 0 88. 00 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	0. 000000	73, 500		0 0	0	74. 00
SECTION SUPPRENT SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE	76. 00	03020 ACUPUNCTURE	0. 000000	0		0 0	0	76. 00
88. 00	76. 97	07697 CARDI AC REHABILI TATI ON	0. 000000	0		0 0	0	76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0. 000000 0 0 0 0 0 0 90. 00 90. 01 09001 DI ABETES CENTER 0. 0.000000 0 0 0 0 0 0 90. 01 90. 02 09002 NEUROPSYCH 0. 0.000000 322 0 0 0 0 0 90. 02 90. 03 09003 WOUND CENTER 0. 0.000000 0 0 0 0 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 0. 000000 0 0 0 0 0 0 90. 03 90. 05 09005 VI MCARE CLI NI C 0. 000000 0 0 0 0 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 0. 000000 0 0 0 0 0 90. 05 91. 00 09100 EMERGENCY 0. 0.000000 7, 876 0 0 0 91. 00 92. 00 09200 DISERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 0 0 0 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS		OUTPATIENT SERVICE COST CENTERS						
90. 00			1			-		
90. 01	89. 00			0			0	89. 00
90. 02	90.00		0. 000000	0		0 0	0	90.00
90. 03	90. 01		0. 000000	0		0 0		
90. 04	90. 02	09002 NEUROPSYCH	0. 000000	322		0 0	0	90. 02
90. 05	90. 03	09003 WOUND CENTER	0. 000000	0		0 0	0	
90. 06			1 1	0		٥		
91. 00			1 1	-		٦		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00			1 1	-		-1		
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00								
95. 00 09500 AMBULANCE SERVI CES 95. 00	92.00		0. 000000	0		0 0	0	92. 00
200.00 Total (lines 50 through 199) 3,248,573 6,879 0 0 200.00		1						
	200.00	Total (lines 50 through 199)		3, 248, 573	6, 87	79 0	0	200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2019	Worksheet D
TIKOUGII COSTS		Component CCN: 15-T112		Date/Time Prepared: 7/24/2020 4:05 pm
		Title XVIII	Subprovi der -	PPS

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

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-011	Period: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 7/24/2020 4:0	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XVIII	Hospi tal	7/24/2020 4: 0 PPS	5 pm		
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS				1. 00		
1. 00 2. 00							
3.00							
	do not complete this line.	,-, , , ,					
4.00	Semi-private room days (excluding swing-bed and observation be		04 0 11	24, 854	4.00		
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	r 31 or the cost	0	5. 00		
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6. 00		
	reporting period (if calendar year, enter 0 on this line)						
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00		
8.00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 of the cost	0	8. 00		
	reporting period (if calendar year, enter 0 on this line)						
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	12, 048	9. 00		
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	oom days)	0	10. 00		
	through December 31 of the cost reporting period (see instruc-		som days)	, and the second	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00		
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00		
12.00	through December 31 of the cost reporting period	Comy (Therading private	c room days)		12.00		
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 you Medically necessary private room days applicable to the Progra			0	14. 00		
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed to	uays)	0	15. 00		
16. 00	Nursery days (title V or XIX only)			0	16. 00		
47.00	SWING BED ADJUSTMENT		6 11	0.00	47.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	r the cost	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00		
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00		
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00		
21 00	reporting period	-)		41 020 277	21 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		na period (line	41, 928, 267 0	21. 00 22. 00		
22.00	5 x line 17)	or or the dost report.	ing period (init	Ŭ	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00		
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	~ 31 of the cost reportio	na period (line	0	24. 00		
24.00	7 x line 19)	or or the cost reporter	ig perrod (Triic	J	24.00		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00		
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		41, 928, 267			
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT						
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0			
30.00	Semi -private room charges (excluding swing-bed charges)			0	•		
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000			
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	1		
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nuc lino 22)(coo inctruo	tions)	0.00	1		
35. 00	Average per diem private room cost differential (line 34 x li		ti ons)	0. 00 0. 00	1		
36. 00	Private room cost differential adjustment (line 3 x line 35)	· /		0.00	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	41, 928, 267	37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 457. 56	38. 00		
39.00	Program general inpatient routine service cost (line 9 x line			17, 560, 683	ı		
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 17, 560, 683	40.00		
	1.02a. Togram gonoral impatriont routine service cost (Tille 37			17, 500, 003	50		

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	41, 928, 267	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, 457. 56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17, 560, 683	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)	17, 560, 683	41.00
	· · · · · · · · · · · · · · · · · · ·	·	

	Financial Systems	COLUMBUS REGION		ON. 15 0110		workshoot D 1	
COMPUI	TATION OF INPATIENT OPERATING COST		Provi der C	UN: 15-0112	Peri od: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre 7/24/2020 4:0	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			0.1	50		72.00
43.00	INTENSIVE CARE UNIT	7, 137, 131	3, 143				
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0			l	
46. 00		0	Ö			ő	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					23, 372, 284	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)		42, 533, 881	49. 00
50. 00	Pass through costs applicable to Program in	patient routine s	services (from	ı Wkst. D, sur	m of Parts I and	2, 335, 578	50.00
E4 00				WI 1 B		0.440.000	F4 00
51. 00	Pass through costs applicable to Program inpand IV)	oatient ancillary	services (Tr	OM WKST. D, S	sum of Parts II	2, 140, 990	51.00
52.00	Total Program excludable cost (sum of lines					4, 476, 568	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anestl	netist, and	38, 057, 313	53. 00
	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)					l	55. 00 56. 00
57. 00	,	ting cost and tar	get amount (I	ine 56 minus	line 53)	ő	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period e	enaing 1996, L	ipaatea ana co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					1	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		G (TITIES 54 X	60), OI 1% O	the target		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decembe	or 31 of the c	ost reporting	neriod (See	0	65. 00
	instructions)(title XVIII only)					Ĭ	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVI	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	t£t D-	21				(0.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after De	ecember 31 or	the cost repo	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 N Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service of				,		71.00
72.00	,		(lima 14 v li	no 2E)			72.00
73. 00 74. 00	Medically necessary private room cost application of the service o						73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	. *					77. 00
78. 00	,						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi			(70 /// //	, ,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in	•	•)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00			ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					3, 912	87. 00
	, ·	*	line 2)			1, 457. 56	1
88. 00	Observation bed cost (line 87 x line 88) (se					5, 701, 975	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112			Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Prep 7/24/2020 4:09	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 143, 124	41, 928, 267	0. 12266	5, 701, 975	699, 433	90.00
91.00 Nursing School cost	0	41, 928, 267	0.00000	5, 701, 975	0	91.00
92.00 Allied health cost	0	41, 928, 267	0.00000	5, 701, 975	0	92.00
93.00 All other Medical Education	0	41, 928, 267	0.00000	5, 701, 975	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 01/01/2019	Worksheet D-1
	Component CCN: 15-T112		
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 601	1.00
2.00	Inpatient days (including private room days, excluding swing-			3, 601	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 601	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om dava) after Dagember 3	1 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 021	9. 00
7. 00	newborn days) (see instructions)	the regram (exertaining	oming sou and	2,02.	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	olli days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar 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)	, 5	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	es through becember 31 or	the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
10.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions		ng ported (line	4, 808, 887	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	g period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00	Total swing-bed cost (see instructions)	(1)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 808, 887	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 /	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0.000000	
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 min	nus line 33)(see instruct	i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		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 a 27 minus line 36)	inu private room cost dif	remential (IINe	4, 808, 887	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 335. 43	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		2, 698, 904 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		2, 698, 904	
	,	,	1	_, 5.0, .01	55

	Financial Systems	COLUMBUS REGIONA			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 1	Fr	eriod: com 01/01/2019	Worksheet D-1	
			Component CCN:			Date/Time Prep 7/24/2020 4:0	
			Title XVI		Subprovi der – I RF	PPS	
	Cost Center Description	Total Inpatient Cost In	patient Days Diem	erage Per n (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0	OJ .	0.00	O _I	U	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. 00 0. 00	0	0 0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	0	O	0. 00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
40.00	·	-+ D 21 2	11: 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines					1, 435, 972 4, 134, 876	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine se	rvices (from Wks	st. D, sum o	of Parts I and	368, 590	50. 00
51. 00		atient ancillary	services (from W	Vkst. D, sun	n of Parts II	126, 559	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				495, 149	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-physici	an anesthet	ist, and	3, 639, 727	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00						0. 00	
	Target amount (line 54 x line 55)		-+ (1:	F/! !!	[2)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (iine	50 III IIUS II	ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, updat	ed and comp	oounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upda	ted by the marke	et basket		0. 00	60. 00
61. 00		s 55, 59 or 60 en	ter the lesser o	of 50% of th		0	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the cos	st reportino	period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost	reporting p	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)(t	itle XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through D	ecember 31 of th	ne cost repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of the	cost report	ing period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68)	1		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service co			(Trie 37)			71.00
72.00	Program routine service cost (line 9 x line	,	lino 14 v lino 1)E)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			35)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	,	,	sheet B, Par	t II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces						79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		t limitation (li	ne 78 minus	s line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (82. 00
83.00	Reasonable inpatient routine service costs (83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thro					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	diem (line 27 ÷ l	ine 2)			0. 00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T112	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	656, 758	4, 808, 887	0. 13657	'2 0	0	90.00
91.00 Nursing School cost	0	4, 808, 887	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 808, 887	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 808, 887	0. 00000	0 0	0	93. 00

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

	Titialiciai Systems Coedinado Redi divae				tu or rorm cm3-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO	CN: 15-0112	Peri od:	Worksheet D-3	
				From 01/01/2019		
				To 12/31/2019		pared:
					7/24/2020 4:0	5 nm
		T: ±1 =	WILL	11: 4-1		о рііі
		HITTE	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
	·		To Charges	Program	Program Costs	
			10 charges			
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3.00	
	I NDATIENT DOUTINE CEDVICE COST CENTERS			2.00	0.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			21, 327, 287		30.00
31.00	03100 I NTENSI VE CARE UNI T			4, 852, 011		31.00
	03200 CORONARY CARE UNIT			_	l	1
32. 00				0	l	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT			0)	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				ol .	34.00
40. 00	04000 SUBPROVI DER - I PF					40.00
					'	1
41.00	04100 SUBPROVI DER - I RF			0)	41.00
42.00	04200 SUBPROVI DER				ol .	42.00
43. 00	04300 NURSERY					43. 00
43.00					L	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	O5000 OPERATING ROOM		0. 36759	96 11, 292, 545	4, 151, 094	50.00
51. 00	05100 RECOVERY ROOM		0. 2917:			1
			1		1	1
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 00000			52. 00
53.00	05300 ANESTHESI OLOGY		0. 02119	91 2, 069, 733	43, 860	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 8078		549, 703	54.00
			1			1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2518	689, 715	173, 718	54. 01
54. 02	05404 ULTRA SOUND		0. 1930	576, 338	111, 279	54. 02
54.03	05405 MAMMOGRAPHY		0. 4616		1	1
			l .			1
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 3099	55 109, 868	34, 055	55. 00
57.00	05700 CT SCAN		0. 09303	3, 841, 374	357, 386	57.00
58.00	05800 MRI		0. 1104!		1	1
			1		1	1
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1819	41 6, 889, 773	1, 253, 532	59. 00
60.00	06000 LABORATORY		0. 24392	25 6, 579, 431	1, 604, 888	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL		0. 2373			1
			1		1	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3185	561, 840	178, 980	62. 00
65. 00	06500 RESPI RATORY THERAPY		0. 47349	90 3, 507, 208	1, 660, 628	65.00
66.00	06600 PHYSI CAL THERAPY		0. 4731			66. 00
			1			1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 4329			1
68. 00	06800 SPEECH PATHOLOGY		0. 7194	58 106, 926	76, 930	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 17460	3, 257, 969	568, 841	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 30260			1
	1 1		1		1	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3512	4, 555, 882	1, 600, 404	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 56919	94 4, 843, 253	2, 756, 751	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 36082			1
			1			1
74. 00	07400 RENAL DI ALYSI S		0. 5828		1	1
76. 00	03020 ACUPUNCTURE		0. 00000	00	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 38628	36 13, 125	5, 070	76. 97
, ,	OUTPATIENT SERVICE COST CENTERS		0.0002	10, 120	0,010	1 . 5. ,,
					_	٠
88. 00	08800 RURAL HEALTH CLINIC		0.0000	JU	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89. 00
	09000 CLINIC		0. 6772			
					l _	1
	09001 DI ABETES CENTER		1. 2490			1
90. 02	09002 NEUROPSYCH		0. 7339	30 1, 127	827	90. 02
90. 03	09003 WOUND CENTER		0. 2798			
			l .		1	1
90. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 3623		1	1
90. 05	09005 VI MCARE CLI NI C		1. 6542	71 1, 210	2, 002	90. 05
90.06	09006 MEDICATION MGMT CLINIC		0. 7150	3, 061	2, 189	90.06
91. 00			1		1	1
	09100 EMERGENCY		0. 2152		1	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3898	30 0) 0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES					95. 00
				75 504	00 070 55:	1
200.00				75, 594, 101	23, 372, 284	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0)	201. 00
202.00			1	75, 594, 101		202. 00
202.00	The charges (True 200 millios True 201)		I	13,374,101	I	1202.00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2019 To 12/31/2019		pared:
		Title	e XVIII	Subprovider -	7/24/2020 4: 0 PPS	5 pm
	Cost Center Description		Ratio of Cost To Charges	IRF Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY			0 0 0 0 0 0 3, 838, 998		30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
50. 00 51. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM		0. 36759 0. 29172		22, 391 2, 370	1
52. 00 53. 00 54. 00 54. 01 54. 02	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDICINE-DI AGNOSTI C 05404 ULTRA SOUND		0. 00000 0. 02119 0. 80786 0. 25186 0. 19308	1 15, 280 9 25, 799 9 0	0 324 20, 842 0 2, 246	53. 00 54. 00 54. 01
54. 02 54. 03 55. 00 57. 00 58. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI		0. 46162 0. 30996 0. 09303 0. 11045	1 0 5 0 6 31, 191	2, 240 0 0 2, 902 752	54. 03 55. 00
59. 00 60. 00 60. 01 62. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 18194 0. 24392 0. 23736 0. 31856	1 7, 262 5 269, 983 3 5, 557 0 12, 276	1, 321 65, 856 1, 319 3, 911	59. 00 60. 00 60. 01 62. 00
65. 00 66. 00 67. 00 68. 00 69. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0. 47349 0. 47316 0. 43297 0. 71946 0. 17460	3 894, 700 5 811, 293 8 349, 851	19, 994 423, 339 351, 270 251, 707 3, 812	66. 00 67. 00 68. 00
70. 00 71. 00 72. 00 73. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0. 30260 0. 35128 0. 56919 0. 36082	3 67, 537 4 18, 573 4 505, 279	229 23, 725 10, 572 182, 317	71. 00 72. 00 73. 00
74. 00 76. 00 76. 97	07400 RENAL DIALYSIS 03020 ACUPUNCTURE 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS		0. 58288 0. 00000 0. 38628	0 0	42, 842 0 0	76. 00
88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 DIABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARIC OXYGEN THERAPY 09005 VI MCARE CLINIC 09006 MEDICATION MGMT CLINIC		0. 00000 0. 00000 0. 67723 1. 24903 0. 73398 0. 27987 0. 36234 1. 65427 0. 71502	0 4 4 0 0 322 7 0 0 0 0 0	0 0 0 0 236 0 0	89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05

0

1, 435, 972 200. 00

1, 695

7, 876

3, 248, 573

3, 248, 573

91.00

92. 00

95.00

201. 00

202. 00

0. 215223

0. 389880

91.00

92.00

200.00

201.00

202.00

09006 MEDICATION MGMT CLINIC

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)

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	: 15-0112	From 01/01/2019	Worksheet E Part A Date/Time Prepared: 7/24/2020 4:05 pm

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 22, 10 instructions)	PPS	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 22,10 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 8,14 instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount)	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 22, 10 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 8, 14 instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount)	
1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 22, 10 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 8, 14 instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 1.05 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 1.06 Outlier payments for discharges. (see instructions) 1.07 Outlier reconciliation amount		
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount	0	1. 00
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount	09, 306	1. 01
1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount	11, 743	1. 02
1.04 DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount	0	1. 03
2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier reconciliation amount	0	1. 04
	0	2.00
	0	2. 01 2. 02
	06, 824	2. 02
	53, 681	2. 04
3. 00 Managed Care Simulated Payments	0	3. 00
	146. 28	4. 00
Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	0. 00	5. 00
or before 12/31/1996. (see instructions)		
6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0. 00	6. 00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00 0. 00	7. 00 7. 01
cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0. 00	8. 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 teaching hospital	0. 00	8. 02
under § 5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see	0. 00	9. 00
instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records	0. 00	10. 00
11.00 FTE count for residents in dental and podiatric programs.	0.00	
12.00 Current year allowable FTE (see instructions)	0.00	12.00
13.00 Total allowable FTE count for the prior year.	0. 00	13.00
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	14. 00
otherwise enter zero.	0.00	15 00
15.00 Sum of lines 12 through 14 divided by 3.		15. 00 16. 00
16.00 Adjustment for residents in initial years of the program 17.00 Adjustment for residents displaced by program or hospital closure		17. 00
18.00 Adjusted rolling average FTE count		18. 00
		19. 00
	000000	20.00
21.00 Enter the Lesser of Lines 19 or 20 (see instructions) 0.0	000000	21. 00
22.00 IME payment adjustment (see instructions)	0	22. 00
22.01 IME payment adjustment - Managed Care (see instructions)	0	22. 01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 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 lower of line 23 or line 24 (see	0.00	
instructions)		
· · · · · · · · · · · · · · · · · · ·	000000	26. 00
	000000	27. 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)	0	28. 00 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) Disproportionate Share Adjustment	0	29. 01
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4. 94	30. 00
	23. 51	31. 00
	28. 45	
	12. 69	33. 00
34.00 Disproportionate share adjustment (see instructions) 95	59, 715	34. 00

	Financial Systems COLUMBUS REGIONA			u of Form CMS-2	2552-10	
CALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od: From 01/01/2019	Worksheet E Part A		
			To 12/31/2019			
		Title XVIII	Hospi tal	PPS	o piii	
			Prior to 10/1			
	Uncompensated Care Adjustment		1. 00	2. 00		
35. 00			8, 272, 872, 447	8, 350, 599, 096	35. 00	
35. 01			0. 000357119	0. 000405768	35. 01	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enterinstructions)	er zero on this line) (se	ee 2, 954, 400	3, 388, 407	35. 02	
35. 03	,	ount (see instructions)	2, 209, 729	851, 730	35. 03	
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0	03)	3, 061, 459		36. 00	
10.00	Additional payment for high percentage of ESRD beneficiary di		igh 46) 0		40.00	
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGS	0		40. 00	
41.00		683, 684 an 685. (see	0		41.00	
41 01	instructions)	DDC- /F2 /02 /02 /02			41 01	
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-NKGS 652, 682, 683, 684	0		41. 01	
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42. 00	
43.00		82, 683, 684 an 685. (see	0		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	
	days)	3	0.00000			
45. 00 46. 00	, ,		0.00		45. 00 46. 00	
47. 00	Subtotal (see instructions)	1.01)	34, 732, 728		47.00	
48. 00	,	small rural hospitals	0		48. 00	
	only. (see instructions)					
				Amount 1.00		
49. 00	Total payment for inpatient operating costs (see instructions	s)		34, 732, 728	49. 00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			2, 669, 331		
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	The Trace That detrois).		139, 634	53.00	
54.00	Special add-on payments for new technologies			0	54.00	
54. 01	Islet isolation add-on payment	(0)		0	54. 01	
55.00		•		0	55. 00	
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35)	0	56. 00 57. 00	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		in ough 33).	169, 455		
59. 00	Total (sum of amounts on lines 49 through 58)	,		37, 711, 148		
60.00	Pri mary payer payments			24, 795	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		37, 686, 353	61. 00	
62.00	Deductibles billed to program beneficiaries			3, 335, 816	62. 00	
63.00	Coinsurance billed to program beneficiaries			61, 344		
64.00				403, 174		
	Adjusted reimbursable bad debts (see instructions)	tt:		262, 063		
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		143, 787		
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS DDCs (s	oo instructions)	34, 551, 256 0	67. 00 68. 00	
48 UU	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69. 00	
68.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (101 301 300 Thisti detroi	13)	0	70. 00	
69. 00		tration) adjustment (see	instructions)	0	70. 50	
	Rural Community Hospital Demonstration Project (§410A Demons	, , , , , , , , , , , , , , , , , , ,				
69. 00 70. 00	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration					
69. 00 70. 00 70. 50	Demonstration payment adjustment amount before sequestration			0	70.00	
69. 00 70. 00 70. 50 70. 87	Demonstration payment adjustment amount before sequestration	tructions)		U		
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	tructions)		0	70. 89 70. 90	
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70. 89 70. 90 70. 91	
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions)		0 0 0	70. 89 70. 90 70. 91 70. 92	
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instHSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	tructions)		0		

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der (CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 7/24/2020 4:0	
		Ti tl	e XVIII	Hospi tal	PPS	
<u>. </u>			FFY	(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fit the corresponding federal year for the corresponding federal year.		n column 0		0	0	70. 96
70 97 Low volume adjustment for federal fig	scal vear (vvvv) (Enter in	n column O		0	0	70 97

	itle XVIII	Hocni tal	772472020 4. 0 PPS	5 piii
		Hospi tal		
	FFY	(уууу)	Amount	
		0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column	0	0	0	70. 96
the corresponding federal year for the period prior to 10/1)				
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column	0	0	0	70. 97
the corresponding federal year for the period ending on or after 10/1				
70. 98 Low Volume Payment-3			0	70. 98
70.99 HAC adjustment amount (see instructions)			99, 231	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			34, 414, 958	1
71. 01 Sequestration adjustment (see instructions)			688, 299	1
71.02 Demonstration payment adjustment amount after sequestration			0	
71.03 Sequestration adjustment-PARHM pass-throughs	l			71. 03
72.00 Interim payments			33, 631, 236	72. 00
72.01 Interim payments-PARHM				72. 01
73.00 Tentative settlement (for contractor use only)			0	73. 00
73.01 Tentative settlement-PARHM (for contractor use only)				73. 01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, a	nd		95, 423	1
73)			707 120	/ 00
74.01 Balance due provider/program-PARHM (see instructions)				74. 01
			1 522 540	1
75.00 Protested amounts (nonallowable cost report items) in accordance with	'		1, 532, 540	75. 00
CMS Pub. 15-2, chapter 1, §115.2				-
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90. 00
plus 2.04 (see instructions)				
91.00 Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions)			0	
94.00 The rate used to calculate the time value of money (see instructions)			0.00	
95. 00 Time value of money for operating expenses (see instructions)	į		0.00	1
3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	
96.00 Time value of money for capital related expenses (see instructions)		D ' 1 40/4		96.00
		Prior to 10/1		
		1. 00	2. 00	
HSP Bonus Payment Amount				
100.00 HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment				1
101.00 HVBP adjustment factor (see instructions)		1.0005262539	0. 9980916793	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment		9		1.02.00
103. 00 HRR adjustment factor (see instructions)		0. 9985	1 0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104. 00
Rural Community Hospital Demonstration Project (§410A Demonstration)				4
200.00 Is this the first year of the current 5-year demonstration period unc	er the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.]
Cost Reimbursement				
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201. 00
202.00 Medicare discharges (see instructions)				202. 00
203.00 Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first y	ear of the currer	it 5-vear demonst	ration	1
period)	cai oi the carrer	re o year demonse		
204. 00 Medi care target amount				204. 00
				1
205.00 Case-mix adjusted target amount (line 203 times line 204)				205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)				206. 00
Adjustment to Medicare Part A Inpatient Reimbursement				1
207.00 Program reimbursement under the §410A Demonstration (see instructions	,			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)				209. 00
210. 00 Reserved for future use				210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)				211. 00
Comparision of PPS versus Cost Reimbursement				1-11.00
				212 00
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)				212. 00
213.00 Low-volume adjustment (see instructions)				213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost	reımbursement)			218. 00
(Lino 212 minus Lino 212) (soo instructions)		1		1

	THIRD OF BOY BANKENT BERGENTAGE	COLUMBOS KEGI ONA	_			u 01 101111 0113-2	
CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CO	CN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet DSH Date/Time Pre	pared:
			Ti +Lo	XVIII	Hospi tal	7/24/2020 4: 0 PPS	5 pm
		Original .mcrxAc					
		Val ues	Val ues	5 2551. 5			
		1.00	2. 00	3.00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE	1					
1. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4. 94	0. 00	0. 0	0. 00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	23. 51	0. 00			23. 51	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	28. 45	0. 00			23. 51	3. 00
4. 00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4. 00
5. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	146. 28	0. 00			146. 28	5. 00
6. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12. 69	0. 00			8. 61	6. 00
7. 00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7. 00
8.00	S-2, Li ne 22	Yes				Yes	8. 00
9. 00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9. 00
10.00	S-2, Line 45	Yes				Yes	10.00
11. 00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11. 00
12. 00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7	4. 94	0. 00	0. 0	0.00	0.00	12. 00
13. 00	- Revised from CMS) Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line	Yes				Yes	13. 00
14. 00	75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0. 00	0. 00	0.0	0. 00	0.00	14. 00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAY	YS TO TOTAL DAYS			_		
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1, 378	0			1, 378	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	685	0			685	16. 00
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17. 00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18. 00
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24,	0 5, 091	0 0			0 5, 091	
20. 00	column 5) Other Medicaid days (Worksheet S-2, line 24,	125	0			125	20. 00
21. 00	column 6) Total Medicaid patient days for the DSH	7, 279	0			7, 279	21. 00
22. 00		30, 958	0			30, 958	22. 00
23. 00		0	0			0	23. 00
24. 00		0	0			0	24. 00
25. 00	S-3, Part I, Column 8, Line 30) Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	0	O			0	25. 00
26. 00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	30, 958	0			30, 958	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	23. 51	0. 00			23. 51	27. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-	
CALCULATION OF DSH PAYMENT PERCENTAGE	Provi der CCN: 15-0112	Peri od: From 01/01/2019	Worksheet DSH

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provi der CC		Peri od: From 01/01/2019 To 12/31/2019	Worksheet DSH Date/Time Pre 7/24/2020 4:0	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .m	crx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2. 00	3. 00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	12. 69		0.00	True	28. 00
29. 00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0. 00		0.00	Fal se	29. 00
30.00	Line 28 or 29 as applicable		12. 69		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and		12. 69		0.00		31.00
	fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.						
		Original .mcrx/ Values	Adjusted .mcax Values	HFS Look Up	Overri de Value	Revi sed Value	
		1.00	2. 00	3. 00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32. 00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32. 00
33. 00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33. 00
34. 00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34.00
35. 00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35. 00
36. 00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

Health Financial Systems	COLUMBUS REGIONA	L HOSPITAL	In Lie	u of Form CMS-2	552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0112	Peri od: From 01/01/2019	Worksheet DSH	
				Date/Time Prep 7/24/2020 4:05	
		Title XVIII	Hospi tal	PPS	
	Revi sed	·			
	Percentage				
	4 00				

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6. 00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	8. 61				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29.00	If line 3 is less than 20.2% - 2.5% plus 65%	0. 00				29. 00
	of the difference between 15% and line 3					
30.00	Line 28 or 29 as applicable	8. 61				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	8. 61				31. 00
	fewer than 500 beds, or an SCH with less					
	than 100 beds the lower of line 30 or .1200,					
	if RRC, MDH or otherwise enter line 30.					

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-01	From 01/01/2019	Worksheet E Part B Date/Time Prepared: 7/24/2020 4:05 pm

		Title XVIII	Hospi tal	7/24/2020 4: 05 PPS	5 pm
			, nospi tai		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1.00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			39, 267	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions))		39, 426, 369	1
3.00	OPPS payments			31, 562, 424	1
4. 00	Outlier payment (see instructions)			213, 182	1
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instructions	3)		0. 000	•
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	al 13 line 200		429, 750	
	Organ acquisitions	71. 13, TITIE 200		427, 730	1
	Total cost (sum of lines 1 and 10) (see instructions)			39, 267	1
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e charges				
	Ancillary service charges			108, 826	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69	})		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			108, 826	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for paymen	nt for services on	a charge hasis	0	15. 00
	Amounts that would have been realized from patients liable for payment				
	had such payment been made in accordance with 42 CFR §413.13(e)		g]	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			108, 826	
19. 00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	69, 559	19. 00
20.00	instructions)	1: 11	10) (20.00
20. 00	Excess of reasonable cost over customary charges (complete only if instructions)	Tine II exceeds III	ne 18) (See	0	20.00
21. 00	Lesser of cost or charges (see instructions)			39, 267	21.00
	Interns and residents (see instructions)			0	1
23. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			32, 205, 356	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				4
	Deductibles and coinsurance amounts (for CAH, see instructions)			5, 933, 920	1
	Deductibles and Coinsurance amounts relating to amount on line 24 (0 0 0 700	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus tinstructions)	ine sum of lines 22	and 23] (see	26, 310, 703	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	′/		0	29. 00
	Subtotal (sum of lines 27 through 29)			26, 310, 703	
31. 00	Primary payer payments			5, 693	31.00
32. 00	Subtotal (line 30 minus line 31)			26, 305, 010	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			671 424	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			671, 636 436, 563	
	Allowable bad debts for dual eligible beneficiaries (see instruction	nns)		404, 192	
	Subtotal (see instructions)	71137		26, 741, 573	
	MSP-LCC reconciliation amount from PS&R				38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replaced de	evices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
1	Subtotal (see instructions) Sequestration adjustment (see instructions)			26, 741, 573	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			534, 831	1
	Sequestration adjustment-PARHM pass-throughs			١	40. 02
	Interim payments			26, 269, 767	1
	Interim payments-PARHM			_5, 25,, 157	41. 01
1	Tentative settlement (for contractors use only)			0	1
	Tentative settlement-PARHM (for contractor use only)				42. 01
	Balance due provider/program (see instructions)			-63, 025	
	Balance due provider/program-PARHM (see instructions)	THE ONE DIT 15 5	-1	/50 05:	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2, (cnapter 1,	650, 956	44.00
	§115. 2				1
ŀ	TO BE COMPLETED BY CONTRACTOR				90.00
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			I ∩i	
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0 0	
90. 00 91. 00	Original outlier amount (see instructions)			0	91.00
90. 00 91. 00 92. 00 93. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0 0.00 0	91. 00 92. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Pre 7/24/2020 4:0	
		Ti tl	e XVIII	Hospi tal	PPS	
					Overri des	
					1. 00	
WORKSHEET OVERRIDE VALUES						
112.00 Override of Ancillary service charges (line	12)				0	112. 00

Health Financial Systems COLUITANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0112

				10 12/31/2019	7/24/2020 4: 05	
		Title	: XVIII	Hospi tal	PPS	
	<u> </u>	Inpatien	it Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		33, 581, 13		26, 112, 667	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVIDER	08/09/2019	50, 10		157, 100	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Danish dan da Buranan			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			o	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM			0		3. 50
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				Ö	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		50, 10		157, 100	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		33, 631, 23	6	26, 269, 767	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR		I			F 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				o	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52	Cubtatal (our of lines F 01 F 40 minus are of line			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	O O	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		95, 42	3	ol	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	63, 025	6. 02
7. 00	Total Medicare program liability (see instructions)		33, 726, 65		26, 206, 742	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(0	1.00	2.00	8. 00

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		3, 680, 199 0		0	1. 00 2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3. 04			C		0	3. 04
3. 05			C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM		0			3. 50
3. 51			0			3. 52
3. 53			0			3. 53
3. 54			Ö		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	o o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 680, 199	1	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					F 00
5.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			C)	0	5. 02
5.03			C		0	5. 03
	Provider to Program			1		
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			0		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		C		U	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6.02	SETTLEMENT TO PROGRAM		86, 378		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 593, 821		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor)	1.00	2.00	8. 00
5.00	name of contractor			I	1	0.00

Heal th Financial Systems						
From 01/01/2019 Date/Time Prepared: 7/24/2020 4:05 pm						
TO 12/31/2019 Date/Time Prepared: 7/24/2020 4: 05 pm PPS Title XVIII Hospital PPS TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6 line 2 4.00 Total inpatient days from Wkst. S-3, Pt. I, col. 8 sum of lines 1, 8-12 4.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 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) 20.00 Overrides 1.00 CONTRACTOR OVERRIDES	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0112			
Title XVIII Hospital PPS Title XVIII Hospital PPS To be completed by contractor for nonstandard cost reports HEALTH Information Technology data collection and calculation 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 4.00 Total hospital days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 Total hospital charges from Wkst. S-10, col. 3 line 200 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES						
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from Wkst. S-7, Pt. I, col. 8 sum of lines 1, 8-12 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 Cal ulation of the HIT incentive payment (see instructions) 8.00 Sequestration adjustment amount (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Cal cul ation 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 Overrides CONTRACTOR OVERRIDES				10 12/31/2019	Date/IIMe Pre	eparea: Os om
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 1.00 CAIculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES			Title XVIII	Hospi tal		о рііі
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 1.00 CAIculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 4.00 Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-12 3.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) CONTRACTOR OVERRIDES					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days from Wkst. S-3, Pt. I col. 8 sum of lines 1, 8-12 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions) Dipatient HOSPITAL SERVICES UNDER THE IPPS & CAH Initial/interim HIT payment adjustment (see instructions) 30.00 Total hospital days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst. S-10, col. 3 line 20 6.00 6.00 Calculation of the HIT incentive payment (see instructions) 9.00 Inpatient HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Total hospital charges from Wkst. S-10, col. 3 line 20 8.00 Overrides 1.00 CONTRACTOR OVERRIDES		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 Sequestration adjustment amount (see instructions) 9.00 Sequestration of the HIT incentive payment after sequestration (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) CONTRACTOR OVERRIDES		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
3.00 4.00 Total inpatient days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) CONTRACTOR OVERRIDES	1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 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) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 Overrides	2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00
Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 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) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charges from Wkst. S-10, col. 3 line 20 Total hospital charges from Wkst. S-10, col. 3 line 20 Total hospital charges from Wkst. S-10, col. 3 line 20 Total hospital hospital charges from Wkst. S-10, col. 3 line 20 Total hospital his particular from HIT technology wkst. S-2, Pt. I Total hospital his particular from HIT technology wkst. S-2, Pt. I Total hospital his particular from HIT technology wkst. S-2, Pt. I Total hospital his particular from HIT technology wkst. S-2, Pt. I Total hospital his particular from HIT technology wkst. S-2, Pt. I Total his particular from HIT technology wkst. S-2, Pt. I Total his particular from HIT technology wkst. S-2, Pt. I T	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 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) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
I in e 168 8.00 Cal cul ation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Cal cul ation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 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) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 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 Other Adjustment (specify) 31. 00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides CONTRACTOR OVERRIDES		1				
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial /interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30. 00 31. 00 Other Adjustment (specify) 32. 00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) CONTRACTOR OVERRIDES INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30. 00 31. 00 31. 00 32. 00 Overrides 1. 00	9.00	Sequestration adjustment amount (see instructions)				9. 00
30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) Overrides 1.00 CONTRACTOR OVERRIDES	30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
Overri des 1. 00 CONTRACTOR OVERRI DES	31.00					
CONTRACTOR OVERRIDES 1.00	32.00					
CONTRACTOR OVERRIDES					Overri des	
					1. 00	
108.00 Override of HIT payment 108.00		CONTRACTOR OVERRIDES				
	108.00	Override of HIT payment				108. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112		Worksheet E-3
	Component CCN: 15-T112	From 01/01/2019 To 12/31/2019	Date/Time Prepared:
	Title XVIII	Subprovi der -	7/24/2020 4:05 pm PPS
	Title XVIII	IRF	113

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	3, 426, 352	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	72, 639	3. 00
4.00	Outlier Payments	205, 203	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
0.00	teaching program" (see instructions)	0.00	0.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	9. 865753	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	3, 704, 194	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	1	15. 00
16. 00		o	16. 00
17. 00	Subtotal (see instructions)	3, 704, 194	17. 00
18.00	Primary payer payments	15, 011	18. 00
19.00	Subtotal (line 17 less line 18).	3, 689, 183	19. 00
20.00	Deducti bl es	24, 552	20.00
21. 00	Subtotal (line 19 minus line 20)	3, 664, 631	21. 00
22. 00	Coi nsurance	7, 843	22. 00
23. 00		3, 656, 788	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5, 380	
25. 00	Adjusted reimbursable bad debts (see instructions)	3, 497	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4, 092	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	3, 660, 285	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	6, 879	29. 00
30. 00 31. 00	Outlier payments reconciliation	0	30. 00 31. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 00
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 667, 164	
32. 00	Sequestration adjustment (see instructions)	73, 343	
32. 02	Demonstration payment adjustment amount after sequestration	73,343	32. 02
33. 00	Interim payments	3, 680, 199	33. 00
34. 00	Tentative settlement (for contractor use only)	0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-86, 378	35. 00
36. 00	Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26, 543	36. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	205, 203	50. 00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00			52.00
53. 00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems

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

Provider CCN: 15-0112 | Period: | W | From 01/01/2019 | To 12/31/2019 | To 12/

oni y)					7/24/2020 4:0	5 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	19, 630, 779	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3. 00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	74, 146, 320	l .	0	0	
5. 00 6. 00	Other receivable	2, 297, 013	1	0	0	
7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-34, 268, 933 5, 352, 422	1	0	0	7. 00
8. 00	Prepaid expenses	4, 737, 862	1	0	o o	8.00
9. 00	Other current assets	2, 438, 651	1	-	0	9. 00
10.00	Due from other funds	0	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	74, 334, 114	0	0	0	11. 00
	FIXED ASSETS		1			
12.00	Land	2, 010, 352			0	•
13.00	Land improvements	20, 982, 896	1		0	
14. 00 15. 00	Accumulated depreciation Buildings	-12, 222, 352 208, 762, 459	1	_	0	14. 00 15. 00
16. 00	Accumulated depreciation	-138, 776, 636	1	_	0	16.00
17. 00	Leasehold improvements	0	Ö	_	Ö	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	9, 587, 449	0	0	0	19. 00
20. 00	Accumulated depreciation	-7, 703, 297	1	0	0	20. 00
21. 00	Automobiles and trucks	2, 276, 801	1	_	0	
22. 00	Accumulated depreciation	-1, 643, 706	1		0	22. 00
23. 00	Maj or movable equipment	169, 338, 972	1	-	0	23. 00 24. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-103, 405, 467		0	0	25. 00
26. 00	Accumulated depreciation		0	0	0	26.00
27. 00	HIT designated Assets	Ö	ō	0	Ō	27. 00
28. 00	Accumulated depreciation	0	0	0	0	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)	149, 207, 471	0	0	0	30. 00
21 00	OTHER ASSETS	157 710 205			0	21 00
31.00	Investments Penerits on Leases	157, 719, 205	0		0	31. 00 32. 00
32. 00 33. 00	Deposits on Leases Due from owners/officers			0	0	33.00
34. 00	Other assets	16, 601, 288	Ö	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	174, 320, 493	1	_	ő	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	397, 862, 078	1	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	12, 990, 290	1		0	•
38. 00	Salaries, wages, and fees payable	9, 950, 110	1	0	0	38. 00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	983, 060 6, 780, 000		0	0 0	39. 00 40. 00
40.00	Deferred income	0, 780, 000	0	0	0	41. 00
42. 00	Accel erated payments		ĺ	J		42. 00
43. 00	Due to other funds	0	О	0	0	•
44.00	Other current liabilities	7, 895, 421	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	38, 598, 881	0	0	0	45. 00
	LONG TERM LIABILITIES	40 (70 000	1	1		
46. 00	Mortgage payable Notes payable	42, 670, 000	1		0	
47. 00 48. 00	Unsecured Loans	373, 942	0		0	48.00
49. 00	Other long term liabilities	0 0	0	0	Ö	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	43, 043, 942	1	_	Ö	ł
51.00	Total liabilities (sum of lines 45 and 50)	81, 642, 823	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	316, 219, 255	1			52. 00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,		1		ő	58.00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	316, 219, 255	1	0	0	ł
60. 00	Total liabilities and fund balances (sum of lines 51 and	397, 862, 078	0	0	0	60. 00
	[59]	I	I	l l	I	I

Provi der CCN: 15-0112

				To 12/31/2019		
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3. 00	4. 00	5. 00	
Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	6, 713, 529 0 0 0 0	315, 947, 011 48, 308, 322 364, 255, 333 6, 713, 529 370, 968, 862		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	54, 749, 607 0 0 0 0	54, 749, 607 316, 219, 255	- Franch	0 0 0 0 0	0 0 0 0	13. 00
	Endowment Fund	PI ant	Fund			
	6.00	7. 00	8. 00			
Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0		0 0 0		9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Endowment Fund Endowment Fund 6.00 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Fund balances at beginning of period Sheet (line 11 minus line 18) Fund balances at beginning of period NURSING HOME CONTRIBUTIONS Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Deductions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS O Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS O Total deductions (sum of lines 12-17) Fund balance at end of period per balance	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Deductions (debit adjustments) (specify) Deductions (debit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	Commonstrate Fund Special Purpose Fund 1.00 2.00 3.00 4.00 4.00 3.00 4.00 4.00 3.00 4.00	T7/24/2020 4.0 Total additions (sum of line 4-9) Subtotal (line 11 ml nus line 18) Endowment Fund Special Purpose Fund Endowment Fund Total (sum of line 1 and line 2) Subtotal (line 11 ml nus line 18) Endowment Fund Special Purpose Fund Endowment Fund Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) O O O O O O O O O

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

		7	o 12/31/2019	Date/Time Pre 7/24/2020 4:0	
	Cost Center Description	Inpati ent	Outpati ent	Total	5 pili
	out conton bood (pt) on	1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	59, 406, 845	5	59, 406, 845	1.00
2.00	SUBPROVI DER - I PF			0	2. 00
3.00	SUBPROVIDER - IRF	6, 825, 783	3	6, 825, 783	3. 00
4.00	SUBPROVI DER	(0	4. 00
5. 00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			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)	66, 232, 628	3	66, 232, 628	10.00
	Intensive Care Type Inpatient Hospital Services	00/202/02		00, 202, 020	10.00
11. 00	INTENSIVE CARE UNIT	13, 433, 535	5	13, 433, 535	11. 00
12. 00	CORONARY CARE UNIT	(0	12. 00
13. 00	BURN INTENSIVE CARE UNIT			0	13. 00
14. 00	SURGICAL 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	13, 433, 535		13, 433, 535	16. 00
	11-15)	10, 100, 000			
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	79, 666, 163	3	79, 666, 163	17. 00
18. 00	Ancillary services	156, 661, 756		544, 029, 563	18. 00
19. 00	Outpati ent servi ces	17, 348, 568		76, 450, 910	
20. 00	RURAL HEALTH CLINIC	(0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		ol ol	0	21. 00
22. 00	HOME HEALTH AGENCY	· ·	أ أ	0	22. 00
23. 00	AMBULANCE SERVICES	10, 953	12, 630, 687	12, 641, 640	23. 00
24. 00	CMHC	10,700	12,000,007	12/011/010	24. 00
24. 10	CORF		ا ا	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	· ·	1	Ü	25. 00
26. 00	HOSPI CE				26. 00
27. 00	LEVEL II NURSERY	2, 201, 046	ا ا	2, 201, 046	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.			714, 989, 322	28. 00
20.00	G-3, line 1)	200,000, 100	1077 1007 000	71177077022	20.00
	PART II - OPERATING EXPENSES		1		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		283, 344, 935		29. 00
30.00	PROVISION FOR BAD DEBT	10, 580, 163			30. 00
31. 00		(31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		10, 580, 163		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00) l		39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)	Ì	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er l	293, 925, 098		43. 00
	to Wkst. G-3, line 4)				
		•			•

	Financial Systems	COLUMBUS REGIONAL			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 15-0112	Peri od: From 01/01/2019	Worksheet G-3	
				To 12/31/2019		
					7/24/2020 4:0	5 pm
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	t I. column 3. line	28)		714, 989, 322	1.00
2.00	Less contractual allowances and discounts or				404, 532, 161	
3.00	Net patient revenues (line 1 minus line 2)	•			310, 457, 161	3.00
4.00	Less total operating expenses (from Wkst. G-	-2, Part II, line 4	13)		293, 925, 098	4.00
5.00	Net income from service to patients (line 3		•		16, 532, 063	5.00
	OTHER I NCOME	,				1
6.00	Contributions, donations, bequests, etc				565, 550	6.00
7.00	Income from investments				13, 167, 348	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				98, 558	10.00
11.00	Rebates and refunds of expenses				34, 641	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			1, 015, 547	14. 00
15. 00	Revenue from rental of living quarters				0	
16. 00	Revenue from sale of medical and surgical su		nan patients		0	16. 00
17. 00	Revenue from sale of drugs to other than pat				40, 778	
18. 00	Revenue from sale of medical records and abs				12, 428	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms,	etc.)			24, 553	19. 00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	
21. 00	Rental of vending machines				0	
22. 00	Rental of hospital space				157, 135	
23. 00	Governmental appropriations				625, 000	23. 00
24. 00	UNREALIZED INVESTMENT INCOME				12, 861, 332	24. 00
24. 01	WELLNESS REVENUE				151, 354	24. 01
24. 02	JOINT VENTURES				190, 808	
24. 03	CRHP REVENUE				3, 479, 747	
24. 04	OTHER OPERATING REVENUE				646, 688	
	Total other income (sum of lines 6-24)				33, 071, 467	
	Total (line 5 plus line 25)				49, 603, 530	
27 00	LINSS ON DISPOSAL OF ASSETS				31 020	27 00

31, 929 27. 00 1, 263, 279 27. 01 1, 295, 208 28. 00 48, 308, 322 29. 00

LOSS ON DISPOSAL OF ASSETS

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

Heal th	Financial Systems COLUMBUS REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0112	Peri od: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre 7/24/2020 4:0	pared:
		Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			2, 448, 370	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			75, 773	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	76. 70	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)		1 11	0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by t 1.01) (see instructions)	the sum of lines I and 1.01	, corumns r and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	A patient days (Worksheet E	, part A line	4. 94	7. 00
8.00	Percentage of Medicaid patient days to total days (see inst	tructions)		23. 51	8. 00
9.00	Sum of lines 7 and 8			28. 45	
10.00	3 (10.00
11.00					11.00
12. 00	Total prospective capital payments (see instructions)			2, 669, 331	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	
3.00				0	
4.00	Capital cost payment factor (see instructions)			0	
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	
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)				2.00
4.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)				4.00
5. 00	Capital cost for comparison to payments (line 3 x line 4)				5.00
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)				6. 00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				7. 00
8.00	Capital minimum payment level (line 5 plus line 7)				8. 00
9.00	Current year capital payments (from Part I, line 12, as applicable)			0	9. 00
10.00	Current year comparison of capital minimum payment level to	1 1 3 1	′ ′	0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	
12.00					
13.00					13.00
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the f	ollowing period	0	14. 00
15 00					15. 00
15.00					
16. 00	Current year operating and capital costs (see instructions)			0	16. 00