[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date:

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

Contractor use only

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (15-0112) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

> (Si aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

Date

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	221, 726	71, 608	-17, 491	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-3, 817	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	217, 909	71, 608	-17, 491	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. 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.

23.00	will cit illetilod is used to determine medical d days on in	nes 24 anu	701 23 DelC	w: III Colu		ગ	IN	23.00
	1, enter 1 if date of admission, 2 if census days, or	~ 3 if date	of di schar	ge. Is the				
	method of identifying the days in this cost reporting	g period di	fferent fro	m the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	r "N" for r	no.			
		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	
		pai d days	eligible	Medi cai d	Medi cai d	,	days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	985	796	21	0	5, 867	73	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	15	153	0	0	0		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

Heal th	Financial Systems COLUMBUS	REGI O	NAL HOSPITAL		In L	ieu of Fo	rm CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/201 o 12/31/201	16 Part I	ieet S-2 ime Pre	
					Urban/Rural		.017 8:0 f Geogr	
04.00					1. 00		00	
27. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta	atus at the end	of the cost		1		26. 00
35. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0		35. 00
	orrest in the cost reporting porres.				Begi nni ng:		i ng:	
36 00	Enter applicable beginning and ending dates of SCH st	atus 9	Subscript line	36 for number	1. 00	2.	00	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	S.	•			0		37. 00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo							37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.							38. 00
	·				Y/N		/N	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	)? Ente uiremen	er in column 1 nts in accordan	"Y" for yes ace with 42	1. 00 N		00 N	39. 00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adj us <sup>.</sup> er 1. l	tment? Enter "Y Enter "Y" for y	" for yes or	N		N	40. 00
						V XVIII 00 2.00		
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for (	di sproporti onat	e share in acc	cordance	N Y	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N N	N	46. 00
47. 00 48. 00	rt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N N N	N N	47. 00 48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N		56. 00
57. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes on h of th ", comp	r "N" for no in nis cost report plete Worksheet	column 1. If ing period? I	column 1 Enter "Y"			57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ıns' services a	as	N		58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N		59. 00
	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					Y		60.00
		Y/Ń	I ME	Direct GME	IME	Di red	ct GME	
		1. 00	2. 00	3. 00	4.00		00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.	00	0.0	0 61.00
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0. 0	0			61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0. 0	d			61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0. 0	d			61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00	d			61. 04
61. 05	current cost reporting period.(see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0. 0	d			61. 05

Health Financial Systems	COLUMBUS	S REGION	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA	Provi der CC		eriod: com 01/01/2016 ) 12/31/2016	Worksheet S-2 Part I Date/Time Prep 5/23/2017 8:09	pared:
		Y/N	IME	Direct GME	IME	Direct GME	<u> </u>
61.06 Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary	1.00	2. 00 0. 00	3. 00	4.00	5. 00	61.06
	,	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specif specialty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents ctions) Enter in in column 2, the the IME FTE umn 4, direct GME				0.00		61. 10
61.20 Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program comparts 3, the IME FTE unweighted count and 4, direct GME FTE unweighted count	e number of FTE am. (see the program name, de, enter in column nd enter in column				0. 00	0. 00	61. 20
						1. 00	
ACA Provisions Affecting the Heal						1.00	
62.00 Enter the number of FTE residents your hospital received HRSA PCRE	funding (see instruc	ctions)					62. 00
62.01 Enter the number of FTE residents during in this cost reporting per	iod of HRSA THC prog	gram. (s	<u>see instruction</u>		your hospital	0. 00	62. 01
Teaching Hospitals that Claim Res 63.00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
	,			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te 1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year							
period that begins on or after Ju 64.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighted r hospital. Enter ir	ty train n-primar all non d non-pr n column	ned residents by care provider imary care a 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
65.00 Enter in column 1, if line 63	1. 00		2. 00	3. 00 0. 00	4. 00 0. 00	5. 00 0. 000000	(F. 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				3. 00	C. 00	0.00000	. 55. 55

Health Financial Systems COLUMBUS REGIO	ONAL HOSPITAL		l n	Li eu	of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eriod: rom 01/01/2 o 12/31/2		Worksheet S-2 Part I Date/Time Pro	
		1'		2016	5/23/2017 8:0	
			1. 00		2. 00	+
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			0. 00 N		0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	pplicable colum	n.	0. 00		0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (C 106.00 of this facility qualifies as a CAH, has it elected the all		hod of payment	N N			105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see inst	ructions) If	N			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108. 00
	Physi cal 1.00	0ccupational 2.00	Speech 3.00	1	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N		N N	109. 00
				-	1.00	+
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for		N	110. 00
				1. 00	2.00 3.00	
Miscellaneous Cost Reporting Information	!!N!! £ :	1 1 16	1 1	N.		115.00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	2. If column 2 ent for long te	is "E", enter i rm care (includ	n column les	N	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			N" for	Y Y		116. 00 117. 00
no.  118.00 s the mal practice insurance a claims-made or occurrence po		,		1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses		Insurance	
		1. 00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		664, 868		0		0 118. 01
			1. 00		2.00	+
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche	center other	than the			2.00	
and amounts contained therein.	edure frstriig C	ost centers	N		2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	d Harmless pro n column 1, "Y qualifies for t	vision in ACA " for yes or he Outpatient			N N	118. 02 119. 00 120. 00
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl	d Harmless pro n column 1, "Y qualifies for t ents? (see inst	vision in ACA " for yes or he Outpatient ructions)	N			119. 00
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the state of the s	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N N			119. 00 120. 00
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes?	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N N Y			119. 00 120. 00
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device P Enter "Y" for the Worksheet A	vision in ACA " for yes or ne Outpatient ructions) s charged to yes or "N" line number	N N Y			119. 00 120. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, e</li> </ul>	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device P Enter "Y" for the Worksheet A For yes and "N"	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N N Y N			119. 00 120. 00 121. 00 122. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified heart transplant center, en</li> </ul>	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device P Enter "Y" for the Worksheet A For yes and "N" enter the certi 2. hter the certif	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number  for no. If	N N Y N			119. 00 120. 00 121. 00 122. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en</li> </ul>	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device P Enter "Y" for the Worksheet A For yes and "N" enter the certif 2. hter the certif 2.	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number  for no. If fication date	N N Y N			119. 00 120. 00 121. 00 122. 00 125. 00 126. 00
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entermination date, if applicable, in column	d Harmless pronounced to compare the certification of the worksheet A certification of the worksheet A certification of the certificati	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number  for no. If fication date ication date	N N Y N			119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00
<ul> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with &lt; 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included.  Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column</li> <li>127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column</li> <li>128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> <li>129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column</li> </ul>	d Harmless pro n column 1, "Y qualifies for t ents? (see inst antable device P Enter "Y" for the Worksheet A  For yes and "N" enter the certif 2. tter the certific er the certific enter the certific enter the certific	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number  for no. If fication date ication date cation date in	N N Y N			119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
119.00  120.00  13 this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.  121.00  121.00  122.00  122.00  123.00  124.00  125.00  126.00  127.00  128.00  129.00  120.00	d Harmless pron column 1, "Y qualifies for tents? (see instantable device? Enter "Y" for the Worksheet A for yes and "N" enter the certification that certification is the certification of the certif	vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number  for no. If fication date i cation date cation date in tification	N N Y N			119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems		ONAL HOSPITAL		15		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-0112		: 1/01/2016 2/31/2016	Worksheet S- Part I Date/Time Pr 5/23/2017 8:	epared:
					1. 00	2.00	$\dashv$
33.00 If this is a Medicare certified of			cation date		1.00	2.00	133. 0
in column 1 and termination date, 34.00 If this is an organ procurement or and termination date, if applicable	ganization (OPO), enter		n column 1				134. 0
All Providers							
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home of	office cost	S	Y		140. 0
1.00	2.	. 00			3. 00		
If this facility is part of a chain home office and enter the home off				name and	d address	of the	
41. 00 Name:	Contractor's Name:	COITTI ACTOL Hullibe		tor's Nu	ımber:		141.0
42. 00 Street:	PO Box:						142. 0
43. 00 Ci ty:	State:		Zi p Cod	e:			143. 0
						1.00	$\dashv$
44.00 Are provider based physicians' cos	sts included in Worksheet	: A?				Y	144. C
45.00  f costs for renal services are cl	aimed on What A line 7	M are the costs	for		1. 00 Y	2. 00	145. C
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio	n column 1. If co	olumn 1 is		'		145. 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c	gy changed from the previ n column 1. (See CMS Pub.			f	N		146. 0
						1. 00	_
47.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for i	no.			1.00 N	147. (
48.00 Was there a change in the order of						N	148. (
49.00 Was there a change to the simplifi	ed cost finding method?					N	149. (
		Part A 1.00	2.00	- 1	3.00	Title XIX 4.00	$\dashv$
Does this facility contain a provi	der that qualifies for a			cation of			
or charges? Enter "Y" for yes or '	'N" for no for each compo			(See 42			<b>-</b>
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. ( 156. (
57. 00 Subprovider - TRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. (
60.00 HOME HEALTH AGENCY 61.00 CMHC		N	N N		N N	N N	160. (
51. 10 CORF			N		N	N	161.
						1.00	-
Multicampus							
65.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campus	ses in diff	erent CE	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State Z	i p Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 If line 165 is yes, for each 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 column 5 (see instructions)						0. 0	00 166. 0
, , , , , , , , , , , , , , , , , , , ,			'			1. 00	
Health Information Technology (HI				ent Act			
657.00 s this provider a meaningful user	05 is "Y") and is a meani	ngful user (line		), enter	the	Y	167. 0 0168. 0
reasonable cost incurred for the H 68.01 If this provider is a CAH and is r			gualify fo	r a haro	ishi p		168. (
exception under §413.70(a)(6)(ii)?					P		1.50.
59.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") an				enter the	0.2	25169. (

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Peri od: From 01/01/2016			
			To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
			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)				06/29/2016	170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider has section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see insti	on Wkst. S-3, Pt. I, f column 1 is yes, en	line 2, col. 6? Enter	n N	0	171. 00

Heal th	Financial Systems COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	epared:		
				Y/N	5/23/2017 8:0 Date	J5 pm		
				1. 00	2. 00			
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	sponses. Ente					
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.00		
1.00	reporting period? If yes, enter the date of the change in o					1.00		
			Y/N	Date	V/I			
			1.00	2. 00	3. 00	2.00		
<ol> <li>2.00</li> <li>3.00</li> </ol>	yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.							
3.00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providual officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)			3.00				
			Y/N	Type	Date			
	Financial Data and Dananta		1.00	2. 00	3. 00			
4.00	Financial Data and Reports  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 avaicolumn 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.		)/ /N	1 1 0			
				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?	If yes, is th	e provider is	S N		6. 00		
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	Y N		7. 00 8. 00		
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00		
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			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	V (1)	11. 00		
					Y/N 1. 00			
	Bad Debts				1.00			
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 00 13. 00		
14. 00	period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	structi ons.	N	14. 00		
15. 00	Bed Complement Did total beds available change from the prior cost reporti		yes, see inst		N N	15. 00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	04/18/2017	Y	04/18/2017	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	04/18/2017	Υ	04/18/2017	17. 00		
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00		
19. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.							

Heal th	Financial Systems COLUMBUS REGIO	ONAL	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CC	CN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016		epared:
			Descri	pti on	Y/N	Y/N	J
			(		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	MGD DAYS	CARE PART	Υ	N	20. 00	
	Report data for other? Describe the other adjustments:	DAYS	Y/N	Date	Y/N	Date	
			1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N		21. 00
	-						
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVO	·FDT (	CHILL DDENC TI	OCDLTALC)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPI	THI LUKENS H	JSPI TALS)			+
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e ins	structions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed ir	nto during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the	cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he co	ost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	ne cos	st reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	entere	ed into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or			bt Service R	eserve Fund)	Υ	29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled matu	ructi uri ty	ons y with new	debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuar	nce of new	debt? If yes	, see	N	31. 00
32. 00 33. 00	Purchased Services  Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instructions instructions are see instructions.	uctio	ons.			N	32.00
	no, see instructions. Provider-Based Physicians						
34. 00	Are services furnished at the provider facility under an an If yes, see instructions.	ırranç	gement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in			ts with the	provi der-based	Y	35. 00
					Y/N	Date	
	LL 055				1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?				N		36.00
	If line 36 is yes, has a home office cost statement been pu	repar	red by the	home office?			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end						38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.				,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home	e office?	If yes, see			40. 00
		2.	00				
	Cost Report Preparer Contact Information		1.				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CATH	HERI NE		SIMMONS		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COLL	JMBUS REGIO	NAL HOSPITAL			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-	-376-5248		CSI MMONS@CRH. O	RG	43. 00

Heal th	Financial Systems COLUMB	BUS REGION	NAL HOSPITAL	In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN/	AI RE	Provi der CCN: 15-0112	i od: m 01/01/2016 12/31/2016		pared:		
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/posit		MANAGER ACCOUNTING			41. 00		
	held by the cost report preparer in columns 1, 2, a	and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost report					42. 00		
	preparer.							
43.00	Enter the telephone number and email address of the	e cost				43.00		
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems COLUMBUS REGIONA	L HOSPITAL		Non-CMS HFS Wor	rksheet	
HFS Su	upplemental Information	Provi der CCN: 15-0112	Period: From 01/01/2016 To 12/31/2016		pared:	
			Title V	Title XIX		
			1. 00	2. 00		
	TITLES V AND/OR XIX FOLLOWING MEDICARE					
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Interstepdown adjustments on W/S B, Part I, column 25? Enter Y/N i and Y/N in column 2 for Title XIX.		Y	Y	1. 00	
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the repor Part I (e.g. net of Physician's component)? Enter Y/N in colu in column 2 for Title XIX.		Y	Y	2. 00	
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calcu Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX.			Y	3. 00	
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01	
			Inpati ent	Outpati ent		
			1. 00	2. 00		
	CRITICAL ACCESS HOSPITALS					
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Access reimbursed 101% of cost? Enter Y or N in column 1 for inpatie for outpatient.		N N	N	4. 00	
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Accreimbursed 101% of cost? Enter Y or N in column 1 for inpatie for outpatient.			N	5. 00	
			Title V	Title XIX		
			1. 00	2. 00		
	RCE DI SALLOWANCE					
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disall column 4? Enter Y/N in column 1 for Title V and Y/N in column		Y	Y	6. 00	
	PASS THROUGH COST			Υ	7. 00	
7. 00	OD Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for Worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.					
	RHC					
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Ent Title V and Y/N in column 2 for Title XIX.	er Y/N in column 1 for	N	N	8. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

From 01/01/2016 Part I 12/31/2016

33.00

Date/Time Prepared: 5/23/2017 8:05 pm I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 132 48, 312 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 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 132 48, 312 0.00 0 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 31.00 18 6,588 0.00 0 8.00 CORONARY CARE UNIT 9.00 32.00 C 0 0.00 0 9.00 BURN INTENSIVE CARE UNIT 10.00 33.00 C 0 0.00 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 150 54, 900 0.00 0 14.00 CAH visits 15.00 15.00 0 SUBPROVIDER - IPF 16.00 40.00 16.00 SUBPROVIDER - IRF 17.00 41.00 18 6,588 0 17.00 18.00 SUBPROVI DER 42.00 0 18.00 19.00 SKILLED NURSING FACILITY 44.00 0 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 101.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 HOSPICE (non-distinct part) 24. 10 30.00 24.10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 99. 10 0 25. 10 RURAL HEALTH CLINIC 26.00 88.00 26.00 0 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 168 27.00 Observation Bed Days 28.00 0 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions)

LTCH non-covered days

Provider CCN: 15-0112

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 8:05 pm

Title XVIII							5/23/2017 8: 0	5 pm
1.00			I/P Days	o/P Visits	/ Tri ps	Full Time	Equi val ents	
1.00		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8   8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2.90   1.0					Pati ents	& Residents	Payrol I	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions)							10.00	
Hospice days) (See instructions for col. 2   for the portion of LIDP room available beds)   2.00   HMO and other (See instructions)   2,933   0   3.00   4.00   HMO infer Subprovider   0   0   0   0   0   3.00   4.00   HMO IPF Subprovider   4.40   0   0   0   5.00   Hospital Adults & Peds. Swing Bed SNF   0   0   0   0   0   5.00   6.00   0.0	1.00		11, 337	5, 620	25, 803			1. 00
For the portion of LDP room available beds)   2,00								
2.00   HM0 and other (see instructions)   2.933   0   3.00   4.00   4.00   6.00								
3.00   MMO IPF Subprovider	2 00		2 022					2 00
4.00   HMO IRF Subprovider			2, 933	U				
5.00			140	0				
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0			
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions)			J	0	0			
Beds) (see instructions)   Rand   R			11 337	5 620	25 803			
8. 00   INTENSIVE CARE UNIT   1,171   399   2,505   8. 00   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   1.000   9. 00   9.	7.00		11, 337	3, 020	23, 003			7.00
9.00   CORONARY CARE UNIT   0   0   0   0   0   10.00	8 00		1 171	399	2 505			8 00
10.00   BURN INTENSIVE CARE UNIT   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	_,			
11. 00   SURGICAL INTENSIVE CARE UNIT   0   0   0   0   12. 00   12. 00   12. 00   13. 00   14. 00   14. 00   15. 00   14. 00   15. 00   14. 00   15. 00   15. 00   16. 00   16. 00   17. 00   18. 00   18. 00   19. 00				0	0			
12.00   OTHER SPECIAL CARE (SPECIFY)   1,723   3,634   12.00   13.00   NURSERY   1,723   3,634   13.00   14.00   15.00   15.00   CAH visits   0 0 0 0 0 0 0 0 0 0 0 15.00   15.00   15.00   15.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l ol	o	0			
13.00   NURSERY   1,723   3,634   13.00   14.00   Total (see instructions)   12,508   7,742   31,942   0.00   1,263.00   14.00   15.00   0.00   0.00   0.00   15.00   15.00   0.00   0.00   0.00   15.00   0.00   0.00   0.00   15.00   0.00   0.00   0.00   0.00   15.00   0.00   0.00   0.00   0.00   0.00   15.00   0.00   0.00   0.00   0.00   0.00   17.00   0.0	12. 00							12. 00
15.00   CAH visits   0 0 0 0 0 0 0 0 0 16.00   15.00   16.00   16.00   17.00   SUBPROVIDER - IRF   2,288   168   3,825   0.00   24.00   17.00   17.00   SUBPROVIDER   IRF   2,288   168   3,825   0.00   24.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   18.00   18.00   19.00	13.00	•		1, 723	3, 634			13.00
16. 00   SUBPROVI DER - IPF   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00	Total (see instructions)	12, 508	7, 742	31, 942	0.00	1, 263. 00	14.00
17. 00 SUBPROVI DER - IRF	15.00	CAH visits	o	o	0			15.00
18. 00 SUBPROVI DER	16.00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16.00
19. 00	17. 00	SUBPROVI DER - I RF	2, 288	168	3, 825			17. 00
20. 00   NURSING FACILITY   20. 00   21. 00   21. 00   21. 00   21. 00   22. 00   22. 00   HOME HEALTH AGENCY   0   0   0   0   0. 00   0. 00   22. 00   23. 00   AMBULATORY SURGICAL CENTER (D. P.)   23. 00   24. 00   24. 10   40. 00   24. 10   25. 00   25. 00   25. 10   26. 00   26. 00   26. 00   26. 00   26. 00   26. 25   26. 00   26. 25   26. 00   26. 25   27. 00   26. 26. 25   27. 00   28. 00   29. 00	18. 00	SUBPROVI DER		0	0			18. 00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 CMHC - CMHC 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF  20.00 O O O O O O O O O O O O O O O O O O			0	0	0	0.00	0.00	
22.00   HOME HEALTH AGENCY   0   0   0   0   0   0   0   0   0								
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 22. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 24. 00 24. 00 24. 00 24. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
24. 00       HOSPICE         24. 10       HOSPICE (non-distinct part)       0         25. 00       CMHC - CMHC         25. 10       CMHC - CORF       0         26. 00       RURAL HEALTH CLINIC       0         26. 05       FEDERALLY QUALIFIED HEALTH CENTER       0         27. 00       Total (sum of lines 14-26)         28. 00       Observation Bed Days         29. 00       Ambul ance Trips         30. 00       Employee discount days (see instruction)         31. 00       Employee discount days - IRF			0	0	0	0.00	0.00	
24. 10     HOSPICE (non-distinct part)     0     0     0     0     24. 10       25. 00     CMHC - CMHC     25. 00     0     0     0     0.00     0.00     25. 00       25. 10     CMHC - CORF     0     0     0     0.00     0.00     25. 10       26. 00     RURAL HEALTH CLINIC     0     0     0     0.00     0.00     0.00     26. 00       26. 25     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0.00     0.00     0.00     26. 25       27. 00     Total (sum of lines 14-26)     0.00     1, 287. 00     27. 00       28. 00     Observation Bed Days     761     3, 522     28. 00       29. 00     Ambul ance Trips     4, 160     29. 00       30. 00     Employee discount days (see instruction)     30. 00       31. 00     Employee discount days - IRF     0     31. 00								
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 25. 00 0 0 0 0. 00								
25. 10 CMHC - CORF 0 0 0 0 0 0.00 25. 10 26. 00 RURAL HEALTH CLINIC 0 0 0 0 0.00 0.00 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 1, 287. 00 28. 00 Observation Bed Days 761 3, 522 28. 00 30. 00 Employee discount days (see instruction) 0 0 0 0.00 31. 00 31. 00 Employee discount days - IRF 0 0 0 0 0.00 0.00 26. 25 25. 10 0 0 0 0.00 0.00 0.00 26. 20 26. 20 0 0 0.00 0.00 0.00 0.00 26. 20 27. 00 0 0.00 0.00 0.00 0.00 0.00 26. 20 28. 00 0.00 0.00 0.00 0.00 0.00 0.00 26. 20 28. 00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			0	O	0			
26.00     RURAL HEALTH CLINIC     0     0     0     0.00     0.00     0.00     26.00       26.25     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0     0.00     0.00     26.25       27.00     Total (sum of lines 14-26)     0     0.00     1,287.00     27.00       28.00     Observation Bed Days     761     3,522     28.00       29.00     Ambul ance Trips     4,160     29.00       30.00     Employee discount days (see instruction)     0     30.00       31.00     Employee discount days - IRF     0     31.00					0	0.00	0.00	
26. 25     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0.00     0.00     26. 25       27. 00     Total (sum of lines 14-26)     0     0.00     1, 287. 00     27. 00       28. 00     Observation Bed Days     761     3, 522     28. 00       29. 00     Ambul ance Tri ps     4, 160     29. 00       30. 00     Employee discount days (see instruction)     0     30. 00       31. 00     Employee discount days - IRF     0     31. 00			١	0	0			
27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 30. 00 Total (sum of lines 14-26) 31. 00 Document of the property of			0	0	0			
28. 00   Observation Bed Days   761   3,522   28. 00   29. 00   Ambul ance Tri ps   4,160   30. 00   Employee discount days (see instruction)   31. 00   Employee discount days - IRF   0   31. 00   31.			۷	٩	U			
29. 00       Ambul ance Tri ps       4, 160         30. 00       Empl oyee di scount days (see i nstruction)       0         31. 00       Empl oyee di scount days - IRF       0				761	2 522		1, 207.00	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF  30.00 31.00			4 160	701	3, 322			
31.00 Employee discount days - IRF			4, 100		0			
					0			
32.00   Educit & delition y days (300 Histiactions)   0  0  0  0    32.00				0	0			
32.01 Total ancillary labor & delivery room 0 32.01		,	١	ď	0			
outpatient days (see instructions)	JZ. 01				0			52.01
33. 00 LTCH non-covered days 0 33. 00	33. 00		0					33. 00

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0112

				To	12/31/2016	Date/Time Prep 5/23/2017 8:09	
		Full Time		Di sch	arges	372372017 0.0.	J piii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 3, 652	1, 631	8, 595	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)			824	0		2. 00
3.00	HMO IPF Subprovider			024	Ö		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		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		0 3, 652	1, 631	8, 595	
15.00	CAH visits	0.00				0	15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	0. 00 0. 00		0 0 168	0 19	0 293	16. 00 17. 00
18. 00	SUBPROVI DER	0.00		100	19	293	18.00
19. 00	SKILLED NURSING FACILITY	0.00	,		ď	U	19. 00
20. 00	NURSING FACILITY	0.00					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	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32. 00 32. 01
32. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days						33. 00
	1	1		1	'	'	

Provider CCN: 15-0112

Instructions   Description						10	12/31/2010	Date/lime Pre 5/23/2017 8:0	
MARTIEL - BMORE DATA					on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷	
SAMANIES			1.00	2. 00				6. 00	
1.00   Total salaries (save   1.00   76,194,152   -524,016   75,670,137   2,632,745,00   28,74   1.00   1									1
A. Don-physic clan anestherist Part   0   0   0   0   0   0   0   0   0	1.00	Total salaries (see	200. 00	76, 194, 152	-524, 015	75, 670, 137	2, 632, 745. 00	28. 74	1.00
4. 00 Physician Part A - Teaching	2. 00			0	0	0	0. 00	0. 00	2.00
4. 00 Physician Part A - Teaching	3 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3 00
Administrative A. D. Physicians - Part A. Teaching Physicians - Part A. Teaching Physician and Non Set 306 0 581, 306 3, 579, 00 162, 42 5, 50		В		0	0	0			
Physician Part B   For   Non-physician Part B   Non-physician Part		Admi ni strati ve		0	ļ				
Non-physic clam-Part B for hospital claused RENG cand FORC   182, 436   0   182, 436   4, 160, 00   43, 85   6, 00   6, 00   182, 436   4, 160, 00   43, 85   6, 00   6, 00   182, 436   4, 160, 00   0, 00		Physician and Non		581, 306	1	1			
1.00   Interns & residents (in an approved program)   0   0   0   0   0   0   0   0   0	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		182, 436	О	182, 436	4, 160. 00	43. 85	6. 00
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related area sal aries and interns and residents (in an approved programs) 8.00 Home office and/or related area sal aries (see all all all all all all all all all a	7. 00		21. 00	0	0	0	0.00	0. 00	7. 00
1.00	7. 01	Contracted interns and		0	0	0	0.00	0. 00	7. 01
9.00   SRÊ   44.00   0   0   0   0   0   0   0   0   0	8. 00	Home office and/or related		0	0	0	0. 00	0. 00	8.00
Instructions   OTHER WAGES & RELATED COSTS		SNF	44. 00	0	0	0			
11. 00   Contract labor: Direct Patient   12.043.058   0   12.043.058   246.874.00   48.78   11.00   Care   Carter labor: Top level   1.714,187   0   1.714,187   33,571.00   51.06   12.00	10. 00	instructions)		4, 601, 597	896, 291	5, 497, 888	231, 719. 00	23. 73	10.00
Care   Contract Labor: Top Level   1,714,187   0   1,714,187   33,571.00   51.06   12.00	11. 00			12, 043, 058	0	12, 043, 058	246, 874. 00	48. 78	11.00
management and other management and administrative services	12. 00					1, 714, 187	33, 571, 00	51. 06	12. 00
13. 00   Contract labor: Physician-Part   3,098,867   0   3,098,867   28,086.00   110.33   13.00     14. 00   Home office and/or related orgalization salaries and wage-related costs     14. 01   Home office salaries and wage-related   5,354,278   0   5,354,278   51,515.00   103.94   14.00     14. 02   Home office salaries   0   0   0   0   0   0   0     15. 00   Home office salaries   0   0   0   0   0   0   0     15. 00   Home office and Contract   0   0   0   0   0   0   0     16. 00   Physician Part A - Teaching   0   0   0   0   0   0     17. 00   Wage-related costs (core) (see instructions)   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0   0   0     19. 00   Excluded areas   0   0   0     1		management and other management and administrative		, ,,					
14.00   Home office and/or related organization sall aries and wage-related costs   0   0   0   0   0   0   0   0   0	13. 00	Contract Labor: Physician-Part		3, 098, 867	0	3, 098, 867	28, 086. 00	110. 33	13. 00
14. 01   Home office salaries   0   0   0   0   0   0   0   0   0	14. 00	Home office and/or related orgainzation salaries and		5, 354, 278	О	5, 354, 278	51, 515. 00	103. 94	14. 00
15.00   Home office: Physician Part A		Home office salaries		0	0	0			
16.00   Home office and Contract   Physicians Part A - Teaching   MAGE-RELATED COSTS     17.00   Wage-related costs (core) (see instructions)   18.00   Wage-related costs (other)   0   0   0   0   0   0   18.00     19.00   Excluded areas   1,902,270   0   1,902,270   19.00   20.00   0   0   0   0     21.00   Non-physician anesthetist Part   0   0   0   0   0   0   0     22.00   Physician Part A - Teaching   0   0   0   0   0   0     23.00   Physician Part B   264,244   0   264,244   23.00     24.00   Wage-related costs (RHC/FQHC)   0   0   0   0   0     25.00   Interns & residents (in an approved program)   25.51   Related orgal nzative   wage-related   0   0   0   0   0     25.52   Home office & Contract   Physician Part A - Teaching   0   0   0   0     25.53   Home office & Contract   Physician Part A - Teaching   0   0   0   0     26.00   Employee Benefits Department   4.00   1,256,518   -1,143,511   113,007   3,913.00   28.88   26.00     26.00   Employee Benefits Department   4.00   1,256,518   -1,143,511   113,007   3,913.00   28.88   26.00		Home office: Physician Part A		0	0	0			
17.00   Wage-related costs (core) (see instructions)   17.00   18.00   Wage-related costs (other)   0   0   0   0   0   18.00   19.0	16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
18.00   Wage-related costs (other)   (see instructions)   18.00   (see instructions)   19.00   Excluded areas   1,902,270   0   1,902,270   19.00   20.00   Non-physician anesthetist Part   0   0   0   0   0   0   0   0   0	17 00			24 193 427	0	24 193 427			] ] 17 00
19.00   Excluded areas   1,902,270   0   1,902,270   20.00   Non-physician anesthetist Part   20.00   0   0   0   0   0   0   0   0   0		instructions) Wage-related costs (other)				, , , , , ,			18. 00
21.00   Non-physician anesthetist Part				1, 902, 270	0	1, 902, 270			19. 00
B	20. 00	Non-physician anesthetist Part A		0	0	0			20.00
Administrative Physician Part A - Teaching 22. 01 Physician Part B Physician Part A Physician Part B Physician Part P Physici	21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
23. 00	22. 00			0	0	0			22. 00
24. 00       Wage-rel ated costs (RHC/FQHC)       0       0       0       0       24. 00         25. 00       Interns & residents (in an approved program)       0       0       0       0       0       25. 00         25. 50       Home office wage-rel ated       0       0       0       0       0       25. 50         25. 51       Rel ated orgainzation wage-rel ated       0       0       0       0       0       25. 51         25. 52       Home office: Physician Part A - Administrative - wage-rel ated       0       0       0       0       0       25. 52         4       Home office & Contract Physicians Part A - Teaching - wage-rel ated       0       0       0       0       0       25. 53         5       Employee Benefits Department       4. 00       1, 256, 518       -1, 143, 511       113, 007       3, 913. 00       28. 88       26. 00				0	0	0			22. 01
25. 00				264, 244 0	0	264, 244			
25. 50 Home office wage-related		Interns & residents (in an		0	Ö	Ö			25. 00
wage-related   Home office: Physician Part A		Home office wage-related		0	0	0			25. 50
- Administrative - wage-related		wage-rel ated		0					
25. 53 Home office & Contract	25. 52	- Administrative -		0	0	0			25. 52
OVERHEAD COSTS - DIRECT SALARIES           26.00 Employee Benefits Department         4.00         1,256,518         -1,143,511         113,007         3,913.00         28.88         26.00	25. 53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25. 53
	27. 22	OVERHEAD COSTS - DIRECT SALARIE		1 05/ 510	4 4 4 0 5 5 5	440.00=	2 042 22	20.22	1 2/ 22

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | Part II | P Provider CCN: 15-0112

					''	0 12/31/2010	5/23/2017 8:0	
		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 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		4, 982, 403	0	4, 982, 403	61, 648. 00	80. 82	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	2, 214, 717	1				
31. 00	Laundry & Linen Service	8. 00	53, 255	135	53, 390	i i		
32. 00	Housekeepi ng	9. 00	1, 644, 657	13, 566	1, 658, 223	117, 830. 00	14. 07	
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	1, 859, 712	-1, 277, 376	582, 336	35, 657. 00	16. 33	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, 293, 147	1, 293, 147	81, 862. 00	15. 80	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	3, 399, 337	24, 848	3, 424, 185	76, 201. 00	44. 94	38. 00
39. 00	Central Services and Supply	14. 00	430	-137	293	25.00	11. 72	39. 00
40.00	Pharmacy	15. 00	3, 513, 299	-161, 032	3, 352, 267	74, 522. 00	44. 98	40.00
41.00	Medical Records & Medical	16. 00	1, 489, 044	-679, 388	809, 656	32, 620. 00	24. 82	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	509, 370	8, 169	517, 539	15, 071. 00	34. 34	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

							5/23/2017 8: 0	5 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		80, 412, 813	-524, 015	79, 888, 798	2, 686, 654. 00	29. 74	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 601, 597	896, 291	5, 497, 888	231, 719. 00	23. 73	2.00
	instructions)							
3.00	Subtotal salaries (line 1		75, 811, 216	-1, 420, 306	74, 390, 910	2, 454, 935. 00	30. 30	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		22, 210, 390	0	22, 210, 390	360, 046. 00	61. 69	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 193, 427	0	24, 193, 427	0.00	32. 52	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		122, 215, 033	-1, 420, 306	120, 794, 727	2, 814, 981. 00	42. 91	6. 00
7.00	Total overhead cost (see		32, 682, 238	-1, 293, 044	31, 389, 194	998, 819. 00	31. 43	7. 00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	From 01/01/2016	Worksheet S-3 Part IV Date/Time Prepared

	To 12/31/2016	Date/Time Prep 5/23/2017 8:09	
		Amount	<b>.</b>
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 354, 138	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)	1, 542, 988	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13, 473, 087	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)	0	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	528, 274	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59, 799	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 155, 013	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	280, 985	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	5, 490, 887	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment I nsurance	39, 893	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	59, 148	
23. 00	Tuition Reimbursement	375, 729	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	26, 359, 941	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	eu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0112	From 01/01/2016	Worksheet S-3 Part V Date/Time Prepared: 5/23/2017 8:05 pm

		Го 12/31/2016	Date/Time Pre 5/23/2017 8:0	
	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	12, 043, 058		1. 00
2. 00	Hospi tal	12, 043, 058	26, 359, 941	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10. 00
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
	Hospital-Based-CMHC 10	0	0	
	Renal Dialysis	0	0	17. 00
18. 00	Other	0	0	18. 00

Hool +h	Financial Systems	COLUMBUS REGIONAL	HOCDI TAI		In Lie	u of Form CMS-2	DEE2 10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	COLUMBOS KEGI ONAL	Provi der Co	N. 1E 0112	Peri od:	Worksheet S-1	
позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider C	JN. 13-0112	From 01/01/2016	WOLKSHEEL 3-10	J
					To 12/31/2016	Date/Time Pre	pared:
						5/23/2017 8: 0	5 pm
						1. 00	
1 00	Uncompensated and indigent care cost compu			202	- 0)	0.275205	1 00
1. 00	Cost to charge ratio (Worksheet C, Part I Medicaid (see instructions for each line)	Tine 202 column 3 d	ivided by it	ne 202 coi umi	1 8)	0. 375395	1. 00
2.00	Net revenue from Medicaid					15, 191, 969	2. 00
3.00	Did you receive DSH or supplemental paymen	nts from Medicaid?				13, 191, 909 Y	3. 00
4. 00	If line 3 is "yes", does line 2 include al		al payments	from Medicai	17	N N	4. 00
5. 00	If line 4 is "no", then enter DSH or suppl			om mour our		3, 575, 554	5. 00
6.00	Medicaid charges	1.13				85, 323, 933	6. 00
7.00	Medicaid cost (line 1 times line 6)					32, 030, 178	7. 00
8.00	Difference between net revenue and costs f	or Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	13, 262, 655	8. 00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP)	(see instructions	for each lin	e)			
9. 00	Net revenue from stand-alone CHIP					0	9. 00
10. 00	Stand-alone CHIP charges					0	10. 00
11. 00	Stand-alone CHIP cost (line 1 times line 1					0	11.00
12. 00	Difference between net revenue and costs f	or stand-alone CHIP	(line 11 mi	nus line 9;	f < zero then	0	12. 00
	enter zero) Other state or local government indigent c	aro program (soo in	etructions f	or each line			
13. 00	Net revenue from state or local indigent of					0	13. 00
14. 00	Charges for patients covered under state of	. 9 (			,	0	14. 00
11.00	10)	n rocar margem ca	re program (	Not Theradea	111 111103 0 01	o l	11.00
15. 00	State or local indigent care program cost	(line 1 times line	14)			0	15. 00
16.00	Difference between net revenue and costs f			program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)						
	Uncompensated care (see instructions for e	,					
	Private grants, donations, or endowment in					0	
18. 00	Government grants, appropriations or trans				( 61:	0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHI	P and State and Loc	ai indigent	care program	s (sum or lines	13, 262, 655	19.00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col . 2)	
				1.00	2. 00	3. 00	
20. 00	Charity care charges for the entire facili	ty (see instruction	s)	5, 969, 5		9, 738, 930	20. 00
21.00	Cost of patients approved for charity care	e (line 1 times line	20)	2, 240, 9	53 1, 414, 993	3, 655, 946	21.00
22. 00	Partial payment by patients approved for c			120, 8		120, 864	22. 00
23. 00	Cost of charity care (line 21 minus line 2	22)		2, 120, 0	39 1, 414, 993	3, 535, 082	23. 00
0.4.00						1. 00 N	0.4.00
24. 00	24.00 Does the amount in 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?						24. 00
25. 00				naram's Lena	th of stay limit	0	25. 00
26. 00						12, 456, 626	
27. 00	Medicare bad debts for the entire hospital					589, 417	
28. 00	Non-Medicare and non-reimbursable Medicare			s line 27)		11, 867, 209	
29. 00	Cost of non-Medicare and non-reimbursable				e 28)	4, 454, 891	
30.00	Cost of uncompensated care (line 23 column		,		- /	7, 989, 973	
	Total unreimbursed and uncompensated care		line 30)			21, 252, 628	
	•	•	•				

	Financial Systems	COLUMBUS REGIONA		ON 15 0110 1		u of Form CMS-1	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EXPENSES	Provi der Co		Period: From 01/01/2016	Worksheet A	
				1	To 12/31/2016	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/23/2017 8:0 Reclassi fi ed	o piii
	2000 200000 200000 40000			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		17, 872, 057	17, 872, 057	7 -7, 177, 600	10, 694, 457	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(	9, 541, 923	9, 541, 923	2. 00
3.00	00300 OTHER CAP REL COSTS	1 05/ 540	0	(	0	0	3.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 256, 518 11, 759, 496	30, 460, 726 37, 506, 523			27, 987, 726 45, 798, 950	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 214, 717	6, 189, 330			6, 214, 809	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	53, 255	608, 000			661, 390	1
9.00	00900 HOUSEKEEPI NG	1, 644, 657	520, 524			2, 178, 747	9. 00
10.00	01000 DI ETARY	1, 859, 712	1, 017, 476			898, 259	
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	3, 399, 337	148, 548	3, 547, 885	., ,	1, 994, 700 3, 572, 733	
14. 00	01400 CENTRAL SERVICES & SUPPLY	430	938, 145			1, 134, 317	
15. 00	01500 PHARMACY	3, 513, 299	2, 015, 134			5, 399, 952	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 489, 044	1, 801, 019	3, 290, 063	-1, 829, 584	1, 460, 479	16. 00
17. 00	01700 SOCIAL SERVICE	509, 370	1, 465			521, 915	
23. 00	02300 PARAMED ED PRGM-(SPECIFY) 02301 XRAY EDUCATION	152 401	1 947	150 550	-	493 004	
23. 01 23. 02	02302 PHARMACY RESIDENCY PROG	153, 691 168, 794	4, 867 4, 561	158, 558 173, 359		483, 904 361, 945	1
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	100,771	1, 001	170,000	100,070	301,710	20.02
30.00	03000 ADULTS & PEDIATRICS	14, 133, 951	1, 522, 679	15, 656, 630	525, 146	16, 181, 776	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 883, 182	1, 151, 266	3, 034, 448	-132, 790	2, 901, 658	1
32.00	03200 CORONARY CARE UNIT	0	0	(	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF		0			0	40.00
41. 00	04100 SUBPROVI DER – I RF	1, 373, 021	103, 121	1, 476, 142	193, 911	1, 670, 053	•
42.00	04200 SUBPROVI DER	O	0	(	0	0	
43.00	04300 NURSERY	724, 068	16, 964			732, 017	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	(	)  0	0	44.00
50. 00	05000 OPERATING ROOM	531, 596	25, 051, 220	25, 582, 816	-6, 794, 991	18, 787, 825	50.00
51. 00	05100 RECOVERY ROOM	1, 399	1, 065, 670			1, 349, 572	
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	(	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	179, 456			250, 284	1
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05402  NUCLEAR   MEDI CI NE-DI AGNOSTI C	1, 791, 455 318, 215	478, 103 1, 088, 952			2, 122, 575	
54. 01	05404 ULTRA SOUND	475, 385	1, 088, 932		·	1, 141, 052 668, 550	
54. 03	05405 MAMMOGRAPHY	722, 033	254, 115		·	1, 116, 663	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 522, 694	146, 648	1, 669, 342	322, 235	1, 991, 577	55. 00
57. 00	05700 CT SCAN	604, 322	322, 088			932, 983	
	05800 MRI   05900 CARDIAC CATHETERIZATION	287, 317	68, 885 3, 215, 104			430, 989 2, 191, 390	
	06000 LABORATORY	1, 583, 587 3, 669, 603	3, 392, 979			7, 157, 211	
60. 01	06001 LABORATORY-PATHOLOGI CAL	338, 673	173, 423			738, 337	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	528, 075	528, 075	82, 229	610, 304	62. 00
65. 00	06500 RESPI RATORY THERAPY	1, 550, 245	304, 389			1, 805, 653	
66.00	06600 PHYSI CAL THERAPY	4, 117, 949	610, 826			3, 995, 057	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	497, 773 726, 244	8, 893 301, 912			1, 427, 901 859, 711	
69. 00	06900 ELECTROCARDI OLOGY	530, 862	192, 927			614, 379	
70. 00	07000 ELECTROENCEPHALOGRAPHY	644, 497	217, 960		·	888, 230	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	5, 958, 498	5, 958, 498	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	7, 582, 734	7, 582, 734	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	17, 026, 798 549, 970			17, 026, 798 549, 970	
76.00	03020 ACUPUNCTURE		349, 970 O	549, 970		349, 970	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	167, 059	133, 291	300, 350			1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	700,000	220,000	1 127 103	0	1 120 414	89.00
90. 00	09000   CLI NI C   09001   DI ABETES CENTER	799, 082 81, 113	338, 099 99, 742	1, 137, 18 <sup>2</sup> 180, 855		1, 139, 414 223, 368	
90. 02	09002 NEUROPSYCH	265, 181	13, 592			284, 014	
90. 03	09003 WOUND CENTER	493, 692	957, 662			1, 298, 017	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	(	252, 540	252, 540	
90.05	09005 VI MCARE CLI NI C	171, 802	28, 310			200, 112	
91. 00 92. 00	09100   EMERGENCY   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART	5, 259, 741	1, 159, 967	6, 419, 708	1, 667, 922	8, 087, 630	91. 00 92. 00
/Z. UU	OTHER REIMBURSABLE COST CENTERS			1	1		, ,2.00
	09500 AMBULANCE SERVICES	2, 733, 537	325, 004			3, 124, 522	
99. 10	09910 CORF	0	0	(	0	0	99. 10

	OOLUMBUIG BEOLON	AL LIGORI TAL			C.E. OHO	2550 40
Heal th Financial Systems	COLUMBUS REGION	_	N 45 0440 I		u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 01/01/2016	Worksheet A	
				Γο 12/31/2016	Date/Time Pre	pared:
					5/23/2017 8:0	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
101.00 10100 HOME HEALTH AGENCY	0	0	(	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	(	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(	0		111. 00
113.00 11300 INTEREST EXPENSE		1, 443, 046				113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	76, 021, 598	161, 670, 115	237, 691, 713	-2, 186, 364	235, 505, 349	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0		190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	(	269, 493	269, 493	
194. 01 07951 BUI LDI NG RENTALS	0	78, 408	78, 408	3 0	78, 408	194. 01
194. 02 07952 HOSPI CE	0	70, 946	70, 946	6 0	70, 946	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	(	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	(	264, 590	264, 590	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(	1, 605, 965	1, 605, 965	194. 05
194.06 07956 CRH FOUNDATION	932	444	1, 376	5 0	1, 376	194. 06
194.07 07957 HEALTHY COMMUNITIES	171, 622	8, 069	179, 69°	-5, 222	174, 469	194. 07
194. 08 07958 CRHP	0	0	(	51, 538	51, 538	194. 08
200.00 TOTAL (SUM OF LINES 118-199)	76, 194, 152	161, 827, 982	238, 022, 134	1 0	238, 022, 134	200. 00
		·		•		•

Provi der CCN: 15-0112

| Period: | Worksheet A | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 5/23/2017 8:05 pm

			5/23/2017 8: 05	
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
OFNEDAL CERVILOR COCT OFNITERS	6.00	7. 00		
1. 00 GENERAL SERVICE COST CENTERS  1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-65, 426	10, 629, 031		1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP	-344, 185	9, 197, 738		2. 00
3. 00 00300 OTHER CAP REL COSTS	0	0, 177, 700	1	3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-629, 957	27, 357, 769	1	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-16, 307, 405	29, 491, 545		5.00
7.00   00700 OPERATION OF PLANT	-18, 916	6, 195, 893		7.00
8.00   00800   LAUNDRY & LINEN SERVICE	0	661, 390		8.00
9. 00   00900   HOUSEKEEPI NG	-170	2, 178, 577	·	9. 00
10. 00   01000   DI ETARY	-9, 614	888, 645	l .	10. 00
11. 00   01100   CAFETERI A	-1, 133, 492	861, 208	l	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-856	3, 571, 877	l	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	1, 134, 317	1	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	-55, 390 -24, 176	5, 344, 562	1	15. 00 16. 00
17. 00  01700  SOCIAL SERVICE	-24, 170	1, 436, 303 521, 915		17. 00
23. 00   02300   PARAMED ED   PRGM-(SPECIFY)	0	321, 713	I I	23. 00
23. 01   02301   XRAY EDUCATION	-20, 495	463, 409		23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	0	361, 945	!	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	'			
30. 00 03000 ADULTS & PEDIATRICS	-588, 127	15, 593, 649		30.00
31.00 03100 INTENSIVE CARE UNIT	0	2, 901, 658		31.00
32. 00   03200   CORONARY CARE UNIT	0	0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	1	33. 00
34. 00   03400   SURGI CAL INTENSI VE CARE UNIT	0	0		34. 00
40. 00   04000   SUBPROVI DER -   1 PF	0	1 (70 052		40.00
41. 00   04100   SUBPROVI DER -   1 RF	0	1, 670, 053		41. 00 42. 00
42. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY	0	732, 017		42.00
44. 00   04400   SKI LLED NURSI NG FACI LI TY	0	732,017	1	44. 00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	J		44.00
50. 00 05000 OPERATI NG ROOM	-114, 297	18, 673, 528		50.00
51. 00   05100 RECOVERY ROOM	0	1, 349, 572	·	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	52.00
53. 00 05300 ANESTHESI OLOGY	-8, 040	242, 244		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-45, 928	2, 076, 647		54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	1, 141, 052	l	54. 01
54. 02   05404   ULTRA SOUND	0	668, 550	1	54. 02
54. 03   05405   MAMMOGRAPHY	-573	1, 116, 090	l	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	-225	1, 991, 352	l	55. 00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	0	932, 983	!	57. 00 58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	-41, 337	430, 989 2, 150, 053	!	59. 00
60. 00   06000   LABORATORY	-19, 958	7, 137, 253		60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	-9, 459	7, 137, 233		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	610, 304	!	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	1, 805, 653	!	65.00
66. 00 06600 PHYSI CAL THERAPY	-142	3, 994, 915		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 427, 901		67.00
68. 00 06800 SPEECH PATHOLOGY	-751	858, 960		68. 00
69. 00   06900   ELECTROCARDI OLOGY	-22, 611	591, 768		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	888, 230	1	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 958, 498	·	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 582, 734	·	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	17, 026, 798 549, 970	·	73. 00 74. 00
76. 00   03020   ACUPUNCTURE	0	349, 970	l l	76. 00
76. 97   07697 CARDI AC REHABI LI TATI ON	-2, 684	303, 095	l l	76. 97
OUTPATIENT SERVICE COST CENTERS	2,001	000, 070		70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	o	1, 139, 414		90.00
90. 01 09001 DI ABETES CENTER	-262	223, 106	l	90. 01
90. 02 09002 NEUROPSYCH	-182, 406	101, 608		90. 02
90. 03 09003 WOUND CENTER	0	1, 298, 017	I I	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	252, 540	!	90. 04
90. 05   09005   VI MCARE   CLI NI C	-32, 132	167, 980	!	90.05
91. 00 09100 EMERGENCY	0	8, 087, 630		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	-430, 961	2, 693, 561		95. 00
99. 10   09910   CORF	-430, 961	2, 693, 561		95. 00 99. 10
101. 00 10100 HOME HEALTH AGENCY	0	0	1	101.00
September 18 Septe	١	J	ı I'	50
-				

Heal th Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0112 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

			5/23/2017 8:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	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	0		111. 00
113.00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-20, 109, 975	215, 395, 374		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
194.00 07950 WELLNESS COMMUNITY	0	269, 493		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	78, 408		194. 01
194. 02 07952 HOSPI CE	0	70, 946		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	264, 590		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	1, 605, 965		194. 05
194.06 07956 CRH FOUNDATION	0	1, 376		194. 06
194.07 07957 HEALTHY COMMUNITIES	0	174, 469		194. 07
194. 08 07958 CRHP	0	51, 538		194. 08
200.00 TOTAL (SUM OF LINES 118-199)	-20, 109, 975	217, 912, 159		200. 00

Peri od: Worksheet Non-CMS W From 01/01/2016 Date/Time Prepared: Provider CCN: 15-0112

		Ţ	o 12/31/2016 Date/Time Pr 5/23/2017 8:	
	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
			Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS		2.00	
1. 00 2. 00	CAP REL COSTS MADE FOULD	00100 00200		1.00
3.00	CAP REL COSTS-MVBLE EQUIP OTHER CAP REL COSTS	00300		3.00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	00400		4. 00
5.00	ADMINISTRATIVE & GENERAL	00500		5. 00
7. 00 8. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	00700 00800		7. 00 8. 00
9. 00	HOUSEKEEPI NG	00900		9. 00
10.00	DI ETARY	01000		10.00
11. 00 13. 00	CAFETERIA	01100 01300		11.00
14. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	01300		13. 00
15. 00	PHARMACY	01500		15. 00
	MEDICAL RECORDS & LIBRARY	01600		16. 00
17. 00 23. 00	SOCIAL SERVICE PARAMED ED PRGM-(SPECIFY)	01700 02300		17. 00 23. 00
	XRAY EDUCATION	02300		23. 00
23. 02	PHARMACY RESI DENCY PROG	02302		23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	02000	I	30.00
30. 00 31. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	03000 03100		30.00
32. 00	CORONARY CARE UNIT	03200		32. 00
33. 00	BURN INTENSIVE CARE UNIT	03300		33. 00
34. 00 40. 00	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	03400		34.00
41. 00	SUBPROVIDER - I PF	04000 04100		40.00
42. 00	SUBPROVI DER	04200		42. 00
43.00		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 53. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	05200 05300		52. 00 53. 00
54. 00	RADI OLOGY-DI AGNOSTI C	05400		54.00
54. 01	NUCLEAR MEDICINE-DIAGNOSTIC	05402		54. 01
54. 02	ULTRA SOUND	05404		54. 02
54. 03 55. 00	MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	05405 05500		54. 03 55. 00
57. 00	CT SCAN	05700		57. 00
58. 00	MRI	05800		58. 00
59. 00 60. 00	CARDI AC CATHETERI ZATI ON LABORATORY	05900 06000		59. 00 60. 00
60. 01	LABORATORY-PATHOLOGI CAL	06001		60.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
65. 00	RESPI RATORY THERAPY	06500		65. 00
66. 00 67. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	06600 06700		66. 00 67. 00
	SPEECH PATHOLOGY	06800		68. 00
69. 00	ELECTROCARDI OLOGY	06900		69. 00
	ELECTROENCEPHALOGRAPHY	07000		70.00
71. 00 72. 00	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	07100 07200		71. 00 72. 00
73. 00	DRUGS CHARGED TO PATIENTS	07300		73. 00
74. 00	RENAL DI ALYSI S	07400		74. 00
76. 00 76. 97	ACUPUNCTURE  CARDI AC REHABI LI TATI ON	03020 07697	ACUPUNCTURE CARDI AC REHABI LI TATI ON	76. 00 76. 97
, 0. 71	OUTPATIENT SERVICE COST CENTERS	07077	OTRUTAG REHADI EL TATTON	J , U. 7/
88. 00	RURAL HEALTH CLINIC	08800		88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90. 00 90. 01	CLINIC DIABETES CENTER	09000 09001		90. 00
90. 02	NEUROPSYCH	09002		90. 02
90. 03	WOUND CENTER	09003		90. 03
90. 04 90. 05	HYPERBARI C OXYGEN THERAPY VI MCARE CLI NI C	09004 09005		90. 04
	EMERGENCY	09005		91.00
	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
05.00	OTHER REIMBURSABLE COST CENTERS	00500		05.00
95. 00 99. 10	AMBULANCE SERVICES CORF	09500 09910		95. 00 99. 10
10		1 07710	I	11 // 10

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
		To 12/31/2016 Date/Time Prepared

			o 12/31/2016 Date/Time 5/23/2017	
Cost Center Description	<b>-</b>	CMS Code	Standard Label For	
· · · · · · · · · · · · · · · · · · ·			Non-Standard Codes	
		1.00	2.00	
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 ISLET ACQUISITION		11100		111. 00
113.00 INTEREST EXPENSE		11300		113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)				118. 00
NONREI MBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN		19000		190. 00
194.00 WELLNESS COMMUNITY		07950		194. 00
194.01 BUILDING RENTALS		07951		194. 01
194. 02 HOSPI CE		07952		194. 02
194. 03 OUTREACH CLINICS		07953		194. 03
194.04 SPEECH - HEARING AIDS		07954		194. 04
194. 05 NONALLOWABLE MARKETING		07955		194. 05
194.06 CRH FOUNDATION		07956		194. 06
194. 07 HEALTHY COMMUNITIES		07957		194. 07
194. 08 CRHP		07958		194. 08
200.00 TOTAL (SUM OF LINES 118-199)				200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112 

						10 12	2/31/2016   Date/lime 5/23/2017	
STELLASS DEPUTED   1.00   0   0   0   0   0   0   0   0   0			Increases					
B								
1.00				4.00	5. 00	<u> </u>		
APP   CAP   CAP   CAP   CAP   CAP   CAP   CAP   CAP   CAP	1 00			O	953 811			1 00
C. RECIASS INSIGNATE   1.00   0   1.760   0   1.760   0   1.760   0   1.760   0   1.760   0   1.760   0   1.760   0   1.760   0   0   0   1.760   0   0   0   0   0   0   0   0   0			•		•			1
1.00		0		0	1, 443, 046			
2.00   CAP REL COSTS-BLOG & FIXT				_1				
ABBUANCE SERVICES		1	1					1
A. 00   ABORATORY		1	•	٩				1
O			•	o				1
1.00		0		0				
Color								
E - RECLASS INTEREBRATIC THERRY   90,04   64,083   149,227   100   149,027   100   149,027   100   149,027   100   149,027   100   149,027   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   100   100   149,027   149,027   1	1. 00	ADMI NI STRATI VE & GENERAL		+				1.00
		F - RECLASS HYPERBARIC THERAP	Y FXPENSE	099, 002	1, 150, 190			
F - RECLASS CAPTERIA & N	1.00			64, 083	149, 221			1. 00
1.00		0		64, 083	149, 221			
1.00				4 000 070	704 550			
C - RECLASS MELLINESS   194_00   171_955   109_342   1.00   1.	1.00	CAFETERIA						1.00
1.00		G - RECLASS WELLNESS		1, 202, 273	701, 555			
New York	1. 00		194. 00	171, 955	109, 342			1.00
1.00 ADMINISTRATIVE & GENERAL 5 00 0 508,000 1,		0						
2.00   ADULTS & PEDIATRICS   30.00   0   229, 383   2.00   3.00   1.00   3.00	<b>.</b> = .			1	Ec 1			
3.00   NTENSIVE CARE UNIT   31.00   0   27, 200   4.00   5.00   4.50   5.00   6.00		1		- 1				1
4.00   SUSPROVIDER   1R		1		-				1
6.00 ARESTRIESIOLOGY - 00 RADIOLOGY - THERAPEUTIC			1					1
7. 00         RADI OLGSY-THERAPEUTIC         55. 00         0         67. 500         9. 00         1.80 CATHETER ZATION         59. 00         0         84. 145         8. 80           9. 00         LABORATORY-PATHOLOGICAL         60. 01         0         225. 000         9. 00           11. 00         PINSICAL THERAPY         66. 00         0         0         14. 00         11. 00           12. 00         ELECTROCARDIOLOGY         69. 00         0         9. 600         13. 00           14. 00         CARDI AC REHABILITATION         76. 97         0         5, 429         14. 00           16. 00         AMBULANCE SERVICES         95. 00         0         17, 500         16. 00           16. 00         MINDICANTE SERVICES         95. 00         0         17, 500         16. 00           18. 00         HYPERBARIC OXYGEN THERAPY         90. 04         0         594         17. 00           19. 00         POLITIES & PEDI ATRICS         30. 00         5. 5826         25, 826         18. 00           19. 00         POLITIES & PEDI ATRICS         30. 00         3. 832, 598         19. 00           10. 00         PINSICAL THERAPY         67. 00         25, 826         25, 826         25, 826		1		0	250, 350			1
0.00   CARDI AC CATHETERI ZATION   59,00   0   84,145   9,00				0				4
0.00   LABORATORY-PATHOLOGICAL,   60.01   0   225.000   11.000		1	•	0				1
11.00		1	1	0	· ·			1
12.00		1	•	Ö				1
14. 00   CARDIAC REHABILITATION   76. 97   0   5. 429   1.4. 00   16. 00   16. 00   MABULANCE SERVICES   95. 00   0   17. 500   16. 00   17. 500   16. 00   17. 500   17. 500   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00   17. 500   18. 00				o				
15.00		1	•	0	· ·			•
16.00   AMBULANCE SERVICES   95.00   0   17.500   17.00   17				0				•
17. 00			•	0				•
18. 00   HYPERBARIC OXYGEN THERAPY   90. 04   0   596   30. 06   0   581, 306   19. 00   0   3. 832, 598   19. 00   0   3. 832, 598   19. 00   19		1	•	0	· ·			•
1 - RECLASS REHAB SERVICES     1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS REHAB SERVICES   1 - RECLASS MARKETING EXPENSE   1 - RECLASS MAINTENANCE EXPENSE   1 - RECLASS MAI		1	•	ō	· ·			1
- RECLASS REHAB SERVICES	19. 00	ADULTS & PEDIATRICS	3000	0				19. 00
1.00		0		0	3, 832, 598			
2. 00   PHYSI CAL THERAPY   66. 00   55, 156   49, 900   3. 00   SPEECH PATHOLOGY   68. 00   14, 381   79, 634   3. 00   3. 00   3. 00   3. 00   5.	1 00		67.00	25 826	25 866			1 00
3.00   SPEECH PATHOLOGY		1						
5. 00         ELECTROENCEPHALOGRAPHY         70. 00         6, 169         3, 882         5. 00           6. 00         SOCI AL SERVI CE         17. 00         4, 626         2, 911         6. 00           7. 00         ADUIT'S & PEDIA TRICS         30. 00         41, 638         26, 202         7. 00           8. 00         NEUROPSYCH         90. 02         6, 169         3, 882         8. 00           9. 00         WOUND CENTER         90. 03         10, 494         86, 174         9. 00           11. 00         HYPERBARI C OXYGEN THERAPY         90. 04         1, 166         37, 236         10. 00           11. 00         DI ABETES CENTER         90. 01         28, 814         13, 586         11. 00           0         J - RECLASS PHARMACY RES PROGRAM         322, 911         335, 096         1         1. 00           1. 00         PHARMACY RESI DENCY PROG         23. 02         183, 230         4, 531         1         1. 00           0         D         194, 05         0         125, 000         1         1. 00         1. 00           0         N - RECLASS MARKETI NG EXPENSE         1         1. 00         1. 00         1. 00         1. 00         1. 00         1. 00         1. 00<								1
6. 00 SCI AL SERVICE 17. 00 4,626 2,911 6. 00 R. 00 ADULTS & PEDIATRICS 30. 00 41,638 26,202 7. 00 R. 00 NEUROPSYCH 90. 02 6,169 3,882 8. 00 P. 00 WOUND CENTER 90. 03 10,494 86,174 9. 00 10. 00 HYPERBARI C OXYGEN THERAPY 90. 04 1,166 37,236 10. 00 DI ABETES CENTER 90. 01 28,814 13,586 11. 00 DI ABETES CENTER 90. 01 322,911 335,096  J - RECLASS PHARMACY RES PROGRAM  1. 00 PHARWACY RESI DENCY PROG 23. 02 183,230 4,531 1. 00 DO 183,230 4,531 1. 00 DO 125,000 M - RECLASS MARKETI NG 194,05 0 125,000 125,000 M - RECLASS DEPRECIATION EXPENSE  1. 00 R - RECLASS MAINTENANCE EXPENSE  1. 00 R - RECLASS MAINTENANCE EXPENSE  1. 00 ESPIRATORY THERAPY 66. 00 0 9,052,688 0 1. 00 DO 2. 00 ELECTROCARDI OLOGY 69. 00 0 3,801 2. 00 S. 00 OPERATI NG ROOM 50. 00 0 283,135 5. 00 G. 00 OPERATI NG ROOM 50. 00 0 283,135 5. 00 G. 00 DEPARTING ROOM 50. 00 0 258,415 5. 00 G. 00 LABORATORY - PATHOLOGI CAL 60. 00 1 10, 917 8. 00 WHOLE BLOOD & PACKED RED								1
7. 00     ADULTS & PEDIATRICS     30. 00     41,638     26,202       8. 00     NEUROPSYCH     90. 02     6,169     3,882     8. 00       90. 00     WOUND CENTER     90. 03     10,494     86,174     9. 00       10. 00     HYPERBARI C OXYGEN THERAPY     90. 04     1,166     37,236     10. 00       11. 00     DI ABETES CENTER     90. 01     28,814     13,586     10. 00       1. 00     DI ABETES CENTER     90. 01     28,814     13,586     10. 00       1. 00     DI ABETES CENTER     90. 01     28,814     13,586     11. 00       2. RECLASS PHARMACY RES PROGRAM     PHARMACY RESIDENCY PROG     23. 02     183,230     4,531     1. 00       1. 00     NONALLOWABLE MARKETING EXPENSE       1. 00     0     125,000     1. 00       M - RECLASS DEPRECIATION EXPENSE     PECLASS MAINTENANCE EXPENSE       1. 00     0     9,052,688     1. 00       0     0     9,052,688     1. 00       1. 00     RESPIRATORY THERAPY     65. 00     0     3,801     2. 00       2. 00     ELECTROCARDI OLOGY     69. 00     0     3,801     2. 00       3. 00     CARDI AC CATHETERI ZATI ON     59. 00     0     283, 13		l l						1
8. 00   NEUROPSYCH   90. 02   6, 169   3, 882   8. 00   9. 00   WOUND CENTER   90. 03   10, 494   86, 174   9. 00   10		l l						
9.00   MOUND CENTER   90.03   10,494   86,174   10.00   HYPERBARI C OXYGEN THERAPY   90.04   1,166   37,236   10.00   10.00   1.		l l						4
10.00   HYPERBARI C OXYGEN THERAPY   90.04   1, 166   37, 236   10.00   10.00   128, 814   13,586   10.00		1						
1.00   PHARMACY RES   PROGRAM	10.00	1		1, 166	37, 236			
1.00   PHARMACY RESIDENCY PROG   23.02   183,230   4,531	11. 00	DI ABETES CENTER	<u> </u>					11. 00
1.00   PHARMACY RESIDENCY PROG   23.02   183,230   4,531		U DECLASS DHADMACY DES DOCC	DΛM	322, 911	335, 096			
Test	1, 00			183. 230	4, 531			1.00
L - RECLASS MARKETING EXPENSE   194.05	50	0						
Test								
M - RECLASS DEPRECIATION EXPENSE   1.00	1.00	NONALLOWABLE MARKETING	1 <u>94.</u> 05					1. 00
1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 9, 052, 688 0 1. 00 9, 052, 688 N - RECLASS MAI NTENANCE EXPENSE  1. 00 RESPI RATORY THERAPY 65. 00 0 16, 600 2. 00 ELECTROCARDI OLOGY 69. 00 0 3, 801 2. 00 3. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 289, 619 3. 00 OPERATI NG ROOM 50. 00 0 283, 135 5. 00 OPERATI NG ROOM 50. 00 0 283, 135 5. 00 6. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 258, 415 6. 00 7. 00 LABORATORY 60. 00 0 151, 570 7. 00 8. 00 LABORATORY-PATHOLOGI CAL 60. 01 0 10, 917 8. 00 WHOLE BLOOD & PACKED RED 62. 00 0 14, 176		M DECLASS DEDDECLATION EVDE	NCE	0	125, 000			
O   O   P, 052, 688   N - RECLASS MAINTENANCE EXPENSE	1, 00			O	9, 052, 688			1 00
N - RECLASS MAINTENANCE EXPENSE           1. 00         RESPI RATORY THERAPY         65. 00         0         16, 600         1. 00           2. 00         ELECTROCARDI OLOGY         69. 00         0         3, 801         2. 00           3. 00         CARDI AC CATHETERI ZATI ON         59. 00         0         289, 619         3. 00           5. 00         OPERATI NG ROOM         50. 00         0         283, 135         5. 00           6. 00         RADI OLOGY-THERAPEUTI C         55. 00         0         258, 415         6. 00           7. 00         LABORATORY         60. 00         0         151, 570         7. 00           8. 00         LABORATORY-PATHOLOGI CAL         60. 01         0         10, 917         8. 00           9. 00         WHOLE BLOOD & PACKED RED         62. 00         0         14, 176         9. 00	50	0						1.00
2. 00       ELECTROCARDI OLOGY       69. 00       0       3,801       2.00         3. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       289,619       3. 00         5. 00       OPERATI NG ROOM       50. 00       0       283,135       5. 00         6. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       258,415       6.00         7. 00       LABORATORY       60. 00       0       151,570       7. 00         8. 00       LABORATORY-PATHOLOGI CAL       60. 01       0       10,917       8. 00         9. 00       WHOLE BLOOD & PACKED RED       62. 00       0       14,176       9. 00								
3. 00     CARDI AC CATHETERI ZATI ON     59. 00     0     289, 619     3. 00       5. 00     OPERATI NG ROOM     50. 00     0     283, 135     5. 00       6. 00     RADI OLOGY-THERAPEUTI C     55. 00     0     258, 415     6. 00       7. 00     LABORATORY     60. 00     0     151, 570     7. 00       8. 00     LABORATORY-PATHOLOGI CAL     60. 01     0     10, 917     8. 00       9. 00     WHOLE BLOOD & PACKED RED     62. 00     0     14, 176     9. 00		1						1
5. 00     OPERATING ROOM     50. 00     0     283, 135     5. 00       6. 00     RADI OLOGY-THERAPEUTI C     55. 00     0     258, 415     6. 00       7. 00     LABORATORY     60. 00     0     151, 570     7. 00       8. 00     LABORATORY-PATHOLOGI CAL     60. 01     0     10, 917     8. 00       9. 00     WHOLE BLOOD & PACKED RED     62. 00     0     14, 176     9. 00		1						1
6. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 258, 415 6. 00 7. 00 LABORATORY 60. 00 0 151, 570 7. 00 8. 00 LABORATORY-PATHOLOGI CAL 60. 01 0 10, 917 8. 00 9. 00 WHOLE BLOOD & PACKED RED 62. 00 0 14, 176 9. 00		1	1	-				
7. 00     LABORATORY     60. 00     0     151, 570     7. 00       8. 00     LABORATORY-PATHOLOGI CAL     60. 01     0     10, 917     8. 00       9. 00     WHOLE BLOOD & PACKED RED     62. 00     0     14, 176     9. 00		1		0				1
8. 00 LABORATORY-PATHOLOGICAL 60. 01 0 10, 917 8. 00 9. 00 WHOLE BLOOD & PACKED RED 62. 00 0 14, 176 9. 00				ő				
	8.00	1		O	10, 917			
IRFOOD CETF	9. 00		62.00	0	14, 176			9. 00
		IDLUUU VELL		<u> </u>				

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2016 | To 12/31/2016 | Worksheet A-6 | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 8:05 pm Provider CCN: 15-0112

					5/23/2017	8: 05 pm
		Increases				
-	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
10. 00	RADI OLOGY-DI AGNOSTI C	54.00	4.00	204, 233		10, 00
11. 00	MAMMOGRAPHY	54. 03	Ö	137, 244		11. 00
12.00	ULTRA SOUND	54. 02	0	90, 581		12. 00
13.00	CT SCAN	57.00	0	192, 566		13. 00
14.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	191, 077		14. 00
15. 00	MRI	58.00	0	140, 927		15. 00
16. 00 17. 00	PHARMACY EMERGENCY	15. 00 91. 00	0	37, 082 84, 523		16. 00 17. 00
18. 00	ADMINISTRATIVE & GENERAL	5.00	0	4, 247		18. 00
19. 00	ADULTS & PEDIATRICS	30.00	o	93, 454		19. 00
20.00	INTENSIVE CARE UNIT	31.00	0	12, 743		20. 00
21. 00	SUBPROVI DER - I RF	41.00	•	1 <u>2, 7</u> 43		21. 00
	0 PEOLAGO OPUD EVPENCES		0	2, 229, 653		
1. 00	P - RECLASS CRHP EXPENSES CRHP	194. 08	51, 538	0		1. 00
1.00	TOTALS	194.08	51, 538	<u>o</u>		1.00
	Q - RECLASS XRAY EDUCATION EX	PENSES	0.,000	<u> </u>		
1.00	XRAY EDUCATION	23. 01	50	0		1. 00
2.00	XRAY EDUCATION	23. 01	321, 468	417		2. 00
3.00	XRAY EDUCATION	23. 01	•			3. 00
	D DECLASS ADMINITIAL THY COM	MUNITIFO	321, 518	3, 225		
1. 00	R - RECLASS ADMIN HEALTHY COM ADMINISTRATIVE & GENERAL	5. 00	45, 649	0		1. 00
1.00	0		4 <u>5, 649</u>	<u>0</u>		1.00
	S - RECLASS NON ALLOW ADVERTI	SING COSTS	10, 017	<u> </u>		
1.00	NONALLOWABLE MARKETING	194. 05	0	1, 480, 965		1. 00
	0		0	1, 480, 965		
	T - RECL EQUIP RENTAL TO CHAR					
1.00	MEDICAL CURRILES CHARGED TO	0.00	0	0		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	205, 931		2. 00
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	74, 426		3. 00
	PATI ENT		1	,		
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	35, 385		4. 00
	PATI ENT	74 00		40.405		
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	40, 125		5. 00
	PATI ENT		<del> </del>	355, 867		
	U - RECLASS CHARGEABLE SUPPLY	COST		2227 223		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	210, 301		1. 00
	PATI ENT		_			
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	89, 182		2. 00
3. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	4, 626		3. 00
0.00	PATI ENT	71.00	Ĭ	1, 020		0.00
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 471		4. 00
	PATI ENT					
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 941, 860		5. 00
6 00	PATIENT	72.00	o	5 060 110		4 00
6. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	۷	5, 862, 119		6. 00
7. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	2, 221		7. 00
	PATI ENT					
8. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	58, 486		8. 00
0.00	PATIENT	71 00		4EO 247		0.00
9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	458, 247		9. 00
11. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	o	5, 018		11. 00
	PATI ENT		1	-,		
12. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	4, 238		12. 00
40	PATI ENT		_	100		
13. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	188, 057		13. 00
14. 00	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	o	61, 535		14. 00
14.00	PATIENT	71.00	۷	01, 000		14.00
15. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	1, 265, 688		15. 00
2. 00	PATI ENT		٦	,, 555		10.00
16. 00	IMPL. DEV. CHARGED TO	72. 00	0	1, 720, 615		16. 00
17.00	PATI ENTS	74 00		20 (46		47.00
17. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	38, 649		17. 00
	PATIENT MEDICAL SUPPLIES CHARGED TO	71. 00	o	11, 065		18. 00
18 00		/ 1. 00	Ч	11,003		1 10.00
18. 00	PATI ENT					

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2016 | To 12/31/2016 | Worksheet A-6 | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 8:05 pm Provider CCN: 15-0112

					5/23/2017 8: 05	5 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
20. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	164, 443		20. 00
	PATI ENT	74 00				
21. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	41, 164		21. 00
22. 00	PATIENT	71 00		24 407		22.00
22.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	34, 486		22. 00
23. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	20, 894		23. 00
20.00	PATI ENT	71.00	Ĭ	20, 07 1		20.00
	0			13, 449, 955		
	V - RECL PTO COST FOR STD ELI	MINATION PD		<u> </u>		
1.00		0.00	0	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 947		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 279		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 161		4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	137		5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	35, 488		6. 00
7. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 672		7. 00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	468		8. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 525		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 418		10.00
11. 00 12. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	9, 810		11. 00 12. 00
	EMPLOYEE BENEFITS DEPARTMENT		-	40, 274		
13. 00 14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	24, 263 11, 941		13. 00 14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	130, 895		15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19, 453		16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 934		17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	9, 786		18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	Ö	2, 323		19. 00
20. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	10, 319		20. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	8, 321		21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 485		22. 00
23.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 199		23.00
24.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	273		24.00
25.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 510		25.00
26.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 027		26.00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	36, 499		27.00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 764		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	18, 182		29. 00
30. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 648		30. 00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 800		31. 00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 140		32. 00
33.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52, 837		33. 00
34. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11, 226		34. 00
35. 00 36. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	2, 973 3, 038		35. 00 36. 00
30.00	DEPARTMENT		— — — }	<u>3,036</u> 524,015		30.00
	W - RECLASS DEPT 9902 EMP BEN	IFFI TS	Ο <sub>Ι</sub>	324, 013		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	464, 120		1. 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	195, 879		2. 00
3. 00	OPERATING ROOM	50.00	Ö	2, 027, 321		3. 00
4. 00	RECOVERY ROOM	51.00	o	284, 724	1	4. 00
5. 00	ANESTHESI OLOGY	53. 00	0	25, 828		5. 00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	279, 654		6.00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7, 435	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5. 00	252, 806	0		8.00
9.00	OPERATION OF PLANT	7. 00	43, 087	0		9. 00
10.00	LAUNDRY & LINEN SERVICE	8. 00	603	0		10.00
11. 00	HOUSEKEEPI NG	9. 00	21, 091	0		11. 00
12. 00	DI ETARY	10.00	9, 315	0		12. 00
13.00	CAFETERI A	11.00	20, 684	0		13.00
14.00	NURSI NG ADMI NI STRATI ON	13.00	65, 122	0		14. 00
15. 00	PHARMACY MEDICAL DECODDS & LIBRADY	15.00	46, 461	0		15. 00
16. 00 17. 00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16. 00 17. 00	32, 155 10, 704	0	-	16. 00 17. 00
17.00	XRAY EDUCATION	23. 01	603	0		17. 00
19. 00	PHARMACY RESIDENCY PROG	23. 01	829	0		19. 00
20. 00	ADULTS & PEDIATRICS	30. 00	100, 290	0		20. 00
21. 00	INTENSIVE CARE UNIT	31. 00	10, 328	0		21. 00
22. 00	SUBPROVI DER - I RF	41. 00	15, 818	0		22. 00
23. 00	NURSERY	43. 00	3, 242	0		23. 00
24. 00	OPERATING ROOM	50.00	3, 505	0		24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54.00	37, 476	0		25. 00
26. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	1, 055	0		26.00
		'	<u>'</u>	'	<u>'</u>	

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					5/23/2017 8:05 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4.00	5. 00	
27. 00	ULTRA SOUND	54. 02	2, 299	0	27. 00
28. 00	MAMMOGRAPHY	54. 03	11, 568	0	28.00
29. 00	RADI OLOGY-THERAPEUTI C	55. 00	3, 505	0	29. 00
30.00	CT SCAN	57. 00	2, 337	0	30.00
31. 00	MRI	58. 00	905	0	31.00
32.00	CARDIAC CATHETERIZATION	59. 00	15, 265	0	32.00
33.00	LABORATORY	60.00	44, 462	0	33.00
34.00	LABORATORY-PATHOLOGI CAL	60. 01	1, 809	0	34.00
35.00	RESPI RATORY THERAPY	65. 00	21, 007	0	35. 00
36.00	PHYSI CAL THERAPY	66.00	24, 424	0	36.00
37.00	OCCUPATI ONAL THERAPY	67. 00	12, 660	0	37.00
38. 00	SPEECH PATHOLOGY	68. 00	10, 930	0	38.00
39. 00	ELECTROCARDI OLOGY	69. 00	2, 488	0	39.00
40.00	ELECTROENCEPHALOGRAPHY	70.00	9, 095	0	40.00
41.00	CLINIC	90.00	5, 271	0	41.00
42.00	DI ABETES CENTER	90. 01	113	0	42.00
43.00	NEUROPSYCH	90. 02	389	0	43.00
44.00	WOUND CENTER	90. 03	2, 174	0	44. 00
45.00	HYPERBARIC OXYGEN THERAPY	90. 04	238	0	45. 00
46.00	EMERGENCY	91.00	37, 306	0	46.00
47.00	AMBULANCE SERVICES	95. 00	45, 194	0	47. 00
48.00	WELLNESS COMMUNITY	194. 00	2, 516	0	48.00
49.00	HEALTHY COMMUNITIES	194. 07	40, 427	0	49.00
			978, 991	3, 277, 526	
	X - RECLASS OT SALARIES AND (	THER EXP			
1.00	OCCUPATI ONAL THERAPY	67. 00	694, 152	165, 641	1.00
			694, 152	165, 641	
	Y - RECL MILLRACE FOR WELLNES	SS/OP/PT			
1.00	PHYSI CAL THERAPY	66.00	0	7, 844	1.00
2.00	OCCUPATI ONAL THERAPY	67.00	o	1, 641	2.00
3.00	PHYSI CAL THERAPY	66.00	o	3, 998	3.00
4.00	OCCUPATI ONAL THERAPY	67.00	o	837	4.00
	0 — — — — —			14, 320	
	Z - RECLASS LAB BLOOD SUPERVI	SOR			
1.00	WHOLE BLOOD & PACKED RED	62.00	68, 053	0	1.00
	BLOOD CELL				
	0		68, 053	_	
500.00	Grand Total: Increases		4, 883, 955	39, 365, 531	500.00
	•	. '			'

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112 

COST_COSTEC   Line s						1	To 12/31/2016 Date/Time P 5/23/2017 8	
RECLASS DIRECTED INSUFFICIAL   111.00					<u>'</u>		1	l piii
B								
Interest Expense				0.00	7.00	10.00		
C		1					•	1. 00
Company   Comp	2. 00	INTEREST EXPENSE	11300	+				2. 00
ADMINISTRATIVE & GENERAL   5.00   0   1,200   0   1,200   0   1,200   0   1,200   0   1,200   0   2,277   12   2   2,300   2,300   3,500   3,500   0   0   2,277   12   2   2,300   3,500   0   3,500   0   0   3,500   0		C - RECLASS INSURANCE		<u> </u>	1, 443, 040	<b>'</b>		
ADMINISTRATIVE & GERERAL   5.00   0   35.407   0   3.40   0   4.40   ADMINISTRATIVE & GERERAL   5.00   0   9.01.093   0   9.	1.00		5. 00	0	1, 260		1	1.00
ADMINISTRATIVE & GERERAL   5.00   0   3.144   0   0   0   0   0   0   0   0   0				- 1			1	2.00
O		1		- 1			1	3. 00 4. 00
1.00   DEDICAL RECORDS & LIBRARY   16.00   699, 602   1,150,1796   0   1.   1.   1.   1.   1.   1.   1.	1. 00	0		+				1.00
December   Control   Con						_		
F. PECLASS INFERRANCE THERAPY EXPENSE   10.00   1.40,033   1.49,2271   0   1.00   1.	1.00	MEDICAL RECORDS & LIBRARY		+				1.00
Color		E - RECLASS HYPERBARIC THERAP	Y EXPENSE	077, 002	1, 130, 170	7		
F. RECLASS CAFFERIA EXPENSE   10.00   1.282.273   701.552   0   1.00   1.282.273   701.553   0   1.00   0   1.282.273   701.553   0   1.00   0   1.282.273   701.553   0   1.00   0   1.282.273   701.553   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   0   0   0   0   0   0   0   0	1.00	WOUND CENTER	90.03					1.00
1.00   DETARY		O FOLIAGE CAFFEDIA EXPENSE		64, 083	149, 221			
1,00   G   RECLASS WELLINGSS	1. 00			1, 282, 273	701, 553	3 0		1.00
1.00		0						
1.00	1 00		4 65	174 055	400.613			1
H - RECLASS PHYSICIAN FEES	1.00	0 DENETOTE RENEFITS DESARIMENT					1	1. 00
1.00		H - RECLASS PHYSICIAN FEES		171, 755	107, 542			
3. 00   ADMIN ISTRATIVE & GENERAL   5. 00   0   27, 200   0   4.		OPERATING ROOM		•			1	1.00
A. O.   ADMIN ISTRATI VE & GENERAL   5.00   0   250,350   0   5.50   0   0   5.50   0   0   5.50   0   0   5.50   0   0   5.50   0   0   0   5.50   0   0   0   0   0   0   0   0   0					•		•	2. 00 3. 00
5.00		1				-	1	4. 00
7. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 67. 500 0 7. 78. 8. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 84. 145 0 9. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 14. 0.00 0 11. 12. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 14. 0.00 0 11. 12. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 14. 0.00 0 11. 12. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 9. 600 0 0 13. 14. 0.00 0 11. 12. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 9. 600 0 0 13. 14. 0.00 1 15. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 0 9. 600 0 0 14. 14. 14. 15. 0.0 ADMIN ISTRATI VE & GENERAL 5. 0.0 0 0 1. 17. 500 0 0 1. 18. 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19				o				5. 00
B. OO   ADMIN ISTRATI VE & GENERAL   5.00   0   84, 145   0   0   9   9   0   0   0   0   0   0							1	6.00
9.00 ADMINISTRATIVE & GENERAL 5.00 0 225,000 0 11.00 ADMINISTRATIVE & GENERAL 5.00 0 144,000 0 0 11.10 ADMINISTRATIVE & GENERAL 5.00 0 0 48,744 0 12.2			•	-1				7. 00 8. 00
12.00   ADMIN INSTRATIVE & GENERAL   5.00   0   48,744   0   12.   13.00   ADMIN INSTRATIVE & GENERAL   5.00   0   5.429   0   14.   15.00   ADMIN INSTRATIVE & GENERAL   5.00   0   1.633,416   0   15.   15.   16.00   ADMIN INSTRATIVE & GENERAL   5.00   0   1.633,416   0   16.   15.   16.   16.   16.   16.   16.   16.   17.   16.   17.   1		1					1	9. 00
13.0   ADMI NI STRATI VE & GENERAL   5.00   0   5.429   0   14.     15.00   ADMI NI STRATI VE & GENERAL   5.00   0   5.429   0   14.     15.00   ADMI NI STRATI VE & GENERAL   5.00   0   1.633, 416   0   15.     16.00   ADMI NI STRATI VE & GENERAL   5.00   0   1.7, 500   0   16.     17.00   ADMI NI STRATI VE & GENERAL   5.00   0   5.429   0   17.     18.00   ADMI NI STRATI VE & GENERAL   5.00   0   5.429   0   17.     18.00   ADMI NI STRATI VE & GENERAL   5.00   0   5.429   0   17.     19.00   ADMI NI STRATI VE & GENERAL   5.00   0   5.00   0   5.00   0   19.     1				-1			1	11. 00
14. 00   ADMIN ISTRATI VE & GENERAL   5. 00   0   1. 6. 32, 416   0   1.5. 00   ADMIN ISTRATI VE & GENERAL   5. 00   0   1. 6.33, 416   0   0   1. 6.							1	12.00
15. 00   ADMI NI STRATI VE & GENERAL   5. 00   0   1,633,416   0   16. 00   17. 500   17. 500   0   17. 500   0		1		-1				14. 00
17. 00   ADMI NI STRATIVE & GENERAL   5. 00   0   5. 429   0   117.	15. 00	1		o				15. 00
18. 00				9			1	16.00
19.00		1		٩			1	17. 00 18. 00
- RECLASS REHAB SERVICES   1.00		1		٩			ł .	19. 00
1. 00   ADMI NI STRATI VE & GENERAL   5. 00   25, 826   25, 866   0   0   2. 0   0   0   0   2. 0   0   0   0   2. 0   0   0   0   2. 0   0   0   0   2. 0   0   0   0   2. 0   0   0   0   2. 0   0   0   0   0   0   0   0   0   0		0		0	3, 832, 598	3		
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 55, 156 49, 900 0 3. 3. 0 ADMI NI STRATI VE & GENERAL 5. 00 14, 381 79, 634 0 3. 4. 00 ADMI NI STRATI VE & GENERAL 5. 00 128, 472 5, 823 0 4. 4. 00 ADMI NI STRATI VE & GENERAL 5. 00 6, 169 3, 882 0 5. 0 6. 00 ADMI NI STRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 0 ADMI NI STRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 0 ADMI NI STRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 0 ADMI NI STRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 0 ADMI NI STRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 0 ADMI NI STRATI VE & GENERAL 5. 00 6, 169 3, 882 0 8. 8. 9. 00 ADMI NI STRATI VE & GENERAL 5. 00 10, 494 86, 174 0 9. 10. 00 ADMI NI STRATI VE & GENERAL 5. 00 10, 494 86, 174 0 9. 10. 00 ADMI NI STRATI VE & GENERAL 5. 00 11, 166 37, 236 0 10. 11. 00 ADMI NI STRATI VE & GENERAL 5. 00 28, 814 13, 586 0 10. 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 4, 531 0 11. 00 D ADMI NI STRATI VE & GENERAL 5. 00 183, 230 5, 688 1 11. 00 12. 00 0 9, 052, 688 1 11. 00 12. 00 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 9, 052, 688 1 11. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00		5 00	25 826	25 866			1.00
3.00 ADMI NI STRATI VE & GENERAL 5.00 14, 381 79, 634 0 4.00 ADMI NI STRATI VE & GENERAL 5.00 128, 472 5, 823 0 5 4.00 ADMI NI STRATI VE & GENERAL 5.00 6, 169 3, 882 0 5 5.00 ADMI NI STRATI VE & GENERAL 5.00 4, 626 2, 911 0 6 6.00 ADMI NI STRATI VE & GENERAL 5.00 4, 626 2, 911 0 0 6.00 ADMI NI STRATI VE & GENERAL 5.00 41, 638 26, 202 0 0 7.00 ADMI NI STRATI VE & GENERAL 5.00 41, 638 26, 202 0 0 8.8 8.00 ADMI NI STRATI VE & GENERAL 5.00 6, 169 3, 882 0 8 8.00 ADMI NI STRATI VE & GENERAL 5.00 10, 494 86, 174 0 9.0  9.0 ADMI NI STRATI VE & GENERAL 5.00 11, 166 37, 236 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 1, 166 37, 236 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 1, 166 37, 236 0 11.0 ADMI NI STRATI VE & GENERAL 5.00 28, 814 13, 586 0 11.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 183, 230 4, 531 0 10.0 ADMI NI STRATI VE & GENERAL 5.00 128, 814 51, 500 0 125, 000 0		1					•	2. 00
5.00   ADMI NI STRATI VE & GENERAL   5.00   6, 169   3, 882   0   6.00   ADMI NI STRATI VE & GENERAL   5.00   4, 626   2, 911   0   6.00   7.00   ADMI NI STRATI VE & GENERAL   5.00   41, 638   26, 202   0   7.00   ADMI NI STRATI VE & GENERAL   5.00   6, 169   3, 882   0   8.00   ADMI NI STRATI VE & GENERAL   5.00   10, 494   86, 174   0   9.00   ADMI NI STRATI VE & GENERAL   5.00   10, 494   86, 174   0   9.00   ADMI NI STRATI VE & GENERAL   5.00   10, 494   86, 174   0   9.00   ADMI NI STRATI VE & GENERAL   5.00   28, 814   13, 586   0   10.00   ADMI NI STRATI VE & GENERAL   5.00   28, 814   13, 586   0   11.00   ADMI NI STRATI VE & GENERAL   5.00   28, 814   13, 586   0   11.00   ADMI NI STRATI VE & GENERAL   5.00   183, 230   4, 531   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   183, 230   4, 531   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   DAMI NI STRATI VE & GENERAL   5.00   0   125, 000   0   1.00   0							1	3. 00
6. 00 ADMINISTRATI VE & GENERAL 5. 00 4, 626 2, 911 0 6. 7. 00 ADMINISTRATI VE & GENERAL 5. 00 41, 638 26, 202 0 7. 8. 00 ADMINISTRATI VE & GENERAL 5. 00 6, 169 3, 882 0 8. 9. 00 ADMINISTRATI VE & GENERAL 5. 00 10, 494 86, 174 0 9. 10. 00 ADMINISTRATI VE & GENERAL 5. 00 11, 494 86, 174 0 9. 10. 00 ADMINISTRATI VE & GENERAL 5. 00 11, 166 37, 236 0 10. 10. 11. 00 ADMINISTRATI VE & GENERAL 5. 00 128, 814 13, 586 0 10. 11. 00 ADMINISTRATI VE & GENERAL 5. 00 28, 814 13, 586 0 11. 00 12							•	4. 00
7. 00   ADMI NI STRATI VE & GENERAL   5. 00   41, 638   26, 202   0   7. 8. 00   ADMI NI STRATI VE & GENERAL   5. 00   6, 169   3, 882   0   8. 9. 00   ADMI NI STRATI VE & GENERAL   5. 00   10, 494   86, 174   0   9. 00   ADMI NI STRATI VE & GENERAL   5. 00   10, 494   86, 174   0   9. 00   ADMI NI STRATI VE & GENERAL   5. 00   1, 166   37, 236   0   10. 00   ADMI NI STRATI VE & GENERAL   5. 00   28, 814   13, 586   0   11. 00   ADMI NI STRATI VE & GENERAL   5. 00   28, 814   13, 586   0   11. 00   O   ADMI NI STRATI VE & GENERAL   5. 00   28, 814   13, 586   0   0   11. 00   O   183, 230   4, 531   0   0   1. 00   O   183, 230   0   4, 531   0   0   0   0   0   0   0   0   0								5. 00 6. 00
9. 00 ADMI NI STRATI VE & GENERAL 5. 00 10, 494 86, 174 0 10. 00 ADMI NI STRATI VE & GENERAL 5. 00 1, 166 37, 236 0 110. 11. 00 ADMI NI STRATI VE & GENERAL 5. 00 28, 814 13, 586 0 110.							•	7. 00
10.00   ADMI NI STRATI VE & GENERAL   5.00   1, 166   37, 236   0   0   10.							1	8. 00
11. 00		1					•	9.00
1.00   PHARMACY   15.00   183,230   4,531   0   1.00   183,230   4,531   0   1.00   183,230   4,531   0   1.00   183,230   4,531   0   1.00   183,230   4,531   0   1.00   125,000   0   125,000   0   125,000   0   1.00		1					•	11.00
1. 00 PHARMACY		0						
1.00   ADMI NI STRATI VE & GENERAL   5.00   0   125,000   0   1.00   0   125,000   0   1.00   0	1 00			102 220	4 504		I	1.00
L - RECLASS MARKETING EXPENSE	1.00	0 — — — — — — — — — — — — — — — — — — —					1	1. 00
N - RECLASS DEPRECIATION EXPENSE				. 33, 230			1	
M - RECLASS DEPRECIATION EXPENSE  1. 00	1.00	ADMI NI STRATI VE & GENERAL						1. 00
1. 00   CAP REL COSTS-BLDG & FIXT   1. 00   0   9, 052, 688   9   1.		M DECLASS DEDDECLATION EXDE	NCE	0	125, 000	)		
N - RECLASS MAINTENANCE EXPENSE	1. 00			ol	9, 052, 688	9		1.00
1.00     OPERATI ON OF PLANT     7.00     0     16,600     0       2.00     OPERATI ON OF PLANT     7.00     0     3,801     0       3.00     OPERATI ON OF PLANT     7.00     0     289,619     0       5.00     OPERATI ON OF PLANT     7.00     0     283,135     0     5       6.00     OPERATI ON OF PLANT     7.00     0     258,415     0     6		0 — — — —					<u> </u>	
2.00     OPERATI ON OF PLANT     7.00     0     3,801     0       3.00     OPERATI ON OF PLANT     7.00     0     289,619     0       5.00     OPERATI ON OF PLANT     7.00     0     283,135     0     5       6.00     OPERATI ON OF PLANT     7.00     0     258,415     0     6	1 00			61	47 700		-	1 00
3.00 OPERATION OF PLANT 7.00 0 289, 619 0 3. 5.00 OPERATION OF PLANT 7.00 0 283, 135 0 5. 6.00 OPERATION OF PLANT 7.00 0 258, 415 0 6.							•	1. 00 2. 00
5.00 OPERATION OF PLANT 7.00 0 283, 135 0 5. 6.00 OPERATION OF PLANT 7.00 0 258, 415 0 6.							•	3. 00
	5.00		7. 00	-	283, 135	0	1	5. 00
							•	6.00
	7. 00 8. 00			-1			1	7. 00 8. 00
9.00 OPERATION OF PLANT 7.00 0 14,176 0 9.		OPERATION OF PLANT	7. 00		14, 176	0		9. 00
10.00 OPERATION OF PLANT 7.00 0 204, 233 0 10.	10.00	OPERATION OF PLANT	7. 00	0	204, 233	8 0		10. 00

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					'`	5/23/2015	7 8:05 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
11.00	OPERATION OF PLANT	7. 00	0	137, 244	0		11. 00
12.00	OPERATION OF PLANT	7.00	0	90, 581	0		12. 00
13.00	OPERATION OF PLANT	7.00	0	192, 566	0		13. 00
14.00	OPERATION OF PLANT	7.00	0	191, 077	0		14. 00
15. 00	OPERATION OF PLANT	7.00	o	140, 927	o		15. 00
16.00	OPERATION OF PLANT	7.00	o	37, 082	o		16. 00
17. 00	OPERATION OF PLANT	7.00	o	84, 523	o		17. 00
18. 00	OPERATION OF PLANT	7.00	o	4, 247	o		18. 00
19.00	OPERATION OF PLANT	7.00	o	93, 454	o		19. 00
20. 00	OPERATION OF PLANT	7. 00	o	12, 743	o		20. 00
21. 00	OPERATION OF PLANT	7. 00	0	12, 743			21. 00
200	0			2, 229, 653			200
	P - RECLASS CRHP EXPENSES			2/22//000			
1.00	ADMI NI STRATI VE & GENERAL	5.00	51, 538	0	0		1. 00
	TOTALS		51, 538	— — <u> </u>	<u> </u>		
	Q - RECLASS XRAY EDUCATION EX	(PENSES	01,000	J			
1.00	RESPIRATORY THERAPY	65.00	50	0	0		1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	321, 468	417			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	321, 400	2, 808			3. 00
3.00	DENETTIS DELAKTIMENT		321, 518	$ \frac{2,000}{3,225}$			3.00
	R - RECLASS ADMIN HEALTHY CON	MINITIFS	321, 310	3, 223			
1. 00	HEALTHY COMMUNITIES	194. 07	45 440	0			1. 00
1.00	ULTU COMMONT II E2	— — 1 <del>94.</del> 0/	45, 649	$ \frac{0}{0}$			1.00
	C DECLACE NON ALLOW ADVEDT	CLNC COCTC	45, 649	0			
1 00	S - RECLASS NON ALLOW ADVERTI		ما	1 400 045			1 00
1. 00	ADMI NI STRATI VE & GENERAL		•	<u>1, 480, 965</u>			1.00
	U DECL FOULD DENTAL TO SUIT	OCEARLE CUES	0	1, 480, 965			
4 00	T - RECL EQUIP RENTAL TO CHAR		_1	_			
1.00	ADJULTO A DESCRIPTION	0.00	0	0			1.00
2. 00	ADULTS & PEDIATRICS	30.00	0	205, 931			2. 00
3. 00	INTENSIVE CARE UNIT	31. 00	0	74, 426	1		3. 00
4.00	SUBPROVI DER - I RF	41. 00	0	35, 385	1		4. 00
5. 00	RESPIRATORY_THERAPY	6500	0	4 <u>0, 1</u> 25			5. 00
	0		0	355, 867			
	U - RECLASS CHARGEABLE SUPPLY						
1. 00	ADULTS & PEDIATRICS	30.00	0	210, 301	0		1. 00
2. 00	INTENSIVE CARE UNIT	31. 00	0	89, 182	l 1		2. 00
3.00	SUBPROVI DER - I RF	41. 00	0	4, 626	0		3. 00
4.00	NURSERY	43.00	0	2, 471	0		4. 00
5.00	OPERATING ROOM	50.00	0	2, 941, 860	0		5. 00
6.00	OPERATING ROOM	50.00	0	5, 862, 119	0		6. 00
7.00	RECOVERY ROOM	51.00	0	2, 221	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	O	58, 486	o		8. 00
9.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	O	458, 247	o		9. 00
11.00	MAMMOGRAPHY	54. 03	0	5, 018	o		11. 00
12.00	RADI OLOGY-THERAPEUTI C	55.00	O	4, 238	o		12. 00
13.00	CT SCAN	57.00	О	188, 057	o		13. 00
14.00	MRI	58.00	o	61, 535	o		14. 00
15. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 265, 688			15. 00
16. 00	CARDIAC CATHETERIZATION	59.00	Ö	1, 720, 615			16. 00
17. 00	RESPIRATORY THERAPY	65.00	0	38, 649			17. 00
18. 00	PHYSI CAL THERAPY	66.00	0	11, 065			18. 00
19. 00	SPEECH PATHOLOGY	68. 00	0	264, 590	1		19. 00
20. 00	ELECTROCARDI OLOGY	69. 00	0	164, 443	1		20. 00
21. 00	WOUND CENTER	90. 03	0	41, 164	l l		21. 00
22. 00	EMERGENCY	91. 00	0				22. 00
22. 00	l .	91.00 95.00	O O	34, 486			1
∠3.00	AMBULANCE SERVICES	<u> </u>	0	20, 894			23. 00
	V - RECL PTO COST FOR STD ELI	MI NATI ON DD	U	13, 449, 955			
1.00	V - NECE FIO COST FOR STO ELL	0.00	ol	0	0		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00	2, 947	0			2. 00
	l .						
3.00	MAMMOGRAPHY	54. 03	3, 279	0			3.00
4.00	SOCIAL SERVICE	17.00	7, 161	0			4.00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	137	0	1		5. 00
6.00	ADMINISTRATIVE & GENERAL	5. 00	35, 488	0	0		6. 00
7.00	OPERATION OF PLANT	7. 00	2, 672	0			7. 00
8. 00	LAUNDRY & LINEN SERVICE	8. 00	468	0	0		8. 00
9. 00	HOUSEKEEPI NG	9. 00	7, 525	0	0		9. 00
10.00	DI ETARY	10. 00	4, 418	0	0		10. 00
11. 00	CAFETERI A	11. 00	9, 810	0	0		11. 00
12.00	NURSING ADMINISTRATION	13. 00	40, 274	0	0		12. 00
13.00	PHARMACY	15. 00	24, 263	0	0		13. 00
14.00	MEDICAL RECORDS & LIBRARY	16. 00	11, 941	0	0		14. 00
15.00	ADULTS & PEDIATRICS	30.00	130, 895	0	0		15. 00
16.00	INTENSIVE CARE UNIT	31.00	19, 453	0	0		16. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 8: 05 pm Provider CCN: 15-0112

		Decreases				5/23/2017 8:0	75 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9. 00	10.00		
17. 00	SUBPROVI DER - I RF	41.00	8, 934	0	0		17. 00
18. 00	NURSERY	43. 00	9, 786	0			18. 00
19.00	OPERATING ROOM	50.00	2, 323	0	0		19. 00
20.00	ULTRA SOUND	54. 02	10, 319	0	0		20. 00
21.00	RADI OLOGY-DI AGNOSTI C	54.00	8, 321	0	0		21. 00
22. 00	LABORATORY-PATHOLOGI CAL	60. 01	11, 485	0			22. 00
23. 00	NEUROPSYCH	90. 02	5, 199	0	0		23. 00
24. 00	CT SCAN	57. 00	273	0			24. 00
25. 00	MRI	58. 00	5, 510	0	0		25. 00
26. 00 27. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	10, 027 36, 499	0	0		26. 00 27. 00
28. 00	RESPIRATORY THERAPY	65. 00	7, 764	0	0		28. 00
29. 00	PHYSI CAL THERAPY	66.00	18, 182	0	0		29. 00
30. 00	OCCUPATI ONAL THERAPY	67. 00	6, 648	0	0		30.00
31. 00	SPEECH PATHOLOGY	68. 00	8, 800	0			31.00
32.00	WOUND CENTER	90. 03	3, 140	0	0		32. 00
33.00	EMERGENCY	91. 00	52, 837	0	0		33. 00
34.00	AMBULANCE SERVICES	95. 00	11, 226	0	0		34. 00
35. 00	ELECTROENCEPHALOGRAPHY	70. 00	2, 973	0	0		35. 00
36. 00	CLINIC	90.00	3, 038	0	0		36. 00
	O DECLACE DEPT 0000 FMD DEA	IEEL TO	524, 015				
1 00	W - RECLASS DEPT 9902 EMP BEN			4/4 120	0		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	0	464, 120 195, 879	0		1. 00 2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	2, 027, 321	0		3. 00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	284, 724	0		4. 00
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	25, 828	0		5. 00
6. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ö	279, 654	0		6. 00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7, 435	0	0		7. 00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	252, 806	0	0		8. 00
9.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	43, 087	0	0		9. 00
10.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	603	0	0		10.00
11. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	21, 091	0			11. 00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9, 315	0	0		12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	20, 684	0	0		13.00
14. 00 15. 00	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	65, 122 46, 461	0	0		14. 00 15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	32, 155	0	0		16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	10, 704	0	0		17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	603	0			18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	829	0	0		19. 00
20.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	100, 290	0	0		20. 00
21.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	10, 328	0	0		21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	15, 818	0	0		22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 242	0	0		23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 505	0	0		24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT   EMPLOYEE BENEFITS DEPARTMENT	4.00	37, 476 1, 055	0	0		25. 00
26. 00 27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00		0	0		26. 00 27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 299 11, 568	0	0		28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 505	0			29. 00
30.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 337	0	0		30.00
31.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	905	0	0		31. 00
32.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 265	0	0		32. 00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	44, 462	0	0		33. 00
34.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 809	0	0		34. 00
35. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	21, 007	0	0		35. 00
36.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	24, 424	0	0		36.00
37. 00	EMPLOYEE BENEFITS DEPARTMENT		12, 660	-			37. 00
38. 00 39. 00	EMPLOYEE BENEFITS DEPARTMENT   EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 00	10, 930 2, 488	0	0		38. 00 39. 00
40. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	9, 095	0	0		40.00
41. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5, 271	0	0		41. 00
42. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	113	0	0		42. 00
43. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	389	0	0		43. 00
44.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 174	0	0		44. 00
45.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	238	0	0		45. 00
46.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	37, 306	0	0		46. 00
47. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	45, 194	0	0		47. 00
48. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 516	0	0		48. 00
49. 00	EMPLOYEE BENEFITS DEPARTMENT		40, 427	0	0		49. 00
	0	I	978, 991	3, 277, 526			I

Heal th	Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der (	CCN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A- Date/Time Pr 5/23/2017 8:	epared:
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6. 00	7.00	8. 00	9. 00	10.00			
	X - RECLASS OT SALARIES AND O	THER EXP						
1.00	PHYSI CAL THERAPY	66.00	694, 152	165, 641		0		1. 00
	0 — — — — —	- $  1$	694, 152	165, 641		7		
	Y - RECL MILLRACE FOR WELLNES	SS/0P/PT						
1.00	WELLNESS COMMUNITY	194. 00	0	7, 844		0		1. 00
2.00	WELLNESS COMMUNITY	194.00	O	1, 641		o		2. 00
3.00	WELLNESS COMMUNITY	194.00	O	3, 998		o		3. 00
4.00	WELLNESS COMMUNITY	194.00	O	837		o		4. 00
	0 — — — — —			14, 320		7		1
	Z - RECLASS LAB BLOOD SUPERVI SOR							
1.00	LABORATORY	60.00	68, 053	0		0		1. 00
	0 — — — — —		68, 053			7		
500.00	Grand Total: Decreases		5, 407, 970	38, 841, 516				500.00
	•	•	·		•	•		•

Provider CCN: 15-0112

								<u>5/23/2017 8: 0</u>	)5 p
	Cost Center	Increa	ases Sal ary	Other	Cost Center	Decrea Li ne #	ses Sal ary	Other	
	2.00	3. 00	4. 00	5. 00	6.00	7. 00	8. 00	9. 00	
	B - RECLASS DEPREC BLD								
00	CAP REL COSTS-BLDG &	1. 00	0	953, 811	INTEREST EXPENSE	113. 00	0	953, 811	
00	CAP REL COSTS-MVBLE	2. 00	0	489, 235	INTEREST EXPENSE	113. 00	О	489, 235	
	EQUI P			1, 443, 046		$ \vdash$ $+$		1, 443, 046	
	C - RECLASS INSURANCE								
0	OCCUPATI ONAL THERAPY	67. 00	0	1, 260	ADMINISTRATIVE & GENERAL	5. 00	0	1, 260	
0	CAP REL COSTS-BLDG &	1. 00	O	921, 277	ADMINISTRATIVE &	5. 00	О	921, 277	
0	FIXT AMBULANCE SERVICES	95. 00	o	35, 407	GENERAL ADMINISTRATIVE &	5. 00	0	35, 407	
0	LABORATORY	60. 00	0	2 1/10	GENERAL ADMINISTRATIVE &	5. 00		3, 149	
U		00.00			GENERAL				
	D - RECLASS BILLING CO	CT	0	961, 093	[0		0	961, 093	
0	ADMINISTRATIVE &	5.00	699, 602	1, 150, 196	MEDICAL RECORDS &	16.00	699, 602	1, 150, 196	
	GENERAL				LI BRARY	_			
	O E - RECLASS HYPERBARIC	THEDAD	699, 602	1, 150, 196	0		699, 602	1, 150, 196	
00	HYPERBARIC OXYGEN	90. 04	64, 083	149, 221	WOUND CENTER	90, 03	64, 083	149, 221	
	THERAPY					_			
	F - RECLASS CAFETERIA	EVDENCE	64, 083	149, 221	0		64, 083	149, 221	
0	CAFETERI A	11. 00	1, 282, 273	701, 553	DI ETARY	10.00	1, 282, 273	701, 553	
	0		1, 282, 273	701, 553			1, 282, 273	701, 553	
	G - RECLASS WELLNESS	104 00	171 055	100 242	EMPLOYEE DENEELTS	1 4 00	171 055	100 242	
0	WELLNESS COMMUNITY	194. 00	171, 955	109, 342	EMPLOYEE BENEFITS DEPARTMENT	4.00	171, 955	109, 342	
	0 — — —		171, 955	109, 342			171, 955	109, 342	
_	H - RECLASS PHYSICIAN		-1		I		-1		
0	ADMINISTRATIVE & GENERAL	5. 00	0	508, 000	OPERATING ROOM	50.00	0	508, 000	
0	ADULTS & PEDIATRICS	30. 00	0	229, 383	ADMINISTRATIVE & GENERAL	5. 00	0	229, 383	
0	INTENSIVE CARE UNIT	31. 00	0	27, 200	ADMINISTRATIVE &	5. 00	0	27, 200	
00	SUBPROVI DER - I RF	41. 00	О	80, 000	GENERAL ADMINISTRATIVE &	5. 00	0	80, 000	
00	OPERATING ROOM	50.00	0	250, 350	GENERAL ADMINISTRATIVE &	5. 00	О	250, 350	
00	AMESTHESIOLOGV	E2 00		4E 000	GENERAL OPERATING ROOM	E0 00		4E 000	
)O	ANESTHESI OLOGY RADI OLOGY-THERAPEUTI C	53. 00 55. 00	0		ADMINISTRATIVE &	50. 00 5. 00	0	45, 000 67, 500	1
					GENERAL	0.00	Ĭ	0,,000	
0	CARDI AC	59. 00	0	84, 145	ADMINISTRATIVE &	5.00	0	84, 145	
00	CATHETERI ZATI ON LABORATORY-PATHOLOGI C	60. 01	o		GENERAL ADMINISTRATIVE &	5. 00	0	225, 000	
00	AL PHYSI CAL THERAPY	66. 00	o		GENERAL ADMINISTRATIVE &	5. 00	0	14, 000	1
					GENERAL				
00	ELECTROCARDI OLOGY	69. 00	0		ADMINISTRATIVE & GENERAL	5. 00	٩	48, 744	
00	ELECTROENCEPHALOGRAPH Y	70. 00	0	9, 600	ADMINISTRATIVE & GENERAL	5. 00	0	9, 600	1
00	CARDI AC REHABI LI TATI ON	76. 97	0	5, 429	ADMINISTRATIVE & GENERAL	5. 00	0	5, 429	1
00	EMERGENCY	91. 00	0	1, 633, 416	ADMINISTRATIVE &	5. 00	0	1, 633, 416	1
00	AMBULANCE SERVICES	95. 00	O	17, 500	GENERAL ADMINISTRATIVE &	5. 00	О	17, 500	1
00	WOUND CENTER	90. 03	O	5, 429	GENERAL ADMINISTRATIVE &	5. 00	О	5, 429	1
00	HYPERBARIC OXYGEN	90. 04	0	596	GENERAL ADMINISTRATIVE &	5. 00	0	596	1
	THERAPY	30. 00			GENERAL	5. 00			
00	ADULTS & PEDIATRICS	30.00	0		ADMINISTRATIVE & GENERAL	_ 5.00		581, 306	
	O I - RECLASS REHAB SERV	LCES	0	3, 832, 598	ĮU		0	3, 832, 598	
00	OCCUPATIONAL THERAPY	67. 00	25, 826	25, 866	ADMINISTRATIVE &	5.00	25, 826	25, 866	
					GENERAL				
00	PHYSI CAL THERAPY	66. 00	55, 156		ADMINISTRATIVE & GENERAL	5.00	55, 156	49, 900	
00	SPEECH PATHOLOGY	68. 00	14, 381	79, 634	ADMINISTRATIVE &	5.00	14, 381	79, 634	

In Lieu of Form CMS-2552-10

Period:	Worksheet A-6
From 01/01/2016	Non-CMS Worksheet
To 12/31/2016	Date/Time Prepared:
5/23/2017 8:05 pm	Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

							0 12/31/2016	5/23/2017 8:0	
			eases			Decre		0.1	
	Cost Center	Li ne #	_	Other 5.00	Cost Center	Li ne #	Sal ary	Other	
4. 00	2.00 SUBPROVI DER - I RF	3. 00	4. 00 128, 472	5. 00	6.00 ADMINISTRATIVE &	7.00	8. 00 128, 472	9. 00 5, 823	4. 00
4.00	SOBI KOVI DEK - TKI	41.00	120, 472	3, 023	GENERAL	3.00	120, 472	5, 025	4.00
5.00	ELECTROENCEPHALOGRAPH	70. 00	6, 169	3, 882	ADMINISTRATIVE &	5.00	6, 169	3, 882	5.00
	Υ				GENERAL				
6.00	SOCIAL SERVICE	17. 00	4, 626	2, 911	ADMINISTRATIVE &	5. 00	4, 626	2, 911	6. 00
7 00	ADULTO A DEDIATRICO	20.00	41 (20	27 202	GENERAL	F 00	41 (20	2/ 202	7 00
7. 00	ADULTS & PEDIATRICS	30. 00	41, 638	26, 202	ADMINISTRATIVE & GENERAL	5. 00	41, 638	26, 202	7. 00
8. 00	NEUROPSYCH	90. 02	6, 169	3 882	ADMINISTRATIVE &	5.00	6, 169	3. 882	8. 00
0.00		70.02	5, 10,	0, 002	GENERAL	0.00	0, 10,	0,002	0.00
9.00	WOUND CENTER	90. 03	10, 494	86, 174	ADMINISTRATIVE &	5.00	10, 494	86, 174	9. 00
					GENERAL				
10. 00	HYPERBARI C OXYGEN	90. 04	1, 166	37, 236	ADMINISTRATIVE &	5. 00	1, 166	37, 236	10. 00
11. 00	THERAPY DI ABETES CENTER	90. 01	28, 814	13 596	GENERAL ADMINISTRATIVE &	5.00	28, 814	13, 586	11. 00
11.00	DIABETES CENTER	70.01	20, 014		GENERAL	3.00	20,014	13, 300	11.00
	0 — — — —		322, 911	335, 096			322, 911	335, 096	
	J - RECLASS PHARMACY R	ES PROC	RAM						
1.00	PHARMACY RESIDENCY	23. 02	183, 230	4, 531	PHARMACY	15. 00	183, 230	4, 531	1. 00
	PROG					$\vdash$			
	L - RECLASS MARKETING	EADENCE	183, 230	4, 531	lo .		183, 230	4, 531	
1. 00	NONALLOWABLE	194. 05		125 000	ADMINISTRATIVE &	5.00	ol	125, 000	1. 00
1.00	MARKETI NG	171.00	J	120, 000	GENERAL	0.00	Ĭ	120,000	1. 00
	0			125, 000			0	125, 000	
	M - RECLASS DEPRECIATI								
1. 00	CAP REL COSTS-MVBLE	2. 00	0		CAP REL COSTS-BLDG &	1.00	0	9, 052, 688	1. 00
	EQUI P	<u> </u>			FIXT	$\vdash$	— — — d		
	N - RECLASS MAINTENANC	E EADEN		9, 052, 688	<u>lo</u>	1	υ	9, 052, 088	
1.00	RESPIRATORY THERAPY	65. 00		16 600	OPERATION OF PLANT	7.00	ol	16, 600	1. 00
2.00	ELECTROCARDI OLOGY	69. 00			OPERATION OF PLANT	7. 00	o	3, 801	2. 00
3.00	CARDI AC	59. 00	0	289, 619	OPERATION OF PLANT	7.00	0	289, 619	3.00
	CATHETERI ZATI ON								
5.00	OPERATING ROOM	50.00			OPERATION OF PLANT	7. 00	0	283, 135	5. 00
6.00	RADI OLOGY-THERAPEUTI C	55. 00			OPERATION OF PLANT	7.00	0	258, 415	6. 00
7.00	LABORATORY LABORATORY-PATHOLOGIC	60. 00 60. 01	0		OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	151, 570	7. 00
8. 00	AL	60.01	U	10, 917	OPERATION OF PLANT	7.00	٩	10, 917	8. 00
9. 00	WHOLE BLOOD & PACKED	62. 00	0	14, 176	OPERATION OF PLANT	7.00	0	14, 176	9. 00
	RED BLOOD CELL			•				,	
10.00	RADI OLOGY-DI AGNOSTI C	54. 00			OPERATION OF PLANT	7.00	0	204, 233	10.00
11. 00	MAMMOGRAPHY	54. 03	0		OPERATION OF PLANT	7. 00	0	137, 244	11. 00
12.00	ULTRA SOUND	54. 02	0		OPERATION OF PLANT	7.00	0	90, 581	12.00
13. 00 14. 00	CT SCAN NUCLEAR	57. 00 54. 01			OPERATION OF PLANT OPERATION OF PLANT	7.00	0	192, 566 191, 077	13. 00 14. 00
14.00	MEDI CI NE-DI AGNOSTI C	34.01	U	191, 077	OPERATION OF PLANT	7.00	U	191,077	14.00
15. 00	MRI	58. 00	0	140, 927	OPERATION OF PLANT	7. 00	0	140, 927	15. 00
16.00	PHARMACY	15. 00	0	37, 082	OPERATION OF PLANT	7.00	0	37, 082	16.00
17.00	EMERGENCY	91.00	0	84, 523	OPERATION OF PLANT	7.00	0	84, 523	
18. 00	ADMINISTRATIVE &	5. 00	0	4, 247	OPERATION OF PLANT	7. 00	0	4, 247	18. 00
10.00	GENERAL	20.00	0	02 454	ODEDATION OF DIANT	7 00	0	02.454	10.00
19. 00 20. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00			OPERATION OF PLANT OPERATION OF PLANT	7. 00 7. 00	0	93, 454 12, 743	19. 00 20. 00
21. 00	SUBPROVI DER - I RF	41. 00	•		OPERATION OF PLANT	7. 00	0	12, 743	21. 00
	0	11.00		2, 229, 653			— — <u> </u>	2, 229, 653	
	P - RECLASS CRHP EXPEN	ISES							
1.00	CRHP	194. 08	51, 538	0	ADMINISTRATIVE &	5. 00	51, 538	0	1. 00
					GENERAL	$\vdash$			
	TOTALS	TION EV	51, 538	0	TOTALS		51, 538	0	
1. 00	Q - RECLASS XRAY EDUCA XRAY EDUCATION	23. 01		0	RESPIRATORY THERAPY	65.00	50	0	1. 00
2. 00	XRAY EDUCATION	23. 01			RADI OLOGY-DI AGNOSTI C	54.00	321, 468	417	2. 00
3.00	XRAY EDUCATION	23. 01			EMPLOYEE BENEFITS	4.00	0	2, 808	3. 00
	L		L ĭ		DEPARTMENT		]		
	0		321, 518	3, 225	0		321, 518	3, 225	
	R - RECLASS ADMIN HEAL				LUE A L TUNZ	1.0:			
1. 00	ADMINISTRATIVE &	5. 00	45, 649	0	HEALTHY COMMUNITIES	194. 07	45, 649	0	1. 00
	GENERAL	<u> </u>	45, 649	— — <u> </u>	0 — — —	$\vdash$		— — <u> </u>	
	S - RECLASS NON ALLOW	ADVFRTI		0	<u> </u>		45, 047	0	
1.00	NONALLOWABLE	194. 05		1, 480, 965	ADMINISTRATIVE &	5.00	0	1, 480, 965	1. 00
	MARKETI NG	L	L 1		GENERAL	$\perp$			
	0		0	1, 480, 965	0		o	1, 480, 965	

						D		5/23/2017 8:0	5 pm
	Cost Center	Li ne #	eases Sal ary	Other	Cost Center	Decre Li ne #	Sal ary	Other	
	2. 00	3. 00	4.00	5. 00	6.00	7. 00	8. 00	9. 00	
1. 00	T - RECL EQUIP RENTAL	TO CHAP 0.00		0		0.00	0	0	1. 00
2. 00	MEDICAL SUPPLIES	71. 00	l l	-	ADULTS & PEDIATRICS	30.00	ő	205, 931	2. 00
2 00	CHARGED TO PATIENT	71 00		74 424	INTENSIVE CARE UNIT	21 00		74 424	2 00
3. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	٩	74, 420	INTENSIVE CARE UNIT	31.00	0	74, 426	3. 00
4.00	MEDICAL SUPPLIES	71. 00	o	35, 385	SUBPROVI DER - I RF	41.00	O	35, 385	4. 00
5. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	o	40. 125	RESPI RATORY THERAPY	65.00	o	40, 125	5. 00
	CHARGED TO PATIENT								
	U - RECLASS CHARGEABLE	SUPPLY	0 ( COST	355, 867	[0		0	355, 867	
1.00	MEDICAL SUPPLIES	71. 00		210, 301	ADULTS & PEDIATRICS	30.00	0	210, 301	1. 00
2. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	80 182	INTENSIVE CARE UNIT	31.00	0	89, 182	2. 00
2.00	CHARGED TO PATIENT	71.00		07, 102	THE TENSIVE OAKE ONLY	31.00	Ĭ	07, 102	2.00
3. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	4, 626	SUBPROVI DER - I RF	41.00	0	4, 626	3. 00
4. 00	MEDICAL SUPPLIES	71. 00	o	2, 471	NURSERY	43.00	o	2, 471	4. 00
5. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	2 041 940	OPERATING ROOM	50.00	0	2, 941, 860	5. 00
5.00	CHARGED TO PATIENT	71.00	٩	2, 941, 600	OPERATING ROOM	30.00	٩	2, 941, 660	5.00
6. 00	IMPL. DEV. CHARGED TO	72. 00	0	5, 862, 119	OPERATING ROOM	50.00	0	5, 862, 119	6. 00
7. 00	PATI ENTS MEDI CAL SUPPLI ES	71. 00	o	2, 221	RECOVERY ROOM	51.00	o	2, 221	7. 00
0.00	CHARGED TO PATIENT	74 00		E0. 40/	DADLOLOGY, DLAGNOCTI O	E4 00		50.404	0.00
8. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	58, 486	RADI OLOGY-DI AGNOSTI C	54.00	0	58, 486	8. 00
9. 00	MEDICAL SUPPLIES	71. 00	O	458, 247	NUCLEAR	54. 01	О	458, 247	9. 00
11. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	5 018	MEDI CI NE-DI AGNOSTI C MAMMOGRAPHY	54. 03	0	5, 018	11. 00
	CHARGED TO PATIENT			•				·	
12. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	4, 238	RADI OLOGY-THERAPEUTI C	55. 00	0	4, 238	12. 00
13.00	MEDICAL SUPPLIES	71.00	o	188, 057	CT SCAN	57.00	o	188, 057	13. 00
14. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	o	61, 535	MRI	58. 00	0	61, 535	14. 00
14.00	CHARGED TO PATIENT	71.00	1	01, 555	IVIICI	30.00	9	01, 555	14.00
15. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	1, 265, 688	CARDI AC CATHETERI ZATI ON	59.00	0	1, 265, 688	15. 00
16. 00	IMPL. DEV. CHARGED TO	72. 00	o	1, 720, 615		59.00	o	1, 720, 615	16. 00
17 00	PATIENTS	71 00		20 440	CATHETERI ZATI ON	45 00	0	29 440	17 00
17. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	٩	38, 049	RESPI RATORY THERAPY	65.00	٩	38, 649	17. 00
18. 00	MEDICAL SUPPLIES	71. 00	0	11, 065	PHYSI CAL THERAPY	66. 00	O	11, 065	18. 00
19. 00	CHARGED TO PATIENT SPEECH - HEARING AIDS	194. 04	o	264, 590	SPEECH PATHOLOGY	68. 00	o	264, 590	19. 00
20.00	MEDICAL SUPPLIES	71. 00	O	164, 443	ELECTROCARDI OLOGY	69. 00	O	164, 443	20. 00
21. 00	CHARGED TO PATIENT MEDICAL SUPPLIES	71. 00	0	41 164	WOUND CENTER	90. 03	0	41, 164	21. 00
	CHARGED TO PATIENT								
22. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	34, 486	EMERGENCY	91.00	0	34, 486	22. 00
23. 00	MEDICAL SUPPLIES	71. 00	o	20, 894	AMBULANCE SERVICES	95. 00	o	20, 894	23. 00
	CHARGED TO PATIENT	<u> </u>		<u> </u>		-		13, 449, 955	
	V - RECL PTO COST FOR	STD ELI		10, 447, 700	<u> </u>		<u> </u>	13, 447, 733	
1.00	EMPLOYEE BENEFITS	0.00	1	0	DADIOLOGY THERADEUTIC	0.00	0	0	1.00
2. 00	DEPARTMENT	4. 00	0	2, 947	RADI OLOGY-THERAPEUTI C	55.00	2, 947	o o	2. 00
3.00	EMPLOYEE BENEFITS	4. 00	0	3, 279	MAMMOGRAPHY	54.03	3, 279	0	3. 00
4. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00	o	7, 161	SOCIAL SERVICE	17.00	7, 161	o	4. 00
	DEPARTMENT								
5. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		137	CENTRAL SERVICES & SUPPLY	14.00	137	0	5. 00
6.00	EMPLOYEE BENEFITS	4. 00	o	35, 488	ADMINISTRATIVE &	5. 00	35, 488	0	6. 00
7. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00		2 672	GENERAL OPERATION OF PLANT	7. 00	2, 672	0	7. 00
	DEPARTMENT						2,072		
8.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		468	LAUNDRY & LINEN SERVICE	8. 00	468	0	8. 00
9. 00	EMPLOYEE BENEFITS	4. 00	o	7, 525	HOUSEKEEPI NG	9. 00	7, 525	0	9. 00
10. 00	DEPARTMENT EMPLOYEE BENEFITS	4. 00		4 410	DI ETARY	10.00	4, 418	0	10. 00
10.00	DEPARTMENT	4.00		4, 418	DILIANI	10.00	4,418	o o	10.00
			'			'	<u>'</u>	<u>'</u>	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2016 | Non-CMS Worksheet | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 8:05 pm

		Incre	eases			Decre	eases	5/23/2017 8:0	15 pm
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	Other	
11. 00	2.00 EMPLOYEE BENEFITS	3. 00 4. 00	4. 00	5.00	6. 00 CAFETERI A	7. 00 11. 00	8. 00 9, 810	9. 00	11. 00
11.00	DEPARTMENT	4.00	U	9, 610	CAFETERIA	11.00	9,610	o l	11.00
12. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	40, 274	NURSI NG ADMI NI STRATI ON	13. 00	40, 274	0	12. 00
13. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	24, 263	PHARMACY	15. 00	24, 263	0	13. 00
14. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 941	MEDICAL RECORDS &	16. 00	11, 941	0	14. 00
15. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	130, 895	ADULTS & PEDIATRICS	30.00	130, 895	0	15. 00
16. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	19, 453	INTENSIVE CARE UNIT	31.00	19, 453	0	16. 00
17. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 934	SUBPROVIDER - IRF	41. 00	8, 934	0	17. 00
18. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9, 786	NURSERY	43.00	9, 786	0	18. 00
19. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 323	OPERATING ROOM	50.00	2, 323	0	19. 00
20. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	10, 319	ULTRA SOUND	54. 02	10, 319	0	20. 00
21. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 321	RADI OLOGY-DI AGNOSTI C	54.00	8, 321	0	21. 00
22. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 485	LABORATORY-PATHOLOGIC	60. 01	11, 485	0	22. 00
23. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 199	NEUROPSYCH	90. 02	5, 199	0	23. 00
24. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	273	CT SCAN	57.00	273	0	24. 00
25. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 510	MRI	58. 00	5, 510	0	25. 00
26. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	10, 027	CARDI AC CATHETERI ZATI ON	59. 00	10, 027	0	26. 00
27. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	36, 499	LABORATORY	60.00	36, 499	0	27. 00
28. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	7, 764	RESPI RATORY THERAPY	65. 00	7, 764	0	28. 00
29. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	18, 182	PHYSI CAL THERAPY	66. 00	18, 182	0	29. 00
30. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 648	OCCUPATIONAL THERAPY	67. 00	6, 648	0	30. 00
31. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	8, 800	SPEECH PATHOLOGY	68. 00	8, 800	0	31. 00
32. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 140	WOUND CENTER	90. 03	3, 140	0	32. 00
33. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	52, 837	EMERGENCY	91.00	52, 837	0	33. 00
34. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 226	AMBULANCE SERVICES	95. 00	11, 226	0	34. 00
35. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 973	ELECTROENCEPHALOGRAPH	70. 00	2, 973	0	35. 00
36. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 038	CLI NI C	90.00	3, 038	0	36. 00
	0 W - RECLASS DEPT 9902	FMP BFN		524, 015	0		524, 015	0	
1.00	ADMINISTRATIVE &	5. 00	0	464, 120	EMPLOYEE BENEFITS	4.00	0	464, 120	1. 00
2. 00	GENERAL CENTRAL SERVICES &	14. 00	0	195, 879	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0	195, 879	2. 00
3.00	SUPPLY OPERATING ROOM	50. 00	0	2, 027, 321	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0	2, 027, 321	3. 00
4.00	RECOVERY ROOM	51. 00	0	284, 724	DEPARTMENT EMPLOYEE BENEFITS	4. 00	0	284, 724	4. 00
5. 00	ANESTHESI OLOGY	53. 00	0	25, 828	DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	25, 828	5. 00
6.00	EMPLOYEE BENEFITS	4. 00	0	279, 654	EMPLOYEE BENEFITS	4. 00	0	279, 654	6. 00
7. 00	DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 435	O	DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT	4. 00	7, 435	0	7. 00
8. 00	ADMI NI STRATI VE & GENERAL	5. 00	252, 806	О	EMPLOYEE BENEFITS DEPARTMENT	4. 00	252, 806	0	8. 00
9. 00	OPERATION OF PLANT	7. 00	43, 087	C	EMPLOYEE BENEFITS DEPARTMENT	4. 00	43, 087	0	9. 00
10. 00	LAUNDRY & LINEN SERVICE	8. 00	603	O	EMPLOYEE BENEFITS DEPARTMENT	4. 00	603	0	10. 00
11. 00	HOUSEKEEPI NG	9. 00	21, 091	O	EMPLOYEE BENEFITS	4. 00	21, 091	0	11. 00
	1	l			DEPARTMENT	I I	l		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2016 | Non-CMS Worksheet | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 8:05 pm

	Increases			Decreases			5/23/2017 8:0	5 piii	
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	Salary	Other	
	2. 00	3. 00	4.00	5. 00	6.00	7. 00	8. 00	9. 00	
12. 00	DI ETARY	10.00	9, 315		O EMPLOYEE BENEFITS DEPARTMENT	4.00	9, 315	0	12. 00
13. 00	CAFETERI A	11. 00	20, 684		OEMPLOYEE BENEFITS DEPARTMENT	4.00	20, 684	0	13. 00
14. 00	NURSI NG ADMI NI STRATI ON	13. 00	65, 122		O EMPLOYEE BENEFITS DEPARTMENT	4.00	65, 122	0	14. 00
15. 00	PHARMACY	15. 00	46, 461		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	46, 461	0	15. 00
16. 00	MEDI CAL RECORDS &	16. 00	32, 155		OEMPLOYEE BENEFITS DEPARTMENT	4.00	32, 155	0	16. 00
17. 00	SOCI AL SERVI CE	17. 00	10, 704		O EMPLOYEE BENEFITS DEPARTMENT	4.00	10, 704	0	17. 00
18. 00	XRAY EDUCATION	23. 01	603		O EMPLOYEE BENEFITS DEPARTMENT	4.00	603	0	18. 00
19. 00	PHARMACY RESIDENCY PROG	23. 02	829		O EMPLOYEE BENEFITS DEPARTMENT	4.00	829	0	19. 00
20. 00	ADULTS & PEDIATRICS	30. 00	100, 290		O EMPLOYEE BENEFITS DEPARTMENT	4.00	100, 290	0	20. 00
21. 00	INTENSIVE CARE UNIT	31. 00	10, 328		O EMPLOYEE BENEFITS DEPARTMENT	4.00	10, 328	0	21. 00
22. 00	SUBPROVI DER - I RF	41. 00	15, 818		O EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 818	0	22. 00
23. 00	NURSERY	43. 00	3, 242		O EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 242	0	23. 00
24. 00	OPERATING ROOM	50. 00	3, 505		O EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 505	0	24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54. 00	37, 476		O EMPLOYEE BENEFITS DEPARTMENT	4.00	37, 476	0	25. 00
26. 00	NUCLEAR MEDI CI NE - DI AGNOSTI C	54. 01	1, 055		O EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 055	0	26. 00
27. 00	ULTRA SOUND	54. 02	2, 299		O EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 299	0	27. 00
28. 00	MAMMOGRAPHY	54. 03	11, 568		O EMPLOYEE BENEFITS DEPARTMENT	4.00	11, 568	0	28. 00
29. 00	RADI OLOGY-THERAPEUTI C	55. 00	3, 505		O EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 505	0	29. 00
30. 00	CT SCAN	57. 00	2, 337		O EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 337	0	30. 00
31. 00	MRI	58. 00	905		O EMPLOYEE BENEFITS DEPARTMENT	4.00	905	0	31. 00
32. 00	CARDI AC CATHETERI ZATI ON	59. 00	15, 265		O EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 265	0	32. 00
33. 00	LABORATORY	60. 00	44, 462		OEMPLOYEE BENEFITS DEPARTMENT	4.00	44, 462	0	33. 00
34. 00	LABORATORY-PATHOLOGI C	60. 01	1, 809		O EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 809	0	34. 00
35. 00	RESPIRATORY THERAPY	65. 00	21, 007		O EMPLOYEE BENEFITS DEPARTMENT	4.00	21, 007	0	35. 00
36. 00	PHYSI CAL THERAPY	66. 00	24, 424		O EMPLOYEE BENEFITS DEPARTMENT	4.00	24, 424	0	36. 00
37. 00	OCCUPATI ONAL THERAPY	67. 00	12, 660		O EMPLOYEE BENEFITS DEPARTMENT	4.00	12, 660	0	37. 00
38. 00	SPEECH PATHOLOGY	68. 00	10, 930		OEMPLOYEE BENEFITS DEPARTMENT	4.00	10, 930	0	38. 00
39. 00	ELECTROCARDI OLOGY	69. 00	2, 488		O EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 488	0	39. 00
40. 00	ELECTROENCEPHALOGRAPH Y	70. 00	9, 095		O EMPLOYEE BENEFITS DEPARTMENT	4.00	9, 095	0	40. 00
41. 00	CLI NI C	90. 00	5, 271		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	5, 271	0	41. 00
42. 00	DI ABETES CENTER	90. 01	113		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	113	0	42. 00
43. 00	NEUROPSYCH	90. 02	389		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	389	0	43. 00
44. 00	WOUND CENTER	90. 03	2, 174		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 174	0	44. 00
45. 00	HYPERBARI C OXYGEN THERAPY	90. 04	238		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	238	0	45. 00
46. 00	EMERGENCY	91. 00	37, 306		O EMPLOYEE BENEFITS DEPARTMENT	4. 00	37, 306	0	46. 00
47. 00	AMBULANCE SERVICES	95. 00	45, 194		O EMPLOYEE BENEFITS DEPARTMENT	4.00	45, 194	0	47. 00
48. 00	WELLNESS COMMUNITY	194. 00	2, 516		OEMPLOYEE BENEFITS DEPARTMENT	4.00	2, 516	0	48. 00
49. 00	HEALTHY COMMUNITIES	194. 07	40, 427		O EMPLOYEE BENEFITS DEPARTMENT	4.00	40, 427	0	49. 00

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0112 Period: Worksheet A-6
From 01/01/2016 Non-CMS Worksheet

						To	12/31/2016	Date/Time Pre 5/23/2017 8:0	pared:
		Incre	ases			Decrea	ises	0,20,201, 0.0	о р
	Cost Center	Line #	Sal ary	Other	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	9. 00	
	0		978, 991	3, 277, 526	0		978, 991	3, 277, 526	
	X - RECLASS OT SALARIE	S AND O	THER EXP						
1.00	OCCUPATI ONAL THERAPY	67. 00	694, 152	16 <u>5, 6</u> 41	PHYSICAL THERAPY	66.00	694, 152	16 <u>5, 6</u> 41	1.00
	0		694, 152	165, 641	0		694, 152	165, 641	
	Y - RECL MILLRACE FOR	WELLNES	S/OP/PT						
1.00	PHYSI CAL THERAPY	66. 00	0	7, 844	WELLNESS COMMUNITY	194.00	0	7, 844	1.00
2.00	OCCUPATIONAL THERAPY	67. 00	0	1, 641	WELLNESS COMMUNITY	194.00	0	1, 641	2.00
3.00	PHYSI CAL THERAPY	66. 00	0	3, 998	WELLNESS COMMUNITY	194.00	0	3, 998	3.00
4.00	OCCUPATI ONAL THERAPY	67. 00	0	837	WELLNESS COMMUNITY	194.00	0	837	4.00
	0		0	14, 320	0		0	14, 320	
	Z - RECLASS LAB BLOOD	SUPERVI:	SOR						
1.00	WHOLE BLOOD & PACKED	62. 00	68, 053	0	LABORATORY	60.00	68, 053	0	1. 00
	RED BLOOD CELL								
	0		68, 053	0	0		68, 053	0	
500.00	Grand Total:		4, 883, 955	39, 365, 531	Grand Total:		5, 407, 970	38, 841, 516	500.00
	Increases				Decreases				

					o 12/31/2016	Date/Time Prep	pared:
				Acqui si ti ons		5/23/2017 8: 0	5 pm
		Begi nni ng	Purchases	Donation	Total	Di sposal s and	
		Bal ances	i ui chases	Donation	Total	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	0.00		0.00	
1.00	Land	1, 806, 052	567, 014	C	567, 014	0	1. 00
2.00	Land Improvements	20, 531, 039	977, 924		977, 924	0	2. 00
3.00	Buildings and Fixtures	103, 012, 676	-4, 776, 937	C	-4, 776, 937	90, 595	3. 00
4.00	Building Improvements	98, 501, 867	9, 694, 216	C	9, 694, 216	0	4.00
5.00	Fixed Equipment	8, 157, 000	1, 090, 882	C	1, 090, 882	6, 047	5.00
6.00	Movable Equipment	130, 149, 410	10, 890, 625	C	10, 890, 625	3, 270, 990	6.00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	362, 158, 044	18, 443, 724	C	18, 443, 724	3, 367, 632	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	362, 158, 044	18, 443, 724	C	18, 443, 724	3, 367, 632	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						4 00
1.00	Land	2, 373, 066	0				1. 00
2.00	Land Improvements	21, 508, 963	0				2. 00
3.00	Buildings and Fixtures	98, 145, 144	0				3. 00
4.00	Building Improvements	108, 196, 083	0				4. 00
5.00	Fi xed Equi pment	9, 241, 835	0				5. 00
6.00	Movable Equipment	137, 769, 045	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	377, 234, 136	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	377, 234, 136	0	I			10. 00

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0112	Peri od:	Worksheet A-7	
					From 01/01/2016		nanad.
					To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
			SI	UMMARY OF CAP	I TAL	072072017 0.0	o piii
			_		· · · · <del>-</del>		
	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 WORL	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	17, 872, 057	C		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0	0	2. 00
3.00	Total (sum of lines 1-2)	17, 872, 057			0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum	ו			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00	4			
	DART II. DECONOLINATION OF ANOUNTO FROM WOR	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	17, 872, 057				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	(	)			2.00
3. 00	Total (sum of lines 1-2)	0	17, 872, 057	<b>'</b>			3. 00

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2016 To 12/31/2016		
		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 (col. 1 - col	instructions)		
				2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	239, 465, 089				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	137, 769, 046	l .	1077707701			2.00
3.00	Total (sum of lines 1-2)	377, 234, 135		377, 234, 13			3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1		0.075.040		
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 8, 875, 840		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		9, 007, 616		2.00
3.00	Total (sum of lines 1-2)	0	0	INMARY OF CARL	0 17, 883, 456	0	3. 00
			St.	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLES COCTO OF	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	831, 914	921, 277			10, 629, 031	1. 00
2.00	CAP REL COSTS-BLDG & FTXT	190, 122			0 0		2. 00
3.00	Total (sum of lines 1-2)	1, 022, 036			0 0		
3.00	Total (Sum Of Titles 1-2)	1,022,030	721,2//	'	0	17,020,709	3.00

					To 12/31/2016	Date/Time Prep 5/23/2017 8:05	
				Expense Classification or	n Worksheet A	372372017 0.00	у ріп
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1 00	Lauraturat i array CAR REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-121, 897	CAP REL CUSTS-BLDG & FIXT	1.00	11	1. 00
2.00	Investment income - CAP REL	В	-20, 340	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		_			_	
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time	В	-96, 388	ADMINISTRATIVE & GENERAL	5. 00	o	4. 00
	discounts (chapter 8)						
5.00	Refunds and rebates of	В	-55, 260	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)					]	
7.00	Tel ephone servi ces (pay	A	-100, 694	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	A	-10, 309	OPERATION OF PLANT	7. 00	o	8. 00
	(chapter 21)						
9.00	Parking lot (chapter 21)	В		OPERATION OF PLANT	7. 00		9.00
10. 00	Provider-based physician adjustment	A-8-2	-7, 559, 773			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	О	11.00
	(chapter 23)					_	
12. 00	Related organization transactions (chapter 10)	A-8-1	-751, 959			0	12. 00
13. 00	Laundry and Linen service		0		0.00	o	13. 00
14. 00	Cafeteria-employees and guests	В	-774, 844	CAFETERI A	11. 00	Ō	14. 00
15. 00	Rental of quarters to employee		0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		0		0.00	Ĭ	10.00
	pati ents						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-19 246	MEDICAL RECORDS & LIBRARY	16. 00	o	18. 00
	abstracts		17,210		10.00		
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines	В	-170	  HOUSEKEEPI NG	9. 00	0	20. 00
21. 00	Income from imposition of		0	I I I I I I I I I I I I I I I I I I I	0.00	Ö	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21)		0		0.00	0	22. 00
22.00	Interest expense on Medicare overpayments and borrowings to		U		0.00	٥	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		^	*** Cost Center Deleted ***	114.00		25. 00
25.00	physicians' compensation		U	Cost Center Dereted	114.00		25.00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
	COSTS-MVBLE EQUIP		_				
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	Λ Ω 2	0	OCCUPATIONAL THERADY	0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	Ü	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
31.00	pathology costs in excess of	A 0-3	0	or ELON TATHOLOGY	00.00		31.00
0.5	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	TELEPHONE SERVICES	В	-3. 900	ADMINISTRATIVE & GENERAL	5. 00	o	33. 00
	DEPR PAT PHONES NEW EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2. 00		

Peri od: Worksheet A-8
From 01/01/2016
To 12/31/2016 Date/Time Prepared:

				To	12/31/2016		
				Expense Classification on	Worksheet A	5/23/2017 8:0	5 pm
				To/From Which the Amount is 1			
	Cook Cooker Dooreitstier	D:- (01- (2)	A +	C+ C+	1: //	WI+ A 7 D-6	
	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	
35. 00	TV DEPR NEW EQUIP	1.00 A		CAP REL COSTS-MVBLE EQUIP	2.00		35. 00
36. 00	CAFETERIA VISITORS	A		CAFETERIA	11. 00	l	
37. 00	OPERATING REVENUE OTHER	B		OPERATING ROOM	50.00	l	37. 00
07.00	REVENUE		27, 100	or Electrical Region	00.00		07.00
37. 01	VIMCARE CLINIC OTHER REVENUE	В	-32, 132	VIMCARE CLINIC	90. 05	0	37. 01
38.00	NURSING ADMIN OTHER REVENUE	В	-856	NURSING ADMINISTRATION	13.00	0	38. 00
39.00	INPATIENT PT	В	-142	PHYSI CAL THERAPY	66.00	0	39. 00
40.00	EAP REVENUE	В	-23, 458	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	40.00
41.00	BOND AMORTIZATION	A	82, 092	CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	LAND RENT MOB	В	-2, 000	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
43.00	RENT FOXPOINTE LAND SWAP	В	-37, 214	ADMINISTRATIVE & GENERAL	5. 00	0	43.00
44.00	LABORATORY OTHER REVENUE	В	-19, 958	LABORATORY	60.00	0	44. 00
44. 01	EMPLOY BENEFITS OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	44. 01
45. 00	XRAY EDUCATION	В	· ·	XRAY EDUCATION	23. 01	0	45. 00
45. 01	MEDICAL STAFF INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	l	45. 01
45. 02	RADI OLOGY OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	1	45. 02
45. 03	BREAST FILM COPIES	В		MAMMOGRAPHY	54. 03	l	45. 03
45. 04	MEDICAL RECORDS OTHER REVENUE	В	· ·	MEDICAL RECORDS & LIBRARY	16.00		
45. 05	FACILITIES OTHER REVENUE	В		OPERATION OF PLANT	7. 00	l	45. 05
45. 06	SICK BAY	В		ADULTS & PEDIATRICS	30.00	1	45. 06
45. 07	RADI ATI ON ONCOLOGY OTHER	В	-225	RADI OLOGY-THERAPEUTI C	55. 00	0	45. 07
45. 08	REVENUE ADMIN OTHER REVENUE	В	111 740	ADMINISTRATIVE & CENEDAL	E 00	0	45. 08
45. 09	MRES GRANT OTHER	В		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	l e	45. 09
45. 10	I NFO SERV OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	l	1
45. 10	FOOD OTHER REVENUE	В		DI ETARY	10. 00	i e	45. 10
45. 12	SPEECH THERAPY OTHER REVENUE	B		SPEECH PATHOLOGY	68. 00	l	45. 12
45. 13	PROTECTI VE SERV OTHER REVENUE	В		OPERATION OF PLANT	7. 00	l	45. 13
45. 14	PHARMACY OTHER REVENUE	В		PHARMACY	15. 00	l	45. 14
45. 15	HUMAN RESOURCES OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00		45. 15
45. 16	LACTATION AND PREPARE OTHER	В		ADULTS & PEDIATRICS	30.00	l	1
	REVENUE		., .				
45. 17	VOLUNTEER OTHER REVENUE	В	-82, 028	ADMINISTRATIVE & GENERAL	5. 00	0	45. 17
45. 18	RENTAL PROPERTIES DEPRECIATION	A	-79, 821	CAP REL COSTS-BLDG & FIXT	1.00	9	45. 18
45. 19	BUSINESS PLANNING MARKETING	В	-63, 142	ADMINISTRATIVE & GENERAL	5. 00	0	45. 19
	OTH REV						
45. 20	PENSION EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	l	
45. 21	LOSS ON DISPOSAL DEMOLITION	A	· ·	CAP REL COSTS-BLDG & FIXT	1.00	l	45. 21
45. 22	UNALLOWABLE PHYS RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	l	
45. 23	DEPRECIATION RELIFED	Α		CAP REL COSTS-BLDG & FIXT	1.00	l e	45. 23
45. 24	DEPRECIATION RELIFED	A		CAP REL COSTS-MVBLE EQUIP	2.00	l e	
	DI ABETES CLINIC	В		DI ABETES CENTER	90. 01	0	
	PRIOR YEAR AUDIT ADJUSTMENT	A		CAP REL COSTS-BLDG & FIXT	1.00		10.27
45. 28	NONALLOWABLE INT EXP 1993	A	-78, 677	CAP REL COSTS-MVBLE EQUIP	2. 00	11	45. 28
45. 29	BONDS	_	200 007	CAP REL COSTS-MVBLE EQUIP	2.00	11	45 20
45. 29	NONALLOWABLE INT EXP 2003/2009	A	-200, 096	CAP REL COSTS-MVBLE EQUIP	2. 00	''	45. 29
45. 30	BONDS UNALLOWABLE AHA MEMBERSHIP	A	10 252	ADMINISTRATIVE & GENERAL	5. 00	0	45. 30
45. 30	DUES	"	- 12, 353	ADMINISTRATIVE & GENERAL	5.00	l "	45.30
45. 31	AMBULANCE SERVICES	В	-428 815	AMBULANCE SERVICES	95.00	0	45. 31
45. 32	COPY CENTER OTHER REVENUE	В	· ·	ADMI NI STRATI VE & GENERAL	5. 00	1	
45. 33	WELLCONNECT OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	l	45. 33
45. 34	HAF ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00		1
50. 00	TOTAL (sum of lines 1 thru 49)	.,	-20, 109, 975	1	2.00		50.00
	(Transfer to Worksheet A,		., , , , , ,				
	column 6, line 200.)						
(1) Do	scription - all chapter referen	coc in this col	ump portain to	CMC Dub 1E 1			

<sup>(1)</sup> 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.

<sup>(3)</sup> 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.

 that het bein posted to his kondet A, est dimino i direction and a service of the								
			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
•		Ownershi p		Ownershi p				
1. 00	2. 00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

6. 00	E	J BICKEL	O.OOSI HEALTH MANAGEMENT	0. 00	6. 00
7. 00	E	M HUNT	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:

Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		COLUMBUS REGIONAL	_ HOSPI TAL	In Lieu	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provider CCN: 15-0112	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2016 To 12/31/2016	Date/Time Pre	
							5/23/2017 8:0	)5 pm
		Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQ	QUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED (	ORGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	-751, 959	C						1.00
2.00	0	C						2.00
3.00	0	C						3.00
4.00	0	C						4. 00
5.00	-751, 959							5. 00
* The	amaunta an lin		ooninto	aa anneaneiata) asa tean	oformed in detail to Wen	labort A column	/ Lines so	

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

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0112

							5/23/2017 8:0	)5 pm
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1 00	2.00	2.00	4.00	5. 00	6. 00	Hours	
1. 00	1.00	ADMI NI STRATI VE & GENERAL	3. 00 6, 691, 246		202, 775	211, 500	7. 00	1. 00
2. 00		ADULTS & PEDIATRICS	810, 689			211, 500		2. 00
3. 00		INTENSIVE CARE UNIT	27, 200			211, 500		3. 00
4. 00		SUBPROVI DER - I RF	80, 000			211, 500	2, 133	4. 00
5.00	50. 00	OPERATING ROOM	445, 350	0	445, 350	246, 400	3, 041	5. 00
6.00	53. 00	ANESTHESI OLOGY	45, 000	0	45, 000	246, 400	312	6.00
7. 00		RADI OLOGY-DI AGNOSTI C	55, 300			271, 900		7. 00
8. 00		RADI OLOGY-THERAPEUTI C	67, 500			271, 900		8. 00
9. 00		CARDI AC CATHETERI ZATI ON	84, 145	0		211, 500	421	9.00
10.00		LABORATORY-PATHOLOGI CAL	225, 000			260, 200		10.00
11. 00 12. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY	14, 000 48, 744			211, 500 211, 500	1	11. 00 12. 00
13. 00		ELECTROENCEPHALOGRAPHY	9, 600			211, 500		13. 00
14. 00		CARDI AC REHABI LI TATI ON	5, 429			211, 500	1	14. 00
15. 00		NEUROPSYCH	182, 406			0	o	15. 00
16. 00	90. 03	WOUND CENTER	5, 429	0	5, 429	211, 500	55	16.00
17. 00		HYPERBARIC OXYGEN THERAPY	596	0		211, 500	6	17.00
18. 00		EMERGENCY	1, 633, 416	0		211, 500	17, 328	18. 00
19. 00	95. 00	AMBULANCE SERVICES	17, 500		17, 500	211, 500		19.00
200.00	Wkst. A Line #	Cost Center/Physician	10, 448, 550		3, 196, 367 Cost of	Provi der	30,370 Physician Cost	200. 00
	wkst. A Line #	I denti fi er	Unadjusted RCE Limit		Memberships &		of Malpractice	
		T deliter i i e i	2111111	Li mi t	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	95, 988				0	1. 00
2. 00 3. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	238, 344 28, 064	11, 917 1, 403	0	0	0	2. 00 3. 00
4. 00		ISUBPROVIDER - IRF	216, 889			0		4. 00
5. 00		OPERATI NG ROOM	360, 241	18, 012	0	0	Ö	5. 00
6.00		ANESTHESI OLOGY	36, 960		0	0	0	6. 00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	25, 883	1, 294	0	0	0	7.00
8. 00	55. 00	RADI OLOGY-THERAPEUTI C	95, 296			0	0	8. 00
9. 00		CARDIAC CATHETERIZATION	42, 808			0	0	9. 00
10.00		LABORATORY-PATHOLOGI CAL	215, 541	10, 777	0	0	0	10.00
11. 00		PHYSI CAL THERAPY	32, 945		0	0	0	11. 00
12. 00 13. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	26, 133 10, 270			0	0	12. 00 13. 00
14. 00		CARDI AC REHABI LI TATI ON	2, 745			0	0	14. 00
15. 00		NEUROPSYCH	0	0		0	Ö	15. 00
16. 00		WOUND CENTER	5, 592	280	0	0	o	16.00
17. 00	90. 04	HYPERBARIC OXYGEN THERAPY	610	31	0	0	0	17.00
18. 00		EMERGENCY	1, 761, 958			0	0	18.00
19. 00	95. 00	AMBULANCE SERVICES	15, 354			0	0	19. 00
200.00	Wkst. A Line #	Cost Center/Physician	3, 211, 621 Provi der	160, 581 Adjusted RCE	RCE 0	Adiustment	0	200. 00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Adjustment		
		r deliter i i ei	Share of col.	2111111	Di Sai i Gwanee			
			14					
4.00	1. 00	2.00	15. 00	16. 00	17. 00	18.00		1.00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0		106, 787 0	6, 595, 258 581, 306	1	1. 00 2. 00
3.00		INTENSIVE CARE UNIT			0	0		3. 00
4. 00		SUBPROVI DER - I RF	0			Ö		4. 00
5. 00		OPERATING ROOM	Ö		85, 109	85, 109		5. 00
6. 00	53. 00	ANESTHESI OLOGY	0	36, 960		8, 040		6. 00
7.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	25, 883	29, 417	29, 417		7. 00
8. 00		RADI OLOGY-THERAPEUTI C	0	95, 296	0	0		8. 00
9. 00		CARDIAC CATHETERIZATION	0	,		41, 337		9. 00
10.00		LABORATORY-PATHOLOGI CAL	0		9, 459	9, 459		10.00
11. 00		PHYSI CAL THERAPY		32, 945		0		11. 00
12. 00 13. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	26, 133 10, 270		22, 611 0		12. 00 13. 00
14. 00		CARDI AC REHABI LI TATI ON	0	1		2, 684		14. 00
15. 00		NEUROPSYCH	١	2,749		182, 406	1	15. 00
16. 00		WOUND CENTER	Ö	1		0	1 1	16. 00
17. 00		HYPERBARIC OXYGEN THERAPY	0		0	0		17. 00
18. 00		EMERGENCY	0			0	l l	18. 00
19. 00	95. 00	AMBULANCE SERVICES	0				1	19. 00
200. 00			0	3, 211, 621	307, 590	7, 559, 773	ı l	200. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0112 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 8:05 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 10, 629, 031 10, 629, 031 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 197, 738 9, 197, 738 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 27, 357, 769 189, 719 8,505 27, 555, 993 4.00 1, 044, 515 39, 000, 303 5 00 00500 ADMINISTRATIVE & GENERAL 29, 491, 545 4, 129, 205 4, 335, 038 5 00 7.00 00700 OPERATION OF PLANT 6, 195, 893 5, 311, 425 412, 712 830, 854 12, 750, 884 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 661, 390 10, 532 19, 670 691, 592 8.00 00900 HOUSEKEEPI NG 2, 178, 577 73, 679 12, 970 610, 936 2, 876, 162 9.00 9.00 01000 DI ETARY 1, 234, 061 114, 323 214, 549 10 00 10.00 888.645 16, 544 11.00 01100 CAFETERI A 861, 208 89, 157 36, 739 476, 432 1, 463, 536 11.00 01300 NURSING ADMINISTRATION 5, 043, 148 13.00 3, 571, 877 143, 387 66, 318 1, 261, 566 13.00 01400 CENTRAL SERVICES & SUPPLY 110, 715 99, 355 1, 344, 495 14.00 1.134.317 108 14.00 385, 842 15.00 01500 PHARMACY 5, 344, 562 68, 879 1, 235, 069 7, 034, 352 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 436, 303 58, 143 39, 314 298, 300 1, 832, 060 16.00 01700 SOCIAL SERVICE 17.00 521, 915 4, 393 190, 676 717, 063 17.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 0 23 01 02301 XRAY EDUCATION 463, 409 9,572 10 175 302 648, 293 23 01 361, 945 130, 001 02302 PHARMACY RESIDENCY PROG 497, 416 23.02 5, 470 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 15, 593, 649 22, 299, 906 30.00 03000 ADULTS & PEDIATRICS 1, 111, 473 383, 375 5, 211, 409 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 901, 658 159, 418 148, 576 690, 455 3, 900, 107 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 0 0 0 0 34.00 40.00 04000 SUBPROVIDER - IPF 0 Λ 40.00 04100 SUBPROVI DER - I RF 41.00 1, 670, 053 161, 251 16, 381 555, 728 2, 403, 413 41.00 42.00 04200 SUBPROVI DER 42.00 0 43.00 04300 NURSERY 732, 017 8, 481 16, 912 264, 356 1, 021, 766 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 20, 554, 428 50.00 05000 OPERATING ROOM 18. 673. 528 50.00 568, 414 1, 116, 195 196, 291 51.00 05100 RECOVERY ROOM 1, 349, 572 46, 331 32, 758 515 1, 429, 176 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 05300 ANESTHESI OLOGY 242, 244 10, 960 254, 935 53.00 1, 731 0 53.00 2, 909, 117 05400 RADI OLOGY-DI AGNOSTI C 158, 024 54.00 2, 076, 647 122, 120 552, 326 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 1, 141, 052 49, 226 7,722 117, 628 1, 315, 628 54.01 54.02 05404 ULTRA SOUND 668, 550 21,878 36,606 172, 191 899, 225 54.02 3, 971 05405 MAMMOGRAPHY 1, 116, 090 14, 300 1, 403, 432 54 03 269, 071 54 03 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 991, 352 113, 174 663, 546 561, 209 3, 329, 281 55.00 57.00 05700 CT SCAN 932, 983 21, 398 234, 045 223, 410 1, 411, 836 57.00 58.00 05800 MRI 430, 989 13, 092 13, 796 104, 159 562, 036 58.00 05900 CARDIAC CATHETERIZATION 2, 989, 661 585 368 59 00 2 150 053 154, 137 100 103 59 00 60.00 06000 LABORATORY 7, 137, 253 156, 508 156, 893 1, 329, 846 8, 780, 500 60.00 06001 LABORATORY-PATHOLOGI CAL 728, 878 16, 974 121, 212 884, 695 60.01 17, 631 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 610, 304 7, 622 4. 158 25,073 647, 157 62.00 95, 994 06500 RESPIRATORY THERAPY 1.805,653 576, 014 65.00 127, 648 2, 605, 309 65 00 66.00 06600 PHYSI CAL THERAPY 3, 994, 915 3, 302 25, 229 1, 284, 043 5, 307, 489 66.00 06700 OCCUPATIONAL THERAPY 1, 427, 901 67.00 3, 215 5, 310 450, 869 1, 887, 295 67.00 06800 SPEECH PATHOLOGY 858, 960 1, 153, 217 68.00 20, 605 273.652 68.00 06900 ELECTROCARDI OLOGY 20, 336 69 00 591, 768 28.823 196, 501 837, 428 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 888, 230 13, 901 241, 979 1, 144, 110 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 5, 958, 498 C 5, 958, 498 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 7.582.734 7, 582, 734 72 00 C 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 17, 026, 798 0 0 17, 026, 798 73.00 07400 RENAL DIALYSIS 0 74.00 549, 970 63 550, 033 74.00 03020 ACUPUNCTURE 76.00 76, 00 07697 CARDIAC REHABILITATION 22, 998 12, 804 400, 446 303, 095 76.97 61, 549 76.97 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 98, 540 295, 227 1, 575, 233 90.00 09000 CLI NI C 1, 139, 414 42.052 90 00 09001 DIABETES CENTER 11, 274 40, 542 275, 815 90.01 223, 106 893 90.01 90.02 09002 NEUROPSYCH 101, 608 1, 949 36 30, 997 134, 590 90.02 09003 WOUND CENTER 1, 298, 017 90.03 2,018 161, 790 1, 461, 825 90.03 90.04 09004 HYPERBARIC OXYGEN THERAPY 252, 540 222 24, 127 276, 889 90.04 19, 682 90.05 09005 VIMCARE CLINIC 167, 980 2,589 63, 297 253, 548 90.05 09100 EMERGENCY 8, 087, 630 213, 779 273, 974 91.00 91.00 1, 932, 114 10, 507, 497 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0

Health Financial Systems	COLUMBIA DECLO	NAL HOCDITAL		la li o	u of Form CMC o	JEEO 10
Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	COLUMBUS REGIO	Provider CC		Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet B Part I Date/Time Prep 5/23/2017 8:05	pared:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2. 00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 693, 561	107, 079			4, 108, 766	95.00
99. 10   09910   CORF	0	0		이	0	99. 10
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						400 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100   SLET ACQUI SI TI ON	0	U		이 이		111. 00
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1-117)	245 205 274	10 5/0 010	0 102 50	4 07 411 075		113.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)  NONREI MBURSABLE COST CENTERS	215, 395, 374	10, 569, 913	9, 183, 58	4 27, 411, 075	215, 177, 184	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		10, 575	36	1 0	10, 936	100 00
194. 00 07950  WELLNESS COMMUNITY	269, 493		13, 06		346, 841	
194. 01 07951 BUI LDI NG RENTALS	78, 408	19, 304	13,00	04, 200	97, 712	
194. 02 07952 HOSPI CE	70, 946	17, 304			70, 946	
194. 03 07953 OUTREACH CLINICS	70,710	0				194. 03
194. 04 07954 SPEECH - HEARING AIDS	264, 590	0			264, 590	
194. 05 07955 NONALLOWABLE MARKETING	1, 605, 965	0		ol ol	1, 605, 965	
194. 06 07956 CRH FOUNDATION	1, 376		72	5 343	14, 300	
194. 07 07957 HEALTHY COMMUNITIES	174, 469			0 61, 307	253, 159	
194. 08 07958 CRHP	51, 538			0 18, 988	70, 526	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		ol o	0	201. 00
202.00 TOTAL (sum lines 118-201)	217, 912, 159	10, 629, 031	9, 197, 73	8 27, 555, 993	217, 912, 159	202. 00

				T	o 12/31/2016	Date/Time Pre 5/23/2017 8:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LI NEN SERVI CE 8. 00	9. 00	10. 00	
4.00	GENERAL SERVICE COST CENTERS			ī			1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					I	1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	39, 000, 303				I	5. 00
7. 00	00700 OPERATION OF PLANT	2, 779, 514	15, 530, 398			I	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	150, 757	40, 056			I	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	626, 963 269, 008	280, 226 434, 807		-, ,	1, 968, 893	9. 00 10. 00
11. 00	01100 CAFETERI A	319, 030	339, 093		67, 942	1, 400, 643	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 099, 336	545, 348		10, 339		
14.00	01400 CENTRAL SERVICES & SUPPLY	293, 081	421, 086		34, 710	0	1
15. 00	01500 PHARMACY	1, 533, 390	261, 969		45, 049	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	399, 363	221, 138			0	
17. 00 23. 00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM-(SPECIFY)	156, 310	16, 708 0	0	1, 477	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	141, 319	36, 405	1	8, 124	0	
23. 02	02302 PHARMACY RESIDENCY PROG	108, 430	20, 803			ő	
	INPATIENT ROUTINE SERVICE COST CENTERS		.,				
30.00	03000 ADULTS & PEDIATRICS	4, 861, 092	4, 227, 294	334, 824	1, 329, 304	1, 544, 795	
31. 00	03100 INTENSIVE CARE UNIT	850, 169	606, 318	1	111, 514	148, 453	1
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00 34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	
40. 00	04000 SUBPROVI DER - I PF		0	Ö	0	Ö	
41. 00	04100 SUBPROVI DER - I RF	523, 910	613, 289	49, 258	160, 255	226, 697	
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	222, 731	32, 255		1, 477	0	
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4, 480, 578	2, 161, 864	182, 448	604, 834	4, 434	50.00
51.00	05100 RECOVERY ROOM	311, 540	176, 213			0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1
53.00	05300 ANESTHESI OLOGY	55, 572	6, 584	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	634, 147	464, 462			933	1
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	286, 788	187, 223		,	0	
54. 02	05404 ULTRA SOUND	196, 018	83, 210		20, 678		1
54. 03 55. 00	05405   MAMMOGRAPHY   05500   RADI OLOGY - THERAPEUTI C	305, 929 725, 737	15, 104			0 4, 497	
55.00	05700 CT SCAN	307, 760	430, 436 81, 385			4, 497	1
58. 00	05800 MRI	122, 516	49, 793			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	651, 704	586, 234	4, 227	91, 574	4, 012	
60.00	06000 LABORATORY	1, 914, 026	595, 253	0	87, 143	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	192, 851	67, 055	0	5, 908	0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	141, 071	28, 991	0	2, 954	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	567, 921 1, 156, 958	365, 096 12, 559		96, 744	0 0	
67. 00	06700 OCCUPATI ONAL THERAPY	411, 404	12, 339	9, 195	0	0	
68. 00	06800 SPEECH PATHOLOGY	251, 385	12, 227	7, 179	0	Ö	
69. 00	06900 ELECTROCARDI OLOGY	182, 548	77, 346	Ō	18, 463	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	249, 400	0	1, 129	153, 609	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 298, 869	0	0	0	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 652, 930	0	0	0	0	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	3, 711, 604	0	0	0	0	
76.00	03020 ACUPUNCTURE	119, 899	0	0	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	87, 292	87, 470	0	4, 431	Ö	1
	OUTPATIENT SERVICE COST CENTERS	, ,					
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	1
90.00	09000 CLINIC	343, 379	374, 778				1
90. 01 90. 02	O9001   DI ABETES CENTER   O9002   NEUROPSYCH	60, 124 29, 339	42, 878 7, 414		2, 954	0	1
90. 02	09003 WOUND CENTER	318, 657	7,414	4, 436	0	0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	60, 358	0	486		Ö	1
90. 05	09005 VI MCARE CLI NI C	55, 270	74, 856		0	0	
91.00	09100 EMERGENCY	2, 290, 487	813, 071	66, 453	401, 007	9, 889	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05 05	OTHER REIMBURSABLE COST CENTERS	005 (5-1	407.055	-	-1	-	05.00
	09500 AMBULANCE SERVI CES 09910 CORF	895, 653	407, 255		_	0	
	10100 HOME HEALTH AGENCY	0 0	0	0	_		99. 10 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		<u> </u>	0	1.01.00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00

					5/23/201/ 8:05 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
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	38, 404, 117	15, 305, 552	882, 405	3, 757, 503	1, 968, 893 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 384	40, 222	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	75, 606	0	0	0	0 194. 00
194.01 07951 BUILDING RENTALS	21, 300	73, 418	0	0	0 194. 01
194. 02 07952 HOSPI CE	15, 465	0	0	0	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	57, 677	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	350, 078	0	0	0	0 194. 05
194.06 07956 CRH FOUNDATION	3, 117	45, 091	0	22, 155	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	55, 185	66, 115	0	3, 693	0 194. 07
194. 08 07958 CRHP	15, 374	0	0	0	0 194. 08
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	o	0 201. 00
202.00 TOTAL (sum lines 118-201)	39, 000, 303	15, 530, 398	882, 405	3, 783, 351	1, 968, 893 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: 5/23/2017 8:05 pm

					5/23/2017 8: 0	5 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
			SUPPLY		LIBRARY	
GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00 O0100 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	2, 189, 601	1				11. 00
13. 00 01300 NURSING ADMINISTRATION	77, 907					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	26, 652		2, 228, 911	0.050.747		14.00
15. 00 01500 PHARMACY	75, 857	1	0	8, 950, 617	2 514 0/7	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	61, 506	1	0	0	2, 514, 067 0	16. 00 17. 00
23. 00   02300   PARAMED ED PRGM-(SPECIFY)	14, 351	63, 274	0	0	0	23. 00
23. 01   02301   XRAY EDUCATION	14, 351		0	0	0	23. 00
23. 02   02302   PHARMACY RESI DENCY PROG	8, 201		0	0	Ö	23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,20.	<u> </u>	<u> </u>			20.02
30. 00 03000 ADULTS & PEDIATRICS	520, 746	2, 159, 438	105, 361	8, 368	541, 244	30.00
31.00 03100 INTENSIVE CARE UNIT	57, 405	237, 797	3, 808	1, 447	42, 560	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 -   1 PF	0	0	0	0	0	40. 00
41. 00   04100   SUBPROVI DER -   RF	49, 205	204, 885	0	214	83, 600	41.00
42. 00   04200   SUBPROVI DER	20 502	0 0 0	2 244	0	0	42.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	20, 502	85, 582	3, 264	2	0	43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS		<u>/</u>	U	0	U	44.00
50. 00 05000 OPERATING ROOM	233, 721	972, 227	1, 989, 537	31, 590	753, 916	50. 00
51. 00   05100   RECOVERY   ROOM	26, 652		0	49	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	20,002	1	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	2,050	9, 353	0	36, 478	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	45, 104		1, 269	1, 930	0	54.00
54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	8, 201	O	0	81, 254	0	54.01
54. 02   05404   ULTRA SOUND	10, 251	0	0	356	0	54.02
54. 03   05405   MAMMOGRAPHY	24, 602	1	1, 451	228	0	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	30, 753		0	51	52, 820	55. 00
57. 00   05700   CT   SCAN	18, 452	. 0	0	7, 515	0	57. 00
58. 00   05800   MRI	8, 201	1/0 020	17 220	315	12 172	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	41, 004		17, 228	2, 376	13, 173 0	59.00
60. 00   06000  LABORATORY 60. 01   06001  LABORATORY-PATHOLOGI CAL	157, 864 10, 251	. 0	0	220	246, 492	60. 00 60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 050		0	0	240, 492	62. 00
65. 00 06500 RESPIRATORY THERAPY	53, 305		1, 632	3, 268	4, 433	65. 00
66. 00   06600   PHYSI CAL THERAPY	100, 459		46, 606	1, 612	21, 533	
67. 00 06700 OCCUPATI ONAL THERAPY	32, 803		0	149	4, 560	
68. 00 06800 SPEECH PATHOLOGY	18, 452		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	16, 402	66, 814	0	1, 851	270, 179	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	18, 452	74, 908	0	7	185, 439	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	8, 727, 705	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	0	3, 528	0	74.00
76. 00   03020   ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	6, 151	22, 893	0	0	0	76. 97
88. 00   08800   RURAL HEALTH CLINIC	0	ار	0	<u> </u>	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89. 00
90. 00   09000   CLINIC	28, 703	_	181	348	292, 598	90.00
90. 01 09001 DI ABETES CENTER	2, 050		0	0.0	0	90. 01
90. 02 09002 NEUROPSYCH	4, 100		0	0	1, 520	90. 02
90. 03 09003 WOUND CENTER	16, 402		49, 144	19, 104	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	2, 050	10, 715	0	0	0	90. 04
90. 05   09005   VI MCARE CLI NI C	6, 151		0	1, 003	0	90. 05
91. 00 09100 EMERGENCY	180, 417	637, 225	9, 430	11, 691	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	1 400 4:-	F=0 =0-1	-1	=	-	05.00
95. 00   09500   AMBULANCE SERVI CES	139, 413	1	0	7, 446	0	95.00
99. 10   09910   CORF 101. 00   10100   HOME   HEALTH   AGENCY	0	1	0	0	0	99. 10 101. 00
TOT. DO TO TOO HOWE HEALTH AGENCT	1	'i 이	U	Ü	0	101.00

| Peri od: | Worksheet B | From 01/01/2016 | Part | | To 12/31/2016 | Date/Time Prepared:

			10	12/31/2010	5/23/2017 8:0	
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		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 1-117)	2, 171, 149	6, 737, 737	2, 228, 911	8, 950, 105	2, 514, 067	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	10, 251	38, 341	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	512		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	6, 151		0	0		194. 07
194. 08 07958 CRHP	2, 050	0	0	0	0	194. 08
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	2, 189, 601	6, 776, 078	2, 228, 911	8, 950, 617	2, 514, 067	202. 00

				1	0 12/31/2016	Date/lime Pre   5/23/2017 8:0	
	Cost Center Description	SOCIAL SERVICE		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	23.01	23.02	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE	969, 183					17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
23. 01	02301 XRAY EDUCATION	0		848, 492			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0			638, 543		23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	246, 171	0		ol	20 170 E42	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	61, 059	0		0	38, 178, 543 6, 062, 381	31.00
32. 00	03200 CORONARY CARE UNIT	01,039	0	0	0	0,002,381	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			0	33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0	Ö	o	0	34.00
40.00	04000 SUBPROVI DER - I PF	O	0	0	o	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	146, 347	0	0	O	4, 461, 073	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	0	0	0		1, 401, 256	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
FO 00	ANCILLARY SERVICE COST CENTERS					24 0/0 577	 
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0	0		31, 969, 577 2, 191, 511	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			2, 191, 511	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	364, 972	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	848, 492	o	5, 090, 980	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	O	1, 941, 867	54. 01
54. 02	05404 ULTRA SOUND	0	0	0	О	1, 209, 738	54. 02
54.03	05405 MAMMOGRAPHY	0	0	0	0	1, 796, 032	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	33, 921	0	0	0	4, 808, 367	55. 00
57. 00	05700 CT SCAN	0	0	0	0	1, 838, 764	
58. 00	05800 MRI	0	0	0	0	750, 985	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	4, 571, 032	59.00
60. 00 60. 01	06000  LABORATORY   06001  LABORATORY-PATHOLOGI CAL		0	0	0	11, 535, 006 1, 407, 252	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	1 0	0	822, 223	1
65. 00	06500 RESPIRATORY THERAPY		0	0	o o	3, 922, 179	1
66. 00	06600 PHYSI CAL THERAPY	o	0	Ö	o	7, 074, 512	1
67.00	06700 OCCUPATI ONAL THERAPY	O	0	0	o	2, 495, 565	
	06800 SPEECH PATHOLOGY	0	0	0	o	1, 501, 470	68. 00
69. 00		0	0	0	0	1, 471, 031	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1, 827, 054	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7, 257, 367	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	(00.540	9, 235, 664	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	638, 543	30, 104, 650	
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	0	0	0	0	673, 460 0	74. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	61, 059	0		0	669, 742	76. 00
70. 77	OUTPATIENT SERVICE COST CENTERS	01,037			<u> </u>	007, 742	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	O	0	89. 00
90.00	09000 CLI NI C	193, 837	0	0	0	3, 053, 790	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	396, 400	90. 01
90. 02	09002 NEUROPSYCH	0	0	0	0	193, 139	90. 02
90. 03		0	0	0	0	1, 933, 545	•
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	0	0	350, 498	
90.05	09005 VI MCARE CLI NI C	227 700	0	0	0	419, 092	
91.00	09100 EMERGENCY	226, 789	0	U	U	15, 153, 956	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	nl	0	0	n	6, 138, 326	95. 00
	09910 CORF	0	0	1		0, 130, 320	99. 10
	10100 HOME HEALTH AGENCY	0	0	Ö	O		101. 00
	SPECIAL PURPOSE COST CENTERS				-1		
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
	<u> </u>						

					5/23/2017 8: 0	5 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	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	969, 183	0	848, 492	638, 543	214, 272, 999	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	53, 542	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	0	471, 039	194. 00
194. 01 07951 BUILDING RENTALS	0	0	0	0	192, 430	194. 01
194. 02 07952 HOSPI CE	0	0	0	0	86, 923	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	322, 267	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	1, 956, 043	194. 05
194. 06 07956 CRH FOUNDATION	0	0	0	0	84, 663	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	384, 303	194. 07
194. 08 07958 CRHP	0	0	0	0	87, 950	194. 08
200.00 Cross Foot Adjustments		0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	969, 183	0	848, 492	638, 543	217, 912, 159	202. 00

				To 12/31/2016 Date/lime 5/23/2017	
	Cost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments	2/ 00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00 7. 00	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 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY				13. 00 14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01 23. 02	02301 XRAY EDUCATION 02302 PHARMACY RESIDENCY PROG				23. 01
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				23. 02
30.00		0	38, 178, 543		30.00
31.00	03100 INTENSIVE CARE UNIT	0	6, 062, 381		31.00
32.00	03200 CORONARY CARE UNIT	0	0		32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00	04100 SUBPROVI DER – I RF	O	4, 461, 073		41.00
42.00	04200 SUBPROVI DER	0	0		42. 00
43.00	04300 NURSERY	0	1, 401, 256		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	31, 969, 577		50.00
51. 00	05100 RECOVERY ROOM	O	2, 191, 511		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	o		52. 00
53.00		0	364, 972		53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C	0	5, 090, 980		54. 00 54. 01
	05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C   05404   ULTRA   SOUND	0	1, 941, 867 1, 209, 738		54.01
54. 03	05405 MAMMOGRAPHY	0	1, 796, 032		54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	4, 808, 367		55. 00
57. 00	05700 CT SCAN	0	1, 838, 764		57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	750, 985		58. 00
60.00	06000 LABORATORY	0	4, 571, 032 11, 535, 006		59. 00 60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	1, 407, 252		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	822, 223		62. 00
	06500 RESPI RATORY THERAPY	0	3, 922, 179		65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	7, 074, 512		66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	2, 495, 565 1, 501, 470		68.00
	06900 ELECTROCARDI OLOGY	O	1, 471, 031		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 827, 054		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 257, 367		71. 00
	07200 DRUCS CHARGED TO PATIENTS	0	9, 235, 664		72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		30, 104, 650 673, 460		73. 00 74. 00
76. 00	03020 ACUPUNCTURE	0	0/3, 400		76.00
76. 97	07697 CARDIAC REHABILITATION	0	669, 742		76. 97
	OUTPATIENT SERVICE COST CENTERS		- 1		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88. 00 89. 00
	09000 CLINIC		3, 053, 790		90.00
			396, 400		90. 01
90. 02	09002 NEUROPSYCH	0	193, 139		90. 02
		0	1, 933, 545		90. 03
		0	350, 498		90. 04
90. 05 91. 00	09005 VI MCARE CLINI C 09100 EMERGENCY	0	419, 092 15, 153, 956		90. 05 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	13, 133, 730		91.00
. 2. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			
	09500 AMBULANCE SERVICES	0	6, 138, 326		95. 00
99. 10	09910  CORF	0	0		99. 10

Health Financial Systems	COLUMBUS REGION				of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 1	15-0112	Peri od:	Worksheet B
				From 01/01/2016 To 12/31/2016	Part I Date/Time Prepared:
				10 12/31/2010	5/23/2017 8:05 pm
Cost Center Description	Intern &	Total			0, 20, 201, 0. 00 piii
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments				
	25.00	26. 00			
101.00 10100 HOME HEALTH AGENCY	0	0			101. 00
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	o	o			110. 00
111.00 11100 ISLET ACQUISITION	o	o			111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	O	214, 272, 999			118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53, 542			190. 00
194. 00 07950 WELLNESS COMMUNITY	O	471, 039			194. 00
194. 01 07951 BUI LDI NG RENTALS	0	192, 430			194. 01
194. 02 07952 HOSPI CE	0	86, 923			194. 02
194. 03 07953 OUTREACH CLINICS	0	O			194. 03
194.04 07954 SPEECH - HEARING AIDS	O	322, 267			194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	1, 956, 043			194. 05
194. 06 07956 CRH FOUNDATION	0	84, 663			194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	384, 303			194. 07
194. 08 07958 CRHP	o	87, 950			194. 08
200.00 Cross Foot Adjustments	o	0			200. 00
201.00 Negative Cost Centers	0	O			201. 00
202.00 TOTAL (sum lines 118-201)	0	217, 912, 159			202. 00
	-1				

Health Financial Systems COLUMBUS REC	GLONAL HOSPLTAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION STATISTICS	Provider CCN: 15-0112	From 01/01/2016	Worksheet Non-CMS W  Date/Time Prepared: 5/23/2017 8:05 pm

			5/23/2017 8: 0	5 pm
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1. 00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQ FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DEPR	2. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SAL	4. 00
5.00	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

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

Cost Center Description
BIRDELLIS   STEWN CF COST CINTES
Finnest Service COST CINTERS   1.00   00100   APR REL COSTS-EQUE   1.10   00100   APR REL COSTS-EQUE   1.10   1.00   00100   APR REL COSTS-EQUE   1.10   1.00   1
1.00   10100   CAP REL COSTS-BLDG & FIXT
2.00   00200   CAP REL COSTS-MUSILE EQUIP
9.00 09000   MOSPECKEP IN 6
10.00 01000   DIEJARY   2, 921
11.00   01100   CAFETERIA   6. 485   89, 157   36, 739   123, 281   3, 735   11.00
13.00   01300   NURSING ADMINISTRATION   14,108   143,387   66,318   223,813   9,899   13.00     15.00   01500   PIAGMACY   25,391   68,879   395,842   40,112   9,681   15.00     15.00   01500   PIAGMACY   25,391   68,879   395,842   40,112   9,681   15.00     17.00   01700   SOCI AL SERVICE   67,70   67,70   70,51   70,90
14. 00   01400  CENTRAL SERVICES & SUPPLY   2, 794   110, 715   99, 355   212, 864   1   14. 00   16. 00   01600  MEDICAL RECORDS & LIBRARY   1, 789   68, 879   385, 842   480, 112   9, 681   15. 00   10. 00
15.00   01500   PHARMACY   25, 391   68, 879   385, 842   480, 112   9, 681   15.00
1. 700   01-000   MEDICAL RECORDS & LIERARY   1.789   58, 143   39, 314   99, 246   2. 328   16, 00   230   00   02300   PARAMED ED PROW-CREPCITY   0   0   0   0   0   0   0   23, 00   230   02300   PARAMED ED PROW-CREPCITY   0   0   0   0   0   0   23, 00   230   02300   PARAMED ED PROW-CREPCITY   0   0   5, 470   0   5, 470   10   5, 470   23, 01   230
17. 00   01700   SOLIAL SERVICE   66.7   4,393   79   5,139   1,495   17,000   23,00   230   02300   PRAMED ED PREMI-CEPECT (FY)   0   0   0   0   0   23,000   230   230   230   230   PRAMED ED PREMI-CEPECT (FY)   0   5,470   0   5,470   1,019   23,000
23.01
23.02   PABABMACY RESIDENCY PROG   0   5,470   0   5,470   1,019   23.02
INPATIENT ROUTINE SERVICE COST CENTERS
30.00   03000   ADULTS & PEDI ATRICS   221,098   1,111,473   333,375   1,715,906   40,836   30,00   32,00   03200   INTENSIS VE CARE UNIT   77,070   159,418   148,576   385,064   5,412   31,00   31,00   33,00   03300   BURN INTENSIS VE CARE UNIT   0 0 0 0 0 0 0 0 0 32,00   32,00   33,00   03400   SURRO SURFAS VICE RE UNIT   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
31.00   O3100   INTENSIVE CARE UNIT
32.00   03200   CORONARY CARE UNIT   0   0   0   0   0   32.00
33.00   0.330.0   BURN INTENSIVE CARE UNIT
34.00   03400   SURSICAL INTENSIVE CARE UNIT   0   0   0   0   0   0   34.00
40.00   0.000   0.000   0.00
42.00   04200   SUBPROVI DER   0   0   0   0   0   0   0   0   24.00     44.00   04400   NURSEN   SERVICE COST CENTERS
44.00   04300   NURSERY   1, 108   8, 481   16, 912   26, 591   2, 072   43, 00   44.00   0400   SKILLED NURSING FACILITY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
A4.00   04400   SKI LLED NURSING FACILITY   0   0   0   0   0   0   0   0   0
ANCILLARY SERVICE COST CENTERS   50.00
50.00
51.00   05100   RECOVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   52.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   53.00
53.00   05300   ANESTHESI OLOGY   0   1, 731   10, 960   12, 691   0   53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   12, 754   122, 120   158, 024   292, 898   4, 330   54. 00   54. 01   05402   NUCLEAR MEDI CI NE-DI AGNOSTI C   20, 000   49, 226   7, 722   76, 948   922   54. 01   54. 02   05404   ULTRA SOUND   306   21, 878   36, 606   58, 790   1, 350   54. 02   54. 03   05405   MAMMOGRAPHY   153, 728   3, 971   14, 300   171, 999   2, 109   54. 03   55. 00   05500   RADI OLOGY-THERAPEUTI C   6, 230   113, 174   663, 546   782, 950   4, 399   55. 00   05500   RADI OLOGY-THERAPEUTI C   6, 230   113, 174   663, 546   782, 950   4, 399   55. 00   05700   CT SCAN   46   13, 092   13, 796   26, 934   816   58. 00   05800   RADI OLOGY-THERAPEUTI C   75. 00   75. 00   05900   CARDI AC CATHETERI ZATI ON   18, 762   154, 137   100, 103   273, 002   4, 589   59. 00   05900   CARDI AC CATHETERI ZATI ON   18, 762   154, 137   100, 103   273, 002   4, 589   59. 00   05900   CARDI AC CATHETERI ZATI ON   18, 762   154, 137   100, 103   273, 002   4, 589   59. 00   05900   CARDI ACROMATORY-PATHOLOGI CAL   2, 055   17, 631   16, 74   36, 660   950   60. 01   05000   LABORATORY-PATHOLOGI CAL   2, 055   17, 631   16, 74   36, 660   950   60. 01   06000   LABORATORY-PATHOLOGI CAL   2, 055   17, 631   16, 74   36, 660   950   60. 01   06000   MHOLE BLOOD & PACKED RED BLOOD CELL   46   7, 622   4, 158   11, 826   197   62. 00   65. 00   06000   MHOLE BLOOD & PACKED RED BLOOD CELL   46   7, 622   4, 158   11, 826   197   62. 00   65. 00   06000   CCUPATI ONAL THERAPY   379, 368   3, 302   25, 229   407, 899   10, 065   66. 00   06000   CCUPATI ONAL THERAPY   379, 368   3, 302   25, 229   407, 899   10, 065   66. 00   06000   ELECTROENCEPHALOGRAPHY   149, 134   0   13, 901   163, 035   1, 897   70. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   149, 134   0   13, 901   163, 035   1, 897   70. 00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0
54. 02   0540d   ULTRA SOUND   306   21,878   36,606   58,790   1,350   54,02
54. 03     05405 MAMMOGRAPHY     153, 728     3, 971     14, 300     171, 999     2, 109     54, 03       55. 00     05500 RSD0 RADI OLOGY-THERAPEUTI C     6, 230     113, 174     663, 546     782, 950     4, 399     55. 00       57. 00     05700 CT SCAN     542     21, 398     234, 045     255, 985     1, 751     57. 00       58. 00     05800 MRI     46     13, 092     13, 796     26, 934     816     58. 00       59. 00     05900 CARDI AC CATHETERI ZATI ON     18, 762     154, 137     100, 103     273, 002     4, 589     59. 00       60. 01     06000 LABORATORY     29, 240     156, 508     156, 893     342, 641     10, 424     60. 00       60. 01     06001 LABORATORY PATHOLOGI CAL     2, 055     17, 631     16, 974     36, 660     950     60. 01       65. 00     06200 WHOLE BLOOD & PACKED RED BLOOD CELL     46     7, 622     4, 158     11, 826     197     62. 00       66. 00     06600 PHYSI CAL THERAPY     42, 003     95, 994     127, 648     265, 645     4, 515     65. 00       67. 00     06700 OCUPATI ONAL THERAPY     379, 368     3, 302     25, 229     407, 899     10, 065     66. 00       68. 00     06800 SPECH PATHOLOGY     15, 179
55.00         05500         RADI OLOGY-THERAPEUTI C         6, 230         113, 174         663, 546         782, 950         4, 399         55. 00           57.00         05700         CT SCAN         542         21, 398         234, 045         255, 985         1, 751         57. 00           58.00         05800         MRI         46         13, 092         13, 796         26, 934         816         58. 00           59.00         05900         CARDI AC CATHETERI ZATI ON         18, 762         154, 137         100, 103         273, 002         4, 589         59. 00           60.01         06000         LABORATORY         29, 240         156, 508         156, 893         342, 641         10, 424         60. 00           60.01         06000         LABORATORY         29, 240         156, 508         156, 893         342, 641         10, 424         60. 00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         46         7, 622         4, 158         11, 826         197         62. 00           65.00         06500         RESPIRATORY THERAPY         42, 003         95, 994         127, 648         265, 645         4, 515         65. 00           66.00         06600         P
57. 00   05700   CT SCAN   542   21, 398   234, 045   255, 985   1, 751   57. 00
58. 00         05800 MRI         46         13, 092         13, 796         26, 934         816         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         18, 762         154, 137         100, 103         273, 002         4, 589         59. 00           60. 00         06000 LABORATORY         29, 240         156, 508         156, 893         342, 641         10, 424         60. 00           60. 01         06001 LABORATORY-PATHOLOGI CAL         2, 055         17, 631         16, 974         36, 660         950         60. 01           62. 00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         46         7, 622         4, 158         11, 826         197         62. 00           65. 00         06500 RESPI RATORY THERAPY         42, 003         95, 994         127, 648         265, 645         4, 515         65. 00           66. 00         06600 PHYSI CAL THERAPY         379, 368         3, 302         25, 229         407, 899         10, 065         66. 00           67. 00         06700 OCUPATI ONAL THERAPY         522         3, 215         5, 310         9, 047         3, 534         67. 00           68. 00         06900 ELECTROCARDI OLOGY         15, 179         0         20, 605         35, 784         2, 145
59.00         05900         CARDI AC CATHETERI ZATI ON         18, 762         154, 137         100, 103         273, 002         4, 589         59. 00           60.00         06000         LABORATORY         29, 240         156, 508         156, 893         342, 641         10, 424         60. 00           60.01         06001         LABORATORY-PATHOLOGI CAL         2, 055         17, 631         16, 974         36, 660         950         60. 01           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         46         7, 622         4, 158         11, 826         197         62. 00           65.00         06500         RESPI RATORY THERAPY         42, 003         95, 994         127, 648         265, 645         4, 515         65. 00           66.00         06600         PHYSI CAL THERAPY         379, 368         3, 302         25, 229         407, 899         10, 665         66. 00           67.00         06700         OCCUPATI ONAL THERAPY         522         3, 215         5, 310         9, 047         3, 534         67. 00           68.00         06800         SPEECH PATHOLOGY         15, 179         0         20, 605         35, 784         2, 145         68. 00           69.00 <td< td=""></td<>
60.00   06000   LABORATORY   29, 240   156, 508   156, 893   342, 641   10, 424   60.00   60.01   06001   LABORATORY-PATHOLOGI CAL   2,055   17,631   16,974   36,660   950   60.01   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   46   7,622   4,158   11,826   197   62.00   65.00   06500   RESPI RATORY THERAPY   42,003   95,994   127,648   265,645   4,515   65.00   66.00   06600   PHYSI CAL THERAPY   379,368   3,302   25,229   407,899   10,065   66.00   60.00   00   00   00   00   0
60.01   06001   LABORATORY-PATHOLOGICAL   2,055   17,631   16,974   36,660   950   60.01
65. 00
66. 00   06600   PHYSI CAL THERAPY   379, 368   3, 302   25, 229   407, 899   10, 065   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   522   3, 215   5, 310   9, 047   3, 534   67. 00   68. 00   06800   SPEECH PATHOLOGY   15, 179   0   20, 605   35, 784   2, 145   68. 00   69. 00   06900   ELECTROCARDI OLOGY   564   20, 336   28, 823   49, 723   1, 540   69. 00   07000   ELECTROCARDI OLOGY   149, 134   0   13, 901   163, 035   1, 897   70. 00   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   71. 00   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0
67. 00   06700   OCCUPATI ONAL THERAPY   522   3, 215   5, 310   9, 047   3, 534   67. 00   68. 00   06800   SPEECH PATHOLOGY   15, 179   0   20, 605   35, 784   2, 145   68. 00   69. 00   06900   ELECTROCARDI OLOGY   564   20, 336   28, 823   49, 723   1, 540   69. 00   07000   ELECTROENCEPHALOGRAPHY   149, 134   0   13, 901   163, 035   1, 897   70. 00   71. 00   71. 00   70. 00   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   74. 00
68. 00   06800   SPEECH PATHOLOGY   15, 179   0   20, 605   35, 784   2, 145   68. 00   69. 00   06900   ELECTROCARDI OLOGY   564   20, 336   28, 823   49, 723   1, 540   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   149, 134   0   13, 901   163, 035   1, 897   70. 00   71. 00   71. 00   71. 00   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   72. 00   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0
69. 00   06900   ELECTROCARDI OLOGY   564   20, 336   28, 823   49, 723   1, 540   69. 00   70. 00   7
70. 00   07000   ELECTROENCEPHALOGRAPHY   149, 134   0   13, 901   163, 035   1, 897   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   74.
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   73. 00   73. 00   74. 00   7
74. 00   07400   RENAL DI ALYSI S   0   0   0   63   63   0   74. 00   76. 00   0   0   0   0   0   0   76. 00
76. 00   03020   ACUPUNCTURE   0   0   0   0   0   0   76. 00   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   1, 223   22, 998   12, 804   37, 025   482   76. 97   07697   0
76. 97   07697   CARDI AC REHABILITATION   1,223   22,998   12,804   37,025   482   76.97
SECTION   SERVICE COST CENTERS   SECTION   SERVICE COST CENTERS   SECTION
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   88. 00   89. 00   90. 00
89. 00     08900     FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0     0     89. 00       90. 00     09000     CLI NI C     272     98, 540     42, 052     140, 864     2, 314     90. 00       90. 01     09001     DI ABETES CENTER     994     11, 274     893     13, 161     318     90. 01       90. 02     09002     NEUROPSYCH     8     1, 949     36     1, 993     243     90. 02
90. 00     09000     CLI NI C     272     98, 540     42, 052     140, 864     2, 314     90. 00       90. 01     09001     DI ABETES CENTER     994     11, 274     893     13, 161     318     90. 01       90. 02     09002     NEUROPSYCH     8     1, 949     36     1, 993     243     90. 02
90. 01   09001   DI ABETES CENTER   994   11, 274   893   13, 161   318   90. 01   90. 02   09002   NEUROPSYCH   8   1, 949   36   1, 993   243   90. 02
90. 02 09002 NEUROPSYCH 8 1, 949 36 1, 993 243 90. 02
70. 00   07000  MOUND CENTER   1, 307  0  2, 010  3, 303  1, 208  90. 03
90. 04   09004   HYPERBARI C OXYGEN THERAPY   131, 327   0 222 131, 549 189 90. 04
90. 05   09005   VI MCARE CLI NI C   5, 750   19, 682   2, 589   28, 021   496   90. 05
91. 00   09100   EMERGENCY   14, 617   213, 779   273, 974   502, 370   15, 145   91. 00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART O 92. 00 OTHER REIMBURSABLE COST CENTERS
95. 00   09500   AMBULANCE SERVI CES   32, 388   107, 079   288, 500   427, 967   7, 993   95. 00
1 32,333 33,377 200,000 127,707 77,707 70.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Peri od: From 01/01/2016	Worksheet B Part II

			F	rom 01/01/2016 o 12/31/2016	Part II Date/Time Pre 5/23/2017 8:0	pared: 5 pm
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 747, 275	10, 569, 913	9, 183, 584	22, 500, 772	214, 851	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 575		10, 936		190. 00
194. 00 07950 WELLNESS COMMUNITY	55, 265	0	13, 068			194. 00
194. 01 07951 BUILDING RENTALS	40, 691	19, 304	0	59, 995		194. 01
194. 02 07952 HOSPI CE	0	0	0	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194.04 07954 SPEECH - HEARING ALDS 194.05 07955 NONALLOWABLE MARKETING	0	0	0	0		194. 04 194. 05
194.06 07956 CRH FOUNDATION	0	11, 856	725	12, 581		194. 05
194. 07 07957 HEALTHY COMMUNITIES	0	17, 383		17, 383		194. 00
194. 08 07958 CRHP	0	17, 303		17, 303		194. 07
200.00 Cross Foot Adjustments		O		0		200.00
201.00 Negative Cost Centers		0	١			201.00
202.00 TOTAL (sum lines 118-201)	2, 843, 231	10, 629, 031	9, 197, 738	22, 670, 000		
			•			•

			''	0 12/31/2010	5/23/2017 8:0	
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			Г	T		
1. 00 00100 CAP REL COSTS-BLDG & FIXT					i	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					i	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	5 044 004				1	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	5, 944, 881	,			1	5. 00
7. 00   00700   OPERATION OF PLANT	423, 686	6, 205, 318			i	7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	22, 980	16, 005		000 744	1	8. 00
9. 00 00900 HOUSEKEEPI NG	95, 569	111, 967	0	303, 716	050 (0)	9.00
10. 00   01000   DI ETARY	41, 005	173, 731	0	2, 490	352, 696	1
11. 00   01100   CAFETERI A	48, 630	135, 488		5, 454	0	
13. 00   01300   NURSI NG   ADMI NI STRATI ON	167, 574	217, 899		830	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	44, 675	168, 249	0	2, 786	0	
15. 00   01500   PHARMACY	233, 737	104, 672		3, 616	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	60, 876	88, 358		0	0	1
17. 00   01700   SOCI AL SERVI CE	23, 827	6, 676		119	0	
23. 00   02300   PARAMED ED   PRGM-(SPECIFY)	0	0	0	0	0	
23. 01   02301   XRAY   EDUCATION	21, 541	14, 546		652	0	
23. 02 02302 PHARMACY RESIDENCY PROG	16, 528	8, 312	0	296	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTE		4 (00 055	10.045	404 740	074 704	
30. 00   03000   ADULTS & PEDI ATRI CS	740, 984	1, 689, 055			276, 726	
31.00 03100 INTENSIVE CARE UNIT	129, 593	242, 260		8, 952	26, 593	1
32. 00   03200   CORONARY CARE UNIT	0	0	0	0	0	1
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	1
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	
41. 00   04100   SUBPROVI DER - I RF	79, 861	245, 045	2, 773	12, 865	40, 609	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300 NURSERY	33, 951	12, 888	770	119	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	682, 983	863, 793			794	1
51.00  05100   RECOVERY ROOM	47, 489	70, 408		8, 537	0	1
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53. 00   05300   ANESTHESI OLOGY	8, 471	2, 631	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	96, 664	185, 580	4, 665	8, 241	167	54. 00
54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	43, 716	74, 807	0	5, 039	0	54. 01
54. 02   05404   ULTRA SOUND	29, 879	33, 247	0	1, 660	0	54. 02
54. 03 05405 MAMMOGRAPHY	46, 633	6, 035	388	3, 083	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	110, 625	171, 985	330	5, 454	806	55. 00
57. 00   05700 CT SCAN	46, 912	32, 518		949	0	1
58. 00   05800 MRI	18, 675		0	652	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	99, 340		238		719	
60. 00   06000   LABORATORY	291, 758			6, 996	0	
60. 01 06001 LABORATORY-PATHOLOGI CAL	29, 397	26, 793	0	474	0	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD		11, 584	o o	237	0	
65. 00 06500 RESPIRATORY THERAPY	86, 569	145, 878	0	7, 766	0	1
66. 00   06600   PHYSI CAL THERAPY	176, 357	5, 018		7, 700	0	
67. 00 06700 OCCUPATI ONAL THERAPY	62, 711	4, 885		~ <u> </u>	0	
68. 00 06800 SPEECH PATHOLOGY	38, 319		0	0	0	
69. 00   06900   ELECTROCARDI OLOGY	27, 826	30, 904	0	1, 482	0	1
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	4	30, 704		, , , ,	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	38, 016	0	64	12, 331	0	
	4	0	0	0		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	251, 959	0	0	U	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	565, 766	0	0	0	0	
74. 00   07400   RENAL DI ALYSI S	18, 276	0	0	0	0	1
76. 00   03020   ACUPUNCTURE	0	0	0	0	0	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	13, 306	34, 950	0	356	0	76. 97
OUTPATIENT SERVICE COST CENTERS		^		ما		00.00
88. 00   08800   RURAL HEALTH CLINIC	0	0	0	0	0	1
89.00   08900   FEDERALLY QUALIFIED HEALTH CENT		0	0		0	
90. 00   09000   CLI NI C	52, 342	149, 746			4, 511	1
90. 01   09001   DI ABETES CENTER	9, 165	17, 132		237	0	
90. 02  09002  NEUROPSYCH	4, 472	2, 962		0	0	1
90. 03   09003   WOUND CENTER	48, 574	0	250	0	0	1
90. 04 09004 HYPERBARI C OXYGEN THERAPY	9, 200	0	27	0	0	
90. 05   09005   VI MCARE   CLI NI C	8, 425	29, 909	0	0	0	
91. 00 09100 EMERGENCY	349, 143	324, 870	3, 741	32, 192	1, 771	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART					92. 00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	136, 526	162, 723	0	0	0	95. 00
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						1
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00

			10	12/31/2010	5/23/2017 8:05	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	•
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 1	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 1	111. 00
113.00 11300 INTEREST EXPENSE					1	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 854, 004	6, 115, 479	49, 671	301, 641	352, 696	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	363	16, 071	0	0	0 1	190. 00
194.00 07950 WELLNESS COMMUNITY	11, 525	0	0	0	0 1	194. 00
194.01 07951 BUILDING RENTALS	3, 247	29, 335	0	0	0 1	194. 01
194. 02 07952 HOSPI CE	2, 357	0	0	0	0 1	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 1	194. 03
194.04 07954 SPEECH - HEARING AIDS	8, 792	0	0	0	0 1	194. 04
194. 05 07955 NONALLOWABLE MARKETING	53, 363	0	0	0	0 1	194. 05
194.06 07956 CRH FOUNDATION	475	18, 016	0	1, 779	0 1	194. 06
194. 07 07957 HEALTHY COMMUNITIES	8, 412	26, 417	0	296	0 1	194. 07
194. 08 07958 CRHP	2, 343	0	0	0	0 1	194. 08
200.00 Cross Foot Adjustments					2	200.00
201.00 Negative Cost Centers	0	0	0	0	0 2	201. 00
202.00 TOTAL (sum lines 118-201)	5, 944, 881	6, 205, 318	49, 671	303, 716	352, 696 2	202. 00

			10	12/31/2010	Date/lime Prep   5/23/2017 8:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	рш
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00 O0100 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 7.00   00700 OPERATION OF PLANT						5. 00 7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900 HOUSEKEEPI NG						9. 00
10. 00   01000 DI ETARY						10.00
11. 00   01100   CAFETERI A	325, 688					11. 00
13.00 01300 NURSING ADMINISTRATION	11, 588	631, 593				13. 00
14. 00   01400   CENTRAL SERVICES & SUPPLY	3, 964	10, 149	442, 688			14. 00
15. 00   01500   PHARMACY	11, 283	0	0	843, 101	250 0/7	15.00
16.00   01600   MEDICAL RECORDS & LIBRARY 17.00   01700   SOCIAL SERVICE	9, 149 2, 135	5, 898	0	0	259, 967 0	16. 00 17. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	2, 133	3, 6 <del>7</del> 6	0	0	0	23. 00
23. 01   02301   XRAY EDUCATION	2, 135	0	0	o	0	23. 01
23. 02   02302   PHARMACY RESI DENCY PROG	1, 220	0	0	0	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	77, 453	201, 279	20, 926	788	55, 967	30.00
31. 00   03100   INTENSI VE CARE UNI T	8, 539	22, 165	756	136	4, 401	31.00
32.00   03200   CORONARY CARE UNIT 33.00   03300   BURN   INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
33.00   03300 BURN INTENSIVE CARE UNIT 34.00   03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00   04000   SUBPROVI DER -   1 PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   RF	7, 319	19, 097	0	20	8, 645	41. 00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42. 00
43. 00   04300   NURSERY	3, 050	7, 977	648	0	0	43. 00
44. 00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS	04.7/4	00 (01	205 444	0.07/	77.050	F0 00
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	34, 764 3, 964	90, 621 10, 646	395, 146 0	2, 976	77, 958 0	50. 00 51. 00
52. 00   05200   DELI VERY   ROOM & LABOR   ROOM	3, 904	10, 646	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	305	872	0	3, 436	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 709	0	252	182	0	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 220	0	0	7, 654	0	54. 01
54. 02   05404   ULTRA SOUND	1, 525	0	0	34	0	54. 02
54. 03   05405   MAMMOGRAPHY	3, 659	0	288	21	0	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	4, 574	11, 843	0	5	5, 462	55.00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	2, 745 1, 220	0	0	708 30	0	57. 00 58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	6, 099	15, 831	3, 422	224	1, 362	59.00
60. 00 06000 LABORATORY	23, 481	0	0, 122	21	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	1, 525	0	0	0	25, 489	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	305	0	0	0	0	62. 00
65. 00 06500 RESPI RATORY THERAPY	7, 929	20, 923	324	308	458	
66. 00 06600 PHYSI CAL THERAPY	14, 943		9, 256	152		66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	4, 879		0	14	472 0	67.00
68. 00   06800   SPEECH   PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	2, 745 2, 440		0	174	27, 938	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 745		0	1	19, 175	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	822, 104	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	0	332	0	74. 00
76. 00   03020   ACUPUNCTURE	0	0	0	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	915	2, 134	0	0	0	76. 97
88. 00   08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00   09000   CLI NI C	4, 269	11, 408	36	33	30, 256	90.00
90. 01 09001 DI ABETES CENTER	305	1, 172	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	610		0	0	157	90. 02
90. 03   09003   WOUND CENTER	2, 440	5, 963	9, 761	1, 799	0	90. 03
90. 04   09004   HYPERBARI C OXYGEN THERAPY	305	999	0	0	0	90.04
90. 05   09005   VI MCARE CLI NI C 91. 00   09100   EMERGENCY	915 26, 836		1 072	94 1 101	0	90. 05 91. 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	∠0, 836	59, 395	1, 873	1, 101	U	91.00
OTHER REIMBURSABLE COST CENTERS						,2.00
95. 00 09500 AMBULANCE SERVICES	20, 737	54, 042	0	701	0	95. 00
99. 10   09910   CORF	0	0	0	o	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

					5/23/2017 8:05 pm	_
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 0	)()
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 0	Ю
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 111. 0	Ю
113.00 11300 INTEREST EXPENSE					113. 0	0
118.00 SUBTOTALS (SUM OF LINES 1-117)	322, 943	628, 019	442, 688	843, 053	259, 967 118. 0	0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 0	Ю
194.00 07950 WELLNESS COMMUNITY	1, 525	3, 574	0	0	0 194. 0	Ю
194. 01 07951 BUILDING RENTALS	0	0	0	0	0 194. 0	)1
194. 02 07952 HOSPI CE	0	0	0	48	0 194. 0	)2
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 0	)3
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0 194. 0	)4
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 194. 0	)5
194. 06 07956 CRH FOUNDATION	0	0	0	0	0 194. 0	16
194. 07 07957 HEALTHY COMMUNITIES	915	0	0	0	0 194. 0	)7
194. 08 07958 CRHP	305	0	0	0	0 194. 0	8(
200.00 Cross Foot Adjustments					200. 0	0
201.00 Negative Cost Centers	0	l o	0	O	0 201. 0	Ю
202.00 TOTAL (sum lines 118-201)	325, 688	631, 593	442, 688	843, 101	259, 967 202. 0	00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0112

Peri od: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

5/23/2017 8:05 pm Cost Center Description SOCIAL SERVICE PARAMED ED XRAY EDUCATION PHARMACY Subtotal **PRGM** RESI DENCY PROG 17.00 23.01 24.00 23.00 23.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 45, 289 17.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.01 02301 XRAY EDUCATION 0 49,872 23.01 02302 PHARMACY RESIDENCY PROG 32, 845 23.02 23 02 INPATIENT ROUTINE SERVICE COST CENTERS 4, 956, 981 30.00 03000 ADULTS & PEDIATRICS 11.503 30.00 03100 INTENSIVE CARE UNIT 31.00 2,853 839,074 31.00 32.00 03200 CORONARY CARE UNIT 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 04000 SUBPROVI DER - I PF 40.00 0 40.00 04100 SUBPROVI DER - I RF 41.00 6.839 645, 651 41.00 04200 SUBPROVI DER 42.00 0 Λ 42.00 43.00 04300 NURSERY 0 88,066 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 4, 415, 770 50.00 51.00 05100 RECOVERY ROOM 0 223, 986 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 28 406 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 599, 688 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0 210, 306 54.01 54.01 0 54.02 05404 ULTRA SOUND 126, 485 54.02 05405 MAMMOGRAPHY 0 54.03 234, 215 54.03 1, 100, 018 55.00 05500 RADI OLOGY-THERAPEUTI C 1,585 55.00 57.00 05700 CT SCAN 0 341, 568 57.00 0 58 00 05800 MRI 68, 222 58 00 05900 CARDIAC CATHETERIZATION 59.00 646, 413 59.00 0 06000 LABORATORY 913, 160 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 000000000000 121, 288 60.01 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 45, 653 62 00 65.00 06500 RESPIRATORY THERAPY 540, 315 65.00 66.00 06600 PHYSI CAL THERAPY 665, 055 66.00 06700 OCCUPATIONAL THERAPY 98, 917 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 86, 302 68 00 69.00 06900 ELECTROCARDI OLOGY 148, 255 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 244, 246 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 197, 989 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 251, 959 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 387, 870 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 18, 671 74.00 03020 ACUPUNCTURE 76.00 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 2,853 92, 021 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 9,058 411, 848 90.00 90. 01 09001 DI ABETES CENTER 41, 490 90.01 0 09002 NEUROPSYCH 90.02 0 11, 945 90.02 90.03 09003 WOUND CENTER 0 73, 440 90.03 09004 HYPERBARI C OXYGEN THERAPY 0 142, 269 90.04 90.04 90.05 09005 VIMCARE CLINIC 70, 494 90.05 09100 EMERGENCY 10.598 91.00 1, 329, 035 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 810, 689 95.00 09910 CORF 0 99.10 99 10 Λ 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 109. 00 10900 PANCREAS ACQUISITION 0 109.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2016	Part II
To 12/31/2016	Date/Time Prepared:
5/23/2017 8:05 pm	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLUMBUS REGIONAL HOSPITAL Provider CCN: 15-0112

					5/23/2017 8: 05	5 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	
110.00 11000 INTESTINAL ACQUISITION	0				0	110. 00
111.00 11100 ISLET ACQUISITION	0				0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	45, 289	0	0	0	22, 227, 760	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				27, 370	190. 00
194. 00 07950 WELLNESS COMMUNITY	0				85, 461	194. 00
194. 01 07951 BUILDING RENTALS	0				92, 577	194. 01
194. 02 07952 HOSPI CE	0				2, 405	194. 02
194. 03 07953 OUTREACH CLINICS	0				0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0				8, 792	194. 04
194. 05 07955 NONALLOWABLE MARKETING	O				53, 363	194. 05
194.06 07956 CRH FOUNDATION	O				32, 854	194. 06
194. 07 07957 HEALTHY COMMUNITIES	O				53, 904	194. 07
194. 08 07958 CRHP	o				2, 797	194. 08
200.00 Cross Foot Adjustments		0	49, 872	32, 845	82, 717	200. 00
201.00 Negative Cost Centers	O	0	0	О	0	201. 00
202.00 TOTAL (sum lines 118-201)	45, 289	0	49, 872	32, 845	22, 670, 000	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COLUMBUS REGIONAL HOSPITAL

Provider CCN: 15-0112

				To   12/31/2016   Date/lime Pro     5/23/2017 8:0	
	Cost Center Description	Intern & Residents Cost & Post	Total	5,23,25,7	, p
		Stepdown Adjustments			
	JOSUS DE LOS CONTROLOS DE LA C	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	T	1		1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT				2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
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				17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				23. 00
23. 01	02301 XRAY EDUCATION				23. 01
23. 02	O2302   PHARMACY RESI DENCY PROG				23. 02
30. 00	O3000 ADULTS & PEDIATRICS	0	4, 956, 981		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	839, 074		31.00
32. 00	03200 CORONARY CARE UNIT		039, 074		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		o		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	Ö		34. 00
40.00	04000 SUBPROVI DER - I PF	O	o		40.00
41.00	04100 SUBPROVI DER - I RF	O	645, 651		41.00
42.00	04200 SUBPROVI DER	0	o		42.00
43.00	04300 NURSERY	0	88, 066		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCILLARY SERVICE COST CENTERS		= ===		
50.00	05000 OPERATI NG ROOM	0	4, 415, 770		50.00
51.00	05100 RECOVERY ROOM	0	223, 986		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	28, 406		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		599, 688		54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		210, 306		54. 01
54. 02	05404 ULTRA SOUND	l ol	126, 485		54. 02
54. 03	05405 MAMMOGRAPHY	O	234, 215		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	1, 100, 018		55. 00
57.00	05700  CT SCAN	0	341, 568		57. 00
58.00	05800 MRI	0	68, 222		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	646, 413		59. 00
60.00	06000 LABORATORY	0	913, 160		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	121, 288		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	45, 653		62.00
	06500 RESPI RATORY THERAPY	0	540, 315		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		665, 055 98, 917		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		86, 302		68. 00
	06900 ELECTROCARDI OLOGY	0	148, 255		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	l o	244, 246		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ol	197, 989		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	251, 959		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	1, 387, 870		73. 00
74.00	07400 RENAL DIALYSIS	0	18, 671		74. 00
76. 00	03020 ACUPUNCTURE	0	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	92, 021		76. 97
	OUTPATIENT SERVICE COST CENTERS		al		
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	411 040		89.00
90.00	09000 CETNIC 09001 DI ABETES CENTER	0	411, 848 41, 490		90. 00
90. 01	09001 DIABETES CENTER	0	11, 945		90.01
90. 02	09003 WOUND CENTER	0	73, 440		90. 02
90. 04	09004 HYPERBARI C OXYGEN THERAPY		142, 269		90. 04
90. 05	09005 VI MCARE CLI NI C	o	70, 494		90. 05
91. 00	09100 EMERGENCY	o	1, 329, 035		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ö			92. 00
	OTHER REIMBURSABLE COST CENTERS				
95. 00		0	810, 689		95. 00
99. 10	09910  CORF	0	0		99. 10

Health Financial Systems	COLUMBUS REGIONA		In Lieu of Form CMS-2552-1
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-01	
			From 01/01/2016   Part II To 12/31/2016   Date/Time Prepared:
			5/23/2017 8: 05 pm
Cost Center Description	Intern &	Total	9,29,2017 61 66 5
	Residents Cost		
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26. 00	
101.00 10100 HOME HEALTH AGENCY	0	0	101. 0
SPECIAL PURPOSE COST CENTERS			
109.00 10900 PANCREAS ACQUISITION	0	0	109. 0
110.00 11000 INTESTINAL ACQUISITION	0	0	110. 0
111.00 11100 I SLET ACQUI SI TI ON	0	0	111. 0
113. 00 11300 I NTEREST EXPENSE			113. 0
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	22, 227, 760	118. 0
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27, 370	190. 0
194.00 07950 WELLNESS COMMUNITY	0	85, 461	194. 0
194. 01 07951 BUILDING RENTALS	0	92, 577	194. 0
194. 02 07952 HOSPI CE	0	2, 405	194. 0
194. 03 07953 OUTREACH CLINICS	0	0	194. 0
194.04 07954 SPEECH - HEARING AIDS	0	8, 792	194. O
194. 05 07955 NONALLOWABLE MARKETING	0	53, 363	194. 0
194.06 07956 CRH FOUNDATION	0	32, 854	194. 0
194. 07 07957 HEALTHY COMMUNITIES	0	53, 904	194. 0
194. 08 07958 CRHP	0	2, 797	194. 0
200.00 Cross Foot Adjustments	0	82, 717	200. 0
201.00 Negative Cost Centers	0	o	201. 0
202.00 TOTAL (sum lines 118-201)	0	22, 670, 000	202. 0
			·

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 COLUMBUS REGIONAL HOSPITAL Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 8:05 pm Provider CCN: 15-0112

						5/23/2017 8:0	5 pm
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQ FEET)	(DEPR)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SAL)			
		1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT	730, 681					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9, 051, 106				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 042	8, 369				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	71, 804	4, 063, 376			178, 911, 856	5. 00
7. 00	00700 OPERATION OF PLANT	365, 128	406, 133			12, 750, 884	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	724	400, 133				8.00
			_			691, 592	
9.00	00900 HOUSEKEEPI NG	5, 065	12, 763			2, 876, 162	9. 00
10.00	01000 DI ETARY	7, 859	16, 280			1, 234, 061	10.00
11. 00	01100 CAFETERI A	6, 129				1, 463, 536	11. 00
13.00	01300 NURSING ADMINISTRATION	9, 857	65, 261	3, 424, 185	0	5, 043, 148	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 611	97, 771	293	0	1, 344, 495	14. 00
15.00	01500 PHARMACY	4, 735	379, 691	3, 352, 267	0	7, 034, 352	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 997	38, 687	809, 656	0	1, 832, 060	16. 00
17.00	01700 SOCIAL SERVICE	302	78	517, 539	0	717, 063	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	23. 00
23. 01	02301 XRAY EDUCATION	658	10	475, 812	0	648, 293	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	376	0				23. 02
25. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	370	0	332, 033		477, 410	25.02
30. 00	03000 ADULTS & PEDIATRICS	76, 407	277 262	14, 144, 983	0	22 200 004	30.00
			377, 263				
31.00	03100 I NTENSI VE CARE UNI T	10, 959	146, 207	1, 874, 056	0	-,	31.00
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	C	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	C	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	11, 085	16, 120	1, 508, 377	0	2, 403, 413	41.00
42.00	04200 SUBPROVI DER	0	0	C	0	0	42.00
43.00	04300 NURSERY	583	16, 642	717, 524	0	1, 021, 766	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0			l	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	39, 075	1, 098, 401	532, 779	0	20, 554, 428	50.00
51. 00	05100 RECOVERY ROOM	3, 185	32, 236			,,	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0,133	02,200	.,,,,		0	52.00
53. 00	05300 ANESTHESI OLOGY	119	10, 785		0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 395			_	2, 909, 117	54.00
							•
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 384	7, 599			1, 315, 628	54. 01
54. 02	05404 ULTRA SOUND	1, 504	36, 022			899, 225	54. 02
54. 03	05405 MAMMOGRAPHY	273	14, 072			1, 403, 432	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 780				3, 329, 281	55. 00
57. 00	05700 CT SCAN	1, 471	230, 314			1, 411, 836	•
58. 00	05800 MRI	900	13, 576			562, 036	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	10, 596	98, 507	1, 588, 825	0	2, 989, 661	59. 00
60.00	06000 LABORATORY	10, 759	154, 392	3, 609, 513	0	8, 780, 500	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	16, 703	328, 997	0	884, 695	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	524	4, 092	68, 053	0	647, 157	62.00
65.00	06500 RESPIRATORY THERAPY	6, 599				2, 605, 309	65. 00
66. 00	06600 PHYSI CAL THERAPY	227	24, 827			5, 307, 489	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	221	5, 225			1, 887, 295	
68. 00	06800 SPEECH PATHOLOGY	0	20, 277			1, 153, 217	1
69. 00	06900 ELECTROCARDI OLOGY	1, 398				837, 428	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 370	13, 679			1, 144, 110	70.00
		1	13,0/9	030, 788			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	5, 958, 498	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	7, 582, 734	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	17, 026, 798	73. 00
74. 00	07400 RENAL DI ALYSI S	0	62		0	550, 033	74. 00
76. 00	03020 ACUPUNCTURE	0	0	C	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 581	12, 600	167, 059	0	400, 446	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
90. 00	09000 CLI NI C	6, 774	41, 382			1, 575, 233	90.00
90. 01	09001 DI ABETES CENTER	775				275, 815	90. 01
90. 02	09002 NEUROPSYCH	134	35			134, 590	90. 02
90. 02	09003 WOUND CENTER	0	1, 986			1, 461, 825	90.02
		0					•
90.04	09004 HYPERBARI C OXYGEN THERAPY	-	218			276, 889	•
90.05	09005 VI MCARE CLI NI C	1, 353				253, 548	
91.00	09100 EMERGENCY	14, 696	269, 606	5, 244, 210	1 0	10, 507, 497	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			L	<u> </u>	L	92. 00
_	OTHER REIMBURSABLE COST CENTERS	1		1		Г	l
95.00	09500 AMBULANCE SERVICES	7, 361	283, 901	2, 767, 505	0	4, 108, 766	95.00

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 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 8:05 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description **BENEFITS** (SO FEET) (DFPR) & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SAL) 5. 00 1.00 2.00 4.00 5A 99. 10 09910 CORF 99. 10 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 0 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 I SLET ACQUISITION 0 0 o 0 111. 00 C 113. 00 11300 I NTEREST EXPENSE 113. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 726, 617 9, 037, 178 74, 400, 077 -39, 000, 303 176, 176, 881 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 10, 936 190. 00 727 355 194. 00 07950 WELLNESS COMMUNITY 12, 860 174, 471 346, 841 194. 00 194. 01 07951 BUI LDI NG RENTALS 97, 712 194. 01 1, 327 0 0 0 0 0 0 70, 946 194. 02 194. 02 07952 HOSPI CE 0 0 0 194. 03 194. 03 07953 OUTREACH CLINICS 0 0 0 194.04 07954 SPEECH - HEARING AIDS 0 0 0 264, 590 194. 04 194. 05 07955 NONALLOWABLE MARKETING 0 0 1, 605, 965 194. 05 0 14, 300 194. 06 194.06 07956 CRH FOUNDATION 932 815 713 194. 07 07957 HEALTHY COMMUNITIES 1, 195 166, 401 0 253, 159 194. 07 194. 08 07958 CRHP 51, 538 70, 526 194. 08 200.00 200. 00 Cross Foot Adjustments 201. 00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 10, 629, 031 9, 197, 738 27, 555, 993 39, 000, 303 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 14. 546746 1.016200 0.368428 0. 217986 203. 00 204.00 Cost to be allocated (per Wkst. B, 215, 988 5, 944, 881 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.002888 0. 033228 205. 00

| Period: | Worksheet B-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0112

				To	12/31/2016		
Cost Center Des	cription	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (LDRY LBS)	HOUSEKEEPING (TIME SPT)	DI ETARY (MEALS)	5/23/2017 8: 0: CAFETERI A (FTES)	5 pili
		7.00	8.00	9. 00	10.00	11. 00	
1. 00 O0100 CAP REL COSTS-B 2. 00 00200 CAP REL COSTS-M 4. 00 00400 EMPLOYEE BENEFI	LDG & FIXT VBLE EQUIP						1. 00 2. 00 4. 00
5. 00 00500 ADMINISTRATIVE (7. 00 00700 OPERATION OF PL. 8. 00 00800 LAUNDRY & LINEN 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA	ANT	280, 707 724 5, 065 7, 859 6, 129	1, 036, 861 0 0 0	5, 123 42 92	154, 100 0	1, 068	5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI S' 14. 00 01400 CENTRAL SERVI CE: 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS 17. 00 01700 SOCI AL SERVI CE 23. 00 02300 PARAMED ED PRGM	S & SUPPLY & LI BRARY	9, 857 7, 611 4, 735 3, 997 302 0	0 0 0 0 0	14 47 61 0 2	0 0 0 0 0	38 13 37 30 7 0	13. 00 14. 00 15. 00 16. 00 17. 00 23. 00
23. 01   02301   XRAY   EDUCATION 23. 02   02302   PHARMACY   RESI DEI   I NPATI ENT   ROUTI NE   SER		658	0	11 5	0 0	7 4	23. 01 23. 02
30. 00   03000   ADULTS & PEDI ATI 31. 00   03100   INTENSI VE CARE   0 32. 00   03200   CORONARY CARE   U 33. 00   03300   BURN   INTENSI VE   0	RI CS UNI T NI T	76, 407 10, 959 0 0	393, 431 49, 051 0 0	1, 800 151 0 0	120, 907 11, 619 0 0	254 28 0 0	30. 00 31. 00 32. 00 33. 00
34. 00   03400   SURGI CAL   INTENS 40. 00   04000   SUBPROVI DER -   1 41. 00   04100   SUBPROVI DER -   1 42. 00   04200   SUBPROVI DER	PF	0 0 11, 085 0	0 0 57, 880 0	0 0 217 0	0 0 17, 743 0	0 0 24 0	
43. 00   04300   NURSERY 44. 00   04400   SKI LLED NURSI NG ANCI LLARY SERVI CE COS		583	16, 071 0	0	0	10	1
50. 00   05000   OPERATI NG ROOM   51. 00   05100   RECOVERY ROOM		39, 075 3, 185	214, 384 32, 101	819 144	347 0	114 13	50. 00 51. 00
52.00 05200 DELIVERY ROOM &	LABOR ROOM	0	0	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNI		119 8, 395	97, 380		73	1 22	53. 00 54. 00
54. 01   05402   NUCLEAR MEDICIN 54. 02   05404   ULTRA SOUND	E-DI AGNOSTI C	3, 384 1, 504	0	85 28	0	4 5	54. 01 54. 02
54. 03   05405   MAMMOGRAPHY 55. 00   05500   RADI OLOGY-THERA	PEUTI C	273 7, 780	8, 089 6, 894		0 352	12 15	54. 03 55. 00
57. 00   05700 CT SCAN 58. 00   05800 MRI		1, 471 900	0	16 11	0	9	57. 00 58. 00
59. 00 05900 CARDI AC CATHETE	RI ZATI ON	10, 596	4, 967	124	314	20	59. 00
60. 00   06000   LABORATORY 60. 01   06001   LABORATORY-PATH	OLOGI CAL	10, 759 1, 212	0	118 8	0	77 5	60. 00 60. 01
62. 00   06200   WHOLE BLOOD & PA		524 6, 599	0	4 131	0	1 26	62. 00 65. 00
66.00 06600 PHYSI CAL THERAP	Υ	227	21, 943	0	0	49	66. 00
67. 00   06700   0CCUPATI ONAL THE 68. 00   06800   SPEECH PATHOLOG		221	10, 804 0	0	0	16 9	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLO 70. 00   07000   ELECTROENCEPHAL		1, 398 0	0 1, 327	25 208	0	8	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES	S CHARGED TO PATIENT	0	0		ō	0	71. 00
72. 00   07200   I MPL. DEV. CHAR 73. 00   07300   DRUGS CHARGED TO		0	0	0	0	0	72. 00 73. 00
74. 00   07400   RENAL DI ALYSI S 76. 00   03020   ACUPUNCTURE		0	0	0	o	0	74. 00
76. 97 07697 CARDI AC REHABI L		1, 581	0	6	0	3	76. 00 76. 97
0UTPATIENT SERVICE CO 88. 00 08800 RURAL HEALTH CL		0	0	0	ol	0	88. 00
89.00 08900 FEDERALLY QUALI		0	0	0	0	0	89.00
90. 00   09000   CLI NI C 90. 01   09001   DI ABETES CENTER		6, 774 775	38, 671 0	87 4	1, 971 0	14 1	90. 00 90. 01
90. 02   09002   NEUROPSYCH 90. 03   09003   WOUND CENTER		134	0 5, 212	0	0	2	90. 02 90. 03
90. 04 09004 HYPERBARI C OXYG	EN THERAPY	0	571	0	o	1	90.03
90. 05   09005   VI MCARE CLINI C 91. 00   09100   EMERGENCY		1, 353 14, 696	0 78, 085	0 543	0 774	3	90. 05 91. 00
92. 00 09200 OBSERVATION BED		14, 070	70,000	343	,,,		92.00
95. 00 OTHER REIMBURSABLE CO		7, 361	0	0	ol	68	95. 00
99. 10   09910   CORF 101. 00   10100   HOME   HEALTH   AGE		0	0	0	O	0	99. 10
101. UU TUTUU HUME HEALTH AGE	NC T	0	0	0	0	0	101. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi don CCN: 15 0112	Pori od:	Workshoot P 1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
	005047101105	1.41111551/	LIQUOFICERINO	DI ETABY	5/23/2017 8:0	)5 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
	PLANT	LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
	(SQ FEET)	(LDRY LBS)		10.00	44.00	
	7. 00	8. 00	9. 00	10. 00	11. 00	
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	276, 643	1, 036, 861	5, 08	8 154, 100	1, 059	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	727	0		0 0	0	190. 00
194.00 07950 WELLNESS COMMUNITY	0	0		0 0	5	194. 00
194.01 07951 BUILDING RENTALS	1, 327	0		0 0	0	194. 01
194. 02 07952 HOSPI CE	0	0		0 0	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0		0 0	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0		0 0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0 0	0	194. 05
194.06 07956 CRH FOUNDATION	815	0	3	0	0	194. 06
194. 07 07957 HEALTHY COMMUNITIES	1, 195	0		5 0	3	194. 07
194. 08 07958 CRHP	0	0		0 0	1	194. 08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	15, 530, 398	882, 405	3, 783, 35	1, 968, 893	2, 189, 601	202.00
Part I)	., ,	,		,	, ,	
203.00 Unit cost multiplier (Wkst. B, Part I)	55. 326009	0. 851035	738. 50302	6 12. 776723	2, 050. 188202	203. 00
204.00 Cost to be allocated (per Wkst. B,	6, 205, 318	49, 671	•		325, 688	
Part II)	0, 200, 010	,			,	
205.00 Unit cost multiplier (Wkst. B, Part	22. 106032	0. 047905	59. 28479	4 2, 288748	304. 951311	205. 00
			•			•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 COLUMBUS REGIONAL HOSPITAL Provider CCN: 15-0112 Peri od: From 01/01/2016 To 12/31/2016 Worksheet B-1 Date/Time Prepared: 5/23/2017 8:05 pm SOCIAL SERVICE PHARMACY (DRG COST) MEDI CAL RECORDS & LI BRARY Cost Center Description NURSI NG CENTRAL ADMI NI STRATI ON SERVICES &

			(NURS HRS)	SUPPLY (STER SUP)	,	LIBRARY (TIME SPT)	(TIME SPT)	
1.00   1.00					15. 00		17. 00	
2.00   00000 CAP PIEL COSIS -MYBLE EDUIP	1 00							1 00
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.00000000								•
0.0   CORDINO OF MATHER OF 19 AND   1.00								•
B. 00   000000   AURIDRY A LINEN SIXVICE								•
9.00   0.000		1 1						•
11.00   01100   CAFETERIA     1.667, 564   12.991   1.670, 561   12.991   1.670, 564   12.991   1.670, 564   12.991   1.670, 564   12.991   1.670, 564   12.991   1.670, 564   12.991   1.670, 564   12.991   1.670, 564   1.670		1 1						1
13.00   0300  MIRSING ABININSTRATION   1,657,564   11.00   10.00   10.00   17.094,818   15.00   15.00   15.00   17.094,818   15.00   15.00   17.094,818   15.00   15.00   17.094,818   15.00   15.00   17.094,818   15.00   17.094,818   15.00   17.094,818   15.00   17.094,818   15.00   17.094,818   15.00   17.094,818   17.00   17.094,818   15.00   17.094,818   17.00   17.00								
14.00   01400  CENTRAL SERVICES & SUPPLY   26.636   12.291   17.094, 818   15.00   1		1	1 657 564					
15.00   O1500   PHABMACY   O				12, 291				ł
17. 00   01700  SOCIAL SERVICE   15,478   0   0   0   1,000   17. 00   23.			0		17, 094, 818			ł
23.00			15 479	0	0	19, 848	1 000	ł
23.01   02301   RAMY EDUCATION   0   0   0   0   0   23.01		1 1	15, 476	0	0	ol ol		1
INPATILENT ROUTINE SERVICE COST CENTERS   528, 242   581   15, 982   4, 273   254   30.00   31.00   30000   AULTS & PEDIATRIC S   581, 70   21   2, 763   336   63   31.00   32.00   320000   32000   32000   320000   32000		02301 XRAY EDUCATION	0	0	Ō	ō		1
30.00	23. 02		0	0	0	0	0	23. 02
31.00   03100   INTENSIVE CARE UNIT	30 00		528 242	581	15 982	A 273	254	30 00
33 0.0   03300 BURN INTENSIVE CARE UNIT					· ·			•
34 00   03400 SURRGIAL INTENSIVE CARE UNIT   0   0   0   0   0   0   0   0   0		1	0	0	0	О	0	32. 00
40, 00   04000   04000   04000   0400   0400   0400   0400   0400   0420   04200   0			0	0	0	0		•
11. 00   04-100   SUBPROVI DER   1 IF   50, 119   0   409   660   151   41, 100   42, 200   42, 200   030			0	0	0	0		•
43. 00   04300   NURSERY   20,935   18   3   0   0   43. 00			50, 119	0	-	-1		1
A		1	0	0		-1		•
MOLILLARY SERVICE COST CENTERS			20, 935			۰		1
50.00     05000   0FEATING ROOM   237, 826   10, 971   60, 334   5, 952   0   50.00   0   0   0   0   0   0   0   0   0	44.00		0	0	0		0	44.00
S2.00   05200   05200   05200   05200   05200   05200   05200   0530		05000 OPERATING ROOM		10, 971		5, 952	0	•
1.53.00   05300   ANESTHESI OLOGY   2, 288   0   69, 670   0   0   53.00			27, 940	0		1		1
54.00   05400   RADIOLOGY-DIAGNOSTIC   0   7   3, 686   0   0   54.01			2 288	0		ol Ol		1
54.02   05404   LITRA SOUND		1	0	7		Ö		1
54.03   OSAOS   MAMMOGRAPHY   O			0	0		- 1		ł
55.00   05500   RADI OLOGY-THERAPEUTI C   31,082   0   98   417   33   55.00			0	0		- 1		ł
58.00   05800   MR    0   0   601   0   0   58.00			31, 082	0		- 1		ł
59.00   05900   CARDI ACC CATHETER I ZATI ON   41,546   95   4,537   104   0   59.00			0	0		- 1		ł
60. 00   06000   LABORATORY   0   0   421   0   0   60. 00   60. 01   06000   LABORATORY-PATHOLOGI CAL   0   0   0   0   1,946   0   60. 01   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   54,910   9   6,242   35   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   99,957   257   3,078   170   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   33,741   0   285   36   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   19,182   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   16,344   0   3,536   2,133   0   69. 00   70. 00   07000   ELECTROCARDI OLOGY   18,324   0   13   1,464   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   16,669,080   0   0   73. 00   74. 00   07400   EXAMEDIA THE SERVICE COST CENTERS   88. 00   08800   RURAL REALITH CLINIC   0   0   0   0   0   90. 00   09000   CLINIC ENTRY SERVICE COST CENTERS   88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   90. 01   09001   DIABETES CENTER   3,077   0   0   0   0   90. 02   09002   EVERDROSYCH   3,957   0   0   12   0   90. 03   09003   WOUND CENTER   15,650   271   36,486   0   0   0   90. 04   09004   HYPERBARI C OXYGEN THERAPY   2,621   0   0   0   90. 05   09005   VI MCARE CLINIC   6,691   0   1,915   0   0   90. 00   09000   ENGROSYCH   3,957   0   0   12   0   90. 00   09000   VI MCARE CLINIC   6,691   0   1,915   0   0   90. 00   09000   VI MCARE CLINIC   6,691   0   1,915   0   90. 00   09000   VI MCARE CLINIC   6,691   0   1,915   0   90. 00   09000   VI MCARE CLINIC   6,691   0   1,915   0   90. 00   09000   VI MCARE CLINIC   6,691   0   1,915   0   90. 00   09000   VI MCARE CLINIC   6,691   0   0   0   90. 00   09000   VI MCARE CLINIC   0   0   0   90. 00   09000   VI MCARE CLINIC   0   0   0   0   90. 00   09000   VI MCARE CLINIC   0   0   0   90. 00   09000   VI MCARE CLINIC   0			11 514	_		-1		ı
60.01   06001   LABORATORY-PATHOLOGICAL   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			41, 546					1
65. 00   06500   RESPI RATORY THERAPY   54,910   9   6,242   35   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   99,957   257   3,078   170   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   33,741   0   285   36   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   19,182   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   16,344   0   3,536   2,133   0   69. 00   70. 00   07000   ELECTROCARDI OLOGY   18,324   0   13   1,464   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   16,669,080   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   76. 00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   5,600   0   0   0   0   0   88. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER   0   0   0   0   0   0   99. 00   09900   CLINI C   29,939   1   665   2,310   200   90. 00   90. 01   09000   CLINI C   29,939   1   665   2,310   200   90. 00   90. 02   09002   NEUROPSYCH   3,957   0   0   12   0   90. 01   90. 02   09003   WINGOPSYCH   3,957   0   0   12   0   90. 01   90. 03   09003   WOUND CENTER   15,650   271   36,486   0   0   0   0   90. 04   09004   HYPERBARI C 0XYGEN THERAPY   2,621   0   0   0   0   0   90. 05   09005   VI MCARE CLI NI C   6,914   0   1,915   0   0   91. 00   09000   DRENGENCY   155,878   52   22,328   0   234   91. 00   09000   DRENGENCY   155,878   52   22,328   0   234   91. 00   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0   0   99. 10   09910   ORF   0   0   0   0   0	60. 01		0			1, 946		
66. 00   06600   PHYSI CAL THERAPY   99,957   257   3,078   170   0   66. 00   67. 00   67. 00   06700   0CCUPATI ONAL THERAPY   33,741   0   285   36   0   67. 00   68. 00   68. 00   69. 00   0   0   0   0   0   68. 00   69. 00   0   0   0   0   0   0   0   68. 00   69. 00   0   0   0   0   0   0   0   0   0			0	_	-	0		•
67. 00								•
68. 00   06800   SPEECH PATHOLOGY   19, 182   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   16, 344   0   3, 536   2, 133   0   69, 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   18, 324   0   13   1, 464   0   70, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRIGS CHARGED TO PATI ENTS   0   0   16, 669, 080   0   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   6, 738   0   0   74. 00   76. 00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   5, 600   0   0   0   0   0   89. 00   08800   RURAL HEALTH CLI NI C   0   0   0   0   0   89. 00   09800   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   90. 01   09001   DI ABETES CENTER   3, 077   0   0   0   0   90. 02   09002   NEUROPPSYCH   3, 957   0   0   0   90. 03   09003   NEUROPSYCH   3, 957   0   0   0   90. 04   09004   HYPERBARI C OXYGEN THERAPY   2, 621   0   0   0   90. 05   09005   VI MCARE CLI NI C   6, 914   0   1, 915   0   90. 06   09000   DI LORER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   141, 829   0   14, 221   0   0   99. 10   09910   ORF   0   0   0   0   99. 10   09910   ORF   0   0   99. 10   09910   ORF   0   0   0   99. 10   099910   ORF   0   0   90. 10   14, 221   0   0   99. 10   099910   ORF   0   0   99. 10   099910   ORF   0   0   99. 10   099910   ORF   0   0   90. 10   099910   ORF   0   0   90. 10   099910   ORF   0   90. 10   099910   ORF   0   0   90. 10   099910   ORF   0   90. 10   099910   ORF   0   0   90. 10   099910   ORF   0   0   90. 10   099910   ORF   0   90. 10   099910   ORF   0   0   90. 10   099910   ORF   0						1		•
70.00   07000   ELECTROENCEPHALOGRAPHY   18, 324   0   13   1, 464   0   70.00		06800 SPEECH PATHOLOGY		0	0	- 1	0	1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   71. 00   72. 00   72.00   1MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   73. 00   73.00   73.00   73.00   73.00   73.00   73.00   73.00   73.00   73.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   74.00   76.00   7				0				
72. 00   07200   IMPL   DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00     73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   16, 669, 080   0   0   73. 00     74. 00   07400   RENAL DI ALYSI S   0   0   0   6, 738   0   0   74. 00     76. 00   03020   ACUPUNCTURE   0   0   0   0   0   0   0     76. 97   07697   CARDI AC REHABI LITATI ON   5, 600   0   0   0   0     76. 97   0017PATI ENT SERVI CE COST CENTERS			18, 324	0				
74. 00			0	0	-	ō		1
76. 00			0	0		0		
76. 97 O7697 CARDI AC REHABILITATION 5, 600 0 0 0 0 63 76. 97 OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 01 09001 DI ABETES CENTER 3, 077 0 0 0 0 0 0 0 90. 01 90. 01 09001 DI ABETES CENTER 3, 957 0 0 0 12 0 90. 01 90. 02 09002 NEUROPSYCH 3, 957 0 0 0 12 0 90. 02 90. 03 09003 WOUND CENTER 15, 650 271 36, 486 0 0 90. 03 90. 04 09004 HYPERBARI C OXYGEN THERAPY 2, 621 0 0 0 1, 915 0 0 90. 05 09005 VI MCARE CLINI C 6, 914 0 1, 915 0 0 90. 05 91. 00 09100 EMERGENCY 155, 878 52 22, 328 0 234 91. 00 92. 00 09200 DSSERVATI ON BEDS (NON-DI STI NCT PART 0 0 14, 221 0 92. 00 09500 AMBULANCE SERVI CES 141, 829 0 14, 221 0 0 95. 00 99. 10 09910 CORF			0	0		0		•
SERVICE COST CENTERS   SERVICE COST CENTER   SERVICE COST CENTER   SERVICE COST CENTER   SERVICE COST CENTER   SERVICE CENTER			5, 600	0		- 1		•
89. 00		OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C   29, 939   1   665   2, 310   200   90. 00   90. 01   09001   DI ABETES CENTER   3, 077   0   0   0   0   0   90. 01   90. 02   09002   NEUROPSYCH   3, 957   0   0   0   12   0   90. 02   90. 03   09003   WOUND CENTER   15, 650   271   36, 486   0   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   2, 621   0   0   0   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   6, 914   0   1, 915   0   0   90. 05   91. 00   09100   EMERGENCY   155, 878   52   22, 328   0   234   91. 00   92. 00   09200   OSSERVATI ON BEDS (NON-DI STI NCT PART   155, 878   52   22, 328   0   234   91. 00   09200   OSSERVATI ON BEDS (NON-DI STI NCT PART   92. 00   09500   AMBULANCE SERVI CES   141, 829   0   14, 221   0   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   0   99. 10   0   0   0   0   0   0   0   0   0			0	0		0		1
90. 01   09001   DI ABETES CENTER   3, 077   0   0   0   0   90. 01   90. 02   09002   NEUROPSYCH   3, 957   0   0   12   0   90. 02   90. 03   09003   WOUND CENTER   15, 650   271   36, 486   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   2, 621   0   0   0   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   6, 914   0   1, 915   0   0   90. 05   91. 00   09100   EMERGENCY   155, 878   52   22, 328   0   234   91. 00   92. 00   OBSERVATI ON BEDS (NON-DI STI NCT PART   92. 00		1	29. 939	1	-	2, 310		
90. 03	90. 01	09001 DI ABETES CENTER	3, 077	0		2, 310	0	90. 01
90. 04   09004   HYPERBARI C OXYGEN THERAPY   2,621   0 0 0 0 0 0 90. 04   90. 05   09005   VI MCARE CLI NI C   6,914   0 1,915   0 0 90. 05   91. 00   09100   EMERGENCY   155,878   52   22,328   0 234   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   92. 00   07HER REI MBURSABLE COST CENTERS   141,829   0 14,221   0 0 99. 10   99. 10   09910   CORF   0 0 0 0 0 0 99. 10   90. 04   09000   0 0 0 0 0 0 0 0 99. 10   90. 05   00000   00000   00000   00000   90. 04   00000   00000   90. 04   00000   00000   90. 05   000000   90. 04   000000   90. 05   000000   90. 05   000000   90. 05   000000   90. 05   000000   90. 06   000000   90. 06   0000000   90. 06   00000000000000000000000000000000		1		0	=	12		•
90. 05		1				0		1
91. 00   09100   EMERGENCY   155, 878   52   22, 328   0   234   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   92. 00   071HER REI MBURSABLE COST CENTERS   141, 829   0   14, 221   0   0   95. 00   09910   CORF   0   0   0   0   99. 10   0   0   99. 10   0   0   0   0   0   0   0   0   0				_		ő		1
OTHER REI MBURSABLE COST CENTERS         141,829         0         14,221         0         95.00           99.10         09910 CORF         0         0         0         0         0         99.10				52	22, 328	О	234	
95. 00   09500   AMBULANCE SERVI CES   141, 829   0   14, 221   0   0   95. 00   99. 10   09910   CORF   0   0   0   0   0   99. 10	92. 00							92. 00
99. 10   09910   CORF   0   0   0   0   99. 10	95. 00		141. 829	0	14. 221	ol	0	95. 00
101.00 10100 HOME HEALTH AGENCY   0  0  0  0  0 101.00	99. 10	09910 CORF	0	0	0	o	0	99. 10
	101.0	D 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0112	Dari ad:	Workshoot R_1

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 8:05 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (DRG COST) RECORDS & LI BRARY SUPPLY (TIME SPT) (NURS HRS) (STER SUP) (TIME SPT) 17.00 15.00 13.00 14.00 16.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111. 00 0 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 12, 291 17, 093, 840 1, 000 118. 00 118.00 1, 648, 185 19, 848 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 194. 00 07950 WELLNESS COMMUNITY 9, 379 0 0 0 0 0 0 0 0 194. 00 194. 01 07951 BUILDING RENTALS 0 0 0 0 194. 01 194. 02 07952 HOSPI CE 0 0 194. 02 0 978 194. 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 0 194. 05 0 0 194.06 194.06 07956 CRH FOUNDATION 0 C 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 0 194. 07 194. 08 07958 CRHP 0 0 0 0 194. 08 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 6, 776, 078 2, 228, 911 8, 950, 617 2, 514, 067 969, 183 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 087974 181. 344968 0. 523587 126. 666012 969. 183000 203. 00 45, 289 204. 00 259, 967 204.00 Cost to be allocated (per Wkst. B, 631, 593 442, 688 843, 101 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 381037 36.017248 0.049319 13.097894 45. 289000 205. 00 H)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 8:05 pm Provider CCN: 15-0112

					5/23/2017 8:	
	Cost Center Description	PARAMED ED	XRAY EDUCATION	PHARMACY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		PRGM	(	RESIDENCY PROG		
		(PERCENT)	(PERCENT)	(DEDCENT)		
		23.00	23. 01	(PERCENT) 23.02		
	GENERAL SERVICE COST CENTERS	20.00	20.01	20.02		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10. 00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	100			23. 00
23. 01 23. 02	02301 XRAY EDUCATION		100	100		23. 01 23. 02
23. 02	02302   PHARMACY RESIDENCY PROG   I NPATI ENT ROUTI NE SERVI CE COST CENTERS			100		23.02
30. 00	03000 ADULTS & PEDI ATRI CS	1 0	0	O		30.00
31. 00	03100   NTENSI VE CARE UNI T	0	ĺ			31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0		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	0	0	0		41. 00
42.00	04200 SUBPROVI DER	0	0	0		42. 00
43.00	04300 NURSERY	0	0			43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS		0	0		44. 00
50. 00	05000 OPERATING ROOM	0	0	0		50.00
51. 00	05100 RECOVERY ROOM	0	Ö			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	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	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0			54. 01
54. 02	05404 ULTRA SOUND	0	0	0		54. 02
54. 03 55. 00	05405 MAMMOGRAPHY	0	0	0		54. 03 55. 00
57. 00	05500  RADI OLOGY-THERAPEUTI C   05700  CT SCAN			0		57. 00
58. 00	05800 MRI	0		l ő		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö	Ö		59. 00
60.00	06000 LABORATORY	0	0	0		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	0		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62. 00
	06500 RESPI RATORY THERAPY	0	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0		66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY			0		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	Ö		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	100		73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0		74. 00
76. 00	03020 ACUPUNCTURE	0	0	0		76. 00
76. 97	07697 CARDI AC REHABILITATION	0	0	0		76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0		89.00
90. 00	09000 CLINIC	0	0	0		90.00
90. 01	09001 DI ABETES CENTER	0	0	Ö		90. 01
90. 02		0	0	0		90. 02
90. 03	09003 WOUND CENTER	0	0	0		90. 03
	09004 HYPERBARI C OXYGEN THERAPY	0	0	0		90. 04
90.05	09005 VI MCARE CLI NI C	0	0	0		90. 05
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		L			92. 00
95 NN	09500 AMBULANCE SERVICES		0	O		95. 00
	09910 CORF	0		-		99. 10
	10100 HOME HEALTH AGENCY	0	Ö			101. 00
	· · · · · ·	•		1		·

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0112

					5/23/2017 8:	
Cost Cent	er Description		XRAY EDUCATION			
		PRGM		RESIDENCY PROG		
		(PERCENT)	(PERCENT)			
				(PERCENT)		
		23. 00	23. 01	23. 02		
SPECIAL PURPOSE		_	_	_		
109. 00 10900 PANCREAS		0	0	0		109. 00
110. 00 11000 I NTESTI NA		0	0	0		110. 00
111.00 11100 I SLET ACQ		0	0	0		111. 00
113. 00 11300 I NTEREST						113. 00
	(SUM OF LINES 1-117)	0	100	100		118. 00
NONREI MBURSABLE						
1 1	WER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
194. 00 07950 WELLNESS		0	0	0		194. 00
194. 01 07951 BUI LDI NG	RENTALS	0	0	0		194. 01
194. 02 07952 HOSPI CE		0	0	0		194. 02
194. 03 07953 OUTREACH		0	0	0		194. 03
194. 04 07954 SPEECH -	HEARING AIDS	0	0	0		194. 04
194. 05 07955 NONALLOWA	BLE MARKETING	0	0	0		194. 05
194.06 07956 CRH FOUND	ATI ON	0	0	0		194. 06
194. 07 07957 HEALTHY C	OMMUNI TI ES	0	0	0		194. 07
194. 08 07958 CRHP		0	0	0		194. 08
200.00 Cross Foo	t Adjustments					200. 00
201.00 Negative	Cost Centers					201. 00
202.00 Cost to b	e allocated (per Wkst. B,	0	848, 492	638, 543		202. 00
Part I)						
203.00 Unit cost	multiplier (Wkst. B, Part I)	0. 000000	8, 484. 920000	6, 385. 430000		203. 00
204.00 Cost to b	e allocated (per Wkst. B,	0	49, 872	32, 845		204. 00
Part II)	•					
205.00 Unit cost	multiplier (Wkst. B, Part	0. 000000	498. 720000	328. 450000		205. 00
11)						

				T	0 12/31/2016	Date/Time Pre 5/23/2017 8:0	pared:
			Title	XVIII	Hospi tal	PPS	o piii
	Cost Conton Decemintion	Total Cost	Thorony Limit	Total Costs	Costs	Tatal Casts	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.					
		26)	2.00	2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	38, 178, 543		38, 178, 543	0	38, 178, 543	30.00
31. 00	03100 INTENSIVE CARE UNIT	6, 062, 381		6, 062, 381	o	6, 062, 381	31. 00
32. 00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0		Ö	o	0	40. 00
41.00	04100 SUBPROVI DER - I RF	4, 461, 073		4, 461, 073	O	4, 461, 073	1
42. 00	04200 SUBPROVI DER	0		0	0	0	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	1, 401, 256		1, 401, 256 0	0	1, 401, 256 0	
44.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		1 44.00
50.00	05000 OPERATING ROOM	31, 969, 577		31, 969, 577	85, 109	32, 054, 686	50.00
51.00	05100 RECOVERY ROOM	2, 191, 511		2, 191, 511	0	2, 191, 511	51.00
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	364, 972		364, 972	0 8, 040	0 373, 012	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 090, 980		5, 090, 980	29, 417	5, 120, 397	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 941, 867		1, 941, 867	0	1, 941, 867	54. 01
54. 02	05404 ULTRA SOUND	1, 209, 738		1, 209, 738	0	1, 209, 738	
54. 03	05405 MAMMOGRAPHY	1, 796, 032		1, 796, 032	0	1, 796, 032	54. 03
55. 00 57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN	4, 808, 367 1, 838, 764		4, 808, 367 1, 838, 764	0	4, 808, 367 1, 838, 764	55. 00 57. 00
58. 00	05800 MRI	750, 985		750, 985	o	750, 985	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 571, 032	l e	4, 571, 032	41, 337	4, 612, 369	1
60.00	06000 LABORATORY	11, 535, 006	ł	11, 535, 006		11, 535, 006	1
60. 01 62. 00	O6001   LABORATORY-PATHOLOGI CAL   O6200   WHOLE BLOOD & PACKED RED BLOOD CELL	1, 407, 252 822, 223		1, 407, 252 822, 223	9, 459 0	1, 416, 711 822, 223	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	3, 922, 179	ł		o	3, 922, 179	65. 00
66.00	06600 PHYSI CAL THERAPY	7, 074, 512	0	7, 074, 512	О	7, 074, 512	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 495, 565	0	2, 495, 565	0	2, 495, 565	67. 00
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	1, 501, 470 1, 471, 031	0	1, 501, 470 1, 471, 031	22, 611	1, 501, 470 1, 493, 642	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 827, 054		1, 827, 054	22, 011	1, 827, 054	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 257, 367		7, 257, 367	O	7, 257, 367	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 235, 664	l e	9, 235, 664	0	9, 235, 664	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	30, 104, 650 673, 460		30, 104, 650 673, 460	0	30, 104, 650 673, 460	1
76. 00	03020 ACUPUNCTURE	073, 400		073, 400	ő	073, 400	76. 00
76. 97	07697 CARDI AC REHABILI TATI ON	669, 742		669, 742	2, 684	672, 426	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	1		1	ا		00.00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER	0 0		0	0	0	
	09000 CLINIC	3, 053, 790	l	3, 053, 790	_	3, 053, 790	
90. 01	09001 DI ABETES CENTER	396, 400	l .	396, 400		396, 400	
90. 02	09002 NEUROPSYCH	193, 139		193, 139		193, 139	
90. 03 90. 04	O9003   WOUND CENTER   O9004   HYPERBARI C OXYGEN THERAPY	1, 933, 545 350, 498		1, 933, 545 350, 498	0	1, 933, 545 350, 498	90. 03 90. 04
90. 05	09005 VI MCARE CLI NI C	419, 092	l e	419, 092		419, 092	
91. 00	09100 EMERGENCY	15, 153, 956	l e	15, 153, 956		15, 153, 956	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 585, 327		4, 585, 327		4, 585, 327	92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	6, 138, 326		6, 138, 326	2, 146	6, 140, 472	95. 00
	09910 CORF	0	l	0	_, ]	0	1
101.00	10100 HOME HEALTH AGENCY	0		0		0	101. 00
100 00	SPECIAL PURPOSE COST CENTERS  10900 PANCREAS ACQUISITION	0		Ιο		0	109. 00
	11000   NTESTINAL ACQUISITION						1109.00
111.00	11100 I SLET ACQUI SI TI ON	0	ł	0	l		111. 00
	11300   INTEREST EXPENSE	210, 252, 537		210 050 007	200 000	210 052 122	113.00
200. 00 201. 00	,	218, 858, 326 4, 585, 327	l e	218, 858, 326 4, 585, 327		219, 059, 129 4, 585, 327	
201.00		214, 272, 999					
					·		

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2016	Part
To 12/31/2016	Date/Time Prepared:
5/23/2017 8:05 pm	Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0112

						0 12/31/2010	5/23/2017 8:0	
					XVIII	Hospi tal	PPS	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col . 7)	Ratio	Inpati ent	
			6.00	7. 00	8. 00	9. 00	Rati o 10. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00		ADULTS & PEDIATRICS	55, 679, 192		55, 679, 192	2		30. 00
31. 00	1	INTENSIVE CARE UNIT	10, 454, 297		10, 454, 297			31. 00
32.00		CORONARY CARE UNIT	0		(	)		32. 00
33.00	03300	BURN INTENSIVE CARE UNIT	0		(	)		33. 00
34.00	1	SURGICAL INTENSIVE CARE UNIT	0		(	)		34.00
40. 00		SUBPROVIDER - IPF	0		(	)		40. 00
41.00		SUBPROVI DER - I RF	6, 430, 471		6, 430, 471			41.00
42.00		SUBPROVI DER NURSERY	2 200 254		2 200 25	)		42.00
43. 00 44. 00		SKILLED NURSING FACILITY	3, 298, 254 0		3, 298, 254			43. 00 44. 00
44.00		LARY SERVICE COST CENTERS	O <sub>1</sub>			,		1 44.00
50.00	05000	OPERATI NG ROOM	23, 167, 520	60, 807, 454	83, 974, 974	0. 380704	0. 000000	50.00
51.00		RECOVERY ROOM	2, 189, 657	4, 393, 642			0.000000	
52.00		DELIVERY ROOM & LABOR ROOM	0	0	(	0. 000000	0. 000000	52. 00
53.00		ANESTHESI OLOGY	4, 025, 076	6, 646, 441			0. 000000	
54. 00	1	RADI OLOGY-DI AGNOSTI C	1, 438, 492	4, 135, 032			0. 000000	
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	1, 434, 589	6, 211, 583			0. 000000	
54. 02		ULTRA SOUND	1, 060, 286	4, 177, 949			0.000000	1
54. 03		MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	735	2, 936, 686			0.000000	
55. 00 57. 00	1	CT SCAN	355, 475 4, 658, 121	11, 429, 189 18, 969, 244			0. 000000 0. 000000	
58. 00	1		1, 453, 000	6, 031, 199			0. 000000	
59. 00	1	CARDI AC CATHETERI ZATI ON	11, 438, 644	7, 482, 700			0. 000000	
60.00	1	LABORATORY	11, 341, 075	25, 750, 913			0. 000000	
60. 01	1	LABORATORY-PATHOLOGI CAL	480, 827	4, 630, 418			0.000000	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1, 299, 653	741, 652	2, 041, 305	0. 402793	0. 000000	62. 00
65. 00	06500	RESPI RATORY THERAPY	7, 453, 306	2, 339, 005	9, 792, 311	0. 400537	0. 000000	65. 00
66. 00		PHYSI CAL THERAPY	3, 544, 256	9, 816, 929			0. 000000	
67. 00		OCCUPATI ONAL THERAPY	2, 182, 531	2, 084, 222			0. 000000	
68. 00		SPEECH PATHOLOGY	1, 039, 977	944, 577			0.000000	
69.00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	5, 217, 587	8, 889, 515			0.000000	
70. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	179, 099 9, 737, 693	6, 521, 380 8, 561, 345			0. 000000 0. 000000	
71.00		IMPL. DEV. CHARGED TO PATIENTS	10, 840, 126	5, 219, 595			0. 000000	
73. 00	1	DRUGS CHARGED TO PATIENTS	28, 361, 288	50, 155, 828			0. 000000	
74. 00	1	RENAL DIALYSIS	1, 593, 608	0			0. 000000	
76.00		ACUPUNCTURE	0	0			0.000000	
76. 97		CARDIAC REHABILITATION	25, 745	1, 599, 354	1, 625, 099	0. 412124	0. 000000	76. 97
		TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	0				88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC	20, 020	0	· ·	1	0.000000	89. 00
90. 00 90. 01	1	DI ABETES CENTER	30, 830 172	5, 167, 928 140, 482			0. 000000 0. 000000	
90. 01	1	NEUROPSYCH	4, 060	269, 356			0. 000000	
90. 03	1	WOUND CENTER	57, 090	5, 364, 265			0. 000000	
90. 04	1	HYPERBARI C OXYGEN THERAPY	25, 636	1, 399, 267			0. 000000	
90. 05		VIMCARE CLINIC	698	108, 622			0.000000	
91.00	09100	EMERGENCY	13, 779, 731	52, 306, 439	66, 086, 170	0. 229306	0. 000000	91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	0	10, 191, 935	10, 191, 935	0. 449898	0. 000000	92. 00
		REI MBURSABLE COST CENTERS	اء	44 000 700	11 000 700			
95.00		AMBULANCE SERVICES	0	11, 090, 733	1	0. 553464	0. 000000	
99. 10		HOME HEALTH AGENCY	0	0				99. 10 101. 00
101.00		AL PURPOSE COST CENTERS	O <sub>1</sub>	0		/		101.00
109. 00		PANCREAS ACQUISITION	0	0	(			109. 00
		INTESTINAL ACQUISITION	o	Ō				110.00
111.00	0 11100	ISLET ACQUISITION	0	0	(			111. 00
	1	INTEREST EXPENSE						113. 00
200.00	4	Subtotal (see instructions)	224, 278, 797	346, 514, 879	570, 793, 676			200. 00
201.00	1	Less Observation Beds	224 270 707	24/ 514 070	F70 702 (7)			201. 00
202.00	u	Total (see instructions)	224, 278, 797	346, 514, 879	570, 793, 676	ןי	l	202. 00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0112

Period:
From 01/01/2016
To 12/31/2016

Part I
Date/Time Prepared:
5/23/2017 8:05 pm

					5/23/2017 8:0	5 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS					30. 00
31.00 0	3100 INTENSIVE CARE UNIT					31.00
32.00 03	3200 CORONARY CARE UNIT					32.00
33.00 03	3300 BURN INTENSIVE CARE UNIT					33. 00
34.00 03	3400 SURGICAL INTENSIVE CARE UNIT					34.00
40.00 04	4000 SUBPROVI DER - I PF					40.00
	4100 SUBPROVI DER - I RF					41.00
	4200 SUBPROVI DER					42.00
	4300 NURSERY					43. 00
	4400 SKILLED NURSING FACILITY					44. 00
	NCI LLARY SERVI CE COST CENTERS					44.00
	5000 OPERATING ROOM	0. 381717				50.00
	<u> </u>	1				1
	5100 RECOVERY ROOM	0. 332889				51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	5300 ANESTHESI OLOGY	0. 034954				53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0. 918700				54. 00
	5402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 253966				54. 01
	5404 ULTRA SOUND	0. 230944				54. 02
	5405 MAMMOGRAPHY	0. 611432				54. 03
	5500 RADI OLOGY-THERAPEUTI C	0. 408019				55. 00
57. 00 0	5700 CT SCAN	0. 077823				57. 00
58. 00 0!	5800 MRI	0. 100343				58. 00
59. 00 0!	5900 CARDIAC CATHETERIZATION	0. 243765				59. 00
60.00 0	6000 LABORATORY	0. 310984				60.00
60. 01 0	6001 LABORATORY-PATHOLOGI CAL	0. 277175				60. 01
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 402793				62.00
	6500 RESPIRATORY THERAPY	0. 400537				65. 00
	6600 PHYSI CAL THERAPY	0. 529482				66.00
	6700 OCCUPATI ONAL THERAPY	0. 584886				67. 00
	6800 SPEECH PATHOLOGY	0. 756578				68. 00
	6900 ELECTROCARDI OLOGY	0. 105879				69. 00
	7000 ELECTROENCEPHALOGRAPHY	0. 272675				70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 396598				71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 575082				72.00
		1				1
	7300 DRUGS CHARGED TO PATIENTS	0. 383415				73.00
	7400 RENAL DIALYSIS	0. 422601				74.00
	3020 ACUPUNCTURE	0. 000000				76. 00
	7697 CARDI AC REHABI LI TATI ON	0. 413775				76. 97
	UTPATIENT SERVICE COST CENTERS					4
	8800 RURAL HEALTH CLINIC					88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
	9000 CLI NI C	0. 587408				90. 00
	9001 DI ABETES CENTER	2. 818263				90. 01
90. 02 09	9002 NEUROPSYCH	0. 706392				90. 02
90. 03 09	9003 WOUND CENTER	0. 356653				90. 03
90. 04 09	9004 HYPERBARIC OXYGEN THERAPY	0. 245980				90. 04
90. 05 0	9005 VIMCARE CLINIC	3. 833626				90. 05
	9100 EMERGENCY	0. 229306				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 449898				92.00
_	THER REIMBURSABLE COST CENTERS					
	9500 AMBULANCE SERVICES	0. 553658				95. 00
	9910 CORF	0.00000				99. 10
	0100 HOME HEALTH AGENCY					101. 00
	PECIAL PURPOSE COST CENTERS					101.00
	0900 PANCREAS ACQUISITION					109. 00
	1000 INTESTINAL ACQUISITION					1
						110.00
	1100   SLET ACQUISITION					111.00
	1300 INTEREST 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	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0112	Peri od:	Worksheet D	
				From 01/01/2016	Part I	
				To 12/31/2016	Date/Time Pre	pared:
		Ti +l e	e XVIII	Hospi tal	5/23/2017 8: 0 PPS	5 pm
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B.	Adj d3 tillott	Related Cost		3 / 601. 4)	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1, 00	2.00	3.00	4, 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	1. 00	0.00	
30. 00 ADULTS & PEDIATRICS	4, 956, 981	C	4, 956, 98	31 29, 325	169. 04	30.00
31.00 INTENSIVE CARE UNIT	839, 074		839. 0		334. 96	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	1
40. 00 SUBPROVI DER - I PF	0	l		0 0	0.00	
41. 00 SUBPROVI DER - I RF	645, 651	l c	645, 65	3, 825	168, 80	41.00
42. 00 SUBPROVI DER	0	l c		0 0	0.00	42.00
43. 00 NURSERY	88, 066		88, 06	3, 634	24. 23	1
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
200.00 Total (lines 30-199)	6, 529, 772		6, 529, 77	72 39, 289		200.00
Cost Center Description	Inpatient	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	11, 337					30.00
31.00 INTENSIVE CARE UNIT	1, 171	392, 238	3			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	C	)			34. 00
40. 00   SUBPROVI DER - I PF	0	C	1			40. 00
41. 00 SUBPROVI DER – I RF	2, 288	1	1			41. 00
42. 00 SUBPROVI DER	0	C	)			42. 00
43. 00 NURSERY	0	C	)			43. 00
44.00 SKILLED NURSING FACILITY	0	C	)			44. 00
200.00 Total (lines 30-199)	14, 796	2, 694, 858	3			200. 00

Health Financial Systems	COLUMBUS REGIO	NAL F	IOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ENT ANCILLARY SERVICE CAPITAL COSTS				Peri od: From 01/01/2016 Part II To 12/31/2016 Date/Time Prepa 5/23/2017 8:05			
			Titl∈	e XVIII		Hospi tal	PPS	
Cost Center Description	Capi tal			Ratio of		Inpatient	Capital Costs	

			To	12/31/2016	Date/Time Pre 5/23/2017 8:0	pared: 5 nm
			XVIII	Hospi tal	PPS	o piii
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	T		,			
50. 00   05000   OPERATI NG ROOM	4, 415, 770	83, 974, 974	0. 052584	10, 297, 641	541, 491	50.00
51. 00   05100   RECOVERY ROOM	223, 986	6, 583, 299	0. 034023	1, 046, 674	35, 611	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	28, 406	10, 671, 517	0. 002662	1, 706, 445	4, 543	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	599, 688	5, 573, 524	0. 107596	848, 316	91, 275	54.00
54. 01   05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C	210, 306	7, 646, 172		892, 510	24, 548	54. 01
54. 02   05404   ULTRA SOUND	126, 485	5, 238, 235		562, 188	13, 575	54. 02
54. 03   05405   MAMMOGRAPHY	234, 215	2, 937, 421	0. 079735	0	0	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	1, 100, 018	11, 784, 664	0. 093343	191, 340	17, 860	55. 00
57. 00   05700   CT   SCAN	341, 568	23, 627, 365		2, 505, 136	36, 214	57. 00
58. 00   05800   MRI	68, 222	7, 484, 199		776, 034	7, 074	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	646, 413	18, 921, 344	l	4, 407, 462	150, 572	59. 00
60. 00   06000   LABORATORY	913, 160	37, 091, 988	l	5, 301, 525	130, 518	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	121, 288	5, 111, 245	l	236, 549	5, 613	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	45, 653	2, 041, 305	1	663, 469	14, 838	62. 00
65. 00 06500 RESPI RATORY THERAPY	540, 315	9, 792, 311	0. 055177	4, 119, 691	227, 312	65. 00
66. 00 06600 PHYSI CAL THERAPY	665, 055	13, 361, 185		1, 176, 056	58, 538	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	98, 917	4, 266, 753	1	382, 406	8, 865	
68. 00 06800 SPEECH PATHOLOGY	86, 302	1, 984, 554		123, 610	5, 375	68. 00
69. 00 06900 ELECTROCARDI OLOGY	148, 255	14, 107, 102	1	2, 758, 231	28, 986	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	244, 246	6, 700, 479		107, 813	3, 930	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	197, 989	18, 299, 038	1	4, 729, 252	51, 171	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	251, 959	16, 059, 721	0. 015689	5, 377, 506	84, 368	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 387, 870	78, 517, 116	1	13, 377, 754	236, 465	73.00
74. 00   07400   RENAL DI ALYSI S	18, 671	1, 593, 608		808, 000	9, 467	74.00
76. 00   03020   ACUPUNCTURE	0	0	0.000000	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	92, 021	1, 625, 099	0. 056625	7, 545	427	76. 97
OUTPATIENT SERVICE COST CENTERS			0.000000	ما		00.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	5 400 750	0.000000	0 700	0	89. 00
90. 00   09000   CLI NI C	411, 848	5, 198, 758		25, 729	2, 038	90.00
90. 01   09001   DI ABETES CENTER	41, 490	140, 654	0. 294979	172	51	90. 01
90. 02   09002   NEUROPSYCH	11, 945	273, 416	l	2, 610	114	90. 02
90. 03 09003 WOUND CENTER	73, 440	5, 421, 355	0. 013546	10 700	0	90. 03
90. 04   09004   HYPERBARI C OXYGEN THERAPY	142, 269	1, 424, 903	1	19, 720	1, 969	90.04
90. 05   09005   VI MCARE   CLI NI C	70, 494	109, 320	l	7 770 400	0	90.05
91. 00 09100 EMERGENCY	1, 329, 035	66, 086, 170		7, 772, 403	156, 311	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	595, 345	10, 191, 935	0. 058413	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVI CES	15 400 (44	402 040 700		70 222 707	1 040 110	95.00
200.00   Total (lines 50-199)	15, 482, 644	483, 840, 729	l l	70, 223, 787	1, 949, 119	J200. 00

Health Financial Systems	COLUMBUS REGIC	NAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COS		F	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 8:0	pared: 5 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		All Other	Swi ng-Bed	Total Costs	
		Cost	Medical	Adjustment	(sum of cols.	
			Education Cost		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	-		·	1	
31. 00 03100 I NTENSI VE CARE UNI T	0	1	1	)	0	
32. 00 03200 CORONARY CARE UNIT	0	0	0	)	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	)	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	C		0	
40. 00   04000   SUBPROVI DER - 1 PF	0	0	C	0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	0	0	C	0	0	1 00
42. 00   04200   SUBPROVI DER	0	0	C	0	0	
43. 00   04300   NURSERY	0	0	C		0	43.00
44.00   04400   SKILLED NURSING FACILITY	0	0			0	44. 00
200.00 Total (lines 30-199)	0	0	C		0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent	PSA Adj.	
	Days	5 ÷ col. 6)	Program Days	Program	Nursing School	
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00	11. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	29, 325					00.00
31.00 03100 INTENSIVE CARE UNIT	2, 505			0	0	000
32. 00 03200 CORONARY CARE UNIT	0			0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00		0	0	
40. 00   04000   SUBPROVI DER - I PF	0	0.00		0	0	
41. 00   04100   SUBPROVI DER - I RF	3, 825			8 0	0	1 00
42. 00   04200   SUBPROVI DER	0	0.00		0	0	42. 00
43. 00   04300   NURSERY	3, 634			0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0	0	
200.00 Total (lines 30-199)	39, 289		14, 796	0	0	200. 00
Cost Center Description	PSA Adj.	PSA Adj. All				
	Allied Health					
	Coct	Education Cost				

Cost 12. 00

Education Cost 13.00

30.00

31. 00 32. 00 33. 00

34.00

40. 00 41. 00 42. 00

43.00

44. 00 200. 00

INPATIENT ROUTINE SERVICE COST CENTERS

30. 00 03000 ADULTS & PEDIATRICS

43. 00 | 04300 NURSERY

31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT

44.00 | 04400 | SKILLED NURSING FACILITY | Total (lines 30-199)

34.00 03400 SURGICAL INTENSIVE CARE UNIT

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 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

			1	0 12/31/2016	5/23/2017 8:0	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				ام		F0 00
50. 00   05000   OPERATING ROOM	0	_	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0	0	U	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	040 400	U	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	848, 492	U	848, 492	54.00
54. 01   05402   NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	U	0	54. 01
54. 02   05404   ULTRA SOUND	0	0	0	U	0 0	54. 02 54. 03
54. 03   05405   MAMMOGRAPHY 55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
57. 00   05700   CT   SCAN				0	0	57.00
58. 00   05800   MRI				0	0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON				0	0	59.00
60. 00   06000   LABORATORY	0			0	0	60.00
60. 01   06001 LABORATORY - PATHOLOGI CAL				0	0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0		0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	Ö	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	Ō	638, 543	o	638, 543	73. 00
74.00 07400 RENAL DIALYSIS	0	0	0	o	0	74. 00
76. 00 03020 ACUPUNCTURE	0	0	0	o	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	o	0	76. 97
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
90. 00  09000   CLI NI C	0	0	0	0	0	90.00
90. 01   09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02   09002   NEUROPSYCH	0	0	0	0	0	90. 02
90. 03   09003   WOUND CENTER	0	0	0	0	0	90. 03
90. 04   09004   HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	90. 04
90. 05   09005   VI MCARE CLI NI C	0	0	0	0	0	90. 05
91. 00   09100   EMERGENCY	0	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50-199)	0	0	1, 487, 035	0	1, 487, 035	200. 00

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/23/2017 8:05 pm

				Т	o 12/31/2016	Date/Time Prep 5/23/2017 8:09	pared: 5 nm
			Title	XVIII	Hospi tal	PPS	o piii
	Cost Center Description	Total		Ratio of Cost	Outpati ent	Inpati ent	
	,	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000  OPERATI NG ROOM	0		0. 000000		10, 297, 641	50. 00
51. 00	05100 RECOVERY ROOM	0				1, 046, 674	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 000000		0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	10, 671, 517	0. 000000		1, 706, 445	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	848, 492	5, 573, 524	0. 152236		848, 316	54. 00
54. 01	05402  NUCLEAR MEDICINE-DIAGNOSTIC	0	., ,			892, 510	54. 01
54. 02	05404 ULTRA SOUND	0	-,,			562, 188	
54. 03	05405 MAMMOGRAPHY	0	2, 937, 421	0. 000000		0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	, ,	0. 000000		191, 340	55. 00
57. 00	05700 CT SCAN	0	23, 627, 365			2, 505, 136	57. 00
58. 00	05800  MRI	0	7, 484, 199			776, 034	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				4, 407, 462	
60.00	06000 LABORATORY	0				5, 301, 525	60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	5, 111, 245			236, 549	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				663, 469	62. 00
65. 00	06500 RESPI RATORY THERAPY	0		0. 000000		4, 119, 691	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	,			1, 176, 056	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	.,,			382, 406	
68. 00	06800 SPEECH PATHOLOGY	0	., ,			123, 610	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	, ,			2, 758, 231	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	-, ,			107, 813	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	, ,			4, 729, 252	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	,	0. 000000		5, 377, 506	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	638, 543				13, 377, 754	73. 00
74. 00	07400 RENAL DIALYSIS	0				808, 000	74. 00
76. 00	03020 ACUPUNCTURE	0		0.000000		0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 625, 099	0. 000000	0. 000000	7, 545	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS			0.00000	0.000000		00.00
88. 00	08800 RURAL HEALTH CLINIC	0				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.000000		01	89. 00
90.00	09000 CLINIC	0				25, 729	90.00
90. 01	09001 DI ABETES CENTER	0	140, 654	0.000000		172	90. 01
90. 02	09002 NEUROPSYCH	0	273, 416			2, 610	90. 02
90. 03	09003 WOUND CENTER	0	5, 421, 355			0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0				19, 720	90. 04
90. 05	09005 VI MCARE CLI NI C	0				7 772 403	90. 05
91.00	09100 EMERGENCY	0				7, 772, 403	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 191, 935	0. 000000	0. 000000	0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00	09500 AMBULANCE SERVICES	1 407 005	402 040 700			70 222 707	95. 00
200.00	Total (lines 50-199)	1, 487, 035	483, 840, 729	l		70, 223, 787	J∠UU. UU

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 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

			1	0 12/31/2016	5/23/2017 8:0	
		Ti tl e	xVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
	Program	Program	Program	Physi ci an	Nursing School	
	Pass-Through	Charges	Pass-Through	Anestheti st		
	Costs (col. 8		Costs (col. 9	Cost		
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00	21.00	22. 00	
ANCILLARY SERVICE COST CENTERS	,			ı		
50. 00   05000   OPERATI NG ROOM	0	17, 526, 971	0	0	0	50. 00
51.00  05100   RECOVERY ROOM	0	904, 988		0	1	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	1, 617, 855	i	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	129, 144	1, 442, 490		0	0	54. 00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 708, 356	1	0	0	54. 01
54. 02   05404   ULTRA SOUND	0	1, 231, 835	1	0	0	54. 02
54. 03   05405   MAMMOGRAPHY	0	285, 381	1	0	0	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	5, 477, 340	1	_	0	55. 00
57. 00   05700   CT   SCAN	0	5, 820, 700	1	_	0	57. 00
58. 00   05800   MRI	0	1, 898, 742			0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	2, 892, 310	1	I	0	59.00
60. 00   06000   LABORATORY	0	3, 109, 370			0	60.00
60. 01   06001   LABORATORY-PATHOLOGI CAL	0	1, 257, 679		_	0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	418, 324	1	I	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	989, 573	1	_	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	57, 435	1	_	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	25, 625	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	196, 037	1	0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0	3, 225, 699	1	0	0	69. 00 70. 00
71. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 843, 140 2, 647, 008	1	0	0	70.00
72. 00   07/100   MPL. DEV. CHARGED TO PATIENTS	0	2, 376, 661		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	108, 801	15, 122, 778	1	0	0	73.00
74. 00   07400   RENAL DIALYSIS	100, 801	13, 122, 776	122, 994	0	0	74.00
74. 00 07400 KENAL DI ALTSI 3 76. 00 03020 ACUPUNCTURE	0	0	0	0	0	76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	682, 323	_	0	0	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	002, 323	0			70. 77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	_	_	89.00
90. 00   09000   CLINI C		2, 572, 442	1	_	Ö	90.00
90. 01   09001   DI ABETES CENTER		9, 860	1	_	l o	90. 01
90. 02   09002   NEUROPSYCH		156, 268	l .	_	l o	90. 02
90. 03   09003   WOUND CENTER	o	2, 873, 277		0	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	o	530, 961	l o	0	0	90. 04
90. 05   09005 VI MCARE CLINIC	o	8, 137	0	0	0	90. 05
91. 00 09100 EMERGENCY	O	11, 691, 267	l .	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 554, 185		0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	237, 945	94, 155, 017	342, 593	0	0	200. 00
	•					

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0112
From 01/01/2016
To 12/31/2016
To 12/31/2017 8:05 pm

				<del>-</del>			5/23/2017 8:0	05 pm
		DCA A II	- DC		XVIII	Hospi tal	PPS	
	Cost Center Description	PSA Adj. Allied Health		A Adj. All				
		Allieu nealth		cation Cost				
		23. 00	Luu	24.00				
	ANCILLARY SERVICE COST CENTERS	20.00		21100	1			
50.00	05000 OPERATING ROOM	0		0				50.00
51.00	05100 RECOVERY ROOM	0		0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0				52.00
53.00	05300 ANESTHESI OLOGY	0		0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0				54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0		0				54. 01
54. 02	05404 ULTRA SOUND	0		0				54. 02
54. 03	05405 MAMMOGRAPHY	0		0				54. 03
55. 00	· ·	0		0				55. 00
57. 00	05700 CT SCAN	0		0				57. 00
58. 00	· ·	0		0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0				59. 00
60.00		0	)	0				60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0		0				60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0				62. 00
65. 00	06500 RESPI RATORY THERAPY		]	0				65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	(	0				66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		,	0				68.00
	06900 ELECTROCARDI OLOGY		íl .	0				69. 00
70. 00			íl .	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		á	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0				72. 00
				0				73. 00
	07400 RENAL DI ALYSI S	0		0				74. 00
76. 00	03020 ACUPUNCTURE	0		0				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		0				76. 97
	OUTPATIENT SERVICE COST CENTERS	•						
88. 00	08800 RURAL HEALTH CLINIC	0	)	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89. 00
90.00		0		0				90. 00
90. 01	09001 DI ABETES CENTER	0		0				90. 01
90. 02		0		0				90. 02
90. 03	· ·	0		0				90. 03
90. 04		0		0				90. 04
90. 05	09005 VI MCARE CLI NI C	0	1	0				90. 05
91. 00	09100 EMERGENCY	0		0				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	<u> </u>	0				92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		1					05.00
	09500 AMBULANCE SERVICES			0				95. 00
200.00	Total (lines 50-199)	0	<b>'</b>	0	I			200. 00

Date/Time Prepared: 12/31/2016 5/23/2017 8:05 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. 380704 17, 526, 971 6, 672, 588 50.00 51.00 05100 RECOVERY ROOM 0. 332889 904, 988 0 0 51.00 301, 261 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.034201 1, 617, 855 55, 332 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 913422 1, 442, 490 0 1, 317, 602 54.00 2, 708, 356 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 253966 0 0 687, 830 54 01 0 54.02 05404 ULTRA SOUND 0.230944 1, 231, 835 284, 485 54.02 54.03 05405 MAMMOGRAPHY 0.611432 285, 381 174, 491 54.03 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.408019 5, 477, 340 2, 234, 859 55.00 05700 CT SCAN 0 0.077823 452, 984 57 00 5, 820, 700 57 00 0 58.00 05800 MRI 0.100343 1, 898, 742 0 190, 525 58.00 05900 CARDIAC CATHETERIZATION 2, 892, 310 0 698, 727 59.00 59.00 0.241581 06000 LABORATORY 0.310984 3, 109, 370 0 60.00 3.277 966, 964 60.00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 0.275325 1, 257, 679 0 346, 270 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.402793 418, 324 0 0 168, 498 62.00 06500 RESPIRATORY THERAPY 0.400537 989, 573 65.00 396, 361 65.00 06600 PHYSI CAL THERAPY 0. 529482 0 0 30, 411 66.00 57, 435 66, 00 0 06700 OCCUPATIONAL THERAPY 0 14, 988 67.00 0.584886 25, 625 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.756578 196, 037 0 148, 317 68.00 06900 ELECTROCARDI OLOGY 3, 225, 699 0 0 69.00 0.104276 336, 363 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.272675 1.843.140 502.578 70.00 οĺ 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.396598 2, 647, 008 1, 049, 798 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.575082 2, 376, 661 0 0 1, 366, 775 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0. 383415 15, 122, 778 0 84, 299 5, 798, 300 73.00 07400 RENAL DIALYSIS 0 74.00 0.422601 74.00 C 0 0 0 76.00 03020 ACUPUNCTURE 0.000000 0 Λ 76.00 07697 CARDIAC REHABILITATION 76.97 0.412124 682, 323 281, 202 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 0.587408 2, 572, 442 0 1, 511, 073 90.00 0 09001 DIABETES CENTER 0 90.01 2.818263 9,860 27, 788 90.01 90.02 09002 NEUROPSYCH 0.706392 156, 268 110, 386 90.02 1, 024, 763 90.03 09003 WOUND CENTER 0.356653 2, 873, 277 0 0 0 90.03 09004 HYPERBARI C OXYGEN THERAPY 0. 245980 530, 961 0 130, 606 90.04 90.04 0 09005 VIMCARE CLINIC 31, 194 90.05 90.05 3.833626 8, 137 0 91.00 09100 EMERGENCY 0. 229306 11, 691, 267 2, 680, 878 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.449898 2, 554, 185 0 1, 149, 123 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES 0.553464 0 200.00 Subtotal (see instructions) 94, 155, 017 0 87, 576 31, 143, 320 200.00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

94, 155, 017

0

87, 576

31, 143, 320 202. 00

202.00

Net Charges (line 200 +/- line 201)

| Period: | Worksheet D | From 01/01/2016 | Part V | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 8:05 pm

					5/23/2017 8: 05	pm
			Title XVIII	Hospi tal	PPS	
		Costs				
	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		O			50.00
	OO RECOVERY ROOM		o		<b>I</b>	51. 00
	OO DELIVERY ROOM & LABOR ROOM		Ö		l l	52. 00
	DOLANESTHESI OLOGY		O			53. 00
	00 RADI OLOGY-DI AGNOSTI C		0			54. 00
	02 NUCLEAR MEDICINE-DIAGNOSTIC	0	0			54. 01
	04 ULTRA SOUND	0	0			54. 02
	05 MAMMOGRAPHY	0	O			54. 03
4	00 RADI OLOGY-THERAPEUTI C	0	0			55. 00
	00 CT SCAN	0	0		•	57.00
4	OO MRI	0	0			58. 00
59. 00 0590	OO CARDIAC CATHETERIZATION	0	0			59.00
60.00 0600	00 LABORATORY	0	1, 019			60.00
60. 01 0600	01 LABORATORY-PATHOLOGI CAL	0	O			60. 01
62. 00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o			62.00
65. 00 0650	00 RESPI RATORY THERAPY	0	О			65.00
66. 00 0660	00 PHYSI CAL THERAPY	0	О			66.00
67. 00 0670	OO OCCUPATIONAL THERAPY		o			67.00
	OO SPEECH PATHOLOGY		o			68.00
	OO ELECTROCARDI OLOGY	0	O			69. 00
	00 ELECTROENCEPHALOGRAPHY		o			70. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT		O		•	71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS		Ö			72. 00
	DO DRUGS CHARGED TO PATIENTS		32, 322		•	73. 00
	DO RENAL DIALYSIS		0		•	74. 00
	20 ACUPUNCTURE		0			76. 00
	97 CARDI AC REHABI LI TATI ON		Ö		l l	76. 97
	PATIENT SERVICE COST CENTERS	ı o	O			70. 77
	00 RURAL HEALTH CLINIC	0	0			88. 00
	00 FEDERALLY QUALIFIED HEALTH CENTER		0		l l	89. 00
		0				
	00 CLINIC	0	0		•	90.00
	01 DI ABETES CENTER	0	0		•	90. 01
4	02 NEUROPSYCH	0	O			90. 02
	03 WOUND CENTER	0	0		•	90. 03
	04 HYPERBARIC OXYGEN THERAPY	0	0			90. 04
4	05 VIMCARE CLINIC	0	0			90. 05
	00 EMERGENCY	0	0			91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
	ER REIMBURSABLE COST CENTERS					
95.00 0950	OO AMBULANCE SERVICES	0				95.00
200.00	Subtotal (see instructions)	0	33, 341		2	200. 00
201.00	Less PBP Clinic Lab. Services-Program				2	201. 00
	Only Charges					
202.00	Net Charges (line 200 +/- line 201)	0	33, 341		2	202. 00
		,	•		•	

APPORTI OMMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS   Provider CDN: 15-D112   For 001/01/2016   To 12/31/2016   To 1	Heal th	Financial Systems	COLUMBUS REGIO	ONAL HOSPITAL		In lie	eu of Form CMS-	2552-10
Cost Center Description				Provider C		Period: From 01/01/2016	Worksheet D Part II	
Related Cost   Circon Wist, C.   Col.   1 + col.   Col.   1 + col.   Col.   1 + col.   Charges   Column 4)				Titl∈	× XVIII		PPS	
Part II, col.   Col. 1   Col.   Col. 1   Col.   Charges   Column 4)		Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
ANCILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS						. Charges	column 4)	
ANCILLARY SERVICE COST CENTERS				8)	2)			
ANCILLARY SERVICE COST CENTERS   940								
50.00   050000   0FERTING ROOM   4,415,770   83,974,74   0.052584   18,908   994   50.00   51.00   05100   05200   06200   PELLYRY ROOM & LABOR ROOM   23,966   6,583,299   0.034002   3.682   125   51.00   0.000000   0   0.000000   0   0.000000   0			1.00	2.00	3. 00	4. 00	5. 00	
1.1   00   05100   05100   05100   05100   05100   052   00   052   00   052   00   053   00   00								
S2 00   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05400   05400   RADI OLOGY-DI AGNOSTI C   599, 688   5, 573, 524   0, 107596   20, 920   2, 251   44, 00   44, 01   05400   RADI OLOGY-DI AGNOSTI C   210, 306   7, 646, 172   0, 027505   5, 268   145   54, 00   44, 02   05404   ULTEAR MEDI CINE DI AGNOSTI C   210, 306   7, 646, 172   0, 027505   5, 268   146   54, 02   05404   ULTEAR SOUND   126, 485   5, 238, 235   0, 024146   16, 788   405   54, 02   05404   ULTEAR SOUND   16, 788   405   54, 02   05404   ULTEAR SOUND   16, 788   405   54, 02   05500   RADI OLOGY-THERAPEUTI C   1, 100, 018   11, 784, 664   0, 093343   32, 992   3, 080   55, 00   05500   RADI OLOGY-THERAPEUTI C   1, 100, 018   11, 784, 664   0, 093343   32, 992   3, 080   55, 00   05500   RADI OLOGY-THERAPEUTI C   1, 100, 018   11, 784, 664   0, 093343   32, 992   3, 080   55, 00   05700   CT SCAN   341, 568   23, 627, 365   0, 014456   48, 986   708   57, 00   05700   CT SCAN   44, 199   16, 78, 78, 78, 78, 78, 78, 78, 78, 78, 78		1 1						
1.0   0.53.00   0.63.00   ANESTHESI OLOGY   28, 406   10, 671, 517   0.002662   3, 589   10   53. 00			1	1				
54. 00   05400   RADI DLOGY-DIAGNOSTIC   599, 688   5,573, 524   0,107596   20,920   2,251   54. 00   54. 01   54.02   05404   ULTRA SOUND   126,485   5,238,235   0.024146   16,788   405   54. 02   54. 02   05404   ULTRA SOUND   126,485   5,238,235   0.024146   16,788   405   54. 02   54. 02   05405   MAMMOGRAPHY   234,215   2,937,421   0.077935   0 0 0 54. 03   55. 00   05500   RADI DLOGY-THERAPEUTI C   1,100,018   11,784,664   0.09334   32,992   3,808   55. 00   05500   RADI DLOGY-THERAPEUTI C   34.1,100,018   2,74,841   0.00115   3,856   126   58. 00   05800   MRI   48.986   708   57. 00   05700   CT SCAN   341,568   23,627,365   0.014456   48,986   708   57. 00   05900   CARDI AC CATHETERI ZATI ON   646,413   18,921,344   0.034163   0 0   59.00   05900   CARDI AC CATHETERI ZATI ON   646,413   18,921,344   0.034163   0 0   59.00   05900   CARDIA COLOR PACKED RED BLOOD CELL   45,653   2,041,300   0.023730   950   23   60.01   0.001   LABORATORY PATHOLOGI CAL   121,288   5,111,245   0.023730   950   23   60.01   0.001   CARDINAL THERAPY   646,315   9,792,311   0.055177   73,008   4,028   65.00   0.000   0.000   MRIVER ALL THERAPY   646,315   9,792,311   0.055177   73,008   4,028   65.00   0.000   0.000   CCUPATI ONAL THERAPY   99,917   4,266,753   0.023183   778,696   18,053   67. 00   0.000   ELECTROCARDI OLOGY   88,302   1,984,554   0.04367   518,293   22,559   68.00   0.000   0.000   0.000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000			0	1			0	
54.00   05402   NUCLEAR MEDICINE-DIAGNOSTIC   210, 306   7, 646, 172   0, 027505   5, 268   145   54, 02   54.03   05404   ILTRA SOUND   126, 485   5, 288, 235   0, 024146   16, 788   405   54, 02   54.03   05405   MAMMOGRAPHY   234, 215   2, 937, 421   0, 079735   0   0, 57.00   55.00   05500   RADI OLOGY-THERAPEUTIC   1, 100, 018   11, 784, 664   0, 093343   32, 992   3, 080   55.00   05500   05500   CADI OLOGY-THERAPEUTIC   1, 100, 018   11, 784, 664   0, 093343   32, 992   3, 080   55.00   05800   MRI   68, 222   7, 484, 199   0, 009115   13, 856   126   58.00   05800   MRI   68, 222   7, 484, 199   0, 009115   13, 856   126   58.00   05800   MRI   646, 413   18, 921, 344   0, 034163   0   0   59.00   05900   CARDIAC CATHETERI ZATI ON   646, 413   18, 921, 344   0, 034163   0   0   59.00   05900   CARDIAC CATHETERI ZATI ON   646, 413   18, 921, 344   0, 034163   0   0   59.00   05900   CARDIAC CATHETERI ZATI ON   646, 413   18, 921, 344   0, 034163   0   0   59.00   05900   CARDIAC CATHETERI ZATI ON   646, 413   18, 921, 344   0, 034163   0   0   59.00   05900   CARDIAC CATHETERI ZATI ON   646, 413   18, 921, 343   0, 034163   0   0   0   0   0   0   0   0   0								
54 03   05404   ILTRA SOUND					1		2, 251	
54.03   05405   MANMOGRAPHY   234, 215   2, 937, 421   0.079735   0   0   54.03   55.00   05500   RADI OLOGY-THERAPEUTI C   1,100, 018   11,784, 664   0.093343   32, 992   3,080   55.00   05500   05700   CT SCAN   341,568   23,627,365   0.014456   48,986   708   57.00   05800   05800   MRI   664,413   18,921,344   0.034163   0   0   59.00   05900   CARDI AC CATHETERI ZATI ON   644,413   18,921,344   0.034163   0   0   59.00   06000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000	54. 01		210, 306				145	54. 01
55. 00   05500   RADIOLOCY-THERAPEUTIC   1,100,018   11,784,664   0.093343   32,992   3,080   55. 00   05700   CT SCAN   341,568   23,627,365   0.014456   48,986   708   57. 00   58.00   05800   MRI   68,222   7,484,199   0.099115   13,856   126   58. 00   05800   CARDIAC CATHETERIZATION   646,413   18,921,344   0.034163   0   0.59,00   0.0000   0.00000   LABORATORY   913,160   37,919,988   0.024613   0.024613   0.034163   0.04613							405	
57.00   05700   CT SCAN   341, 568   23, 627, 365   0.014456   48, 986   708   57.00								
S8. 00   05800   MR    68, 222   7, 484, 199   0.009115   13, 856   126   58, 00   60, 00   06000   06000   06000   06000   CARDIAC CATHETERIZATION   64, 413   18, 921, 344   0.034163   0   0.5970   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000			1, 100, 018				3, 080	
59.00   05900   CARDI AC CATHETERI ZATION   646, 413   18, 921, 344   0.034163   0   0   0   59, 00   60.00   06000   LABORATORY   913, 160   37, 091, 988   0.024619   218, 190   5, 372   60.00   60.01   06001   LABORATORY - PATHOLOGI CAL   121, 288   5, 111, 245   0.023730   950   23   60.01   62.00   06000   LABORATORY - PATHOLOGI CAL   121, 288   5, 111, 245   0.023730   950   23   60.01   62.00   06000   LABORATORY - PATHOLOGI CAL   45, 663   2, 041, 305   0.022365   7, 969   178   62.00   66.00   06500   RESPIRATORY THERAPY   540, 315   9, 792, 311   0.055177   73, 008   4.028   65.00   66.00   06000   PHYSI CAL THERAPY   665, 055   13, 361, 185   0.049775   830, 864   41, 356   66.00   66.00   06000   PHYSI CAL THERAPY   98, 917   4, 266, 753   0.023183   778, 696   18, 053   67. 00   67.00   06000   PHYSI CAL THERAPY   98, 917   4, 266, 753   0.023183   778, 696   18, 053   67. 00   69.00   06000   06000   070000   070000   070000   070000   070000   0700000   0700000   0700000   07000000   07000000   07000000   070000000   070000000   0700000000	57.00		341, 568	23, 627, 365	0. 01445	6 48, 986	708	57. 00
COLOR   COLO	58.00	05800 MRI	68, 222	7, 484, 199	0. 00911	5 13, 856	126	58. 00
60.01   06001   LABORATORY-PATHOLOGICAL   121,288   5,111,245   0.023730   950   23   60.01   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   45,653   2,041,305   0.02365   7,969   178   62.00   65.00   06500   RESPIRATORY THERAPY   540,315   9,792,311   0.055177   73,008   4,028   65.00   66.00   06600   PHYSICAL THERAPY   665,055   13,361,185   0.049775   830,864   41,356   66.00   67.00   06700   OCUPATI ONAL THERAPY   98,917   4,266,753   0.023183   778,696   18,056   67.00   68.00   06800   SPEECH PATHOLOGY   86,302   1,984,554   0.043487   518,293   22,539   68.00   69.00   06900   ELECTROCARDIOLOGY   148,255   14,107,102   0.010509   12,280   129   69.00   69.00   06900   ELECTROCARDIOLOGY   148,255   14,107,102   0.010509   12,280   129   69.00   67.00   07000   ELECTROCRECPHALOGRAPHY   244,246   6,700,479   0.036452   4,774   174   70.00   67.00   07000   ELECTROCRECPHALOGRAPHY   244,246   6,700,479   0.036452   4,774   174   70.00   67.00   07000   ELECTROCRECPHALOGRAPHY   197,989   18,299,038   0.010820   88,654   959   71.00   67.00   07000   ELECTROCRECPHALOGRAPHY   197,989   16,059,721   0.015689   0   0   0.7200   67.00   07300   DRUGS CHARGED TO PATIENTS   251,959   16,059,721   0.015689   0   0   0.7600   67.00   07300   DRUGS CHARGED TO PATIENTS   1,387,870   78,517,116   0.017676   635,429   11,232   73.00   67.00   03020   ACUPUNCTURE   0   0   0   0.00000   0   0   0.00000   67.00   07697   CARDIAC REHABILITATION   92,021   1,625,099   0.056625   0   0   0   0.00000   68.00   09000   CLINIC   411,848   5,198,758   0.079220   0   0   0.00000   69.00   09000   DIABETES CENTER   41,490   140,654   0.294979   0   0   0.00000   69.00   09000   EUROPSYCH   11,945   273,416   0.043688   290   13   90.02   69.00   09000   EUROPSYCH   11,945   273,416   0.043688   290   13   90.02   69.00   09000   HYPERBARIC OXYGEN THERAPY   142,269   1,424,903   0.099845   0   0   0.00000   69.00   09000   BISERVATION BEDS (NON-DISTINCT PART   0   10,191,935   0.000000   0   0   0.00000   60.00   09000   090	59.00	05900 CARDI AC CATHETERI ZATI ON	646, 413	18, 921, 344	0. 03416	3 0	0	59. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   45,653   2,041,305   0.022365   7,969   178   62. 00   65.00   06500   RESPIRATORY THERAPY   540,315   9,792,311   0.055177   73,008   4,028   65. 00   66.00   06600   PATS CAL THERAPY   665,055   31,361,185   0.049775   830,864   41,356   66. 00   66.00   06600   PATS CAL THERAPY   98,917   4,266,753   0.023183   778,696   18,053   67. 00   68.00   06900   CCUPATI ONAL THERAPY   98,917   4,266,753   0.023183   778,696   18,053   67. 00   68.00   06900   ELECTROCARDI OLOGY   148,255   14,107,102   0.010509   12,280   129   69. 00   70. 00   07000   ELECTROCARDI OLOGY   148,255   14,107,102   0.010509   12,280   129   69. 00   71. 00   07000   ELECTROENCEPHALGGRAPHY   244,246   6,700,479   0.036452   4,774   174   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   197,989   18,299,038   0.010820   88,654   95   71. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   251,959   16,059,721   0.015689   0   0.72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1,387,870   78,517,116   0.017676   635,429   11,232   73. 00   74. 00   07400   RENAL DI ALYSI S   18,671   1,593,608   0.011716   88,000   1,031   74. 00   76.00   7	60.00	06000 LABORATORY	913, 160	37, 091, 988	0. 02461	9 218, 190	5, 372	60.00
65. 00   06500   RESPIRATORY THERAPY   540, 315   9, 792, 311   0. 055177   73, 008   4, 028   65. 00   66. 00   06600   PHYSI CAL THERAPY   665, 055   13, 361, 185   0. 049775   830, 864   41, 356   66. 00   66. 00   06070   OCCUPATIONAL THERAPY   98, 917   4, 266, 753   0. 023183   778, 696   18, 053   67. 00   68. 00   06800   SPEECH PATHOLOGY   86, 302   1, 984, 554   0. 043487   518, 293   22, 539   68. 00   69. 00   06900   ELECTROCARDI OLOGY   148, 255   14, 107, 102   0. 010509   12, 280   129   69. 00   70. 00   70000   TOROROROROROROROROROROROROROROROROROROR	60. 01	06001 LABORATORY-PATHOLOGI CAL	121, 288	5, 111, 245	0. 02373	0 950	23	60. 01
66. 00   06600   PHYSI CAL THERAPY   665, 055   13, 361, 185   0. 049775   830, 864   41, 356   66. 00   67. 00   06700   0CCUPATI IONAL THERAPY   98, 917   4, 266, 753   0. 023183   778, 696   18, 053   67. 00   68. 00   06800   SPEECH PATHOLOGY   86, 302   1, 984, 554   0. 043487   518, 293   22, 539   68. 00   69. 00   06900   ELECTROCARDI OLOGY   148, 255   14, 107, 102   0. 010509   12, 280   129   69. 00   70. 00   07000   ELECTROCREPHALOGRAPHY   244, 246   6, 700, 479   0. 036452   4, 774   174   70. 00   770. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   177, 899   18, 299, 038   0. 010820   88, 654   959   71. 00   72. 00   73. 00   7300   DRUGS CHARGED TO PATI ENTS   251, 959   16, 059, 721   0. 015689   0   0   72. 00   73. 00   740. 00   7400   RENAL DI ALYSI S   18, 671   1, 593, 608   0. 011716   88, 000   1, 031   74. 00   76. 00   7	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	45, 653	2, 041, 305	0. 02236	5 7, 969	178	62.00
67. 00   06700   0CCUPATIONAL THERAPY   98, 917   4, 266, 753   0. 023183   778, 696   18, 053   67. 00   68. 00   06800   SPEECH PATHOLOGY   86, 302   1, 984, 554   0. 043487   518, 293   22, 539   88. 00   69. 00   06900   ELECTROCARDIO LOGY   148, 255   14, 107, 102   0. 010509   12, 280   129   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   244, 246   6, 700, 479   0. 036452   4, 774   174   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   197, 989   18, 299, 038   0. 010820   88, 654   959   71. 00   72. 00   07200   IMPLD DEV. CHARGED TO PATIENTS   251, 959   16, 059, 721   0. 015689   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 387, 870   78, 517, 116   0. 017676   635, 429   11, 232   73. 00   74. 00   07400   RENAL DIALYSIS   18, 671   1, 593, 608   0. 011716   88, 000   1, 031   74. 00   76. 00   03020   ACUPUNCTURE   0   0   0. 000000   0   0   76. 97   076. 97   O7697   CARDI AC REHABI LITATI ON   92, 021   1, 625, 099   0. 056625   0   0   76. 97   09. 00   08900   RURAL HEALTH CLINIC   0   0   0. 000000   0   0   89. 00   89. 00   08900   RURAL HEALTH CLINIC   0   0   0. 000000   0   0   0   90. 01   09000   CLINIC   411, 848   5, 198, 758   0. 079220   0   0   90. 00   90. 02   09000   CLINIC   411, 848   5, 198, 758   0. 079220   0   0   90. 01   90. 01   09001   DIABETES CENTER   41, 490   140, 654   0. 294979   0   0   90. 01   90. 02   09002   NEUROPSYCH   11, 945   273, 416   0. 043688   290   13   90. 02   90. 03   09003   WOUND CENTER   73, 440   5, 421, 355   0. 013546   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   142, 269   1, 424, 903   0. 099485   0   0   90. 04   90. 05   09005   VIMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   91. 00   09100   DEMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   92. 00   09200   OSERVATION BEDS (NON-DISTINCT PART   0   10, 191, 935   0. 000000   0   0   95. 00   95. 00   09500   AMBULANCE SERVICES	65.00	06500 RESPI RATORY THERAPY	540, 315	9, 792, 311	0. 05517	7 73, 008	4, 028	65. 00
68. 00   06800   SPEECH PATHOLOGY   86, 302   1, 984, 554   0. 043487   518, 293   22, 539   68. 00   69. 00   06900   ELECTROCARDI OLOGY   148, 255   14, 107, 102   0. 010509   12, 280   129   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   244, 246   6, 700, 479   0. 036452   4, 774   174   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   197, 989   18, 299, 038   0. 010820   88, 654   959   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   251, 959   16, 059, 721   0. 015689   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 387, 870   78, 517, 116   0. 017676   635, 429   11, 232   73. 00   74. 00   07400   RENAL DI ALYSI S   18, 671   1, 593, 608   0. 011716   88, 000   1, 031   74. 00   76. 97   07697 CARDI AC REHABI LI TATI ON   92, 021   1, 625, 099   0. 056625   0   0   76. 97   88. 00   08800   RURAL HEALTH CLINI C   0   0   0. 000000   0   0   89. 00   89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER   0   0   0. 000000   0   0   89. 00   90. 01   09000   CLI NI C   411, 848   5, 198, 758   0. 079220   0   0. 90. 01   90. 02   09002   NEUROPSYCH   11, 945   273, 416   0. 043688   290   13   90. 02   90. 03   09003   WOUND CENTER   73, 440   5, 421, 355   0. 013546   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   142, 269   1, 424, 903   0. 099845   0   0   90. 05   91. 00   09000   OBSERVATI ON BEDS (NON-DISTINCT PART   0   10, 191, 935   0. 000000   0   0   90. 05   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0   10, 191, 935   0. 000000   0   0   90. 05   95. 00   009000   OBSERVATI ON BEDS (NON-DISTINCT PART   0   10, 191, 935   0. 000000   0   0   90. 05   95. 00   009000   OBSERVATI ON BEDS (SERVICES   095   0. 000000   0   0   0. 000000   0   0	66.00	06600 PHYSI CAL THERAPY	665, 055	13, 361, 185	0. 04977	5 830, 864	41, 356	66. 00
69. 00 06900 ELECTROCARDI OLOGY 148, 255 14, 107, 102 0. 010509 12, 280 129 69. 00 70000 ELECTROENCEPHALOGRAPHY 244, 246 6, 700, 479 0. 036452 4, 774 174 70. 00 7100 MEDIC CAL SUPPLIES CHARGED TO PATIENT 197, 989 18, 299, 038 0. 010820 88, 654 959 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 251, 959 16, 059, 721 0. 015689 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 1, 387, 870 78, 517, 116 0. 017676 635, 429 11, 232 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 387, 870 78, 517, 116 0. 017676 635, 429 11, 232 73. 00 03020 ACUPUNCTURE 0 0 0. 000000 0 0 0 76. 00 000000 0 0 0 76. 00 000000 0 0 0 76. 00 000000 0 0 76. 00 000000 0 0 76. 00 000000 0 0 76. 00 000000 0 0 76. 00 000000 0 0 76. 00 000000 0 0 0 76. 00 000000 0 0 0 76. 00 000000 0 0 0 0 89. 00 00000 0 0 0 0 89. 00 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00	06700 OCCUPATI ONAL THERAPY	98, 917	4, 266, 753	0. 02318	3 778, 696	18, 053	67. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   244, 246   6, 700, 479   0. 036452   4, 774   174   70. 00   7100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   197, 989   18, 299, 038   0. 010820   88, 654   959   71. 00   72. 00   72. 00   72. 00   72. 00   1 MPL. DEV. CHARGED TO PATI ENTS   251, 959   16, 059, 721   0. 015689   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 387, 870   78, 517, 116   0. 017676   635, 429   11, 232   73. 00   74.	68.00	06800 SPEECH PATHOLOGY	86, 302	1, 984, 554	0.04348	7 518, 293	22, 539	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	148, 255	14, 107, 102	0. 01050	9 12, 280	129	69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	244, 246	6, 700, 479	0. 03645	2 4, 774	174	70. 00
73. 00	71.00		197, 989	18, 299, 038	0. 01082	0 88, 654	959	71. 00
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	251, 959	16, 059, 721	0. 01568	9 0	0	72.00
76. 00	73.00		1, 387, 870			6 635, 429	11, 232	73. 00
76. 97 O7697 CARDI AC REHABILITATION 92, 021 1, 625, 099 0. 056625 0 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0 0 99. 00 99. 00 90. 01 10 10 10 10 10 10 10 10 10 10 10 10	74.00		18, 671	1, 593, 608	0. 01171	6 88, 000	1, 031	74.00
SECTION   SERVICE COST CENTERS   SERVICE COST CENTER   SER	76.00	03020 ACUPUNCTURE	0	0	0.00000	0 0	0	76. 00
88. 00	76. 97		92, 021	1, 625, 099	0. 05662	5 0	0	76. 97
89. 00		OUTPATIENT SERVICE COST CENTERS						
90. 00			0	0			0	88. 00
90. 01	89. 00		0	0			0	89. 00
90. 02   09002   NEUROPSYCH   11, 945   273, 416   0. 043688   290   13   90. 02   90. 03   09003   WOUND CENTER   73, 440   5, 421, 355   0. 013546   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   142, 269   1, 424, 903   0. 099845   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   70, 494   109, 320   0. 644841   0   0   90. 05   91. 00   09100   EMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   10, 191, 935   0. 000000   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00	90.00		411, 848	5, 198, 758			0	90.00
90. 03	90. 01				0. 29497	9 0	0	90. 01
90. 04   09004   HYPERBARI C 0XYGEN THERAPY   142, 269   1, 424, 903   0. 099845   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   70, 494   109, 320   0. 644841   0   0   90. 05   09100   EMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   10, 191, 935   0. 000000   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00   000000   0   0   0   0   0   0	90. 02	09002 NEUROPSYCH	11, 945	273, 416	0. 04368	8 290	13	90. 02
90. 05   09005   VI MCARE CLI NI C   70, 494   109, 320   0. 644841   0   0   90. 05   09100   EMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   10, 191, 935   0. 000000   0   0   92. 00   000000   0   0   0   0   0   0	90. 03	09003 WOUND CENTER	73, 440	5, 421, 355	0. 01354	6 0	0	90. 03
91. 00   09100   EMERGENCY   1, 329, 035   66, 086, 170   0. 020111   6, 840   138   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   10, 191, 935   0. 000000   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00			142, 269	1, 424, 903	0. 09984	5 0	0	90. 04
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   10, 191, 935   0.000000   0   0   92. 00	90. 05		70, 494	109, 320			0	90. 05
OTHER REI MBURSABLE COST CENTERS  95. 00  O9500 AMBULANCE SERVI CES	91.00		1, 329, 035	66, 086, 170	0. 02011	1 6, 840	138	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00		0	10, 191, 935	0.00000	0 0	0	92.00
200. 00   Total (lines 50-199)   14, 887, 299  483, 840, 729    3, 429, 226  113, 069 200. 00								
	200.00	Total (lines 50-199)	14, 887, 299	483, 840, 729	1	3, 429, 226	113, 069	200.00

APPORTI ON THROUGH (	nancial Systems WMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	COLUMBUS REGIONAL RVICE OTHER PASS	Provi der CO	CN: 15-0112	Peri od: From 01/01/2016	u of Form CMS-:   Worksheet D   Part IV	
INKUUGH (	20313		Component (	CCN: 15-T112	To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Nur Anesthetist	sing School	Allied Heal	th All Other Medical	Total Cost (sum of col 1	
		Cost			Education Cost		
		1.00	2. 00	3. 00	4.00	<u>4)</u> 5. 00	
ANI	CILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5. 00	
	OOO OPERATING ROOM	0	0		0 0	0	50.00
	100 RECOVERY ROOM	0	0		o o	0	
	200 DELIVERY ROOM & LABOR ROOM	0	0		ol ol	0	
	300 ANESTHESI OLOGY	0	0		0	0	
	400 RADI OLOGY-DI AGNOSTI C	o	0	848, 4	92 0	848, 492	54.00
	402 NUCLEAR MEDICINE-DIAGNOSTIC	o	0		0	0	
	404 ULTRA SOUND	o	0		0	0	54. 02
	405 MAMMOGRAPHY	0	0		o o	0	
	500 RADI OLOGY-THERAPEUTI C	0	0			0	
	700 CT SCAN	0	0		ol ol	0	
	800 MRI	0	0		ol ol	0	
4	900 CARDI AC CATHETERI ZATI ON	0	0		ol ol	0	
	000 LABORATORY	0	0		ol ol	0	
	001 LABORATORY-PATHOLOGI CAL	o	0		o o	0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		ol ol	0	
65. 00 06	500 RESPI RATORY THERAPY	o	0		0 0	0	65.00
66. 00 06	600 PHYSI CAL THERAPY	o	0		0 0	0	66.00
67. 00 06	700 OCCUPATI ONAL THERAPY	o	0		0 0	0	
68. 00 06	800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06	900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07	000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	O	0	638, 5	43 0	638, 543	73.00
74. 00 07	400 RENAL DIALYSIS	O	0		0 0	0	74.00
76. 00 03	020 ACUPUNCTURE	O	0		0 0	0	76.00
	697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
	TPATIENT SERVICE COST CENTERS						
88. 00 08	800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00 08	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00 09	000 CLI NI C	0	0		0 0	0	90.00
90. 01   09	001 DI ABETES CENTER	0	0		0 0	0	90. 01
90. 02 09	002 NEUROPSYCH	0	0		0 0	0	90. 02
90. 03   09	003 WOUND CENTER	0	0		0 0	0	90. 03
	004 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	90. 04
90. 05   09	005 VIMCARE CLINIC	0	0		0 0	0	90.05
	100 EMERGENCY	0	0		0 0	0	91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
OTI	HER REIMBURSABLE COST CENTERS						
95. 00 09	500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	1, 487, 0	35l ol	1, 487, 035	I200 0

APP0R	n Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	COLUMBUS REGIO RVICE OTHER PAS:	S Provider C	CN: 15-0112 CCN: 15-T112	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/23/2017 8:0	
			Ti tl e	e XVIII	Subprovider -	PPS	-
	Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
	ANOLILIADIA OFFICIA CONTROLLA	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	1				10.000	
50. 00	05000 OPERATING ROOM	0		1		18, 908	
51. 00	05100 RECOVERY ROOM	0				3, 682	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	_			0	
53.00	05300 ANESTHESI OLOGY	0 40 400				3, 589	
54.00	05400 RADI OLOGY-DI AGNOSTI C	848, 492		1		20, 920	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	0	,			5, 268	
54. 02 54. 03	05405 MAMMOGRAPHY	0		1		16, 788	
55. 00				1		0 32, 992	
57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN		, ,	1		32, 992 48, 986	
58. 00	05800 MRI					13, 856	
59. 00	05900 CARDI AC CATHETERI ZATI ON		,	1		13, 630	
60.00	06000 LABORATORY			1		218, 190	
60. 01	06001 LABORATORY-PATHOLOGI CAL			1		950	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			1		7, 969	
65. 00	06500 RESPIRATORY THERAPY		,			73, 008	
66. 00	06600 PHYSI CAL THERAPY	Ö		1		830, 864	
67. 00	06700 OCCUPATI ONAL THERAPY	Ö		1		778, 696	
68. 00	06800 SPEECH PATHOLOGY	Ö	.,			518, 293	
69. 00	06900 ELECTROCARDI OLOGY	0	,	1		12, 280	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		1		4, 774	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				88, 654	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	638, 543	78, 517, 116	0. 00813		635, 429	73.00
74. 00	07400 RENAL DIALYSIS	0	1, 593, 608	0.00000	0. 000000	88, 000	74.00
76. 00	03020 ACUPUNCTURE	0	0	0. 00000	0. 000000	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 625, 099	0.00000	0. 000000	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	·					
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89. 00
90.00	09000 CLI NI C	0	5, 198, 758	0.00000		0	90.00
90. 01	09001 DI ABETES CENTER	0	140, 654	0.00000	0. 000000	0	90. 01
90. 02	09002 NEUROPSYCH	0	273, 416	0.00000	0. 000000	290	90. 02
90. 03	09003 WOUND CENTER	0				0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0				0	
90. 05	09005 VI MCARE CLI NI C	0	,			0	
91. 00	09100 EMERGENCY	0				6, 840	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 191, 935	0.00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95. 00							95. 00
200.00	Total (lines 50-199)	1, 487, 035	483, 840, 729	1	i l	3, 429, 226	1200 00

Heal th	Financial Systems	COLUMBUS REGION	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0112	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-T112	From 01/01/2016 To 12/31/2016		epared:
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	PSA Adj. Non	PSA Adj.	
		Program	Program	Program		Nursing School	
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8 x col. 10)		Costs (col.	9 Cost		
		11.00	12. 00	x col . 12) 13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00	21.00	22.00	
50.00	05000 OPERATING ROOM	0	C	1	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	0 0	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 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 185	0	1	0 0	0	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	1	0 0	0	
54.02	05404 ULTRA SOUND	o	0	1	0 0	0	54. 02
54.03	05405 MAMMOGRAPHY	o	0	1	0 0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0 0	0	55. 00
57.00	05700 CT SCAN	0	0	)	0 0	0	57.00
58.00	05800 MRI	0	0	)	0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	)	0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	1	0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0 5, 168	0	1	0 0	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1	0	1	0 0	0	
	03020 ACUPUNCTURE	0	0	1		0	
	07697 CARDI AC REHABI LI TATI ON	0	0	1	0 0	0	1
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0 0	0	70. 97
88. 00	08800 RURAL HEALTH CLINIC	0	C	l .	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
90.00	09000 CLINIC	0	0		0 0	0	
90. 01	09001 DI ABETES CENTER	0	0		0 0	ő	1
90. 02	09002 NEUROPSYCH	o	0		0 0	ő	
90. 03	09003 WOUND CENTER	0	Ö	,	0 0	0	
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	1
90. 05	09005 VIMCARE CLINIC	0	O		0 0	0	90. 05
91.00	09100 EMERGENCY	0	O		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					-	95. 00
200.00	Total (lines 50-199)		0		0 0		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		Worksheet D
THROUGH COSTS		Component CCN: 15-T112	From 01/01/2016	Part IV Date/Time Prepared:
		compenent con. 13 1112	10 12/31/2010	5/23/2017 8: 05 pm
		Title XVIII	Subprovi der -	PPS

			litte	XVIII	I RF	PPS	
	Cost Center Description	PSA Adj.	PSA Adj. All		1100		
		Allied Health					
			Education Cost				
	ANCILLARY SERVICE COST CENTERS	23. 00	24.00				
50. 00		0	0				50.00
51. 00	05100 RECOVERY ROOM	0	1				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
	05300 ANESTHESI OLOGY	o o	Ö				53. 00
54.00	1	0	0				54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				54. 01
54.02	05404 ULTRA SOUND	0	0				54. 02
54. 03	05405 MAMMOGRAPHY	0	0				54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
57. 00		0	0				57. 00
58. 00	05800 MRI	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00		0	0				60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0				60. 01
62. 00		0	0				62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0				65. 00 66. 00
67. 00							67. 00
68. 00	l l	0	1				68. 00
	06900 ELECTROCARDI OLOGY	0	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00		0	0				74. 00
	03020 ACUPUNCTURE	0					76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
00.00	OUTPATIENT SERVICE COST CENTERS			I			1 00 00
88.00	08800 RURAL HEALTH CLINIC	0	1	1			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00 90. 00
90.00	09001 DI ABETES CENTER						90.00
	09002 NEUROPSYCH						90. 02
	09003 WOUND CENTER	0	0				90. 03
	09004 HYPERBARI C OXYGEN THERAPY	0	0				90. 04
90. 05	09005 VI MCARE CLI NI C	Ö	1				90. 05
91.00		0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	0	0				200. 00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0112	Peri od: From 01/01/2016	Worksheet D-1	
			To 12/31/2016	Date/Time Pre 5/23/2017 8:0	pared: 5 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					

PART   All FROW INFO COMPANTS			Title XVIII	Hospi tal	PPS	
Inpatient days (find using private room days and swing-bed days, excluding newborn)   29,325   1.00   Impatient days (find using private room days, excluding palary)   29,326   2.00   Impatient days (find using private room days, excluding palary)   29,326   2.00   Impatient days (find using private room days)   29,326   2.00		Cost Center Description		-	1 00	
Impattient days (including private room days and sain g-bed days, excluding needorn)		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpartient days (Including private room days, excluding safing-bed and neaborn days)   29,355   2,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.   0   3.00					· ·	
do not complete this line.  4. 05 Semi-portivate room days (excluding swing-bed and observation bed days)  1. Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed (if calendar year, enter 0 on this line)  7. 00 Total swing-bed (if calendar year, enter 0 on this line)  8. 00 Total swing-bed (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if yea inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bed (if yea inpatient days) (including private room days) after December 31 of the cost on the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SW type inpatient days (including private room days) after December 31 of the cost on the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SW type inpatient days applicable to this swing-bed industry through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SW type inpatient days applicable to title sW in a control of the cost reporting period (if calendar year, enter 0 on this line)  11. 00 Swing-bed SW type inpatient days applicable to title sW in a control of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SW type inpatient days applicable to title sW in a control of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed SW type inpatient days applicable to title sW in a control of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Swing-bed Net year inputient days applicable to swing-bed swing-bed days)  15. 00 Total swing-bed SW services applicable to swing-bed swing-bed swing-bed days)  16. 00 Narsery days (title V or XX only)  17. 00 Wedicare rate for swing-bed SW services applicable to services through December 31 of the cost rep				vato room days	· ·	
Semil-private room days (excluding swing-bed and observation bed days)   25,803   4.00	3.00		ys). If you have only pri	vate room days,	O	3.00
reporting period (1° calendar year, including private room days) after December 31 of the cost of reporting period (1° calendar year, including private room days) through December 31 of the cost of reporting period (1° calendar year, enter 0 on this line)  8. 00 reporting period (1° calendar year, enter 0 on this line)  9. 00 Total inpatient days (including private room days) after December 31 of the cost reporting period (1° calendar year, enter 0 on this line)  10. 00 Swing-bed SWI type Inpatient days (including private room days) after December 31 of the cost reporting period (1° calendar year, enter 0 on this line)  10. 00 Swing-bed SWI type Inpatient days applicable to the Program (excluding swing-bed and involved private room days) applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions) (including private room days) after 0 through December 31 of the cost reporting period (see instructions) (including private room days) after 0 through December 31 of the cost reporting period (see instructions) (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 period (see instructions) (including private room days) after 0 period (see instructions) (including private room days) (including 20° calendar) (including 20° calenda	4.00		ed days)		25, 803	4. 00
Total saing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if crailendar year, enter 0 on this line)	5.00		om days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost reporting period in the strength of the stre						, ,,,
Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Proposition (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (see instructions) reporting period (see instructions) and private room days) after becember 31 of the cost reporting period (see instructions) reporting period (see instructions) and private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if year) reporting peri	6.00		om days) arter becember 3	or the cost	Ü	6.00
reporting period  10.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed Swit year inpatient days applicable to title XVIII only (including private room days)  11.00 Swing-bed Swit year inpatient days applicable to XVIII only (including private room days)  11.00 Swing-bed Swit year inpatient days applicable to XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed Swit type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed Swit type inpatient days applicable to titles V or XIX only (including private room days) on 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Swing-bed Swit type inpatient days applicable to titles V or XIX only (including private room days) on 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) on 14.00 swing-bed Swit (itle V or XIX only) (including private room days) on 14.00 swing-bed Swit (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nursery days (itle V or XIX only) on 15.00 Total nurse	7.00		m davs) through December	31 of the cost	0	7. 00
reporting period (if calledar year, enter 0 on this line)  10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period on the Sving-bed SNF type inpatient days applicable to title X or XIX only (including private room days) after through December 31 of the cost reporting period of including private room days after December 31 of the cost reporting period of including private room days after December 31 of the cost reporting period of including reporting period of including private room days applicable to the Program (excluding swing-bed days)  10. 10. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  10. 00 Mursery days (title V or XIX only)  10. 00 Mursery days (title V or XIX only)  10. 00 Mursery days (title V or XIX only)  10. 00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost program (excluding swing-bed SNF services applicable to services through December 31 of the cost program (excluding swing-bed SNF services applicable to services after December 31 of the cost program (excluding swing-bed SNF services applicable to services after December 31 of the cost program (excluding swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 SNF type services after December 31 of the cost reporting period (line 6 SNF type services through December 31 of the cost reporting period (line 6 SNF type services through December 31 of the cost reporting period (line 6 SNF type services through			3 , 3			
10.00   Total inpatient days including private room days applicable to title XVIII only (including private room days)   0.00   10.00	8.00		m days) after December 31	of the cost	0	8. 00
newborn days)  10.00 Simp-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Simp-bed SNF type inpatient days applicable to title XVIII only (including private room days) after  11.00 Simp-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after  12.00 Simp-bed NF type inpatient days applicable to titlet XVII only (including private room days)  13.00 Simp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Simp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Simp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16.01 Simple SNF type inpatient days applicable to titles V or XIX only (including private room days)  17.00 Simple SNF type inpatient days applicable to titles V or XIX only (including private room days)  18.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  19.00 Nursery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 or specific period NF services)  19.00 Nedica	0.00		the Dreamen (evaluding	awing had and	11 227	0.00
10.00   Swing-bed SWF type Inpatient days applicable to title XVIII only (Including private room days)   10.00	9.00		the Program (excluding	Swing-bed and	11, 337	9.00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost or reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost or reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost or services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x line 12) 18.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 13) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 13) 18.00 Swing-bed cost (see instructions) 18.00 Swing-bed cos	10.00	1	nly (including private ro	oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00 Swing-bed NF type inpatient days applicable to titles $\hat{V}$ or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Necessary private room days applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 38.178.543 37.00 Private room charges (excluding swing-bed charges) 0 General inpatient routine service cost net of swing-bed cost (line 27 + line 28) 0 O Average peri diem private room cost differential (line	11. 00			oom days) after	0	11. 00
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after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   14.00   15.00   10.01   17.00   1	12.00		t only (thereating private	, room days)	ŭ	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   16.00   17.00   17.00   18.0	13.00				0	13. 00
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Total swing-bed cost (see instructions)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00  Religher Room DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  9. 00  9. 00  9. 00  9. 00  1. 00	26 00				0	26 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  29.00  20.00  30.		, ,	(line 21 minus line 26)		38, 178, 543	
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 29.00 30.00 30.00 30.00 30.00 30.00 00.00 30		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 00 00 32.00  0.00 32.00  32.00 32.00  32.00 32.00  32.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00		, , , , , , , , , , , , , , , , , , , ,	: line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,				
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 38, 178, 543 37. 00)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 301. 91 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 14, 759, 754 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 38, 178, 543 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 37.00 38.178, 543 37.00 37.00 37.00 38.178, 543 37.00		, , ,	, ,	i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,301.91 Agg. 00  14,759,754 Agg. 00  40.00			ne 31)			
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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			and private room cost dif	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,301.91 38.00 14,759,754 39.00 40.00	200	27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,301.91 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,301.91 38.00  14,759,754 39.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  14,759,754 39.00 40.00	20.00				1 201 01	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			1
		, , ,	•			1
		, , , , , , , , , , , , , , , , , , , ,	•			

COMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		L HOSPITAL Provider CCN: 15		Peri od:	wof Form CMS-2 Worksheet D-1	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/23/2017 8:0	
			Ti tle XVI		Hospi tal	PPS	o piii
	Cost Center Description	Total Inpatient CostIn	patient Days Diem	erage Per (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
12. 00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
13. 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	6, 062, 381	2, 505	2, 420. 11	1, 171	2, 833, 949	12 00
14. 00		0,002,301	2, 505	0.00		2, 633, 949	
15. 00	BURN INTENSIVE CARE UNIT		o	0.00		Ö	
	SURGICAL INTENSIVE CARE UNIT	O	O	0.00		0	1
17. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
18. 00	Program inpatient ancillary service cost (W	kst D-3 col 3	Line 200)			24, 039, 382	48. 00
19. 00	,					41, 633, 085	•
	PASS THROUGH COST ADJUSTMENTS	<b>y</b> , ,	,				1
50. 00	Pass through costs applicable to Program in	patient routine se	ervices (from Wks	t. D, sum	of Parts I and	2, 308, 644	50.00
1 00	Deep through costs applicable to Drogram in	aationt onailloss	comicos (from W	ka+ D a	m of Donto II	2, 187, 064	F1 00
51. 00	Pass through costs applicable to Program in and IV)	patrent andiriary	Services (Irolli Wi	KSI. D, SU	III OI PAILS II	2, 187, 004	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				4, 495, 708	52.00
53. 00	Total Program inpatient operating cost excl	uding capital rela	ited, non-physicia	an anesthe	tist, and	37, 137, 377	53.00
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00							55.00
56. 00						0	
57. 00	Difference between adjusted inpatient opera	0	57.0				
58. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0					
59. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period en	nding 1996, update	ed and com	pounded by the	0.00	59. 0
50. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report upda	ited by the marke	t basket		0.00	60.0
51. 00	If line 53/54 is less than the lower of lin				he amount by	0	1
	which operating costs (line 53) are less th		(lines 54 x 60),	or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
52.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	mont (soo instruct	ione)			0	62.00
55.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see mistruct	.1 0113)				05.00
54. 00		sts through Decemb	er 31 of the cos	t reportir	g period (See	0	64.00
	instructions)(title XVIII only)					_	l
55. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after December	31 of the cost i	reporti ng	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 64	l nlus line 65)(ti	itle XVIII	onLv) For	0	66.00
	CAH (see instructions)	(	p. 22		···· <b>y</b> / · · · · ·		
57. 00	]	ne costs through D	ecember 31 of the	e cost rep	orting period	0	67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	as soots often Dea			ting ported		40.00
08.00	(line 13 x line 20)	ne costs after bed	cember 31 of the c	cost repor	trng perrou	0	68.00
59. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68)			0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER I						
70.00	Skilled nursing facility/other nursing faci			(line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ie /u ÷ IINE 2)				71.00
73.00	Medically necessary private room cost appli	,	line 14 x line 3!	5)			73.00
74. 00	Total Program general inpatient routine ser	,		*			74.00
75. 00	Capital-related cost allocated to inpatient	routine service c	costs (from Works	heet B, Pa	rt II, column		75.00
7/ 00	26, line 45)	ino 2)					7, 0
76. 00 77. 00	•	•					76. 0
78. 00	,	•					78. 0
79. 00	35 5						79. 0
30.00			st limitation (lin	ne 78 minu	s line 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (						81. 0 82. 0
32.00	1 '						83.0
34. 00	Program inpatient ancillary services (see i	•					84. 0
35. 00	Utilization review - physician compensation	(see instructions					85. 0
36. 00	Total Program inpatient operating costs (su		ough 85)				86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instruction					3, 522	   87. 0
27 00	THURST DUSELVALIOUS DEG DAVY CSEE THY HUCH ON	3 I				ı 3, 022	1 0/. U
37. 00 38. 00	Adjusted general inpatient routine cost per	*	ine 2)			1, 301. 91	88. n

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 956, 981	38, 178, 543	0. 12983	7 4, 585, 327	595, 345	90.00
91.00 Nursing School cost	0	38, 178, 543	0.00000	4, 585, 327	0	91.00
92.00 Allied health cost	0	38, 178, 543	0.00000	4, 585, 327	0	92.00
93.00 All other Medical Education	0	38, 178, 543	0.00000	4, 585, 327	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 01/01/2016	Worksheet D-1
	Component CCN: 15-T112		
	Title XVIII	Subprovi der -	PPS

BOOT   All   BOOTO DR COMPOUNTS			II the Aviii	I RF	FF3	
### NAME THE MAX ### NA		Cost Center Description				
NATIENT DAYS		DART I - ALL PROVINER COMPONENTS			1. 00	
Inpatient days (including private room days, excluding saing-bed and neoborn days)   3,325   2,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.   0   3.00	1.00				3, 825	1.00
do not complete this line.  4. 00 Sell-private room days (excluding swing-bed and observation bed days)  1. 10 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I ine)  2. 00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I ine)  3. 02 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I ine)  4. 00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and new period on the swing of the cost reporting period (swing-bed SWF type inpatient days applicable to title SWF in the period of the cost reporting period (soe instruction)  5. 00 Swing-bed SWF type inpatient days applicable to title SWF in the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed SWF type inpatient days applicable to title SWF in the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed SWF type inpatient days applicable to title SWF in the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed NF type inpatient days applicable to title SWF in the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed NF type inpatient days applicable to title SWF in the cost reporting period (if callendar year, enter 0 on this I ine)  5. 00 Swing-bed NF type inpatient days applicable to swing-bed SWF including private room days)  5. 00 Swing-bed NF type inpatient days applicable to swing-bed SWF including private room days)  6. 00 Swing-bed NF type inpatient days applicable to swing-bed SWF including private room days)  7. 00 Swing-bed NF type inpatient of						
	3.00		/s). If you have only pri	vate room days,	0	3.00
Total   swing-bed SNF   type inpatient days (including private room days) after December 31 of the cost   0.6.00	4.00		ed days)		3, 825	4. 00
10   10   10   10   10   10   10   10	5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line) reporting year (if calendar year, enter 0 on this line)			om dava) ofter December 3	)1 of the cost	0	4 00
Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period of Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	6.00		om days) after becember 3	or the cost	U	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)	7. 00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)   0.00   1		' 3 '				
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0.10	8. 00		n days) after December 31	of the cost	0	8. 00
newborn days   10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   10.00   10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after   11.00   11.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after   11.00   12.00   Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days)   12.00   12.00   13	9 00		the Program (excluding	swing-bed and	2 288	9 00
through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line period on the surface)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line period on the surface)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line period on the surface)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line period on the surface)  26.00 Total swing-bed cost spilicable to SNF type services after December 31 of the cost reporting period (line period on the surface)  27.00 Swing-bed cost applicable to SNF type services after December 31					_,	
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (I calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Need inversery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 X I Ine 18) 19.00 Medicare for swing-bed NF services after December 31 of the cost reporting period (line 6 X I Ine 18) 19.00 Medicare for swing-bed NF services after December 31 of the cost reporting period (line 6 X I Ine 18) 19.00 Medicare for swing-bed SWF type services after December 31 of the cost reporting period (line 6 X I Ine 18) 19.00 Medicare for swing-bed SWF type services after December 31 of the cost repo	10. 00			oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically inecessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x Iline 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x Iline 17)  24.00 Wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x Iline 17)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x Iline 17)  26.00 Total swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x Iline 17)  27.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x Iline 17)  28.00 Swing-bed cost applicable to SNF type services a	11 00			nom days) after	0	11 00
12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Norsery days (title V or XIX only)  16.00 Norsery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Redicald rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Redicald rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  21.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29)  24.00 Swing-bed cost applicable to NF ty	11.00	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	Join days) arter	O	11.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line)   14.00   15.00	12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00  16. 00  17. 00 Total nursery days (title V or XIX only)  18. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  19. 00 No Markery days (title V or XIX only)  20. 01 No Markery days (title V or XIX only)  20. 01 No Markery days (title V or XIX only)  20. 02 No Markery days (title V or XIX only)  21. 00 No Markery days (title V or XIX only)  22. 00 No Markery days (title V or XIX only)  23. 00 No Markery days (title V or XIX only)  24. 00 No Markery days (title V or XIX only)  25. 00 No Markery days (title V or XIX only)  26. 00 No Markery days (title V or XIX only)  27. 00 No Markery days (title V or XIX only)  28. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title V or XIX only)  29. 00 No Markery days (title Vor XIX only)  29. 00 No Markery days (title Vor XIX only)  29. 00 No Markery days (title Vor XIX only)  29. 00 No Markery days (title Vor XIX only)  29. 00 No Markery days (title Vor XIX only)  29.	12 00		/ only (including private	, room dovo)	0	12 00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   15.00   Nursery days (title V or XIX only)   0   15.00   Nursery days (title V or XIX only)   17.00   Nursery days (title V or XIX only)   18.00   18.00   Nursery days (title V or XIX only)   19.00   18.00   19.00   Nursery days (title V or XIX only)   19.00   18.00   19.0	13.00				U	13.00
15.00   Total nursery days (title V or XIX only)	14. 00	1 91 1		, i	0	14. 00
SWING BED ADJUSTMENT		Total nursery days (title V or XIX only)				
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost percepting period (18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (19. 00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Nedicare rate for swing-bed NF services applicable to services through December 31 of the cost (19. 00 Nedicare reporting period (19. 00 Nedicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Nedicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Nedicare for swing-bed NF services applicable to services after December 31 of the cost (19. 00 Nedicare for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (19. 00 Nedicare for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Nedicare for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (19. 00 Nedicare for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (19. 00 Nedicare for swing-bed cost (19. 00	16. 00				0	16. 00
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Total swing-bed cost (see instructions)  29. 00 Provate room charges (excluding swing-bed charges)  29. 00 O Semi-private room charges (excluding swing-bed charges)  29. 00 Average private room charges (excluding swing-bed charges)  20. 00 Average per idem private room charge (line 29 + line 3)  30. 00 Average per diem private room charge (line 29 + line 3)  30. 00 Average per diem private room charge (line 3 x line 31)  30. 00 General inpatient routine service cost per diem (see instructions)  30. 00 Average per diem private room charge differential (line 3 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 General inpatient routine service cost per diem (see instructions)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem p	17 00		es through December 31 of	the cost	0.00	17 00
reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed charges)  20.00 Semi-private room charges (excluding swing-bed charges)  20.00 Semi-private room charges (excluding swing-bed charges)  20.00 Average private room per diem charge (line 29 + line 3)  20.00 Average per diem private room charge differential (line 21 minus line 28)  20.00 Average per diem private room charge differential (line 23 minus line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost differential (line 3 x line 31)  20.00 Average per diem private room cost di	17.00		23 th ough becomber 31 of	the cost	0.00	17.00
19.00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	18. 00		es after December 31 of t	the cost	0. 00	18. 00
reporting period  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  Total general inpatient routine service cost (see instructions)  22.00  30.0	10 00		through Docombor 21 of	the cost	0.00	10.00
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21.00   Total general inpatient routine service cost (see instructions)   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   22.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   26.00   27.0	20.00	, , , , , , , , , , , , , , , , , , , ,	s after December 31 of th	ne cost	0.00	20. 00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   4,461,073   27.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   0 29.00   28.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   30.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   31.00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0 .000000   32.00   Average perivate room per diem charge (line 30 ÷ line 4)   0 .00   32.00   Average per diem private room cost differential (line 32 x line 31)   0 .00   33.00   Private room cost differential (line 3 x line 35)   0 .00   35.00   Private room cost differential (line 3 x line 35)   0 .00   37.00   PRATI II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,166.29   38.00   29	04.00		`		4 4/4 070	04 00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  40.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  31.00 General inpatient routine service cost femiliane 35)  32.00 Average per diem private room cost differential (line 3 x line 35)  33.00 Private room cost differential adjustment (line 3 x line 35)  34.00 Average per diem private room cost differential (line 3 x line 35)  35.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ng period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average per ivate room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room charge differential (line 34 x line 31)  30.00 Frivate room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30	22.00		or or the cost reporti	ng perrod (Trie	Ö	22.00
24. 00  24. 00  7 x line 19)  25. 00  8wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  25. 00  8wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00  7 total swing-bed cost (see instructions)  6 eneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  7 round private ROOM DIFFERENTIAL ADJUSTMENT  28. 00  8 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9 rivate room charges (excluding swing-bed charges)  10 Semi-private room charges (excluding swing-bed charges)  11 conductor of the cost reporting period (line 8 x line 20)  12 conductor of the cost reporting period (line 8 x line 20)  25. 00  26. 00  27 conductor of the cost reporting period (line 8 x line 20)  28 conductor of the cost reporting period (line 8 x line 20)  29 conductor of the cost reporting period (line 8 x line 20)  29 conductor of the cost reporting period (line 8 x line 20)  20 conductor of the cost reporting period (line 8 x line 20)  21 conductor of the cost reporting period (line 8 x line 20)  22 conductor of the cost reporting period (line 8 x line 20)  23 conductor of the cost reporting period (line 8 x line 20)  24 conductor of the cost reporting period (line 8 x line 20)  25 conductor of the cost reporting period (line 8 x line 21)  26 conductor of the cost reporting period (line 8 x line 21)  27 conductor of the cost reporting conductor of the cost reporting period (line 8 x line 21)  28 conductor of the cost reporting cost of the cost reporting period (line 21 x line 28)  29 conductor of the cost reporting cost of	23. 00		31 of the cost reporting	period (line 6	0	23. 00
7 x line 19)  25.00	24.00		21 of the cost reporting	na ported (Line	0	24 00
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 29 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073) 37. 00 Agiusted general inpatient routine service cost per diem (see instructions) 38. 00 Algusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 00 40. 00	24.00	, , , , , , , , , , , , , , , , , , , ,	31 of the cost reportin	ig perrod (Trile	U	24.00
26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERNTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Opinion of the private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Opinion of the private room cost differential adjustment (line 3 x line 35)  Average per diem private room cost differential (line 32 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Opinion description description of the program (line 14 x line 35)  Opinion description des	25. 00	l	31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 461, 073 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 34 x line 31)  31. 00 Average per diem private room cost differential (line 34 x line 31)  32. 00 Average per diem private room cost differential (line 34 x line 35)  33. 00 Average per diem private room cost differential (line 34 x line 35)  34. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  35. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  4. 461, 073 JR. 00 JR. 461, 073 JR. 00 JR.	04 00					0/ 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average pri vate room per diem charge (line 29 + line 3)  33.00 Average semi-pri vate room per diem charge (line 30 + line 4)  34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073 and 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  7 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)  9 program general inpatient routine service cost per diem (see instructions)		, ,	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  30.00  0.00  30.00  0.00  31.00  0.00  32.00  32.00  34.00  0.00  34.00  0.00  35.00  0.00  35.00  0.00  36.00  37.00  37.00  37.00  38.00  38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2,668,472  39.00  40.00	27.00		(Trice 21 millias Trice 20)		4, 401, 073	27.00
30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 Ao.00			and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000						
32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073 are 11 - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  7.00 Program general inpatient routine service cost (line 9 x line 38)  8.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  9.00 Value of the company of the company of the cost of the program (line 14 x line 35)  9.00 Value of the company of the cost of the program (line 14 x line 35)  9.00 Value of the cost of the cost of the program (line 14 x line 35)  9.00 Value of the cost of the cost of the program (line 14 x line 35)  9.00 Value of the cost of the cost of the program (line 14 x line 35)  9.00 Value of the cost of the cost of the program (line 14 x line 35)			line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073)  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (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 4, 461, 073)  4, 461, 073  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 166.29  2, 668, 472  39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	1111e 20)			
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 461, 073 and 0.00)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0.00 decided and only only of the cost of the program (line 14 x line 35)  0 0 0.00 decided and only of the cost of the program (line 14 x line 35)  0 0 0.00 decided and only only only only only only only only						
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Ao. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		9	, ,	i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  7.166.29 38.00 Program general inpatient routine service cost (line 9 x line 38)  7.668,472 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  8.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			ne 31)			
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, 166.29 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2, 668, 472 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	and private room cost dif	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,166.29 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  2,668,472 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	27.00	27 minus line 36)		3. 22. (11110	., .51, 575	27.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,166.29 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2,668,472 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			IOTHENTO.			
39.00 Program general inpatient routine service cost (line 9 x line 38) 2, 668, 472 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38 00				1 166 20	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					·	
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 2,668,472   41.00		, , ,	•		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 668, 472	41. 00

	Financial Systems	COLUMBUS REGION.				eu of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN	F	eriod: rom 01/01/2016			
			Component CC	CN: 15-T112   T	o 12/31/2016	Date/Time Prep 5/23/2017 8:09		
			Title	XVIII	Subprovi der - I RF	PPS		
	Cost Center Description	Total Inpatient Costl		•	Program Days	Program Cost (col. 3 x col.		
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)	0	0	0.00			42. 00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0. 00	0	0	43. 00	
44.00	CORONARY CARE UNIT	o	О	0.00	0	0	44. 00	
45. 00 46. 00	BURN INTENSIVE CARE UNIT	0	0	0. 00 0. 00			45. 00 46. 00	
	OTHER SPECIAL CARE (SPECIFY)				_		47. 00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wk					1, 760, 097		
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	11 through 48)(s	ee instruction	s)		4, 428, 569	49. 00	
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	386, 214	50. 00	
51. 00	<pre>                                    </pre>	atient ancillarv	services (fro	m Wkst. D. su	m of Parts II	121, 422	51. 00	
F2 00	and IV)	•	,					
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu		ated, non-phys	ician anesthe	tist, and	507, 636 3, 920, 933		
	medical education costs (line 49 minus line				·			
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00	
55. 00	Target amount per discharge					0.00		
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operations	ng cost and tar	get amount (Li	ne 56 minus L	ine 53)	0	56. 00 57. 00	
58. 00								
59. 00	.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60.00	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
61. 00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
	amount (line 56), otherwise enter zero (see		(TTHES OT X O	0), 01 1% 01	the target			
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0		
PROGRAM INPATIENT ROUTINE SWING BED COST								
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reportin	g period (See	0	64. 00	
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the co	st reporting	period (See	0	65. 00	
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line 6	4 plus line 65	)(title XVIII	only). For	0	66. 00	
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	costs through	Docombor 21 of	the cost ron	orting poriod	0	67. 00	
67.00	(line 12 x line 19)	e costs till ough	becember 31 or	the cost rep	or tring perrou		07.00	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of t	he cost repor	ting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00	
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v lin	e 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine serv		•	c 33)			74. 00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from Wo	rksheet B, Pa	rt 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 minus						77. 00 78. 00	
79. 00							79. 00	
80. 00 81. 00							80. 00 81. 00	
82. 00	Inpatient routine service cost per dreim frim						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		s)				84. 00 85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				[ O	89. 00	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
		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	645, 651	4, 461, 073	0. 14473	0 0	0	90.00
91.00 Nursing School cost	0	4, 461, 073	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 461, 073	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 461, 073	0. 00000	0 0	0	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPI	TAL		In Lieu of Form CMS-255	52-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	der CCN: 15-	From 01/0	Worksheet D-3 01/2016 31/2016 Date/Time Prepa 5/23/2017 8:05	
				0, 20, 20.7 0.00	P

				From 01/01/2016 To 12/31/2016		
		Title XV	111	Hospi tal	PPS	
	Cost Center Description		tio of Cost o Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
			1.00	2. 00	2) 3. 00	
ΙN	IPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
	3000 ADULTS & PEDIATRICS			20, 962, 602		30. 00
31. 00 03	3100 INTENSIVE CARE UNIT			5, 012, 692		31. 00
32. 00 03	3200 CORONARY CARE UNIT			0		32. 00
1	3300 BURN INTENSIVE CARE UNIT			0		33. 00
	3400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
	1000 SUBPROVI DER - I PF			0		40.00
	1100 SUBPROVI DER - I RF			0		41.00
	1200  SUBPROVI DER 1300  NURSERY			0		42. 00 43. 00
	ICI LLARY SERVI CE COST CENTERS					43.00
	5000 OPERATING ROOM		0. 38171	7 10, 297, 641	3, 930, 785	50.00
	5100 RECOVERY ROOM		0. 33288			1
52.00 05	5200 DELIVERY ROOM & LABOR ROOM		0.00000			52.00
53. 00 05	ANESTHESI OLOGY		0. 03495	4 1, 706, 445	59, 647	53. 00
	7400 RADI OLOGY-DI AGNOSTI C		0. 91870	0 848, 316	779, 348	54.00
	NUCLEAR MEDICINE-DIAGNOSTIC		0. 25396			54. 01
	5404 ULTRA SOUND		0. 23094			54. 02
	5405 MAMMOGRAPHY		0. 61143		· -	54. 03
	5500 RADI OLOGY-THERAPEUTI C		0. 40801			
	5700 CT SCAN		0. 07782			57. 00
	5800 MRI 5900 CARDI AC CATHETERI ZATI ON		0. 10034 0. 24376			1
	5000 LABORATORY		0. 24376			60.00
1	5000 LABORATORY 5001 LABORATORY-PATHOLOGI CAL		0. 27717			1
	5200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 40279			62.00
	5500 RESPI RATORY THERAPY		0. 40053		1, 650, 089	1
1	6600 PHYSI CAL THERAPY		0. 52948			1
67. 00 06	5700 OCCUPATIONAL THERAPY		0. 58488	6 382, 406	223, 664	67. 00
	SPEECH PATHOLOGY		0. 75657	8 123, 610	93, 521	68. 00
	900 ELECTROCARDI OLOGY		0. 10587			1
	7000 ELECTROENCEPHALOGRAPHY		0. 27267			1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 39659			1
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 57508			1
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS		0. 38341 0. 42260			
	8020 ACUPUNCTURE		0. 42200			76.00
	7697 CARDI AC REHABI LI TATI ON		0. 41377		-	76. 97
	ITPATIENT SERVICE COST CENTERS		<u> </u>	-, .,,,,,	2, .==	
	3800 RURAL HEALTH CLINIC		0. 00000	0	0	88. 00
89. 00 08	3900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
	POOO CLI NI C		0. 58740	8 25, 729	15, 113	90. 00
	2001 DI ABETES CENTER		2. 81826			1
	2002 NEUROPSYCH		0. 70639			90. 02
	2003 WOUND CENTER		0. 35665		0	
	2004 HYPERBARI C OXYGEN THERAPY		0. 24598			90. 04 90. 05
	2005 VI MCARE CLI NI C		3. 83362		1 702 250	1
	2100 EMERGENCY 2200 OBSERVATION BEDS (NON-DISTINCT PART		0. 22930 0. 44989		1, 782, 259 0	1
	HER REIMBURSABLE COST CENTERS		0. 44 70 7	0		1 /2.00
	PSOO AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)			70, 223, 787	24, 039, 382	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			70, 223, 787		202. 00

		JS REGIONAL HOSPITAL		•	u of Form CMS-	
INPATI	IENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0112	Peri od: From 01/01/2016	Worksheet D-3	
		Component	CCN: 15-T112	To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
		Title	e XVIII	Subprovi der - I RF	PPS	о ріп
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00				0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
32.00				0		32. 00
33. 00				0		33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT			0		34.00
40. 00 41. 00	04000   SUBPROVI DER - I PF   04100   SUBPROVI DER - I RF			3, 841, 044		40. 00 41. 00
42.00	04200 SUBPROVI DER			3, 641, 044		42.00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM		0. 3817	17 18, 908	7, 218	50.00
51. 00			0. 3328		1, 226	1
52. 00			0.0000		0	
53.00	+ I		0.0349		125	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 9187 0. 2539		19, 219 1, 338	1
54. 02	+ I		0. 2309		3, 877	
54. 03	1 I		0. 6114		0	1
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 4080	19 32, 992	13, 461	55. 00
57. 00			0. 0778	23 48, 986	3, 812	57. 00
58. 00	05800 MRI		0. 1003		1, 390	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 2437		0	1
60. 00 60. 01	06000   LABORATORY   06001   LABORATORY-PATHOLOGI CAL		0. 3109 0. 2771		67, 854	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2771		263 3, 210	1
65. 00			0. 4005		29, 242	
66. 00	06600 PHYSI CAL THERAPY		0. 5294		439, 928	1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 5848		455, 448	1
68.00	06800 SPEECH PATHOLOGY		0. 7565		392, 129	
69. 00			0. 1058		1, 300	1
70. 00 71. 00			0. 2726 0. 3965		1, 302 35, 160	1
71.00			0. 3965		35, 160	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0.3730		243, 633	
74. 00			0. 4226		37, 189	
76. 00	03020 ACUPUNCTURE		0.0000		0	1
76. 97	07697 CARDIAC REHABILITATION		0. 4137	75 0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS			00	_	
88. 00	+ I		0.0000		0	1
89. 00 90. 00	+ I		0. 0000 0. 5874		0	1
	09000 DI ABETES CENTER		2. 8182		0	
90. 02			0. 7063		205	1
	09003 WOUND CENTER		0. 3566		0	1
90. 04			0. 2459		0	1
	09005 VI MCARE CLI NI C		3. 8336		0	
Q1 NN	09100 EMERGENCY		U 2203	NAI 6 04N	1 569	01 00

0

1, 760, 097 200. 00

91.00

92.00

95.00

201. 00 202. 00

1, 568

0. 229306

0. 449898

6, 840

3, 429, 226

3, 429, 226

91.00

92.00

200.00

201.00 202.00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

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

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

Health Financial Systems	COLUMBUS REGIONAL HO	SPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN:	From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 8:05 pm
		T1 11 \0	 	222

				5/23/2017 8: 0	5 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (	see	21, 544, 621	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (500	7, 467, 796	1. 02
1.02	instructions)	ing on or arter october	1 (366	7, 407, 770	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring p	orior to October	0	1. 03
	1 (see instructions)				
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring o	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			876, 920	2. 00
2. 01	Outlier reconciliation amount			0/0/720	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	140. 38	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5. 00
3.00	or before 12/31/1996. (see instructions)	recent cost reporting p	berroa enaring on	0.00	3.00
6.00	FTE count for allopathic and osteopathic programs which meet t	he criteria for an add-	on to the cap	0.00	6. 00
	for new programs in accordance with 42 CFR 413.79(e)				
7.00	MMA Section 422 reduction amount to the IME cap as specified u			0.00	7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instruction		)(1)(1V)(B)(2)	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopat		grams for	0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7				
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slot the cost report straddles July 1, 2011, see instructions.	its under section 5503 of	f the ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hosnital	0. 00	8. 02
0.02	under section 5506 of ACA. (see instructions)	rio il om a ol occa toacili.	ig noopi tai	0.00	0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	s (8, 8,01 and 8,02) (s	see	0.00	9. 00
40.00	instructions)				40.00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	nt year from your record	as	0. 00 0. 00	
12. 00	Current year allowable FTE (see instructions)			0.00	
13. 00	Total allowable FTE count for the prior year.			0. 00	
14.00	Total allowable FTE count for the penultimate year if that year	r ended on or after Sep	tember 30, 1997,	0.00	14. 00
	otherwise enter zero.				
15.00	Sum of lines 12 through 14 divided by 3.				15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clos	uro		0. 00 0. 00	
18. 00	Adjusted rolling average FTE count	ui e		0.00	
19. 00	Current year resident to bed ratio (line 18 divided by line 4)			0. 000000	
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section	on 422 of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside		ec. 412.105	0.00	23. 00
	(f)(1)(iv)(C).				
24. 00	IME FTE Resident Count Over Cap (see instructions)				24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the l	ower of line 23 or line	24 (see	0. 00	25. 00
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01	)		0	29. 01
30. 00	Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruc	tions)	5. 97	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	tront days (see mistruc		24. 24	1
32. 00	Sum of lines 30 and 31			30. 21	32. 00
33. 00	Allowable disproportionate share percentage (see instructions)			14. 14	33. 00
34.00	Disproportionate share adjustment (see instructions)			1, 025, 589	34. 00

CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od:	Worksheet E	
			From 01/01/2016 To 12/31/2016		pared:
		Title XVIII	Hospi tal	5/23/2017 8: 0! PPS	5 pm
		ii ti e xviii	Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35. 00
35. 01	Factor 3 (see instructions)		0. 000223584	0. 000217835	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent (see instructions)	,	1, 432, 310		
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.0	)3)	1, 072, 276 1, 400, 479	328, 203	35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)		gn 46) 0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	983, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-an 685. (see instructions)		0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)	. 01)	0 32, 315, 405		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions			32, 315, 405	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an			2, 622, 303 0	50. 00 51. 00
52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53. 00	Nursing and Allied Health Managed Care payment	,		56, 981	
54.00	Special add-on payments for new technologies			1, 036	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	(0)		0	54. 01 55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		237, 945	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			35, 233, 670 43, 359	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		35, 190, 311	
62. 00	Deductibles billed to program beneficiaries			3, 496, 416	
63.00	Coinsurance billed to program beneficiaries			47, 334	
64. 00 65. 00	Allowable bad debts (see instructions)  Adjusted reimbursable had debts (see instructions)			322, 836 209, 843	1
66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		209, 843	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		31, 856, 404	1
68. 00	Credits received from manufacturers for replaced devices for			0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69.00
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	70. 00 70. 50
70. 88	SCH or MDH volume decrease adjustment			Ö	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	
70. 92	HVBP payment adjustment amount (see instructions)				70. 92
70. 94	HRR adjustment amount (see instructions)			-39, 199	
70. 95	Recovery of accelerated depreciation		l	0	70. 95

Health Financial Systems COLUMBUS REGION.	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A	pared:
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1)			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a	in column 0		0	0	70. 97
70. 98 Low Volume Payment-3				0	70. 98
70. 99 HAC adjustment amount (see instructions)				0	1
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			31, 825, 593	
71. 01   Sequestration adjustment (see instructions)	σ, α ,σ,			636, 512	
72.00 Interim payments				30, 967, 355	
73.00 Tentative settlement (for contractor use only)				0	1
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 7	2. and 73)			221, 726	
75.00 Protested amounts (nonallowable cost report items) in accord				1, 587, 474	
CMS Pub. 15-2, chapter 1, §115.2				, ,	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					ĺ
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see in	structi ons)			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see inst	ructions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instru	ictions)			0	93.00
94.00 The rate used to calculate the time value of money (see inst	ructions)			0.00	94.00
95.00 Time value of money for operating expenses (see instructions	i)			0	95. 00
96.00 Time value of money for capital related expenses (see instru	ictions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0. 9996760563	1. 0020123610	
102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0. 9992	0. 9971	
104.00 HRR adjustment amount for HSP bonus payment (see instruction	ıs)		0	0	104. 00

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provi der CC		Peri od: From 01/01/2016 To 12/31/2016	Worksheet DSH Date/Time Pre 5/23/2017 8:09	
		Original .mcrxAdj	usted .mcax	XVIII HFS Look Up	Hospi tal Overri de Val ue	PPS	э рііі
		Val ues 1.00	Val ues 2. 00	3. 00	4. 00	5. 00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE			3.00		J. 33	
1. 00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5. 97	0. 00	0.0	0.00	0. 00	1. 00
2. 00	Percentage of Medicaid patient days to total days (From line 27)	24. 24	0. 00			24. 24	2. 00
3. 00	Sum of lines 1 and 2, if less than 15% DSH	30. 21	0. 00			24. 24	3. 00
4. 00	Payment Percentage = 0 Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4. 00
5. 00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	140. 38	0. 00			140. 38	5. 00
6. 00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line	14. 14	0. 00			9. 21	6. 00
7. 00	33) 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, Li ne 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	5. 97	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	3. 03	0. 00	0.0	0.00	0.00	14. 00
	III, line 2 - Revised from CMS) CALCULATION OF THE PERCENTAGE OF MEDICAID DAY	/S TO TOTAL DAYS					
15. 00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	985	0			985	15. 00
16. 00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	796	0			796	
17. 00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	21	0			21	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
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24, column 5)	5, 867	0			0 5, 867	19. 00
20. 00	1	73	0			73	20. 00
21. 00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	7, 742	0			7, 742	21. 00
22. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	31, 942	0			31, 942	22. 00
23. 00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23. 00
24. 00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24. 00
25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	O	0			0	25. 00
26. 00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	31, 942	0			31, 942	26. 00
27. 00	25) Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	24. 24	0. 00			24. 24	27. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provi der CCN: 15-0112	Period: Worksheet DSH From 01/01/2016

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CO		Peri od: From 01/01/2016 To 12/31/2016	Worksheet DSH Date/Time Pre 5/23/2017 8:0	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .m	ncrx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3. 00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	14. 14		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		14. 14		0.00		30.00
	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of		14. 14		0.00		31. 00
	line 30 or .1200, if RRC, MDH or otherwise enter line 30.						
		Original .mcrx. Values	Adjusted .mcax Values	HFS Look Up	Override 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	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provi der CCN: 15-0112	Peri od: From 01/01/2016	Worksheet DSH	
				Date/Time Prep 5/23/2017 8:05	
		Title XVIII	Hospi tal	PPS	
	Revi sed				
	Percentage				

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	9. 21				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	9. 21				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	9. 21				31. 00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Pre 5/23/2017 8:0	pared: 5 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					

This   Neutral And Other HALIH SERVICES   1.00					5/23/2017 8:0	5 pm
NAME   S.   MEDICAL AND OTHER HEALTH SERVICES   3,33,341   1,00   Well call and other services (see instructions)   3,33,341   1,00   Well call and other services (see instructions)   3,33,341   1,00   2			Title XVIII	Hospi tal	PPS	
NAME   S.   MEDICAL AND OTHER HEALTH SERVICES   3,33,341   1,00   Well call and other services (see instructions)   3,33,341   1,00   Well call and other services (see instructions)   3,33,341   1,00   2					1.00	
Medical and other services (see instructions)		DADT B. MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services reinbursed under OPPS (see instructions)   30,807,727   2,00	1 00				33 3/11	1 00
PSF payments		1	i ons)			
0.00   Outlier payment (see instructions)   102, 267   4.00						
Enter the hospital specific payment to cost ratio (see instructions)		1 3				
2.00   Sum of line 3 plus line 4 divided by line 6   0.00   7.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.00   7.00   0.0	5.00		tions)		0. 000	5.00
1.00   Ancil Flary Service of their pass through costs from ##st. D. Pt. IV, col. 13. Iline 200   342,959   0.00	6.00	Line 2 times line 5			0	6.00
9.00   Ancillary service other pass through costs from Wist. D. Pt. IV. col. 13, Iline 200   342, 593   9.00   10.00   Organ acquisitions acquisitions   33, 341   11.00   10.00   Organ acquisitions   33, 341   11.00   10.00   Comparation of Lisser De Cost Or CHARGES   12.00   Accillary service charges (From Wist. D-4, Pt. III. col. 4, line 69)   0.50   14.00   Organ acquisition charges (From Wist. D-4, Pt. III. col. 4, line 69)   0.50   15.00   Agreepate amount actually collected from patients liable for payment for services on a charge basis   0.50   16.00   Agreepate amount actually collected from patients liable for payment for services on a charge basis   0.50   17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   0.00000000	7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
10.00   Organ acquist froms   10.00   10.00   33.341   10.00   Total cast (sum of lines 1 and 10) (see instructions)   33.341   10.00   Total cast (sum of lines 1 and 10) (see instructions)   37.576   12.00   38.						
1.00   Total cost (sum of lines 1 and 10) (see instructions)   33, 341   11, 00			V, col. 13, line 200			
Computation to Placeses of Cost or Charges   87,576   12.00   Ancil Harry service charges   87,576   12.00   Ancil Harry service charges   87,576   12.00   13.00   Organ acquisition charges (from West. D-4, Pt. 111, col. 4, line 69)   67,576   14.00   13.00   Organ acquisition charges (sum of lines 12 and 13)   67,576   14.00   15					_	
Reasonable charges   12.00   Ancil Tary service charges   13.00   7.576   14.00   Total reasonable charges (sum of lines 12 and 13)   87.576   14.00   15.00	11.00				33, 341	11.00
2.00   Ancil lary service charges   87,576   12,00   13.00   Total reasonable charges (from West. D-4, Pt. III., col. 4, line 69)   0.13.00   13.00   Total reasonable charges (sum of lines 12 and 13)   0.13.00   13.00						
13.00   organ acquisition charges (From Wist. D4, Pt. III., col. 4, line 69)   0   13.00	12 00				87 576	12 00
14. 00   Total reasonable charges (sum of lines 12 and 13)   87,50   14,00			ne 69)			
Customary_charges						
16.00   Amounts that would have been realized from patients   Liable for payment for services on a chargebasis   0   16.00   Nature   Na						
had such payment been made in accordance with 42 CFR \$413.13(e)	15.00	Aggregate amount actually collected from patients liable for p	ayment for services on a	charge basis	0	15.00
17. 00	16.00	· ·	1 3	a chargebasis	0	16.00
18. 00   Total customery charges (see instructions)   87,576   18. 00   19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   54,225   19. 00   1   19. 00   Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see   0   20. 00   20		1 1 3	)			
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   54, 235   19. 00   Instructions)   20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00   Instructions)   33, 341   21. 00   21. 00   22. 00   23. 00   25. 00						
Instructions			! €   ! == 10 -   ! ==	11) (		
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19.00		y it line 18 exceeds line	II) (see	54, 235	19.00
Instructions	20 00	1	v if line 11 evceeds line	18) (500	0	20 00
21.00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   33, 341   21.00	20.00		y II IIIle II exceeds IIIle	10) (366	U	20.00
22.00   Interns and residents (see instructions)   0   22.00   23.00   23.00   25.00   7.00	21. 00	,	instructions)		33, 341	21. 00
24. 00   Total prospective payment (sum of lines 3, 4, 8 and 9)   23, 763, 522   24. 00   COMPUTATION OF REINBURSEMENT SETTLEMENT   25. 00   Deduct1 ble sand col nsurance (for CAH, see instructions)   0, 26. 00   26. 00   Deduct1 ble sand col nsurance relating to amount on line 24 (for CAH, see instructions)   0, 26. 00   27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   19, 120, 561   27. 00   Instructions)   0, 28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0, 29. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   19, 120, 561   30. 00   29. 00   2			•			
COMPUTATION OF RELIMBURSEMENT SETILEMENT   Set   10   10   10   10   10   10   10   1	23.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23.00
25.00   Deductible sand Coinsurance (For CAH, see instructions)   4,676,302   25.00	24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			23, 763, 522	24.00
26. 00   Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions)   0   26. 00						
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00   10   10   10   10   10   10   10					4, 676, 302	
Instructions   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0 28.00   29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   0 29.00   29		,	· · · · · · · · · · · · · · · · · · ·			
28. 00	27.00		ius the sum of lines 22 a	na 23] (see	19, 120, 561	27.00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   Subtotal (sum of lines 27 through 29)   19, 120, 561 30.00   30.00   Subtotal (sum of lines 27 through 29)   19, 120, 561 30.00   31.00   31.00   31.00   32.00   Subtotal (line 30 minus line 31)   19, 115, 649   32.00   AllowABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   582, 672   34.00   378, 737   35.00   36.00   Adjusted reimbursable bad debts (see instructions)   378, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   35.00   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 737   379, 739, 739, 739, 739, 739, 739, 739,	28 00	,	ne 50)		0	28 00
30.00   Subtotal (sum of lines 27 through 29)   19, 120, 561   30.00   Primary payer payments   4, 912   31.00   Subtotal (line 30 minus line 31)   19, 115, 649   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   33.00   Composite rate ESRD (from West. I -5, line 11)   0   34.00   All owable bad debts (see instructions)   378.737   35.00   Composite rate of the sea of			ne 30)		_	
31.00   Primary payer payments   4, 912   31.00   20.00   Subtotal (line 30 minus line 31)   19, 115, 649   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00		,			_	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00		,				
33.00   Composite rate ESRD (from Wkst. I-5, line 11)	32.00				19, 115, 649	32.00
34.00   All owable bad debts (see instructions)   582,672   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   378,737   35.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   438,673   35.00   37.00   Subtotal (see instructions)   438,673   36.00   37.00   Subtotal (see instructions)   19,494,386   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0 38.00   MSP-LCC reconciliation amount from PS&R   0 39.00   39.50   70.00   70			ES)			
35. 00						
36.00						
37.00   Subtotal (see instructions)   19,494,386   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   91.00   92.00   93.00   93.00   94.00						
38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   39.00   39.00   39.00   39.50   39.98   39.98   39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   3			uctions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.80 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.90 Subtotal (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.98 RECOVERY OF ACCELERATED 39.98 RECOVERY OF ACCELERATED 39.98 RECOVERY OF ACCELERATED 39.98 RECOVERY OF ACCELE		,				
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Total (sum of lines 91 and 93)  WORKSHEET OVERRIDE VALUES						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Bal ance due provider/program (see instructions)  44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44. 00 5115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Total (sum of lines 91 and 93)  WORKSHEET OVERRIDE VALUES			)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 19, 494, 386 40. 00 40. 01 Sequestration adjustment (see instructions) 389, 888 40. 01 41. 00 Interim payments 19, 032, 890 41. 00 42. 00 Tentative settlement (for contractors use only) 0 0 42. 00 43. 00 Bal ance due provider/program (see instructions) 71, 608 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44. 00 5115. 2 510 BE COMPLETED BY CONTRACTOR 510 Outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 52. 00 93. 00 Time Value of Money (see instructions) 0 93. 00 94. 00 Total (sum of lines 91 and 93) 0 0 000 0verrides 1. 00  Overrides 1. 00				ons)		
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44.00 \$\frac{115.2}{5115.2}\$  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)  WORKSHEET OVERRIDE VALUES	39. 99	·	•	ŕ	0	39. 99
19,032,890   41.00   1   1   1   1   1   1   1   1   1	40.00	Subtotal (see instructions)			19, 494, 386	40.00
Tentative settlement (for contractors use only)   42.00	40. 01	Sequestration adjustment (see instructions)			389, 888	40. 01
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 519, 673 44.00    80.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 The rate used to calculate the Time Value of Money  92.00 Time Value of Money (see instructions)  94.00 Total (sum of lines 91 and 93)  94.00 WORKSHEET OVERRIDE VALUES	41. 00				19, 032, 890	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$19,673 44.00 \$\text{\$\tex		,				
\$115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 utlier reconciliation adjustment amount (see instructions)  1 the rate used to calculate the Time Value of Money  1 ime Value of Money (see instructions)  1 total (sum of lines 91 and 93)    WORKSHEET OVERRIDE VALUES    Value of Money (see instructions)		, , , , , , , , , , , , , , , , , , , ,				
TO BE COMPLETED BY CONTRACTOR   90.00   Original outlier amount (see instructions)   0   90.00   91.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00   92.00   Time value of Money (see instructions)   0   93.00   94.00   Total (sum of lines 91 and 93)   Overrides	44. 00		ce with CMS Pub. 15-2, ch	apter 1,	519, 673	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)  Overrides 1.00  WORKSHEET OVERRIDE VALUES						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)  Overrides 1.00  WORKSHEET OVERRIDE VALUES	90 00				Ω	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)  Overrides 1.00  WORKSHEET OVERRIDE VALUES		, ,				
93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)  Overrides 1.00  WORKSHEET OVERRIDE VALUES		,				
94.00 Total (sum of lines 91 and 93)  0 94.00  Overrides 1.00  WORKSHEET OVERRIDE VALUES						
WORKSHEET OVERRIDE VALUES  Overrides 1.00						
WORKSHEET OVERRIDE VALUES						
					1. 00	
112.00 Uverride of Ancillary service charges (line 12)   0 112.00						
	112.00	uverriae of Ancillary service charges (line 12)			0	112. 00

| Peri od: | Worksheet E-1 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0112

				10 12/31/2010	5/23/2017 8: 05	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T= -1'.	1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		30, 886, 05		18, 951, 090	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
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/03/2016	81, 30		81, 800	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04 3. 05				0	0	3. 04 3. 05
3.05	Provider to Program		'	0	U	3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ABSOSTMENTS TO TROOK III			Ö	o l	3. 51
3. 52				o	ol	3. 52
3.53				O	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		81, 30	0	81, 800	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		30, 967, 35	5	19, 032, 890	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			•		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03				0	0	5. 03
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51 5. 52				0	0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
5. 77	5. 50-5. 98)				Ĭ	3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		221, 72	6	71, 608	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		31, 189, 08	1	19, 104, 498	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2. 00	8. 00
0.00	INAILE OF COTTE ACTO					0.00

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 078, 54		0	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
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	1 0	3. 01
3. 02	The section of the trace of the			o	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	1 0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0		3. 50 3. 51
3. 52				0		3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)		4 070 54	7		4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		4, 078, 54	/	0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)  Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TENTATIVE TO TROVIDER			Ö		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
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52
5. 77	5. 50-5. 98)					3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		3, 81 4, 074, 73		0	6. 02 7. 00
7.00	Total medicale program frability (see Instructions)		4,074,73	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		-	)			
8. 00	Name of Contractor		)	1. 00	2. 00	8. 00

Heal th	Financial Systems COLUMBUS REG	I ONAL HOSPI TAL	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0112	Peri od:	Worksheet E-1	10
			From 01/01/2016 To 12/31/2016		oared:
				5/23/2017 8: 0	5 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				
1. 00	Total hospital discharges as defined in AARA §4102 from V		e 14	8, 595	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12		12, 508	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2, 933	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines			28, 308	4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20			570, 793, 676	5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col.			9, 738, 930	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instruction	ns)		484, 039	8.00
9.00	Sequestration adjustment amount (see instructions)			9, 681	9. 00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)		474, 358	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			491, 849	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instruction	ns)	-17, 491	32.00
				Overri des	
				1. 00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0	108. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112		Worksheet E-3
	Component CCN: 15-T112	From 01/01/2016 To 12/31/2016	
	component con. 10 1112	12/01/2010	5/23/2017 8:05 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF	113	
		1. 00	
4 00	PART III - MEDICARE PART A SERVICES - IRF PPS	0 550 505	4 00
1.00	Net Federal PPS Payment (see instructions)	3, 558, 535	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0303	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	81, 846	3. 00
4.00	Outlier Payments	549, 183	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	5. 01
6. 00	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  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	
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new 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)	10. 450820	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12. 00
13. 00	Total PPS Payment (see instructions)	4, 189, 564	
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. 00
17.00	Subtotal (see instructions)	4, 189, 564	17. 00
18.00	Primary payer payments	0	18. 00
19.00	Subtotal (line 17 less line 18).	4, 189, 564	19. 00
20.00	Deductibles	20, 580	
21.00	Subtotal (line 19 minus line 20)	4, 168, 984	21. 00
22. 00	Col nsurance	20, 286	
23.00	Subtotal (line 21 minus line 22)	4, 148, 698	23. 00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 288	24. 00
25.00	Adjusted reimbursable bad debts (see instructions)	837	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 288	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	4, 149, 535	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	8, 353	29. 00
30.00	Outlier payments reconciliation	0	30. 00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 157, 888	32.00
32. 01	Sequestration adjustment (see instructions)	83, 158	
33.00	Interim payments	4, 078, 547	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, 33, and 34)	-3, 817	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	17, 007	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	549, 183	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	0 349, 103	51. 00
51.00	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)		53. 00
55.00	Time value of moley (see firstituetions)	1	33.00

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

Peri od: Worksheet G From 01/01/2016 To 12/31/2016 Date/Time Prepared: onl y)

onl y)			''	0 12/31/2010	5/23/2017 8:0	
		General Fund		Endowment 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	17, 738, 687		0	0	
2.00	Temporary investments	0	1	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 62, 879, 482	1	0	0 0	3. 00 4. 00
5.00	Other recei vable	18, 564, 029		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-29, 188, 823		0	0	6. 00
7.00	Inventory	3, 310, 526	0	0	0	7. 00
8. 00	Prepai d expenses	3, 542, 638		0	0	8. 00
9.00	Other current assets	377, 608		0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	77, 224, 147	ή	0	0 0	1
11.00	FI XED ASSETS	11,227,171		<u> </u>		11.00
12.00	Land	2, 373, 066	0	0	0	12. 00
13. 00	Land improvements	21, 508, 964	1	0	0	13. 00
14.00	Accumulated depreciation	-11, 858, 183	1	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	206, 819, 753 -122, 843, 426	1	0	0 0	15. 00 16. 00
17. 00	Leasehold improvements	-122, 043, 420	0	o	0	•
18. 00	Accumulated depreciation	O	Ö	O	0	
19. 00	Fi xed equipment	9, 241, 834	0	0	0	19. 00
20. 00	Accumulated depreciation	-6, 149, 212		0	0	20.00
21. 00 22. 00	Automobiles and trucks	1, 935, 011	1	0	0 0	21. 00 22. 00
23. 00	Accumulated depreciation Major movable equipment	-1, 409, 576 135, 355, 509		0	0	23. 00
24. 00	Accumulated depreciation	-101, 856, 823	1	ő	Ö	24. 00
25. 00	Mi nor equi pment depreci abl e	O	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable		0	0	0 0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	133, 116, 917		o	0	30.00
	OTHER ASSETS			-		
31. 00	Investments	1, 199, 262		0	0	
32. 00	Deposits on Leases	0	0	0	0	
33. 00 34. 00	Due from owners/officers Other assets	187, 557, 948	0	0	0 0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	188, 757, 210		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	399, 098, 274	1	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	10, 213, 362	1	0	0	
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	8, 616, 865 1, 017, 184	1	0	0 0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	5, 770, 000	1	0	0	1
41. 00	Deferred income	0	Ö	0	0	
42.00	Accel erated payments	0			I	42. 00
43.00	Due to other funds	7 005 007	0	0	0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	7, 325, 907 32, 943, 318			0	
43.00	LONG TERM LIABILITIES	32, 743, 310	,	<u> </u>	0	43.00
46. 00	Mortgage payable	61, 965, 000	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	ł
48. 00	Unsecured Loans	0	1	0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	1, 442, 079 63, 407, 079		0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	96, 350, 397		· ·	0	
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	302, 747, 877				52. 00
53.00	Specific purpose fund		0		I	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			0	I	56.00
57. 00	Plant fund balance - invested in plant		1		0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	202 747 677	,			E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	302, 747, 877 399, 098, 274		0	0 0	1
00.00	[59]	377, 070, 274			l	00.00
		•	•	. '		

Provider CCN: 15-0112

					То	12/31/2016	Date/Time Prep 5/23/2017 8:09	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	, p
				·				
1.00	TE	1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		287, 843, 273			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		14, 904, 604			0		2.00
3. 00 4. 00	Additions (credit adjustments) (specify)	0	302, 747, 877		0	U	0	3. 00 4. 00
5.00	Additions (credit adjustillents) (specify)				0			5. 00
6. 00					0		0	6. 00
7. 00					0		Ö	7. 00
8. 00					0		0	8. 00
9. 00		o			0		o o	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11. 00	Subtotal (line 3 plus line 10)		302, 747, 877			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		O			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16.00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		302, 747, 877			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	 Fund				
		Eridolillorre i dira						
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)		U		0			10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0		Ŭ			12. 00
13. 00	Security (Specify)		0					13. 00
14. 00			0					14. 00
15. 00			O					15. 00
16.00			o					16.00
17. 00			O					17.00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	I I		I			l	

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

			То	12/31/2016	Date/Time Prep 5/23/2017 8:0	
	Cost Center Description	Inpati ent		Outpati ent	Total	) pili
	COST CENTER DESCRIPTION	1.00		2.00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	55, 679, 1	92		55, 679, 192	1. 00
2.00	SUBPROVI DER - I PF		0		0	2. 00
3.00	SUBPROVI DER - I RF	6, 430, 4	71		6, 430, 471	3. 00
4.00	SUBPROVI DER		0		0	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY		0		0	7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	62, 109, 6	63		62, 109, 663	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>				
11.00	INTENSIVE CARE UNIT	10, 454, 2	97		10, 454, 297	11.00
12.00	CORONARY CARE UNIT		0		0	12.00
13.00	BURN INTENSIVE CARE UNIT		0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT		0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of lin	es 10, 454, 2	97		10, 454, 297	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72, 563, 9	60		72, 563, 960	17.00
18.00	Ancillary services	134, 413, 2		284, 830, 375	419, 243, 577	18.00
19.00	Outpati ent servi ces	13, 779, 7	31	52, 306, 439	66, 086, 170	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			0	0	22.00
23. 00	AMBULANCE SERVICES		0	11, 090, 733	11, 090, 733	23.00
24. 00	CMHC					24.00
24. 10	CORF		0	0	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26. 00	HOSPI CE					26. 00
27. 00	LEVEL 11 NURSERY	3, 298, 2		0	3, 298, 254	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 224, 055, 1	47	348, 227, 547	572, 282, 694	28. 00
	G-3, line 1)	I				
20.00	PART II - OPERATING EXPENSES			238, 022, 134		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		0	238, 022, 134		29. 00 30. 00
30.00	PROVISION FOR BAD DEBT	10, 748, 2	-			30.00
32. 00	PROVISION FOR DAD DEDI	10, 746, 2	0			32. 00
32.00			0			32.00
34. 00		ł	0			34. 00
35. 00		ł	0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	10, 748, 226		36. 00
37. 00	DEDUCT (SPECIFY)		0	10, 740, 220		37. 00
38. 00	DEDUCT (SECOTE)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		U	٥		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		248, 770, 360		43. 00
	to Wkst. G-3, line 4)			, . , . , . ,		
	·		1	,		

	El	HOODITAL		6 E 040 (	2550 40
	Financial Systems COLUMBUS REGIONAL ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet G-3	
SIAILN	LINI OF REVENUES AND EXPENSES	FIOVIDE CCN. 15-0112	From 01/01/2016	WOLKSHEET G-3	
			To 12/31/2016	Date/Time Pre 5/23/2017 8:0	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		572, 282, 694	1. 00
2.00	Less contractual allowances and discounts on patients' accoun-	ts		306, 529, 501	2. 00
3.00	Net patient revenues (line 1 minus line 2)			265, 753, 193	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		248, 770, 360	
5.00	Net income from service to patients (line 3 minus line 4)			16, 982, 833	5. 00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			95, 517	6. 00
7. 00	Income from investments			5, 207, 156	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		3, 900	
9. 00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			96, 388	
11. 00	Rebates and refunds of expenses			55, 260	
12. 00	Parking lot receipts			175	
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			969, 866	
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		0	
17. 00	Revenue from sale of drugs to other than patients			41, 365	
18. 00	Revenue from sale of medical records and abstracts			19, 246	
	Tuition (fees, sale of textbooks, uniforms, etc.)			20, 495	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			170	
22. 00	Rental of hospital space			136, 541	
23. 00	Governmental appropriations			403, 255	
24. 00	UNREALIZED INVESTMENT GAINS(LOSSES)			3, 459, 629	
24. 01	WELLNESS REVENUE			192, 342	
24. 02	JOINT VENTURES			-155, 918	
24. 03	EHR REVENUE			996, 838	
24. 04	EAP REVENUE			23, 458	
24. 05	OTHER OPERATING REVENUE			862, 055	
25. 00	Total other income (sum of lines 6-24)			12, 427, 738	
26. 00	Total (line 5 plus line 25)			29, 410, 571	
	LOSS ON DISPOSAL OF ASSETS			85, 128	
27. 01	OTHER NON OPERATING EXPENSES			2, 011, 981	
27. 02	EQUITY TRANSFERS			12, 408, 858	
	Total other expenses (sum of line 27 and subscripts)			14, 505, 967	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			14, 904, 604	29. 00

CALCU	Financial Systems COLUMBUS REGIO	ONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0112	Peri od: From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				İ
1.00	Capital DRG other than outlier			2, 332, 533	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			142, 587	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00 4. 00	Total inpatient days divided by number of days in the cost Number of interns & residents (see instructions)	reporting period (see inst	ructions)	77. 34 0. 00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	
0.00	1. 01) (see instructions)	the sum of firmes f and f. of	, cor anno i ana	G	0.00
7.00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet E	, part A line	5. 97	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see ins	tructions)		24. 24	
9.00	Sum of lines 7 and 8	`		30. 21	9.00
10.00	Allowable disproportionate share percentage (see instructi	ons)		6. 31 147, 183	
11. 00 12. 00				2, 622, 303	1
12.00	Total prospective capital payments (see Thistructions)			2, 022, 303	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions	)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	1
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total Tripatrent program capital cost (Title 3 x Title 4)			0	3.00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	1 00
1.00	Program i posti ont capital costs for ovtraordinary direumst	ancos (soo instructions)		0	
2.00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2. 00
2. 00 3. 00	Net program inpatient capital costs (line 1 minus line 2)	ances (see instructions)		0	2. 00 3. 00
2.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	ances (see instructions)		0	2. 00 3. 00 4. 00
2.00 3.00 4.00	Net program inpatient capital costs (line 1 minus line 2)	, ,		0 0 0. 00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	instructions)	:line 6)	0 0 0. 00 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7)	instructions) ary circumstances (line 2 x	line 6)	0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap	instructions) ary circumstances (line 2 x plicable)	ŕ	0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level t	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8	less line 9)	0 0.00 0 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri	less line 9) or year	0 0.00 0 0.00 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level t Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en	rinstructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus lin ter the amount on this line	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
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2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordin Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions) ary circumstances (line 2 x plicable) o capital payments (line 8 r capital payment (from pri payments (line 10 plus lin ter the amount on this line r capital payment for the f instructions)	less line 9) or year e 11)	0 0.00 0.00 0.00 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00