This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0112 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 8: 40 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2023 8: 40 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 7. Contractor No. 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. In the contractor's Vendor Code: 15. In the contractor's Vendor Code: 16. NPR Date: 17. Contractor's Vendor Code: 17. Contractor's Vendor Code: 18. In the contractor's Vendor Code: 19. In the code of the code Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX		
	1	2	SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Ti tle XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	481, 143	-41, 239	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	59, 975	1		0	3.00
4.00	SUBPROVI DER (OTHER)						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		o	541, 118	-41, 238		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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 8:40 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2400 EAST 17TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: COLUMBUS Zip Code: 47201-County: BARTHOLOMEW 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COLUMBUS REGIONAL 150112 18020 07/01/1966 Ν 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF COLUMBUS REGIONAL REHAB 15T112 18020 01/01/1984 N Р Ν 5.00 5 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospital -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 8 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column Ν Ν 22.02 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

22.04

23.00

3

Ν

MCRI F32 - 19. 1. 175. 2

yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

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

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

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

Health Financial Systems In Lieu of Form CMS-2552-10 COLUMBUS REGIONAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 8:40 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 1. 322 637 38 7, 741 168 24.00 0 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 101 0 0 0 447 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 8: 40 am XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23. 01 60 01 1 60 01 instructions) 60.02 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.02 1 60.02 instructions) Y/N LME Direct GME IME Direct GME 1. 00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61. 01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 3.00 1.00 2.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded 0 00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1. 00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 62.00 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings

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

N

63.00

Health Financial Systems	COLUMBUS	S REGIONAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMP				riod: com 01/01/2022	Worksheet S-2 Part I Date/Time Pre 5/30/2023 8:4	pared:		
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
C	ETE Deal leader to M		1.00	2. 00	3. 00			
Section 5504 of the ACA Base Yea period that begins on or after J			·This base year	is your cost	reporting			
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)								
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.			
		-	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))			
	1. 00	2.00	3. 00	4. 00	5. 00			
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col.	65.00		
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))			
			1. 00	2. 00	3. 00			
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective fo	or cost report	ing periods			
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00		
(22.20)	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.			
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))			
	1. 00	2. 00	Si te 3.00	4. 00	5. 00			
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1. 00	2.00	0.00	0.00		67. 00		

Health Financial Systems COLUMBUS REGIONA	AL HOSPITAL		Li	n lieu	ı of Form	CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0112	Period: From 01/01/		Workshee Part I				
			To 12/31/		Date/Tir	ne Pre	pared:		
					5/30/202	23 8: 4	o am		
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 8	7 FD 49065_40	0072 (August	10 2022)		1.00	0			
68.00 For a cost reporting period beginning prior to October 1, 20	22, did you o	btain permis	sion from yo		N		68. 00		
MAC to apply the new DGME formula in accordance with the FY (August 10, 2022)?	2023 IPPS Fin	al Rule, 87	FR 49065-490	072					
(/Mgd5t 10, 2022).									
Inpatient Psychiatric Facility PPS				1.00	2.00	3. 00			
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or	does it cont	ain an IPF s	subprovi der?	N			70. 00		
Enter "Y" for yes or "N" for no. 71.00 f line 70 is yes: Column 1: Did the facility have an approv	ed GME teachi	ng program i	n the most	N	N	0	71. 00		
recent cost report filed on or before November 15, 2004? En 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility tr									
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? En	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.								
Column 3: If column 2 is Y, indicate which program year bega (see instructions)	n during this	cost report	ing period.						
Inpatient Rehabilitation Facility PPS									
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), subprovider? Enter "Y" for yes and "N" for no.	or does it c	ontain an IF	?F	Y			75. 00		
76.00 If line 75 is yes: Column 1: Did the facility have an approv				N	N	0	76. 00		
recent cost reporting period ending on or before November 15 no. Column 2: Did this facility train residents in a new tea									
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.	Column 3: If	column 2 is	; Y,						
indicate which program year began during this cost reporting	perrou. (see	: THSTI UCTI OF	15)						
Long Term Care Hospital PPS					1. 00	0			
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes					N		80.00		
81.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.	r all of the	cost reporti	ng period? I	Enter	N		81.00		
TEFRA Provi ders									
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude				r no.	N		85. 00 86. 00		
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.									
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under sectio	on		N		87. 00		
			Approved Permane		Number				
			Adjustm		Approv Perman				
			(Y/N) 1.00		Adjustm 2.00				
88.00 Column 1: Is this hospital approved for a permanent adjustme					2.00		88. 00		
amount per discharge? Enter "Y" for yes or "N" for no. If ye 89. (see instructions)	s, complete c	ol. 2 and li	ne						
Column 2: Enter the number of approved permanent adjustments									
		Wkst. A Lir No.	ne Effecti Date		Approv Perman				
					Adj usti	ment			
					Amount Di scha				
00.00 Column 1. If line 00, column 1 in V and the Wall I is 1.	l no number:	1.00	2.00)	3. 00	0	00.00		
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was		0.	00			O	89. 00		
Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA ta	•								
per di scharge.	iget allouitt								
Column 3: Enter the amount of the approved permanent adjustm TEFRA target amount per discharge.	ent to the								
The first can got amount por an obtain go.		I.	V		XIX				
Title V and XIX Services			1.00		2. 00	O			
90.00 Does this facility have title V and/or XIX inpatient hospita	I services? E	nter "Y" for	N		Υ		90.00		
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t	N		Υ		91.00				
full or in part? Enter "Y" for yes or "N" for no in the appl	icable column	ı.			N		92. 00		
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.									
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V an	d XIX? Enter	N		N		93.00		
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N		N		94.00		
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	licable colum	ın.	0.00		0. 00	0	95. 00		
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N N		N N		96.00		
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	ın.	0.00		0. 00	0	97. 00		
,			,	'					

HUCDITAL AND HUCDITAL HEALTH CARE COMPLEY IDENTIFICATION DATA	OSPI TAL			eu of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovi der (F	eriod: rom 01/01/2022 o 12/31/2022		epared:
			V 1. 00	XI X 2. 00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the interrstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y column 1 for title V, and in column 2 for title XIX.			N	Υ Υ	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			N	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.			N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rein outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost rein Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f column 2 for title XIX.			N	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-incl	usive me	thod of payment			106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you	(see in	structions)	N		107.00
approved medical education program in the CAH's excluded IPF ar Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		` ,	N		108.00
	nysi cal	Occupati onal	Speech	Respi ratory	
109.00 olf this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4.00 N	109. 00
110.00 Did this hospital participate in the Rural Community Hospital De Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheapplicable.	or yes o	r "N" for no. I	f yes,	1.00 N	110.00
			1.00	2. 00	-
111.00 If this facility qualifies as a CAH, did it participate in the F Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici	reporting n 1 is Y, pating i	period? Enter enter the n column 2.	N		111.00
Enter all that apply: "A" for Ambulance services; "B" for additi	Onai bed	3, and/or c			
Enter all that apply: "A" for Ambulance services; "B" for additi	onal bed	1.00	2.00	3.00	
Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health N (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participatin demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost	Model ing 1 1 is ng in the	1.00 N	2.00	3.00	
Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health M (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.	Model ing 1 1 is ng in the	1.00 N	2.00	3.00	
Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health M (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" percent for long term care (incle psychiatric, rehabilitation and long term hospitals providers) by	dodel ing 1 1 is ng in the I Rural for no E only) percent udes	1.00 N	2.00		113.00
Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health M (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" pfor short term hospital or "98" percent for long term care (inclusive definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for	dodel ing 1 1 is ng in the I Rural for no E only) percent udes pased on	1.00 N	2.00		113. 00 - 0 115. 00
Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health M (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" pfor short term hospital or "98" percent for long term care (incle psychiatric, rehabilitation and long term hospitals providers) by the definition in CMS Pub. 15-1, chapter 22, §2208.1.	fodel ing in 1 is ing in the if Rural for no E only) bercent udes based on yes or	1.00 N	2.00		112. 00 113. 00 0 115. 00 116. 00

Health Financial Systems COLUMBUS	REGIONAL HOSPITAL		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		CCN: 15-0112	Period: From 01/01/2022 To 12/31/2022	Worksheet S Part I Date/Time F	S-2 Prepared:
		Premi ums	Losses	5/30/2023 8 Insurance	
tro other transfer of the state		1.00	2.00	3. 00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		611, 7	18 0		0118.01
110.00			1.00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in Administrative and General? If yes, submit supportin and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatie \$3121 and applicable amendments? (see instructions) E "N" for no. Is this a rural hospital with < 100 beds Hold Harmless provision in ACA §3121 and applicable a Enter in column 2, "Y" for yes or "N" for no.	nter in column 1, '' that qualifies for	Y" for yes or the Outpatien		N	119.00 120.00
121.00 Did this facility incur and report costs for high cospatients? Enter "Y" for yes or "N" for no.	t implantable devid	ces charged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes Act?Enter "Y" for yes or "N" for no in column 1. If c	olumn 1 is "Y", ent				122. 00
the Worksheet A line number where these taxes are inc 123.00 Did the facility and/or its subproviders (if applicab services, e.g., legal, accounting, tax preparation, b management/consulting services, from an unrelated org for yes or "N" for no.	le) purchase profes ookkeeping, payroll	, and/or			123. 00
If column 1 is "Y", were the majority of the expenses professional services expenses, for services purchase located in a CBSA outside of the main hospital CBSA? "N" for no.	d from unrelated or	gani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified trans	plant center? Enter	"Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (126.00 f this is a Medicare-certified kidney transplant pro		rtification da	to		126. 00
in column 1 and termination date, if applicable, in c	olumn 2.				
127.00 f this is a Medicare-certified heart transplant prog in column 1 and termination date, if applicable, in c	ram, enter the cert	tification dat	е		127. 00
128.00 If this is a Medicare-certified liver transplant prog	ram, enter the cert	ification dat	е		128. 00
in column 1 and termination date, if applicable, in c 129.00 If this is a Medicare-certified lung transplant progr		fication date			129. 00
in column 1 and termination date, if applicable, in c	olumn 2.				
130.00 f this is a Medicare-certified pancreas transplant p date in column 1 and termination date, if applicable,		certification			130. 00
131.00 If this is a Medicare-certified intestinal transplant		e certification	n		131. 00
date in column 1 and termination date, if applicable, 132.00 If this is a Medicare-certified islet transplant prog in column 1 and termination date, if applicable, in c	ram, enter the cert	tification dat	е		132. 00
133.00Removed and reserved 134.00 f this is a hospital-based organ procurement organiz in column 1 and termination date, if applicable, in c		the OPO numbe	r		133. 00
All Providers 140.00Are there any related organization or home office cos chapter 10? Enter "Y" for yes or "N" for no in column are claimed, enter in column 2 the home office chain	1. If yes, and hom number. (see instru	ne office cost			140.00
1.00 If this facility is part of a chain organization, ent	2.00 er on lines 141 th	rough 143 the	3.00 name and address	of the home	е
office and enter the home office contractor name and 141.00Name: COLUMBUS REGIONAL Contractor's Na		Contract	or's Number: 0810	11	141. 00
142.00 Street: 2400 EAST 17TH STREET PO Box:	ille. Wi S	Contract	or a Number, our	<i>,</i> 1	142. 00
143.00 Ci ty: COLUMBUS State:	I N	Zi p Code	: 4720)1	143. 00
144.00 Are provider based physicians' costs included in Work	sheet A?			1. 00 Y	144. 00
			1.00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, I inpatient services only? Enter "Y" for yes or "N" for no, does the dialysis facility include Medicare utili period? Enter "Y" for yes or "N" for no in column 2.	no in column 1. If	column 1 is	Y		145. 00
146.00Has the cost allocation methodology changed from the Enter "Y" for yes or "N" for no in column 1. (See CMS yes, enter the approval date (mm/dd/yyyy) in column 2	Pub. 15-2, chapter		N f		146. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CO	CN: 15-0112	Peri od: From 01/01/2022 To 12/31/2022		epared:
					1. 00	+
147.00 Was there a change in the statist					Y	147. 00
148.00 Was there a change in the order o					N	148. 00
149.00 Was there a change to the simplif	led cost finding method? E	nter "Y" for y	Part B	or no. Title V	N Title XIX	149. 00
		1.00	2. 00	3.00	4.00	
Does this facility contain a prov						
or charges? Enter "Y" for yes or	"N" for no for each compor					455.00
155.00 Hospi tal 156.00 Subprovi der – IPF		N N	N N	N N	N N	155. 00 156. 00
157. 00 Subprovi der – TRF		N N	N	N N	N N	157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF		N	N	N	N	159. 00
160. 00 HOME HEALTH AGENCY		N	N	N	N	160.00
161. 00 CMHC 161. 10 CORF			N N	N N	N N	161. 00 161. 10
181. TOJCORF			l IN	I IN	IN	101.10
					1.00	
Mul ti campus					1	
165.00 Is this hospital part of a Multic	ampus hospital that has or	ne or more camp	ouses in dif1	ferent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Z	ip Code CBSA	FTE/Campus	
	0	1. 00	2.00	3.00 4.00	5. 00	
166.00 If line 165 is yes, for each					0.0	00 166. 00
campus enter the name in column						
O, county in column 1, state in column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
				·		
Usalah Jafannati an Tabbadani. (III	T) :	D	D-:	^	1. 00	
Health Information Technology (HI 167.00 Is this provider a meaningful use				ent act	Y	167.00
168.00 If this provider is a CAH (line 1				'), enter the		168. 00
reasonable cost incurred for the				,,		
168.01 If this provider is a CAH and is	not a meaningful user, doe	es this provide	er qualify fo	or a hardship		168. 01
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful	? Enter "Y" for yes or "N"	for no. (see	instructions	S)		00169. 00
transition factor. (see instructi		I IS HOL A CAH	(Time 105 Is	s N), enter the	0.0	00169.00
Transfer an Factor (coo Finction)				Begi nni ng	Endi ng	
				1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the r	eporti ng			170. 00
				1. 00	2. 00	
171.00 If line 167 is "Y", does this pro	vider have any days for in	ndi vi dual si enco	olled in	1.00 N	2.00	0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	ol. 6? Enter			1, 1, 00

Hoal th	Financial Systems COLUMBUS REGION	IAI HOSDITAI		In lie	u of Form CMS-	2552_10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0112	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022		epared:
				V /N	5/30/2023 8: 4	
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTION	NAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					+
1.00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				
			1.00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare P	rogram? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in column	n 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	a managamant	Y			3.00
3.00	contracts, with individuals or entities (e.g., chain home or		'			3.00
	or medical supply companies) that are related to the provide	er or its				
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe relationships? (see instructions)	rsimilar				
	relationships: (see Thati detions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 00	Financial Data and Reports		1	Δ.		4
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for		Y	A		4. 00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit recommends		Y			5.00
	those on the fired financial statements: If yes, submit rec	Onci i i a ti on.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities				I	
6. 00	Column 1: Are costs claimed for a nursing program? Column : the legal operator of the program?	2: If yes, i	s the provide	er N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in:	structi ons.		Υ		7.00
8.00	Were nursing programs and/or allied health programs approve	d and/or rene	wed during th	ne N		8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduata madi	ool odwootion	n N		9.00
9.00	program in the current cost report? If yes, see instructions		car education	I IN		9.00
10.00	Was an approved Intern and Resident GME program initiated o		the current	N		10.00
44.00	cost reporting period? If yes, see instructions.					1
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 Ap	proved	N		11.00
	reaching frogram on worksheet A: 11 yes, see first detrons.				Y/N	
					1.00	
12.00	Bad Debts	!+	±!			10.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			rost reporting	Y N	12. 00 13. 00
13.00	period? If yes, submit copy.	orrey change	during this c	cost reporting		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsural	nce amounts w	aived? If yes	s, see	N	14. 00
	instructions. Bed Complement					-
15. 00	Did total beds available change from the prior cost reporting	na period? If	ves. see ins	structions.	Y	15. 00
			t A		t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
16. 00		Υ	04/11/2023	Υ	04/11/2023	16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	04/11/2023	Υ	04/11/2023	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
10.00	Report data for additional claims that have been billed	1.4		IV		10.00
	but are not included on the PS&R Report used to file this					
10.00	cost report? If yes, see instructions.	N.I.		N.1		10.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.00
	information? If yes, see instructions.					
	· '					

Heal th	Financial Systems COLUMBUS REGIO	ONAL HOSPITAL		In Lie	u of Form CMS	5-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0112	Period: From 01/01/2022 To 12/31/2022	Worksheet S- Part II	-2 repared:
		Desc	cription	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	MCD CAPE DAD	O T A DISCH & PT	1. 00 Y	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:	DAYS	A DISON & TI	'	14	20.00
		Y/N	Date	Y/N	Date	
21 00	Wee the seat general general selection the grant deal of	1.00	2.00	3.00	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	S HOSPITALS)			
22.00	Capi tal Related Cost		NI NI			
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, so Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00
20.00	reporting period? If yes, see instructions.	due to appir	ar sar s made ad	ring the cost		20.00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	eporting period?	Υ	24. 00		
25. 00	Have there been new capitalized leases entered into during	g the cost re	porting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost rope	rting poriod?	If you soo	N	26. 00
26.00	instructions.	the cost repo	ting period?	i i yes, see	IN	26.00
27. 00	Has the provider's capitalization policy changed during th	ne cost repor	ting period? I	f yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or letters of credit e	Υ	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)	Υ	29. 00		
27.00	treated as a funded depreciation account? If yes, see inst	(cscr ve runa)		27.00		
30.00	Has existing debt been replaced prior to its scheduled mat	s, see	N	30.00		
31. 00	instructions. Has debt been recalled before scheduled maturity without instructions.	s, see	N	31.00		
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se		shed through c	ontractual	Υ	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		nina to compet	tive biddina? If	,	33. 00
	no, see instructions.					
0.4.00	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement	with provider-	based physicians?	Υ	34.00
35. 00	If line 34 is yes, were there new agreements or amended ex		ments with the	provi der-based	Υ	35. 00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?		66	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.	prepared by t	ne home office	? Y		37.00
38. 00	If line 36 is yes , was the fiscal year end of the home of			f N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to other.			s. Y		39.00
	see instructions.		,	N N		
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00			
			1 00		00	
	Cost Report Preparer Contact Information		1. 00	2.	00	
41. 00	Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42. 00	respectively. Enter the employer/company name of the cost report	FORVI S				42.00
12.00	preparer.	. 51.7.5				12.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000		KERRY. BEJARANO	@FORVIS.COM	43.00

Health Financial Systems COLUM	MBUS REGIONA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provider Co	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 8:4	pared:	
		3	00				
Cost Report Preparer Contact Information		0.	00				
41.00 Enter the first name, last name and the title/posi		RECTOR				41.00	
held by the cost report preparer in columns 1, 2,	and 3,						
respecti vel y.							
42.00 Enter the employer/company name of the cost repor	^t					42.00	
preparer.							
43.00 Enter the telephone number and email address of the						43.00	
report preparer in columns 1 and 2, respectively.							

| Period: | Worksheet S-3 | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Heal th Fi nancial SystemsCOLUMBUSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0112

					Т	o 12/31/2022	Date/Time Pre 5/30/2023 8:4	
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A Line No.	No.	of Beds	Bed Days	CAH Hours	Title V	
		1. 00	2	2. 00	Avai I abl e 3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00		. 00	3.00	4.00	3.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		206	75, 190	0.00	0	1.00
00	8 exclude Swing Bed, Observation Bed and	00.00		200	707170	0.00	, and the second	
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			206	75, 190	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00	1	17	6, 205		0	
9. 00	CORONARY CARE UNIT	32. 00	1	0	C		0	
10.00	BURN INTENSIVE CARE UNIT	33. 00	i .	0	C		0	
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	C	0. 00	0	
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	
14.00	Total (see instructions)			223	81, 395	0.00	0	
15.00	CAH visits	40.00			_		0	15.00
16.00	SUBPROVI DER - I PF	40.00		0	(005		0	16.00
17.00	SUBPROVI DER - I RF	41. 00		19	6, 935		0	
18.00	SUBPROVI DER	42.00		0	C		0	
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44. 00		U	(,	U	19. 00 20. 00
21.00	OTHER LONG TERM CARE		ŀ					21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					O	23.00
24. 00	HOSPI CE		ŀ					24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	55. 55						25.00
25. 10	CMHC - CORF	99. 10					0	
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26, 25
27.00	Total (sum of lines 14-26)			242				27.00
28.00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges	05.55		_	_		_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	l	0	C	y I	0	34.00

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

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared:

				''	0 12/31/2022	5/30/2023 8: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	<u> </u>
		.,. baye	, , , , , , , , , , , , , , , , , , , ,	,ps		equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	· · · · ·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 310	961	33, 894			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)	9, 016	8, 416				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO IRF Subprovider	560	447				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	12, 310	961	33, 894			7. 00
	beds) (see instructions)	,					
8.00	INTENSIVE CARE UNIT	856	115	3, 846			8.00
9. 00	CORONARY CARE UNIT	0	0				9.00
10.00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)		_	_			12.00
13. 00	NURSERY		246	3, 018			13.00
14. 00	Total (see instructions)	13, 166	1, 322		0.00	1, 218. 86	ł
15. 00	CAH visits	0	0		0.00	1,2.0.00	15. 00
16. 00	SUBPROVIDER - I PF	0	0		0.00	0.00	ł
17. 00	SUBPROVIDER - I RF	1, 899	101	3, 453	0.00	•	
18. 00	SUBPROVI DER	1,077	0		0.00	l	ł
19. 00	SKILLED NURSING FACILITY	0	0		0.00	0.00	1
20.00	NURSING FACILITY	J	J	J	0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	J	J	J	0.00	0.00	23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	•
26. 00	RURAL HEALTH CLINIC	0	0		0.00	l e	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0			l e	l .
27. 00	Total (sum of lines 14-26)	O ₁	O	J O	0.00	l	•
28. 00	Observation Bed Days		944	3, 783	0.00	1, 230. 00	28.00
29. 00	Ambulance Trips	3, 854	744	3, 703			29.00
30.00	Employee discount days (see instruction)	3, 034		0			30.00
31.00	Employee discount days (see Histruction)						31.00
32.00	Labor & delivery days (see instructions)	0	168				32.00
32. 00	Total ancillary labor & delivery room	٥	108	0 312			32.00
32.01	outpatient days (see instructions)			l "			32.01
33. 00	LTCH non-covered days						33.00
33. 00	LTCH site neutral days and discharges	0					33.00
	Temporary Expansi on COVID-19 PHE Acute Care	0	0	0			34.00
34.00	Tremporary Expansion Covid-19 File Acute Care	l 이	O _l	1	l	I	1 34.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0112

				To	12/31/2022	Date/Time Pre 5/30/2023 8:4	
		Full Time	•	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART I - STATISTICAL DATA				0.044	0 (10	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 100	2, 014	9, 619	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			1, 799	0		2.00
3. 00	HMO IPF Subprovider			1, 799	0		3.00
4. 00	HMO IRF Subprovider				0		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
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3, 100	2, 014	9, 619	14.00
15.00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0.00	0		0	0	16.00
17. 00	SUBPROVI DER - I RF	0. 00	0		36	270	17. 00
18. 00	SUBPROVI DER	0. 00	0		0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	2 22					21.00
22. 00	HOME HEALTH AGENCY	0. 00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00 24. 10	HOSPICE						24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
25. 00	CMHC - CORF	0.00					25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				l		34.00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0112

Period:
From 01/01/2022
To 12/31/2022

Wkst. A Line
Number

Paported

In Lieu of Form CMS-2552-10

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2023 8: 40 am

Average

Related to Hours Wage

					To	5 12/31/2022	Date/Time Pre 5/30/2023 8:4	
	·	Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	i on of Sal ari es	Salaries (col.2 ± col.	Related to	Hourly Wage	
				(from Wkst.	3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
				A-6)		001. 1	001. 0)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	99, 592, 168	-920, 056	98, 672, 112	2, 643, 716. 00	37. 32	1.00
1.00	instructions)	200.00	77,072,100	720, 000	70, 072, 112	2, 010, 710.00	07.02	1.00
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
3.00	B		U	0	0	0.00	0.00	3.00
4.00	Physician-Part A -		0	0	0	0.00	0.00	4.00
4 04	Administrative					0.00	0.00	4 04
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		3, 416, 617	0	-	0. 00 13, 620. 00	0. 00 250. 85	
3.00	Physician-Part B		3, 410, 017		3, 410, 017	15, 020. 00	250.05	3.00
6.00	Non-physician-Part B for		195, 913	0	195, 913	4, 160. 00	47. 09	6.00
	hospi tal -based RHC and FQHC							
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7.00
	approved program)		_	_				
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office and/or related		0	0	0	0. 00	0. 00	8.00
	organi zati on personnel							
9.00	SNF	44. 00	0	1 144 510	0 7, 612, 002	0.00	0.00	
10. 00	Excluded area salaries (see instructions)		6, 465, 492	1, 146, 510	7,612,002	237, 222. 00	32. 09	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		54, 026, 700	0	54, 026, 700	548, 260. 00	98. 54	11.00
12. 00	Care Contract Labor: Top Level		1, 490, 904	0	1, 490, 904	24, 029. 00	62.05	12.00
12.00	management and other		1, 470, 704		1, 470, 704	24, 027. 00	02.03	12.00
	management and administrative							
12 00	services		4 O44 F27	0	4 O44 E27	E7 040 00	100 10	12 00
13. 00	Contract Labor: Physician-Part A - Administrative		6, 964, 537	0	6, 964, 537	57, 949. 00	120. 18	13.00
14.00	Home office and/or related		0	0	0	0. 00	0.00	14.00
	organization salaries and							
14. 01	wage-related costs Home office salaries		4, 960, 551	0	4, 960, 551	43, 421. 00	114. 24	14 01
14. 02	Related organization salaries		0	0	0	0.00	0.00	
15. 00	Home office: Physician Part A		0	0	0	0. 00	0. 00	15.00
16. 00	- Administrative Home office and Contract		0	0		0. 00	0.00	14 00
10.00	Physicians Part A - Teaching		U	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
14 00	- Teaching		0	0	0	0. 00	0.00	14 02
16. 02	Home office contract Physicians Part A - Teaching		Ü	0	0	0.00	0.00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		24, 884, 390	0	24, 884, 390			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
. 5. 60	(see instructions)							.5.55
19. 00	Excluded areas		2, 143, 540	0	2, 143, 540			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		0	0	o			21.00
	В			-				
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		O	n	n			22. 01
23. 00	Physician Part B		1, 017, 288	0	1, 017, 288			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25. 00	Interns & residents (in an approved program)		0	0	0			25.00
25. 50	Home office wage-related		700, 391	0	700, 391			25. 50
	(core)							
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		n	0				25. 52
_5.02	- Administrative -		0					_0.02
	wage-related (core)							
	- Administrative -							

HOSPI T	AL WAGE INDEX INFORMATION			Provi der Co		Period: From 01/01/2022 To 12/31/2022		pared:
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0		0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26. 00	Employee Benefits Department	4. 00		-228, 110				
27. 00	Administrative & General	5. 00	21, 963, 425	-312, 925		•	l	
28. 00	Administrative & General under		6, 621, 498	0	6, 621, 49	8 79, 021. 00	83. 79	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0		0.00		29. 00
30.00	Operation of Plant	7. 00	3, 353, 243	46, 299				
31.00	Laundry & Linen Service	8. 00	39, 243	278		1 2, 036. 00	19. 41	31.00
32.00	Housekeepi ng	9. 00	2, 249, 632	-10, 959	2, 238, 67	3 117, 580. 00	19. 04	32.00
33. 00	Housekeeping under contract (see instructions)		0	0		0. 00	0. 00	33. 00
34.00	Dietary	10.00	2, 533, 104	-1, 449, 459	1, 083, 64	5 52, 504. 00	20. 64	34.00
35. 00	1		0	0		0.00		35. 00
36. 00	Cafeteri a	11. 00	0	1, 458, 926	1, 458, 92	65, 602. 00	22.24	36. 00
37. 00	Maintenance of Personnel	12.00	0	1, 430, 720		0 05, 002. 00		
38. 00	Nursing Administration	13.00	5, 810, 936	190, 285				
39. 00	Central Services and Supply	14. 00	· ·	190, 283			l	
40. 00	Pharmacy	15.00		-220, 866				40.00
41.00	Medical Records & Medical		2, 550, 581	-220, 866 -1, 180, 745		•	l	
41.00	Records Li brary	16. 00	2, 550, 581	-1, 180, 745	1, 369, 83	37, 501.00	30. 53	41.00
42.00	Social Service	17. 00	0	0		0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0		0.00	0.00	43.00

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

110311	TAL WAGE TRUES THE ORIGINATION			. Trovider c		From 01/01/2022 To 12/31/2022	Part III Date/Time Prep 5/30/2023 8:40	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		102, 601, 136	-920, 056	101, 681, 08	2, 704, 957. 00	37. 59	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 465, 492	1, 146, 510	7, 612, 00	237, 222. 00	32. 09	2.00
	instructions)							
3.00	Subtotal salaries (line 1		96, 135, 644	-2, 066, 566	94, 069, 07	2, 467, 735. 00	38. 12	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		67, 442, 692	0	67, 442, 69	673, 659. 00	100. 11	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		25, 584, 781	0	25, 584, 78	0. 00	27. 20	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		189, 163, 117					
7. 00	Total overhead cost (see		48, 984, 887	-1, 707, 215	47, 277, 67	2 1, 175, 481. 00	40. 22	7.00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	Peri od: Worksheet S-3 From 01/01/2022 Part IV	
		To 12/31/2022 Date/Time Prepared:	

	To 12/31/2022	Date/Time Prep 5/30/2023 8:40	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 064, 033	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	14, 688, 825	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	411, 646	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	47, 380	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 379, 970	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	248, 787	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	7, 163, 443	
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	-111, 200	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23. 00	Tuition Reimbursement	152, 334	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	28, 045, 218	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	, I	25. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	Peri od: From 01/01/2022	Worksheet S-3 Part V

2. 00 Hospi tal 54, 026, 700 28, 045, 218 3. 00 SUBPROVI DER - I PF 0 0 4. 00 SUBPROVI DER - I RF 0 0 5. 00 Subprovi der - (0ther) 0 0	am
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: Total facility's contract labor and benefit cost 54,026,700 28,045,218 2.00 Hospital 54,026,700 28,045,218 54,026,700 28,045,218 3.00 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0	
PART V - Contract Labor and Benefit Cost	
Hospital and Hospital-Based Component Identification:	
1. 00 Total facility's contract labor and benefit cost 54,026,700 28,045,218 2. 00 Hospital 54,026,700 28,045,218 3. 00 SUBPROVI DER - I PF 0 0 4. 00 SUBPROVI DER - I RF 0 0 5. 00 Subprovi der - (0ther) 0 0	
2. 00 Hospi tal 54,026,700 28,045,218 3. 00 SUBPROVI DER - I PF 0 0 4. 00 SUBPROVI DER - I RF 0 0 5. 00 Subprovi der - (0ther) 0 0	
3. 00 SUBPROVI DER - I PF 0 0 4. 00 SUBPROVI DER - I RF 0 0 5. 00 Subprovi der - (0ther) 0 0	1.00
4. 00 SUBPROVI DER - I RF 0 0 5. 00 Subprovi der - (0ther) 0 0	2.00
5.00 Subprovi der - (0ther) 0 0	3.00
	4.00
/ 00 Cut == D=d= CNE	5.00
6.00 Swi ng Beds - SNF 0 0	6.00
7.00 Swi ng Beds - NF 0 0	7.00
8.00 SKILLED NURSING FACILITY 0 0	8.00
9.00 NURSING FACILITY	9.00
10.00 OTHER LONG TERM CARE I	0.00
11.00 Hospi tal -Based HHA 0 0 1	1.00
12.00 AMBULATORY SURGICAL CENTER (D.P.) I	2.00
13.00 Hospi tal -Based Hospi ce	3.00
14.00 Hospital-Based Health Clinic RHC 0 0 0 1	4.00
15.00 Hospital-Based Health Clinic FQHC 0 0 1	5.00
16.00 Hospital-Based-CMHC	6.00
16. 10 Hospi tal -Based-CMHC 10 0 0 1	6. 10
17. 00 RENAL DIALYSIS I 0 0 0 1	7.00
18.00 Other 0 0 0 1	8.00

NSPI T	Financial Systems COLUMBUS REGIONAL HO AL UNCOMPENSATED AND INDIGENT CARE DATA Pr		N: 15-0112	Peri od:	u of Form CMS-2 Worksheet S-1		
USFII	AL UNCOMPENSATED AND INDIGENT CARE DATA	ovider cc	N. 15-0112	From 01/01/2022	WOLKSHEET 3-1	U	
				To 12/31/2022	Date/Time Pre 5/30/2023 8:4		
					1. 00		
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 col u	mn 8)	0. 347331	1.	
00	Medicaid (see instructions for each line)				00 005 740		
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				28, 925, 719 Y	2. 3.	
00	If line 3 is yes, does line 2 include all DSH and/or supplementa	l navment	s from Medi	cai d?	N	4.	
00	If line 4 is no, then enter DSH and/or supplemental payments fro			our u.	2, 790, 070		
00	Medi cai d charges				157, 446, 178	1	
. 00	Medicaid cost (line 1 times line 6)				54, 685, 938	7.	
00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine 7 min	us sum of l	ines 2 and 5; if	22, 970, 149	8.	
	Children's Health Insurance Program (CHIP) (see instructions for	each lin	e)				
00	Net revenue from stand-alone CHIP				0	1	
0.00	Stand-alone CHIP charges				0		
1. 00 2. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	ina 11 mi	nus line 0:	if / zero then	0	1	
2.00	enter zero)	1110 11 1111	nus iine 7,	TT \ Zero then	O	'2.	
	Other state or local government indigent care program (see instr						
3. 00	Net revenue from state or local indigent care program (Not inclu			,		13.	
1. 00	Charges for patients covered under state or local indigent care 10)	program (Not include	d in lines 6 or	0	14.	
5. 00	State or local indigent care program cost (line 1 times line 14)				0	15.	
5. 00	Difference between net revenue and costs for state or local indi	gent care	program (I	ine 15 minus line	0	16.	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	o/Local indi	igont care progra	ume (eoo	-	
	instructions for each line)			Tyent care progra	illis (see		
7.00	Private grants, donations, or endowment income restricted to fun	9	,		0	1	
	O Government grants, appropriations or transfers for support of hospital operations O Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 22,970,149)						
7. 00	8, 12 and 16)	That gent	care progra	iis (suiii 01 1111es	22, 970, 149	17.	
			Uni nsured		Total (col. 1		
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
0. 00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	11, 619, 7	3, 093, 808	14, 713, 542	20.	
1.00	Cost of patients approved for charity care and uninsured discoun	ts (see	4, 035, 8	3, 093, 808	7, 129, 702	21.	
	instructions)						
2. 00	Payments received from patients for amounts previously written o charity care	off as		0 0	0	22.	
3. 00			4, 035, 8	94 3, 093, 808	7, 129, 702	23.	
					1. 00		
4. 00	Does the amount on line 20 column 2, include charges for patient	days bey	ond a Lengt	h of stay limit	N N	24.	
5. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		care progra	am's length of	0	25.	
5 00	stay limit Total bad debt expense for the entire hospital complex (see inst	ructions)			Q 700 724	26	
6. 00 7. 00	Medicare reimbursable bad debts for the entire hospital complex		ructions)		8, 708, 736 493, 104	1	
	Medicare allowable bad debts for the entire hospital complex (se	•			758, 622	1	
7. 01					7, 950, 114		
	Non-Medicare bad debt expense (see instructions)						
7. 01 8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see	i nstructi on:	s)	3, 026, 839		
8. 00 9. 00 0. 00	, ,	·	i nstructi on:	s)	3, 026, 839 10, 156, 541 33, 126, 690	30.	

	Financial Systems	COLUMBUS REGIONA	_	011 15 0110		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0112	Period: From 01/01/2022	Worksheet A	
				-	Γο 12/31/2022		
	Coot Contar Department on	Colorias	Other	Total (col 1	Dool oooi fi oot	5/30/2023 8: 4	0 am
	Cost Center Description	Sal ari es	other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 001. 2)	A-6)	(col. 3 +-	
						col . 4)	
	JOSUS DA LA CONTROL DE LA CONT	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT		24, 897, 693	24, 897, 693	-14, 806, 292	10, 091, 401	1.00
2. 00	00200 CAP REL COSTS-BEDG & TTAT		24, 077, 073		13, 765, 434		
3.00	00300 OTHER CAP REL COSTS		0		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	239, 280	32, 946, 376	33, 185, 65	-2, 420, 819	30, 764, 837	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	21, 963, 425	54, 072, 073				5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 353, 243	8, 945, 665 771, 368			9, 742, 277	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	39, 243 2, 249, 632	542, 078				9.00
10.00	01000 DI ETARY	2, 533, 104	1, 419, 904			1, 688, 803	
11. 00	01100 CAFETERI A	0	0		2, 273, 672	2, 273, 672	
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 810, 936	844, 049				
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	602 3, 623, 343	985, 952 2, 778, 537			1, 248, 760 6, 223, 977	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 550, 581	250, 211				
17.00	01700 SOCIAL SERVICE	0	0	, , , , ,	0	0	17. 00
23. 00	02300 PARAMED ED PRGM	0	0		0	0	
23. 01	02301 XRAY EDUCATION	129, 616	6, 692			639, 060	
23. 02	02302 PHARMACY RESIDENCY PROG INPATIENT ROUTINE SERVICE COST CENTERS	225, 412	6, 118	231, 530	122, 265	353, 795	23. 02
30. 00		19, 645, 624	22, 566, 993	42, 212, 61	7 -1, 878, 178	40, 334, 439	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 354, 317	7, 110, 929				
32.00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0			0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	1, 812, 796	556, 900	2, 369, 69	200, 266	2, 569, 962	
42.00	04200 SUBPROVI DER	0	0	, , , , ,	0	0	1
43.00	04300 NURSERY	1, 353, 494	379, 601	1, 733, 09	-25, 978	1, 707, 117	
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 121, 827	33, 512, 799	34, 634, 620	-8, 236, 500	26, 398, 126	50.00
51. 00	05100 RECOVERY ROOM	-329	1, 596, 812			1, 923, 964	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		2, 308, 551	2, 308, 551	
53.00	05300 ANESTHESI OLOGY	0	91, 007				
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 630, 909 568, 559	1, 645, 774 1, 451, 380			2, 962, 128 2, 142, 578	
54. 02	05404 ULTRA SOUND	443, 992	624, 929				
54.03	05405 MAMMOGRAPHY	628, 219	168, 379				
55.00	05500 RADI OLOGY-THERAPEUTI C	679, 713	1, 354, 820		· ·		
57.00	05700 CT SCAN 05800 MRI	733, 552	1, 031, 720				
	05900 CARDI AC CATHETERI ZATI ON	420, 653 1, 778, 964	191, 179 4, 329, 551				
	06000 LABORATORY	4, 340, 318	8, 130, 380			,	
60. 01	06001 LABORATORY-PATHOLOGI CAL	365, 426	1, 214, 530			1, 933, 508	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	677, 725			764, 712	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 107, 035 244, 291	2, 422, 914 6, 536, 364				1
67.00	06700 OCCUPATI ONAL THERAPY	62, 354	1, 370, 271				
68.00	06800 SPEECH PATHOLOGY	208, 607	885, 445			961, 558	
69. 00	06900 ELECTROCARDI OLOGY	806, 774	462, 837			1, 274, 882	
70.00	07000 ELECTROENCEPHALOGRAPHY	641, 087	413, 696	1		1, 219, 342	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		7, 780, 546 8, 758, 504	7, 780, 546 8, 758, 504	
73. 00	07300 DRUGS CHARGED TO PATIENTS		24, 994, 971			24, 994, 971	
74.00	07400 RENAL DIALYSIS	O	817, 533			817, 533	1
76.00	03020 ACUPUNCTURE	0	0		0	0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	270, 521	120, 888	391, 40	9 4, 482	395, 891	76. 97
88. 00	08800 RURAL HEALTH CLINIC	O	0		0 0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0	0	89. 00
90.00	09000 CLI NI C	1, 663, 327	361, 285	2, 024, 612	46, 643	2, 071, 255	90.00
90. 01	09001 DI ABETES CENTER	0	0	(0	0	90. 01
90. 02 90. 03	09002 NEUROPSYCH 09003 WOUND CENTER	310, 261 676, 684	11, 648 938, 799			326, 026 1, 659, 836	1
90. 03	09004 HYPERBARI C OXYGEN THERAPY	070,004	730, 777		261, 683		
90. 05	09005 VI MCARE CLINI C	582, 418	35, 149				
90.06	09006 MEDICATION MGMT CLINIC	262, 635	2, 580			251, 109	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	6, 862, 055	1, 392, 236	8, 254, 29 ⁻	2, 398, 791	10, 653, 082	91. 00 92. 00
,z. 00	OTHER REIMBURSABLE COST CENTERS	1		1			, ,2.00
95.00	09500 AMBULANCE SERVICES	2, 698, 830	473, 119	3, 171, 94	64, 000	3, 235, 949	95.00

	COLUMBUS REGION	_			u of Form CMS-2	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CO		eri od:	Worksheet A	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre	narod:
			'	0 12/31/2022	5/30/2023 8: 4	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
99. 10 09910 CORF	0	0	C	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	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0		111.00
113.00 11300 INTEREST EXPENSE		1, 127, 426	1, 127, 426	-1, 127, 426	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	97, 993, 330	257, 469, 285	355, 462, 615	-1, 378, 506	354, 084, 109	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	43, 646		190. 00
194.00 07950 WELLNESS COMMUNITY	0	0	0	313, 596		
194. 01 07951 BUILDING RENTALS	0	713, 476		·	187, 572	
194. 02 07952 HOSPI CE	0	109, 892	109, 892	0	109, 892	1
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	226, 075	· ·	1
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	515, 569	515, 569	1
194. 06 07956 CRH FOUNDATION	53, 326	1, 046	54, 372	106	54, 478	1
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0		194. 07
194. 08 07958 CRHP	1, 545, 512	1, 169, 669	2, 715, 181	805, 418		
194.09 07959 NEUROPSYCH PART B	0	0	0	0		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	99, 592, 168	259, 463, 368	359, 055, 536	0	359, 055, 536	200. 00

				5/30/2023 8: 4	o am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
	I	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	05 001	10 107 202	,	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	95, 981	10, 187, 382	1	1. 00 2. 00
3. 00	00300 OTHER CAP REL COSTS	171, 221 0	13, 936, 655 0	l .	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-373, 625	1	1	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	-27, 037, 837	43, 998, 321		5.00
7. 00	00700 OPERATION OF PLANT	-644, 315			7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	0 11,010			8.00
9. 00	00900 HOUSEKEEPI NG	-150			9. 00
10.00	01000 DI ETARY	-16, 497	1, 672, 306		10.00
11.00	01100 CAFETERI A	-931, 588			11.00
13.00	01300 NURSING ADMINISTRATION	-7, 000	6, 843, 311		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-2, 553	1, 246, 207		14.00
15.00	01500 PHARMACY	-50, 783	6, 173, 194		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5, 776	1, 585, 968		16.00
17.00	01700 SOCIAL SERVICE	0	0		17.00
23. 00	02300 PARAMED ED PRGM	0		I and the second	23. 00
23. 01	02301 XRAY EDUCATION	-34, 072	604, 988		23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	353, 795		23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	221 01/	40 / 55 455		1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	321, 016 0			30.00
32.00	03200 CORONARY CARE UNIT	0			31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	•	33.00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
40. 00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00	04100 SUBPROVI DER – I RF	0	2, 569, 962		41.00
42. 00	04200 SUBPROVI DER	0	0		42.00
43.00	04300 NURSERY	0	1, 707, 117	,	43.00
44.00	04400 SKILLED NURSING FACILITY	0			44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-5, 102, 413	21, 295, 713		50.00
51.00	05100 RECOVERY ROOM	66, 491	1, 990, 455		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 308, 551		52.00
53.00	05300 ANESTHESI OLOGY	-187, 382			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 003, 100			54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0			54.01
54. 02	05404 ULTRA SOUND	0	1, 154, 825		54. 02
54. 03	05405 MAMMOGRAPHY	-682	1, 119, 292		54.03
55. 00 57. 00	O5500 RADI OLOGY-THERAPEUTI C	-29, 445 0			55. 00 57. 00
58.00	05700 CT SCAN 05800 MRI	0			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-11, 989		·	59.00
60.00	06000 LABORATORY	2, 940			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	-138, 684	1, 794, 824		60.01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			62.00
	06500 RESPIRATORY THERAPY	-16, 817	4, 477, 869		65.00
66.00	06600 PHYSI CAL THERAPY	-37, 608		'	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 387, 951		67.00
68. 00	06800 SPEECH PATHOLOGY	-830	960, 728		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 274, 882		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	1, 219, 342		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7, 780, 546	i e	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 758, 504	1	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	24, 994, 971		73.00
74.00	07400 RENAL DI ALYSI S	0		l .	74.00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0		I .	76. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	0	373, 071		10.91
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.00
90.00	09000 CLI NI C	0	2, 071, 255		90.00
90. 01	09001 DI ABETES CENTER	0	0		90. 01
90. 02	09002 NEUROPSYCH	-195, 914	130, 112		90. 02
90. 03	09003 WOUND CENTER	-26, 317	1, 633, 519	l .	90. 03
90.04	09004 HYPERBARIC OXYGEN THERAPY	-976			90.04
90.05	09005 VI MCARE CLI NI C	0	637, 102		90.05
90.06	09006 MEDICATION MGMT CLINIC	0	251, 109		90.06
91.00	09100 EMERGENCY	-185, 139	10, 467, 943		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
05	OTHER REIMBURSABLE COST CENTERS		0.00:		4
95.00	09500 AMBULANCE SERVICES	-34, 939		l e e e e e e e e e e e e e e e e e e e	95.00
99. 10	09910 CORF	0	0	1	99. 10

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

			10 12,01,2022	5/30/2023 8: 40 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS				
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 ISLET ACQUISITION	0	0		111.00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-35, 418, 782	318, 665, 327		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	43, 646		190. 00
194.00 07950 WELLNESS COMMUNITY	0	313, 596		194. 00
194. 01 07951 BUI LDI NG RENTALS	0	187, 572		194. 01
194. 02 07952 HOSPI CE	0	109, 892		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	226, 075		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	515, 569		194. 05
194. 06 07956 CRH FOUNDATION	0	54, 478		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0		194. 07
194. 08 07958 CRHP	0	3, 520, 599		194. 08
194.09 07959 NEUROPSYCH PART B	0	0		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-35, 418, 782	323, 636, 754		200. 00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0112

11.00 ELECTROCARDI OLOGY 69,00 0 3,600 12.00 ELECTROCARDI OLOGY 70.00 0 20,000 13.00 WOUND CENTER 90.03 0 67,397 14.00 HYPERBARI C OXYGEN THERAPY 90.04 0 2,603 15.00 EMERGENCY 91.00 0 2,393,041 16.00 AMBULANCE SERVI CES 95.00 0 17,500 17.00 VI MCARE CLINI C 90.05 0 20,000 10.00 EMERGENCY 91.00 0 5,558,506 1 - ADMINI STRATI VE SALARI ES						5/30/2023 8: 40	
2.00 3.00 4.00 5.00			Increases		·		
B. FECLASS INTEREST							
DOP ELECTISTS-MYSELE CORPS 1.00 0 941, 782			3. 00	4. 00	5. 00		
DATE CONTENT	1 00		1 00		041 700		1 00
DITALS		1				l l	1.00
C - RECLASS INSURANCE 1.00 CAP RECLASS INSURANCE 2.00 LABORATION THERAPY 6.00 0 1,008,938 4.00 1,008,938 5.00 RECLASS INSURING COST 0 - RECLASS BILLIN COST 1.00 ACMINISTRATI VE & GENERAL 1.00 1,109,274 1.00 ACMINISTRATI VE & GENERAL 1.00 1,109,074 1.00 ACMINISTRATI VE & GENERAL 1.00 1,221,633 1.00 RECLASS BILLIN COST 1.00 ACMINISTRATI VE & GENERAL 1.00 1,221,633 1.00 RECLASS BILLIN COST 1.00 ACMINISTRATI VE & GENERAL 1.00 1,221,633 1.00 COST 1.00 ACMINISTRATI VE & GENERAL 1.00 1,221,633 1.00 COST 1.00 ACMINISTRATI VE & GENERAL 1.00 ACMINISTRATI VE & G	2.00						2. 00
CAP FIT COSTS RIDG & FIXT				U	939, 815		
LABORATORY 0.0 0	1 00		1 00	٥	1 000 020		1. 00
OCCUPATIONAL THERAPY			•	1			2.00
AUSULANCE SERVICES			•	- 1			3.00
TOTALS 0 - RECLASS BILLING COST 1 - CO CREME 1 - CO CRE				-			4.00
D	4.00			+			4.00
ADMINISTRATIVE & CENERAL 5.00 1,221,633 19,880 19,800 101ALS 194,06 1,221,633 28,303 19,880 19,800 101ALS 194,06 1,221,633 28,303 19,880 19,800 194,000 193,001 193,00				U _I	1, 137, 274		
DRIP	1 00		5 00	1 221 633	10 996		1.00
TOTALS E - RECLASS HYPERBARIC THERAPY FOR ALL STREET AS CAPTERIA E EXPENSE HYPERBARIC OVICEN THERAPY TOTAL 1.00 TOTALS 1.00 TOTALS 1.00 MELLINESS COMMUNITY 1.01 1.00 MELLINESS COMMUNITY 1.01 MOUNTS OF MELLINESS 1.00 MOUNTS OF MELINESS 1.00 MOUNT		1					2.00
E - RICLASS IMPERBARIC INTERRAPY 90.04 139,604 4,039 TOTALS F - RICLASS CALTERIA EXPENSE 1.00 MORRABINE CONTROL THERAPY 11.00 1.453,494 314,746 TOTALS CAFFLERIA 11.00 1.93,610 33,296 TOTALS CAFFLERIA 11.00 1.93,610 33,296 TOTALS CAFFLERIA 11.00 1.93,610 33,296 TOTALS CAFFLERIA 11.00 0.744,684 L. RICLASS PHYSICIAN FEES 1. O. ADULTS A FEDIATINE ON 10.00 0.744,684 2. O. SUBPROVIDER - 1.RF 41.00 0.757,795 4. O. ADULTS A FEDIATINE ON 10.00 0.757,795 4. O. AMESTHESIOLOGY 53,00 0.241,889 5. O. RADIOLOGY-DIARASTIC 54.00 0.50,000 6. O. BODIOLOGY-DIARASTIC 54.00 0.50,000 6. O. BODIOLOGY-DIARASTIC 54.00 0.50,000 6. O. BODIOLOGY-DIARASTIC 55.00 0.45,000 7. O. MESPIRATORY THERAPY 0.50,000 0.50,000 8. O. LARGADIROY-PATROLOGICA 0.00 0.30,000 8. ESPIRATORY THERAPY 0.50,000 0.50,000 10. OR RESPIRATORY THERAPY 0.50,000 0.50,000 10. OR RES	2.00						2.00
International Content Inte			Y FXPENSE	1, 221, 033	20, 303		
TOTALS F - RECLASS CAFETERIA EXPENSE CAFETERIA CAFETERIA EXPENSE CAFETERIA CAFETERIA CAFETERIA EXPENSE 1.00 CAFETERIA CAF	1 00			139 604	4 039		1.00
F. RECLASS CAFETERIA EXPENSE 11.00	1.00		— /0. 0 				1.00
1.00 CAFETERIA 11.00 1.453,494 814,746 814,746 8 8 8 8 8 8 8 8 8				107,001	1,007		
TOTALS	1 00			1 453 494	814 746		1.00
S. RECLASS WELLNESS 193,610 33,296 101AS 101AS 102A 103,610 33,296 101AS 101AS 103,610 33,296 101AS							
NELLNESS COMMUNITY				, .==, ., .	2.177.10		
TOTALS	1. 00	-	194, 00	193, 610	33, 296		1.00
H - BECLASS PHYSICIAN FEES 10.00	55		— — · <i>··</i> ··•				55
1.00				-,	22, 270		
2.00 SUBPROVIDER - IRF	1. 00		30.00	ol	744, 684		1.00
3. 0.0 OPERATING ROOM 50. 0.0 0 757. 975 4.00 AMSTHESI OLOGY 53. 0.0 0 241.889 5. 0.0 RADI OLOGY-DI AGNOSTI 54. 0.0 0 50. 0.00 7. 0.0 CARDI OLOGY-DI AGNOSTI 55. 0.0 0 45. 0.00 7. 0.0 CARDI AGNOSTI 55. 0.0 0 55. 0.00 8. 0.0 LABORATORY-PATHOLOGI CAL 60. 01 0 32.6, 400 9. 0.0 RESPIRATORY HERAPY 65. 0.0 0 50. 0.00 11. 0.0 PRIST CALT THERAPY 65. 0.0 0 50. 0.00 11. 0.0 PRIST CALT THERAPY 70. 0.0 0 50. 0.00 11. 0.0 CARDI AGNOSTI 70. 00 0 20. 0.00 13. 0.0 AUDITOR OF THE ROOM OF THE R			•	•			2.00
4.00	3.00	OPERATI NG ROOM	50.00	o	757, 975		3.00
6. 0.0 RADI OLOGY—THERAPEUTI C 55. 0.0 0 45. 0.00 R. 0.0 LABORATORY—PATHOLOGI CAL 60. 0.1 0 32.6, 400 R. 0.0 C REPI PLATORY THERAPY 65. 0.0 0 55. 0.00 R. 0.0 D LABORATORY—PATHOLOGI CAL 60. 0.1 0 32.6, 400 R. 0.0 RS PI PLATORY THERAPY 66. 0.0 0 50. 0.00 R. 0.0 PHYSI CAL THERAPY 66. 0.0 0 50. 0.00 R. 0.0 PHYSI CAL THERAPY 66. 0.0 0 50. 0.00 R. 0.0 PHYSI CAL THERAPY 70. 0.0 0 20. 0.00 R. 0.0 RECTROCARPIOLOGY 69. 0.0 0 3. 6.00 R. 0.0 RECTROCARPIOLOGY 69. 0.0 0 20. 0.00 R. 0.0 RECTROCARPIOLOGY 70. 0.0 0 20. 0.00 R. RECLASS DEPRECIATION EXPENSE R. 0.0 RECTROCARPIOLOGY 70. 0.0 0 132, 895 R. 0.0 RECTROCARPIOLOGY 70. 0.0 0 132,	4.00	ANESTHESI OLOGY	53.00	O			4.00
7. 0.0 CARDI AC CATHETER I ZATI I ON 8.0	5.00	RADI OLOGY-DI AGNOSTI C	54.00	O			5.00
B. OO LABORATORY-PATHOLOGICAL 60. 01 0 326, 400 70. 00	6.00	RADI OLOGY-THERAPEUTI C	55.00	o	45, 000		6.00
9.00 RESPI RATORY THERAPY 65.00 0 50.000 11.00 PISTO CAL THERAPY 66.00 0 50.000 11.00 ELECTROCARDIOLOGY 69.00 0 3.600 12.00 ELECTROCARDIOLOGY 70.00 0 20.000 13.00 WOUND CENTER 90.03 0 67.397 14.00 HYPERBARI C OXYGEN THERAPY 90.03 0 67.397 15.00 EMERGENCY 91.00 0 2.393.041 16.00 AMBULANCE SERVI CES 95.00 17.500 17.00 MACRE CLINI C 90.05 0 17.500 17.00 MACRE CLINI C 90.05 0 20.000 17.01 TOTALS 1 0 5.058, 506 17.00 TOTALS 243,550 15.467 17.01 TOTALS 243,550 15.467 17.01 TOTALS 243,550 15.467 17.01 TOTALS 243,550 15.467 17.01 TOTALS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	CARDIAC CATHETERIZATION	59. 00	O	55, 000		7.00
10. 00	8.00	LABORATORY-PATHOLOGI CAL	60. 01	o	326, 400		8.00
11.00 ELECTROCARDIOLOGY	9.00	RESPI RATORY THERAPY	65.00	o	50, 000		9.00
12. 00 LECTROENCEPHALOGRAPHY 70. 00 0 20. 000 13. 00 WOUND CENTER 90. 03 0 67. 397 14. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 2, 603 15. 00 EMERGENCY 91. 00 0 2, 393, 041 16. 00 AMBULANCE SERVI CES 95. 00 0 17. 500 17. 00 VI MCARE CLINI C 90. 05 0 20, 000 17. 00 VI MCARE CLINI C 90. 05 0 5, 058, 506 1 - ADMINI STRATI VE SALARI ES	10.00	PHYSI CAL THERAPY	66.00	o	50, 000		10.00
13.00 MOUND CENTER 90.03 0 67,397 14.00 HYPPERBARIC CXYGEN THERAPY 90.04 0 2,603 15.00 EMERGENCY 91.00 0 2,393,041 16.00 AMBULANCE SERVI CES 95.00 0 17,500 17.00 IMCARE CLINI C 90.05 0 20,000 17.10 TOTALS 0 5,058,506 1.00 CRIP 194.08 243,550 15,467 17.01 TOTALS 243,550 15,467 17.00 TOTALS 243,550 15,467 19.00 PHARMACY RESI DENCY PROG 23.02 114,233 4,613 2.00 3.00 0 0 0 0 3.00 0 0 0 0 4.00 TOTALS 114,233 4,613 K - RECLASS RENT EXPENSE 114,233 4,613 1.00 ADMINI STRATIVE SCHEARL 5.00 0 8,832 2.00 ADMINI STRATIVE SCHEARL 5.00 0 4,684 3.00 XRAY EDUCATION 23.01 0 10,010 4.00 AMMOGRAPHY 54.03 0 201,193 5.00 LABORATORY 60.00 0 24,679 6.00 PHYSI CAL THERAPY 66.00 0 415,644 7.00 OCCUPATIONAL THERAPY 67.00 0 166,338 8.00 SPEECH PATHOLOGY PHYSI 70.00 0 58,523 12.00 AMBULANCE SERVI CES 95.00 0 15,630 14.00 AMMUNINGER PHY 70.00 0 58,523 12.00 AMBULANCE SERVI CES 95.00 0 15,630 14.00 CRIP 194.08 0 437,733 170TALS TOTALS	11.00	ELECTROCARDI OLOGY	69.00	0	3, 600		11.00
14. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 2, 603 15. 00 EMERGENCY 91. 00 0 2, 393, 041 16. 00 AMBULANCE SERVI CES 95. 00 0 17, 500 17. 00 VI MCARE CLINI C 90. 05 0 20, 000 17. 500 17. 500 17. 500 18. 00 CRIP 194. 08 243, 550 15, 467 10. 01 TOTALS 243, 550 15, 467 10. 01 OTOTALS 243, 550 15, 467 10. 01 OTOTALS 243, 550 15, 467 10. 01 OTOTALS 243, 550 15, 467 10. 02 OTOTALS 243, 550 15, 467 10. 03 OTOTALS 243, 550 15, 467 10. 04 OTOTALS 243, 550 15, 467 10. 05 OTOTALS 243, 550 15, 467 10. 06 OTOTALS 243, 550 15, 467 10. 07 OTOTALS 243, 550 15, 467 10. 08 OTOTALS 243, 550 15, 467 10. 08 OTOTALS 243, 550 15, 467 10. 00 OTOTALS 243, 550 15, 463 10. 00 OTOTALS 243, 550 244, 613 10. 00 OTOTALS 244, 613 10. 00 OTOT	12.00	ELECTROENCEPHALOGRAPHY	70. 00	0	20, 000		12.00
15. 00 MABULANCE SERVICES	13.00	WOUND CENTER	90. 03	0	67, 397		13.00
16. 00 AMBULANCE SERVI CES 95. 00 0 17, 500 17	14.00	HYPERBARIC OXYGEN THERAPY	90. 04	0	2, 603		14.00
17.00	15.00		•	0	2, 393, 041		15.00
TOTALS	16.00	AMBULANCE SERVICES	95. 00	0			16.00
1 ADMINISTRATIVE SALARIES	17.00	VIMCARE CLINIC	90.05	0	20, 000		17.00
1.00 CRHP				0	5, 058, 506		
TOTALS							
1. 00	1. 00		194. 08				1. 00
1. 00 PHARMACY RESIDENCY PROG 23. 02 114, 233 4, 613 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				243, 550	15, 467		
2. 00 3. 00 4. 00							
3. 00 4. 00 107ALS 114, 233 4, 613		PHARMACY RESIDENCY PROG				1	1.00
1.00				- 1			2.00
TOTALS							3. 00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 8, 832 2. 00 OPERATI ON OF PLANT 7. 00 0 94, 684 3. 00 XRAY EDUCATI ON 23. 01 0 10, 010 4. 00 MAMMOGRAPHY 54. 03 0 201, 193 5. 00 LABORATORY 60. 00 0 24, 679 6. 00 PHYSI CAL THERAPY 66. 00 0 415, 644 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPEECH PATHOLOGY 68. 00 0 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 0 90, 000 TOTALS 0 90, 000 TOTALS 0 90, 000 M - RECLASS DEPRECIATI ON EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401	4. 00		000				4. 00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 8, 832 2. 00 OPERATI ON OF PLANT 7. 00 0 94, 684 3. 00 XRAY EDUCATI ON 23. 01 0 10, 010 4. 00 MAMMOGRAPHY 54. 03 0 201, 193 5. 00 LABORATORY 60. 00 0 24, 679 6. 00 PHYSI CAL THERAPY 66. 00 0 415, 644 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPECCH PATHOLOGY 68. 00 0 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 MONALLOWABLE MARKETI NG EXPENSE 1. 00 CAP REL COSTS - MYBLE EQUI P 2. 00 0 13, 667, 401				114, 233	4, 613		
2. 00	4 60		- acl	el .	0.055		4 00
3. 00				•			1.00
4. 00 MAMMOGRAPHY 54. 03 0 201, 193 5. 00 LABORATORY 60. 00 0 24, 679 6. 00 PHYSI CAL THERAPY 66. 00 0 415, 644 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPEECH PATHOLOGY 68. 00 0 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1,820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 CAP REL COSTS-MYBLE EQUI P 2. 00 0 13, 667, 401				•			2.00
5. 00 LABORATORY 60. 00 24, 679 6. 00 PHYSI CAL THERAPY 66. 00 0 415, 644 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPECH PATHOLOGY 68. 00 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401				-			3.00
6. 00 PHYSI CAL THERAPY 66. 00 0 415, 644 7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPEECH PATHOLOGY 68. 00 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 NONALLOWABLE MARKETI NG 194. 05 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401							4.00
7. 00 OCCUPATI ONAL THERAPY 67. 00 0 166, 338 8. 00 SPEECH PATHOLOGY 68. 00 0 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 MONALLOWABLE MARKETI NG 194. 05 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401							5.00
8. 00 SPEECH PATHOLOGY 68. 00 0 70, 635 9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 MONALLOWABLE MARKETI NG 194. 05 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401				0			6.00
9. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 132, 895 10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 1. 00 NONALLOWABLE MARKETI NG EXPENSE NONALLOWABLE MARKETI NG EXPENSE 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401 10. 00 13, 667, 401 10. 00 13, 667, 401 10. 00 13, 667, 401 10. 00 10			•	0			7.00
10. 00 WOUND CENTER 90. 03 0 105, 914 11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 MOUND CENTER 90. 03 0 105, 914 15, 630 17, 803 18, 20, 513 18, 20, 513 194. 08 0 90, 000 190, 000 100 100 100 100 100 100 100 100 100		1		0			8.00
11. 00 HYPERBARI C OXYGEN THERAPY 90. 04 0 58, 523 12. 00 AMBULANCE SERVI CES 95. 00 0 15, 630 13. 00 WELLNESS COMMUNI TY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETI NG EXPENSE 1. 00 MORALLOWABLE MARKETI NG 194. 05 0 90, 000 TOTALS 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 13, 667, 401				ol			9.00
12. 00				0			10.00
13. 00 WELLNESS COMMUNITY 194. 00 0 77, 803 14. 00 CRHP 194. 08 0 437, 733 TOTALS 0 1, 820, 513 L - RECLASS MARKETING EXPENSE 1. 00 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 13, 667, 401							11.00
14. 00		1	•	٩			12.00
TOTALS 0 1,820,513 L - RECLASS MARKETI NG EXPENSE 1. 00 NONALLOWABLE MARKETI NG 194.05 0 90,000 TOTALS 0 90,000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUIP 2.00 0 13,667,401			•	1		l l	13.00
L - RECLASS MARKETING EXPENSE 1. 00 NONALLOWABLE MARKETING 194. 05 0 90, 000 TOTALS 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 13, 667, 401	14.00		194.08	+			14. 00
1. 00 NONALLOWABLE MARKETING 194. 05 0 90, 000 TOTALS 0 90, 000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 13, 667, 401				U	1, 820, 513		
TOTALS 0 90,000 M - RECLASS DEPRECIATION EXPENSE 1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 13,667,401	1 00			O	00,000		1 00
M - RECLASS DEPRECIATION EXPENSE 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 13,667,401	1.00		194.05				1. 00
1.00 CAP REL COSTS-MVBLE EQUI P 2.00 0 13,667,401			NSE	U	90, 000		
TOTALS 0 13, 667, 401	1 00			ما	13 667 401		1. 00
[1017L5] U 13,007,401	1.00		<u> </u>				1.00
		11011120	ı	Ч	13, 507, 401	I I	

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 8: 40 am

		1			5/30/2023 8: 4	tu alli
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	N - RECLASS MAINTENANCE EXPEN					l
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	16, 369		1.00
2.00	NURSING ADMINISTRATION	13. 00	0	5, 041		2.00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	o	41, 803		3.00
4. 00	PHARMACY	15. 00	o	42, 963		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	o	1, 621		5.00
		•	-			
6. 00	OPERATING ROOM	50.00	0	373, 409		6.00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	223, 692		7. 00
8. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	101, 864		8. 00
9. 00	MAMMOGRAPHY	54. 03	0	228, 196		9. 00
10.00	ULTRA SOUND	54. 02	0	89, 754		10.00
11.00	RADI OLOGY-THERAPEUTI C	55. 00	ol	490, 579		11.00
12.00	CT SCAN	57. 00	o	337, 699		12.00
13. 00	MRI	58. 00	0	127, 125		13.00
14. 00	CARDI AC CATHETERI ZATI ON	59. 00	o	234, 648		14.00
15. 00	LABORATORY	60.00	0	330, 071		15.00
16. 00	LABORATORY-PATHOLOGI CAL	60. 01	0	20, 656		16. 00
17. 00	EMERGENCY	<u>91.</u> 00	0	3 <u>2, 1</u> 24		17.00
	TOTALS		0	2, 697, 614		ſ
	O - RECLASS DIRECTOR PHARMACY	′				
1.00	RADI OLOGY-THERAPEUTI C	55. 00	24, 147	0		1.00
2. 00	RESPI RATORY THERAPY	65. 00	24, 147	0		2.00
3. 00	OCCUPATIONAL THERAPY	67. 00	2, 012	0		3.00
	SPEECH PATHOLOGY			-		1
4. 00		68. 00	2, 012	0		4.00
5. 00	ELECTROENCEPHALOGRAPHY	70. 00	2, 012	0		5.00
6. 00	CLI NI C	90. 00	24, 147	0		6.00
7.00	NEUROPSYCH	90. 02	2, 012	0		7.00
8. 00	AMBULANCE SERVICES	95.00	16, 098	0		8. 00
9. 00	CRHP	194. 08	48, 295	0		9.00
	TOTALS		144, 882	— — <u> </u>		1
	P - GIFT SHOP		111,002	<u> </u>		1
1. 00	GIFT FLOWER COFFEE SHOP &	190. 00	43, 646	0		1.00
1.00	CANTEEN COITEL SHOP &	170.00	43, 040	U		1.00
		+	— — — , , , , , , , , , , , , , , , , ,	— — _o		1
	TOTALS	(DENOTO	43, 646	U		ł
	Q - RECLASS XRAY EDUCATION EX					
1. 00	XRAY EDUCATION	23. 01	490, 127	868		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		490, 127	868		ſ
	R - OTHER EXPENSE	I	,,			1
1. 00	CRHP	194. 08	0	41, 469		1.00
1.00	TOTALS — — — — —		— — ŏ	41, 469		1.00
	S - RECLASS NON ALLOW ADVERTI	CLNC COCTC	Ų	41, 407		ł
1 00			ما	105 5/0		1 00
1. 00	NONALLOWABLE MARKETING	1 <u>94.</u> 05	•	42 <u>5, 5</u> 69		1.00
	TOTALS		0	425, 569		ļ
	T - EQUIPMENT LEASE					l
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	941, 486		1.00
2.00	OPERATING ROOM	50. 00	0	839, 837		2.00
	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	29, 863		3.00
4. 00	MRI	58. 00	Ö	85, 234		4. 00
5. 00	LABORATORY	60.00	0	19, 279		5. 00
	•	90. 04	0	56, 914		1
6. 00	HYPERBARI C OXYGEN THERAPY	90.04				6. 00
	TOTALS	/ COCT	0	1, 972, 613		ł
	U - RECLASS CHARGEABLE SUPPLY		-			
1. 00	LABORATORY	60. 00	0	1, 123		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 780, 546		2.00
	PATI ENT					l
3.00	IMPL. DEV. CHARGED TO	72. 00	0	8, 758, 504		3.00
	PATI ENTS	- 1	٦			
4. 00	SPEECH - HEARING AIDS	194. 04	0	226, 075		4.00
5. 00	11271111110 711 00	0.00	o	0		5. 00
		0.00	0	0		1
6.00			-	0		6.00
7. 00		0.00	0	0		7.00
8. 00		0. 00	0	0		8.00
9. 00		0. 00	0	0		9. 00
10.00		0. 00	0	0		10.00
11.00		0. 00	O	0		11.00
12. 00		0.00	o	n		12.00
13. 00		0. 00	0	0		13.00
14. 00		0.00	0	0		14.00
			0	0		
15. 00		0.00	-	0		15.00
16.00		0.00	0	0		16.00
17. 00	<u></u>	0.00	0	0		17. 00
_	TOTALS		0	16, 766, 248		<u> </u>

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 8: 40 am

					5/30/2023 8: 4	io am
	2	Increases	6.1	011		
	Cost Center	Li ne #	Sal ary	Other 5		
	2.00	3.00	4. 00	5. 00		
4 00	V - RECL PTO COST FOR STD ELI			000.05/		4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	920, 056		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00		0. 00	0	0		4.00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7. 00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9. 00		0. 00	0	0		9.00
10. 00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	O	0		14.00
15.00		0.00	О	0		15.00
16.00		0.00	О	0		16.00
17. 00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20.00
21. 00		0.00	o	0		21.00
22. 00		0.00	0	0		22.00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24.00
25. 00		0.00	0	0		25.00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27.00
		0.00	0	0	-	
28. 00		•	•			28.00
29. 00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31. 00		0.00	0	0	•	31.00
32.00		0.00	0	0		32.00
33. 00		0. 00	0	0		33.00
34.00		0. 00	0	0		34.00
35. 00		0. 00	0	0		35.00
36.00	<u></u>	0.00	•	0		36. 00
	TOTALS	THE 51/5	0	920, 056		
1 00	X - RECLASS OT SALARIES AND (0	702 405		1 00
1. 00	OCCUPATI ONAL THERAPY	67.00				1. 00
	Y - LDRP		Ŋ	783, 405		
1 00	DELIVERY ROOM & LABOR ROOM	E2 00	1, 684, 027	4 F.O. 4 F.O.		1 00
1. 00		52.00		650, 458		1. 00
	TOTALS	COD	1, 684, 027	650, 458		
1 00	Z - RECLASS LAB BLOOD SUPERVI		0/ 007	0		1 00
1. 00	WHOLE BLOOD & PACKED RED	62. 00	86, 987	0		1. 00
	BLOOD CELL	+		— — ₀		
	TOTALS	DENEET TO	86, 987	U		
4 00	WA - RECLASS CONTRACT LABOR I			407.777		4 00
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	486, 766		1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	210, 913		2.00
3. 00	OPERATI NG ROOM	50. 00	0	2, 133, 203		3. 00
4. 00	RECOVERY ROOM	<u>51.</u> 00	•	31 <u>8, 6</u> 13		4.00
	TOTALS		0	3, 149, 495		
	WB - RECLASS SALARIES TO HOMI					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	72, 778		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	148	0		2.00
3. 00	OPERATION OF PLANT	7. 00	67, 045	0		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	278	0		4. 00
5. 00	HOUSEKEEPI NG	9. 00	36, 871	0		5.00
6.00	DI ETARY	10. 00	24, 068	0		6.00
7.00	CAFETERI A	11. 00	32, 403	0		7.00
8.00	NURSING ADMINISTRATION	13. 00	236, 014	0		8.00
9. 00	CENTRAL SERVICES & SUPPLY	14. 00	61	9, 429		9.00
10.00	PHARMACY	15. 00	50, 107	0		10.00
11. 00	MEDICAL RECORDS & LIBRARY	16. 00	53, 549	0		11.00
12.00	XRAY EDUCATION	23. 01	1, 747	0		12.00
13.00	PHARMACY RESIDENCY PROG	23. 02	3, 419	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	132, 709	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	22, 116	0		15.00
16.00	SUBPROVI DER - I RF	41.00	25, 642	0		16.00
17. 00	NURSERY	43.00	8, 909	O	İ	17. 00
18. 00	OPERATING ROOM	50.00	23, 299	94, 523	j	18.00
19. 00	RECOVERY ROOM	51. 00	549	8, 319	j	19. 00
				•	l	

					5/30/2023 8: 40 am
		Increases		·	
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
20.00	RADI OLOGY-DI AGNOSTI C	54.00	77, 418	0	20.00
21.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	3, 206	0	21.00
22.00	ULTRA SOUND	54. 02	6, 916	0	22.00
23.00	MAMMOGRAPHY	54. 03	21, 088	0	23.00
24.00	RADI OLOGY-THERAPEUTI C	55. 00	4, 076	0	24.00
25.00	CT SCAN	57. 00	7, 949	0	25. 00
26.00	MRI	58. 00	6, 035	0	26.00
27.00	CARDI AC CATHETERI ZATI ON	59. 00	29, 891	0	27.00
28.00	LABORATORY	60.00	76, 623	0	28.00
29.00	LABORATORY-PATHOLOGI CAL	60. 01	7, 147	0	29.00
30.00	RESPI RATORY THERAPY	65. 00	18, 344	0	30.00
31.00	PHYSI CAL THERAPY	66. 00	3, 831	0	31.00
32.00	OCCUPATI ONAL THERAPY	67. 00	687	0	32.00
33.00	SPEECH PATHOLOGY	68. 00	4, 431	0	33.00
34.00	ELECTROCARDI OLOGY	69. 00	6, 627	0	34.00
35.00	ELECTROENCEPHALOGRAPHY	70. 00	14, 055	0	35.00
36.00	CARDIAC REHABILITATION	76. 97	4, 482	0	36.00
37.00	CLINIC	90. 00	29, 239	0	37.00
38.00	NEUROPSYCH	90. 02	3, 928	0	38.00
39.00	WOUND CENTER	90. 03	21, 134	0	39.00
40.00	VIMCARE CLINIC	90. 05	8, 469	0	40.00
41.00	MEDICATION MGMT CLINIC	90. 06	1, 132	0	41.00
42.00	EMERGENCY	91.00	52, 945	0	42.00
43.00	AMBULANCE SERVICES	95. 00	6, 335	0	43.00
44.00	WELLNESS COMMUNITY	194. 00	9, 114	0	44.00
45.00	CRH FOUNDATION	194. 06	106	0	45.00
46.00	CRHP	194. 08	10, 487	0	46.00
	TOTALS		1, 154, 629	185, 049	
	WC - RECLASS SEVERANCE PAY	•			
1.00		0. 00	0	0	1.00
	TOTALS				
500.00	Grand Total: Increases		6, 970, 422	51, 228, 817	500.00
	·		•		·

RECLASSI FI CATI ONS

Provider CCN: 15-0112

Peri od: Worksheet A-6 From 01/01/2022

Date/Time Prepared:

12/31/2022

5/30/2023 8:40 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - RECLASS INTEREST 939, 815 1.00 INTEREST EXPENSE 113.00 0 11 1.00 2.00 0 2.00 0.00 11 ō TOTALS 939, 815 C - RECLASS INSURANCE ADMINISTRATIVE & GENERAL 1.00 5. 00 0 1, 159, 274 12 1.00 2.00 0.00 ol 0 2.00 0.00 3.00 0 0 0 3.00 4.00 0.00 0 4.00 TOTALS 0 1, 159, 274 D - RECLASS BILLING COST 1.00 MEDICAL RECORDS & LIBRARY 16.00 1, 221, 633 28, 303 0 1.00 2.00 0.00 0 2.00 TOTALS 1, 221, 633 28, 303 E - RECLASS HYPERBARIC THERAPY EXPENSE 90. 03 1.00 WOUND CENTER 139,604 4,039 0 1.00 TOTALS 139, 604 4, 039 - RECLASS CAFETERIA EXPENSI 10. 00 1.00 DI ETARY 1, 45<u>3, 4</u>94 814, 746 0 1.00 TOTALS 1, 453, 494 814, 746 G - RECLASS WELLNESS 4. 00 33, 296 EMPLOYEE BENEFITS DEPARTMENT 19<u>3, 6</u>10 1 00 1.00 0 193, 610 33, 296 H - RECLASS PHYSICIAN FEES 1.00 ADMINISTRATIVE & GENERAL 5. 00 4, 330, 197 0 1.00 OPERATING ROOM 2.00 50.00 0 626, 909 0 2.00 3.00 LABORATORY 60.00 0 101, 400 0 3.00 4.00 0.00 0 0 0 4.00 0 0 5.00 0.00 0 5.00 6.00 0.00 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 8.00 0 0.00 0 9.00 0 9.00 10.00 0.00 0 0 10.00 0 11.00 0.00 11.00 0 12.00 0.00 0 12.00 O 0 13.00 0.00 13.00 14.00 0.00 0 0 14.00 15.00 0.00 0 0 0 15.00 16.00 0.00 0 0 0 16.00 0.00 0 17.00 17.00 TOTALS 5, 058, 506 - ADMINISTRATIVE SALARIES ADMINISTRATIVE & GENERAL 5. 00 243, 550 15, 467 1.00 0 1.00 243, 550 TOTALS 15, 467 J - RECLASS PHARMACY RES PROGRAM 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 1, 884 0 1.00 ADMINISTRATIVE & GENERAL 19, 219 2.00 5.00 2, 729 0 2.00 3.00 PHARMACY 15.00 79, 776 0 0 3.00 4.00 MEDICATION MGMT CLINIC 90.06 15, 238 0 4.00 TOTALS 114, 233 4,613 K - RECLASS RENT EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1. 00 0 1, 217, 168 9 1.00 2.00 INTEREST EXPENSE 113.00 0 77, 441 0 2.00 BUILDING RENTALS 0 525, 904 0 3 00 194 01 3 00 4.00 0.00 0 0 0 4.00 5.00 0.00 0 0 0 5.00 0 6.00 0.00 0 6.00 0 O 0 7 00 0 00 0 7 00 8.00 0.00 0 0 8.00 9.00 0.00 o 0 9.00 0 0 10.00 10.00 0.00 ol 0 0.00 11.00 0 11.00 12.00 0.00 0 0 0 12.00 0 0 13.00 0.00 13.00 0. 00 14.00 0 14.00 TOTALS ō 1, 820, 513 - RECLASS MARKETING EXPENSE 1.00 OPERATING ROOM 50.00 90, 000 1.00 0 0 TOTALS 90,000 M - RECLASS DEPRECIATION EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 13, 667, 401 1.00 TOTALS 13, 667, 401

Heal th	Financial Systems		COLUMBUS REGIC	NAL HOSPITAL		In Lieu	of Form CMS-	2552-10
	SI FI CATI ONS			Provi der C		Peri od:	Worksheet A-6	5
						From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
							5/30/2023 8: 4	
	Cost Center	Decreases Line #	Callany	Other	Wkst. A-7 Ref.	I		
	6. 00	7. 00	Sal ary 8. 00	9. 00	10.00	_		
	N - RECLASS MAINTENANCE EXPE		0.00	7. 00	10.00			
1.00	OPERATION OF PLANT	7.00	0	2, 697, 614	C			1.00
2.00		0.00	O	0	C		ļ	2.00
3.00		0.00	0	0	(ļ	3. 00
4.00		0.00	0	0	(1		4.00
5. 00 6. 00		0. 00 0. 00	0	0	(ľ	5. 00 6. 00
7. 00		0.00	0	0	(ſ	7.00
8. 00		0.00	0	0	(ŀ	8. 00
9. 00		0.00	ő	0	(9. 00
10.00		0.00	O	0	Č			10.00
11.00		0.00	O	0	C		ļ	11.00
12.00		0.00	0	0	(ļ	12.00
13.00		0.00	0	0	(ľ	13.00
14.00		0.00	0	0	(ĺ	14.00
15. 00 16. 00		0. 00 0. 00	0	0	(ľ	15. 00 16. 00
17. 00		0.00	0	0	(1	ŀ	17. 00
17.00	TOTALS — — — —		$$ $\stackrel{\circ}{}$	2, 697, 614	`			17.00
	O - RECLASS DIRECTOR PHARMAC	Υ						
1.00	PHARMACY	15. 00	144, 882	0	(1		1.00
2.00		0.00	0	0	(•	ļ	2.00
3. 00 4. 00		0. 00 0. 00	0	0	(ľ	3. 00 4. 00
5. 00		0.00	0	0	(ľ	5. 00
6. 00		0.00	Ö	0	(6. 00
7. 00		0.00	Ö	0	Ċ		İ	7. 00
8.00		0.00	O	0	(ļ	8. 00
9. 00		0.00	0	0				9. 00
	TOTALS		144, 882	0				
1. 00	P - GIFT SHOP ADMINISTRATIVE & GENERAL	5.00	43, 646	0	(7		1.00
1.00	TOTALS		43, 646	— — — ŏ				1.00
	Q - RECLASS XRAY EDUCATION E	XPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	868	(•	ļ	1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	489, 786	0	(2.00
3. 00	MAMMOGRAPHY	54.03	341 490, 127			<u>)</u>	ľ	3. 00
	R - OTHER EXPENSE		490, 127	000				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	41, 469	C			1.00
	TOTALS			41, 469				
4.00	S - RECLASS NON ALLOW ADVERT		ما	105 510				
1. 00	ADMINISTRATIVE & GENERAL		0	42 <u>5, 5</u> 69 425, 569	9	<u>)</u>	ľ	1. 00
	T - EQUIPMENT LEASE		U _I	425, 509				
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 862, 443	Ç			1.00
2.00	INTEREST EXPENSE	113. 00	o	110, 170	C		ļ	2.00
3.00		0.00	0	0	C		1	3.00
4. 00		0.00	0	0	C	•	ľ	4. 00
5.00		0.00	0	0	(ļ	5.00
6. 00	TOTALS — — — — —	0.00		1, 972, 613		<u>/</u>	ľ	6. 00
	U - RECLASS CHARGEABLE SUPPL	Y COST	U _I	1, 7/2, 013				
1. 00	ADULTS & PEDIATRICS	30.00	0	237, 635	(1.00
2.00	INTENSIVE CARE UNIT	31.00	O	157, 242	Č	1		2.00
3.00	SUBPROVI DER - I RF	41.00	O	5, 171	C		ļ	3.00
4.00	NURSERY	43. 00	0	4, 416	(1	ļ	4. 00
5.00	OPERATING ROOM	50.00	0	11, 728, 463	(5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	140, 641	(ľ	6.00
7. 00 8. 00	ULTRA SOUND MAMMOGRAPHY	54. 02 54. 03	0	2, 819 108, 482	(•	ľ	7. 00 8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55.00	0	3, 513	(9.00
10. 00	CT SCAN	57. 00	o	31, 453	(•	1	10.00
11. 00	CARDIAC CATHETERIZATION	59.00	Ö	3, 951, 416	Č	•		11.00
12.00	RESPI RATORY THERAPY	65. 00	0	105, 049	C	•	ŀ	12.00
13.00	PHYSI CAL THERAPY	66.00	0	17, 782	(1		13.00
14.00	SPEECH PATHOLOGY	68.00	0	208, 293	(14.00
15.00	VI MCARE CLINIC	90.05	0	4, 560	(1		15.00
16. 00 17. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	40, 755 18, 558	(1	1	16. 00 17. 00
. 7 . 00	TOTALS	73.00	— — o	16, 766, 248				. 7 . 50
			-1			•	'	

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 8: 40 am

						5/30/2023 8: 4	<u>0 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	Other V	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	V - RECL PTO COST FOR STD EL						
1.00	ADMI NI STRATI VE & GENERAL	5.00	108, 162	0	0		1.00
2. 00	OPERATION OF PLANT	7. 00	20, 746	o	o		2. 00
					0	+	
3. 00	HOUSEKEEPI NG	9. 00	47, 830	0			3. 00
4. 00	DI ETARY	10. 00	20, 033	0	0		4.00
5.00	CAFETERI A	11. 00	26, 971	0	0		5.00
6.00	NURSING ADMINISTRATION	13. 00	45, 729	0	0		6.00
7.00	PHARMACY	15. 00	46, 315	0	o		7.00
8. 00	MEDICAL RECORDS & LIBRARY	16. 00	12, 661	0	o		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	185, 072	Ö	o		9. 00
		31.00		0	- 1		
10.00	INTENSIVE CARE UNIT		15, 050	-	0		10.00
11. 00	SUBPROVI DER - I RF	41. 00	33, 622	0	0		11. 00
12. 00	NURSERY	43. 00	30, 471	0	0		12.00
13.00	OPERATING ROOM	50.00	13, 374	0	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	25, 934	0	0		14.00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	35, 238	0	0		15.00
16. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	12, 294	0	o		16. 00
17. 00	ULTRA SOUND	1		0	- 1	•	
	1	54. 02	7, 947	-	0		17.00
18. 00	MAMMOGRAPHY	54. 03	18, 278	0	0		18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55. 00	15, 231	0	0		19. 00
20.00	CT SCAN	57. 00	7, 906	0	0		20.00
21.00	MRI	58. 00	5, 258	0	0		21.00
22.00	CARDIAC CATHETERIZATION	59. 00	23, 027	0	o		22.00
23. 00	LABORATORY	60.00	37, 885	0	o		23. 00
				-			
24. 00	LABORATORY-PATHOLOGI CAL	60. 01	651	0	0		24.00
25. 00	RESPI RATORY THERAPY	65. 00	22, 705	0	0		25.00
26. 00	PHYSI CAL THERAPY	66. 00	6, 798	0	0		26.00
27.00	SPEECH PATHOLOGY	68. 00	1, 279	0	0		27.00
28.00	ELECTROCARDI OLOGY	69. 00	4, 956	0	O		28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	4, 403	0	o	i	29.00
30. 00	CLI NI C	90.00	6, 743	0	o		30.00
31. 00	NEUROPSYCH	90.02		0	0		31.00
	II.		1, 823	0			
32. 00	WOUND CENTER	90. 03	6, 449	0	0		32.00
33. 00	VIMCARE CLINIC	90. 05	4, 374	0	0		33.00
34.00	EMERGENCY	91.00	38, 564	0	0		34.00
35.00	AMBULANCE SERVICES	95. 00	26, 050	0	0		35.00
36.00	WELLNESS COMMUNITY	194. 00	227	0	o		36.00
	TOTALS		920, 056		— — 1	İ	
	X - RECLASS OT SALARIES AND	OTHER EXP	720,000	<u> </u>			
1. 00	PHYSI CAL THERAPY			783, 405	0		1. 00
1.00		66.00	0		4		1.00
	TOTALS		0	783, 405			
	Y - LDRP						
1. 00	ADULTS & PEDIATRICS	30.00	1, 684, 027	650, 458	0		1.00
	TOTALS		1, 684, 027	650, 458			
	Z - RECLASS LAB BLOOD SUPERV	I SOR					
1.00	LABORATORY	60.00	86, 987	0	0		1.00
1.00	TOTALS	— ••••	— — <u>86, 9</u> 87				1.00
	1 3 11 12 3		00, 707	U _I			
1 00	WA - RECLASS CONTRACT LABOR I			2 440 40-	_1		1 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 149, 495	0		1. 00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS			3, 149, 495			
	WB - RECLASS SALARIES TO HOM	F DEPT	<u> </u>	., , , , , , ,			
1. 00	ADMI NI STRATI VE & GENERAL	5.00	1, 120, 129	185, 049	0		1.00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00			0		
	EMPLOYEE BENEFITS DEPARTMENT		34, 500	0			2.00
3. 00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	O	0	0		6.00
7. 00		0.00	o	0	0	1	7.00
8. 00		0.00	o	0	o	1	8. 00
9. 00		0.00	o	0	0		9. 00
				<u> </u>			
10.00		0.00	0	0	0		10.00
11. 00		0. 00	0	0	0		11. 00
12.00		0.00	0	0	0		12.00
13.00		0.00	O	0	0	1	13.00
14.00		0.00	O	0	o		14.00
15. 00		0.00	o	0	o		15. 00
16. 00		0.00	o	0	0		16.00
			0	0	0		
17. 00		0.00		-	- 1		17.00
18. 00		0.00	0	0	0		18. 00
19. 00		0.00	0	0	0		19. 00
20.00		0.00	0	0	0		20.00

Peri od: Worksheet A-o From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am

						5/30/2023 8:4	40 am
		Decreases				ı	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
21.00		0. 00	0	0			21.00
22.00		0. 00	0	0	0		22. 00
23.00		0. 00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0. 00	0	0	0		25.00
26.00		0. 00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28. 00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	O	0	0		32.00
33.00		0.00	O	0	0		33.00
34.00		0.00	o	0	0		34.00
35.00		0.00	o	0	0		35.00
36.00		0.00	O	0	0		36.00
37.00		0.00	O	0	0		37.00
38.00		0.00	O	0	0		38.00
39.00		0.00	O	0	0		39.00
40.00		0. 00	O	0	0		40.00
41.00		0.00	0	0	0		41.00
42.00		0. 00	0	0	0		42.00
43.00		0. 00	0	0	0		43.00
44.00		0. 00	0	0	0		44.00
45.00		0. 00	o	0	0		45.00
46.00		0. 00	o	0	0		46.00
	TOTALS		1, 154, 629	185, 049			
	WC - RECLASS SEVERANCE PAY		, , , , , , , ,	22, 211	I		1
1. 00		0.00	0	0	0		1.00
	TOTALS — — — — —		— — 	<u> </u>	<u> </u>		
500 00	Grand Total: Decreases		7, 890, 478	50, 308, 761			500.00
300.00	10. aa. 10 tai 1 2001 0a303	ı İ	7,070,170	30, 300, 701	I .	I	, 500. 00

					o 12/31/2022	Date/Time Pre 5/30/2023 8:4	pared: O am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	1, 872, 375	0	C	0	80, 000	1.00
2.00	Land Improvements	21, 020, 698	0	C	0	1, 300	2.00
3.00	Buildings and Fixtures	103, 640, 183	826, 077	C	826, 077		3.00
4.00	Building Improvements	107, 336, 329	493, 720	C	493, 720	· ·	4.00
5. 00	Fixed Equipment	9, 618, 375	29, 722	C	29, 722	· ·	5.00
6.00	Movable Equipment	176, 993, 003	14, 522, 133	C	14, 522, 133	22, 412, 218	
7. 00	HIT designated Assets	127, 429	0	C	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	420, 608, 392	15, 871, 652	C	15, 871, 652	23, 018, 891	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	420, 608, 392	15, 871, 652	C	15, 871, 652	23, 018, 891	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_1				
1. 00	Land	1, 792, 375	0				1.00
2. 00	Land Improvements	21, 019, 398	0				2.00
3.00	Buildings and Fixtures	103, 981, 731	0				3.00
4.00	Building Improvements	107, 806, 004	0				4.00
5. 00	Fi xed Equipment	9, 631, 298	0				5.00
6.00	Movable Equipment	169, 102, 918	0				6. 00
7. 00	HIT designated Assets	127, 429	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	413, 461, 153	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	413, 461, 153	0				10.00

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Li	eu of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0112	Peri od: From 01/01/202	Worksheet A-7	,
					To 12/31/202	22 Date/Time Pre	
					L	5/30/2023 8: 4	O am
			SI	JMMARY OF CAP	71 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					i nstructi ons)	
		9. 00	10. 00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	23, 798, 755	0		0 1, 098, 93	38 0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0	0 0	2.00
3.00	Total (sum of lines 1-2)	23, 798, 755	0		0 1, 098, 93	38 O	3.00
		SUMMARY 0	F CAPITAL			•	
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	24, 897, 693				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2.00
3.00	Total (sum of lines 1-2)	0	24, 897, 693				3.00
		•	•	•			•

Heal th	n Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 8: 4	pared:
		COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	0.00	col . 2)	4.00		
	DART III DECONOLILIATION OF CARLTAL COCTO	1. 00	2. 00	3.00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			244 250 22	0 501007	0	1 00
1.00	CAP REL COSTS BLDG & FIXT	244, 358, 236		2 , 000 , 20		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	169, 102, 919		1 .0,, .02, , .			2.00
3. 00	Total (sum of lines 1-2)	413, 461, 155	TION OF OTHER	413, 461, 15		F CAPITAL	3. 00
		ALLUCA	IION OF OTHER	CAPITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel at	col s. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00	CAP REL COSTS-BLDG & FLXT	0	1		0 7, 009, 374		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0 13, 839, 852	0	2.00
3. 00	Total (sum of lines 1-2)	0			0 20, 849, 226	0	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	'		(see	instructions	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
			,		instructions)	, ,	
		11. 00	12. 00	13. 00	14. 00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	980, 132			0 0	10, 187, 382	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	96, 803		1	0 0	13, 936, 655	2.00
3.00	Total (sum of lines 1-2)	1, 076, 935	2, 197, 876		0 0	24, 124, 037	3.00

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL 138, 350 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В 13,666 CAP REL COSTS-MVBLE EQUIP 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) -45, 868 ADMI NI STRATI VE & GENERAL 4.00 Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -46, 128 ADMINISTRATIVE & GENERAL 5.00 B 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -157, 169 ADMINISTRATIVE & GENERAL 5 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -14, 993 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 9.00 0.00 -10, 901, 610 Provi der-based physici an 10.00 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 -328, 156 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -705, 974 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and -5, 776 MEDICAL RECORDS & LIBRARY 18.00 В 16.00 18.00 abstracts 19.00 Nursing and allied health -34, 072 XRAY EDUCATION 23. 01 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00 20.00 21.00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

				To	om 01/01/2022 12/31/2022	Date/Time Pre	
				Expense Classification on	Worksheet A	5/30/2023 8: 4	0 am
				To/From Which the Amount is			
					J		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
21 00	Adi yetment for encoch	1.00	2. 00	3.00 SPEECH PATHOLOGY	4.00	5. 00	21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHULUGY	68. 00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	TELEPHONE SERVICES	В		ADMINISTRATIVE & GENERAL	5. 00	9	33.00
33. 01 33. 02	DEPR PAT PHONES NEW EQUIP TV DEPR NEW EQUIP	A A		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP	2. 00 2. 00	9	33. 01 33. 02
33. 02	CAFETERIA VISITORS	A		CAFETERI A	11. 00	0	33. 03
33. 04	OPERATIN ROOM OTHER REV	В	· ·	OPERATING ROOM	50. 00	0	33. 04
33.05	BOND AMORTIZATION	Α	10, 008	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 05
33. 06	LAND RENT MOB	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	EMPLOY BENEFITS OTHER REV	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 08 33. 09	MEDICA STAFF INCOME	B B		EMERGENCY ADMINISTRATIVE & GENERAL	91. 00 5. 00	0	33. 08 33. 09
33. 10	RADI OLOGY OTHER REV	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 10
33. 11	BREAST FILM COPIES	В	· ·	MAMMOGRAPHY	54. 03	0	33. 11
33. 12	FACILITIES OTHER REVENUE	В		OPERATION OF PLANT	7. 00	0	33. 12
33. 13	RADIATION ONCOLOGY OTHER REV	В		RADI OLOGY-THERAPEUTI C	55. 00	0	33. 13
33. 14	CRHP OTHER REVENUE ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	CRHP OTHER REVENUE EMPLOYEE	В	-403, 683	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 15
33. 16	BENEFITS FOOD OTHER REV	В	-16 497	DI ETARY	10. 00	0	33. 16
33. 17	PROTECTIVE SERV OTHER REV	В		OPERATION OF PLANT	7. 00	0	33. 17
33. 18	PHARMACY OTHER REVENUE	В		PHARMACY	15. 00	0	33. 18
33. 19	HUMAN RESOURCES OTHER REVENUE	В	-60	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 19
33. 20	VOLUNTEER OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	RENTAL PROPERTIES DEPRECIATION			CAP REL COSTS-BLDG & FLXT	1.00	9	33. 21
33. 22 33. 23	LOSS ON DISPOSAL DEMOLITION UNALLOWABLE PHYS RECRUITMENT	A A		CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	1. 00 5. 00	9	33. 22 33. 23
33. 24	DEPRECIATION RELIFED BUILDING	A		CAP REL COSTS-BLDG & FLXT	1.00	9	33. 24
33. 25	DEPRECIATION RELIFED EQUIPMENT	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 25
33. 26	NONALLOWABLE INT EXP 1993	Α	-4, 204	CAP REL COSTS-MVBLE EQUIP	2. 00	11	33. 26
33. 27	NONALLOWABLE INT EXP 2003/2009	Α	· ·	CAP REL COSTS-MVBLE EQUIP	2. 00	11	33. 27
33. 28	UNALLOWABLE AHA MEMBERSHI P	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	AMBULANCE SERVICES	В		AMBULANCE SERVICES	95.00	0	33. 29 33. 30
33. 30 33. 31	HAF ADJUSTMENT AUDIOLOGY - OTHER REVENUE	A B		ADMINISTRATIVE & GENERAL SPEECH PATHOLOGY	5. 00 68. 00	0	
33. 32	LAB SPECIMENT PROC OTHER	В		LABORATORY	60.00	0	1
	REVENUE		3,221		33.00	0	
33. 33	CARDIAC STEPDOWN OTHER REVENUE			ADULTS & PEDIATRICS	30. 00	0	
33. 34	RESPIRATORY CARE OTHER REVENUE			RESPI RATORY THERAPY	65. 00	0	
33. 35	OUTPATIENT PT AND OT MARR ROAD	В	-27	PHYSI CAL THERAPY	66. 00	0	33. 35
33. 36	PT SOLUTIONS OF WEST COLUMBUS	В	_8 057	PHYSI CAL THERAPY	66. 00	0	33. 36
33. 30	OTHER	В	-0, 737	ITITOTO TILINALI	00.00	0	33.30
33. 37	PT SOLUTIONS OF SOUTH	В	-4, 858	PHYSI CAL THERAPY	66. 00	0	33. 37
	INDIANAPOLIS O						
33. 38	LAB CORE OTHER REVENUE	В		LABORATORY	60.00	0	
33. 39	NURSI NG RESOURCES OTHER	В	-7, 000	NURSING ADMINISTRATION	13. 00	0	33. 39
33. 40	REVENUE ENVI RONMENTAL SERVI CES	В	-150	HOUSEKEEPI NG	9. 00	0	33. 40
55. 40	RESTROOM VEND			- COURTE I NO	7. 00	0	00.40
50.00	TOTAL (sum of lines 1 thru 49)		-35, 418, 782				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

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Line No. Cost Center Expense I Lems Amount of All lowable Cost Included in Nexs. A. column					10 12/31/2022	5/30/2023 8: 4	
1.00		Li ne No.	Cost Center	Expense Items	Amount of		
1.00				·	Allowable Cost	Included in	
A. COSTS I NOURBED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 3.00 4.00 EMPLOYEE BENEFITS DEPARTMENT TRANSACTIONS WITH TRAVEL & ENTERTAINMENT 4.00 EMPLOYEE BENEFITS DEPARTMENT HUMAN RESOURCES - SALARIES 7.55 0.4.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HUMAN RESOURCES - SENEFITS 7.55 0.4.00 4.01 5.00 ADMIN IN STRATI VE & GENERAL 5.00 ADMIN IN STRATI VE & GENERAL 5.00 ADMIN IN STRATI VE & GENERAL 6.00 ADMIN IN STRATI VE & GENERAL 6.00 ADMIN IN STRATI VE & GENERAL 6.00 ADMIN STRATI							
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Worksheet A-8, column 2,		T					
line 12.							

* 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.

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						Related Organization(s) and/	or Home Office	
			Symbol (1)	Name	Percentage of	Name	Percentage of	
					Ownershi p		Ownershi p	
			1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	E	J BICKEL	O.OOSI HEALTH MANAGEMENT	0.00	6. 00
7. 00	Е	D TRAPP	O.OOSI HEALTH MANAGEMENT	0.00	7.00
8. 00	Е	Z ELLISON	O.OOSI HEALTH MANAGMENT	0.00	8.00
9. 00	Е	R SHEDD	O.OOSI HEALTH MANAGEMENT	0.00	9.00
10.00	Е	S STARK	O.OOSI HEALTH MANAGEMENT	0.00	10.00
10. 01	Е	D DOUP	O.OOSI HEALTH MANAGMENT	0.00	10. 01
10. 02	E	D MI CHAEL	O.OOSI HEALTH MANAGMENT	0.00	10.02

STATEMENT OF COSTS OF SERVICE OFFICE COSTS	ES FROM RELATED ORGANIZATIONS AND F	HOME Provider		riod: om 01/01/2022 12/31/2022	Worksheet A-B Date/Time Pro 5/30/2023 8:4	epared:
			Related Organiza	ation(s) and/o	or Home Office	
Symbol (1)	Name	Percentage of Ownership	Name	9	Percentage of Ownership	
1.00	2. 00	3. 00	4. 00)	5. 00	
100.00 G. Other (financial or	-					100.00

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

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

Health Financial Systems

non-financial) specify:

- 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.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- 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 provi der.

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.

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6. 00	MANAGEMENT COMPANY		6.00
7.00	MANAGEMENT COMPANY		7.00
8.00	MANAGEMENT COMPANY		8.00
9.00	MANAGEMENT COMPANY		9.00
10.00	MANAGEMENT COMPANY		10.00
10. 01	MANAGEMENT COMPANY		10. 01
10.02	MANAGMENT COMPANY		10. 02
100.00		10	00.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0112	Peri od: From 01/01/2022	Worksheet A-8-1
OFFICE COSTS				Date/Time Prepared: 5/30/2023 8:40 am
Related Organization(s) and/or Home Office				
Type of Business				
6.00				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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 provi der.

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am

							5/30/2023 8: 4	·U alli
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	3, 615, 103	3, 415, 153	199, 950	211, 500	721	1.00
2.00	30.00	ADULTS & PEDIATRICS	744, 684	0	744, 684	211, 500	4, 829	2.00
3.00	41.00	SUBPROVI DER - I RF	213, 417	0	213, 417	211, 500	8, 703	3.00
4.00	50.00	OPERATING ROOM	7, 910, 485	5, 282, 223	2, 628, 262	246, 400	21, 453	4.00
5.00	53.00	ANESTHESI OLOGY	241, 889	181, 889	60, 000	246, 400	460	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 002, 637	952, 637	50, 000	271, 900	336	6.00
7.00	55. 00	RADI OLOGY-THERAPEUTI C	45, 000	0	45, 000	271, 900	198	7.00
8.00	59. 00	CARDIAC CATHETERIZATION	55, 000	0	55, 000	211, 500	423	8.00
9.00	60. 01	LABORATORY-PATHOLOGI CAL	326, 400	101, 400	225, 000	260, 300	1, 500	9.00
10.00	65. 00	RESPIRATORY THERAPY	50, 000	0	50, 000	211, 500	334	10.00
11.00	66. 00	PHYSI CAL THERAPY	50, 000	0	50, 000	211, 500	258	11.00
12.00	69. 00	ELECTROCARDI OLOGY	3, 600	0	3, 600	211, 500	36	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	20, 000	0	20, 000	211, 500	200	13.00
14.00	90. 02	NEUROPSYCH	195, 914	195, 914	0	211, 500	0	14.00
15.00	90. 03	WOUND CENTER	67, 397	0	67, 397	211, 500	404	15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	2, 603	0	2, 603	211, 500	16	16.00
17.00	90. 05	VIMCARE CLINIC	20, 000	0	20, 000	211, 500	363	17.00
18.00	91.00	EMERGENCY	2, 843, 041	100, 000	2, 743, 041	211, 500	26, 419	18.00
19.00	95.00	AMBULANCE SERVICES	17, 500	0	17, 500	211, 500	158	19.00
200.00			17, 424, 670	10, 229, 216	7, 195, 454		66, 811	200.00

						127 0 17 2022	5/30/2023 8: 4	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCI	E Memberships &	Component	of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	73, 313	3, 66		0	0	1.00
2. 00		ADULTS & PEDIATRICS	491, 026			0	0	2.00
3.00		SUBPROVI DER - I RF	884, 945	· ·	7 C	0	0	3.00
4.00	50.00	OPERATING ROOM	2, 541, 355	127, 068	3 0	0	0	4.00
5.00	53.00	ANESTHESI OLOGY	54, 492	2, 72	5 0	0	0	5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	43, 922	2, 19	5 C	0	0	6.00
7.00	55.00	RADI OLOGY-THERAPEUTI C	25, 883	1, 29	4 C	0	0	7.00
8.00	59. 00	CARDIAC CATHETERIZATION	43, 012	2, 15°	1 C	0	0	8.00
9.00	60. 01	LABORATORY-PATHOLOGI CAL	187, 716	9, 38	5 C	0	0	9.00
10.00	65.00	RESPI RATORY THERAPY	33, 962	1, 698	3	0	0	10.00
11. 00	66. 00	PHYSI CAL THERAPY	26, 234	1, 31:	2 0	0	0	11.00
12.00	69. 00	ELECTROCARDI OLOGY	3, 661	183	3	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	20, 337	1, 01	7 C	0	0	13.00
14.00	90. 02	NEUROPSYCH	0	(0	0	0	14.00
15.00	90. 03	WOUND CENTER	41, 080	2, 05	4 C	0	0	15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	1, 627	8.	1 C	0	0	16.00
17.00	90. 05	VIMCARE CLINIC	36, 911	1, 84	5 C	0	0	17.00
18.00	91.00	EMERGENCY	2, 686, 355	134, 318	3 0	0	0	18.00
19.00	95.00	AMBULANCE SERVICES	16, 066	803	3 0	0	0	19.00
200.00			7, 211, 897	360, 59	5 C	0	0	200.00

							5/30/2023 8: 4	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0	73, 313				1. 00
2.00		ADULTS & PEDIATRICS	0	491, 026		253, 658		2. 00
3.00		SUBPROVI DER - I RF	0	884, 945		0		3. 00
4. 00		OPERATING ROOM	0	2, 541, 355				4. 00
5.00	53. 00	ANESTHESI OLOGY	0	54, 492	5, 508	187, 397		5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	43, 922	6, 078	958, 715		6.00
7.00	55. 00	RADI OLOGY-THERAPEUTI C	0	25, 883	19, 117	19, 117		7. 00
8.00	59. 00	CARDIAC CATHETERIZATION	0	43, 012	11, 988	11, 988		8.00
9.00	60. 01	LABORATORY-PATHOLOGI CAL	0	187, 716	37, 284	138, 684		9.00
10.00	65. 00	RESPI RATORY THERAPY	0	33, 962	16, 038	16, 038		10.00
11. 00	66. 00	PHYSI CAL THERAPY	0	26, 234	23, 766	23, 766		11.00
12.00	69. 00	ELECTROCARDI OLOGY	0	3, 661	0	0		12.00
13.00	70. 00	ELECTROENCEPHALOGRAPHY	0	20, 337	0	0		13.00
14.00	90. 02	NEUROPSYCH	0	0	0	195, 914		14.00
15.00	90. 03	WOUND CENTER	0	41, 080	26, 317	26, 317		15.00
16.00	90. 04	HYPERBARIC OXYGEN THERAPY	0	1, 627	976	976		16.00
17.00	90. 05	VIMCARE CLINIC	0	36, 911	0	0		17.00
18.00	91. 00	EMERGENCY	0	2, 686, 355	56, 686	156, 686		18.00
19.00	95. 00	AMBULANCE SERVICES	0	16, 066	1, 434	1, 434		19.00
200.00			0	7, 211, 897	672, 394	10, 901, 610		200.00

Period: Worksheet B From 01/01/2022 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0112

						o 12/31/2022	Date/Time Pre	
				CAPI TAL REI	_ATED_COSTS		5/30/2023 8: 4	0 am
						5MD1 01/55		
	Cost Center D	escription	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7)	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COS	ST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS 00200 CAP REL COSTS	-BLDG & FLXT	10, 187, 382 13, 936, 655	10, 187, 382	13, 936, 655			1.00 2.00
4. 00	00400 EMPLOYEE BENE		30, 391, 212	155, 614				4. 00
5.00	00500 ADMI NI STRATI V		43, 998, 321	801, 816			57, 520, 766	5.00
7. 00 8. 00	00700 OPERATION OF 00800 LAUNDRY & LIN		9, 097, 962 810, 889	4, 978, 864 11, 075			15, 494, 059 834, 678	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	EN SERVICE	2, 780, 601	72, 633			3, 706, 318	9. 00
10.00	01000 DI ETARY		1, 672, 306	109, 970			2, 139, 962	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMIN	II STRATI ON	1, 342, 084 6, 843, 311	86, 435 140, 484			1, 910, 077 8, 944, 566	11. 00 13. 00
14. 00	01400 CENTRAL SERVI		1, 246, 207	106, 237			1, 413, 077	14. 00
15.00	01500 PHARMACY	DC 0 LLDDADY	6, 173, 194	67, 123			7, 570, 247	15.00
16. 00 17. 00	01600 MEDICAL RECOR 01700 SOCIAL SERVIC		1, 585, 968 0	51, 084 0		440, 651 0	2, 079, 006 0	16. 00 17. 00
23. 00	02300 PARAMED ED PR	GM	0	0	O	0	Ō	23. 00
23. 01	02301 XRAY EDUCATIO		604, 988	4, 894			818, 131	
23. 02	02302 PHARMACY RESI	SERVICE COST CENTERS	353, 795	5, 258	8, 514	99, 273	466, 840	23. 02
30.00	03000 ADULTS & PEDI	ATRI CS	40, 655, 455	1, 086, 252			47, 693, 477	30. 00
31. 00 32. 00	03100 I NTENSI VE CAR 03200 CORONARY CARE		9, 315, 070	153, 251	80, 739 0		10, 308, 674 0	31. 00 32. 00
33. 00	03300 BURN I NTENSI V		0	0		0	0	33.00
34.00	03400 SURGICAL INTE	NSIVE CARE UNIT	0	0	į o	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - 04100 SUBPROVI DER -		0 2, 569, 962	0 155, 013	0 10, 494	-	0 3, 316, 045	40. 00 41. 00
42.00	04200 SUBPROVI DER	INI	2, 504, 402	155, 013		380, 370	3, 310, 043	42.00
43.00	04300 NURSERY		1, 707, 117	8, 153			2, 157, 740	
44. 00	04400 SKILLED NURSI ANCILLARY SERVICE O		0	0	0	0	0	44.00
50.00	05000 OPERATING ROO	М	21, 295, 713	556, 942			23, 929, 589	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM		1, 990, 455	44, 539			2, 041, 091	•
52. 00 53. 00	05300 ANESTHESI OLOG		2, 308, 551 145, 514	53, 545 1, 664			2, 915, 651 149, 371	52. 00 53. 00
54.00	05400 RADI OLOGY-DI A		1, 959, 028	118, 808	167, 427	369, 550	2, 614, 813	54.00
54. 01 54. 02	05402 NUCLEAR MEDIC 05404 ULTRA SOUND	I NE-DI AGNOSTI C	2, 142, 578 1, 154, 825	47, 000 21, 032			2, 519, 096 1, 335, 997	54. 01 54. 02
54. 03	05405 MAMMOGRAPHY		1, 119, 292	1, 412			1, 507, 722	54. 03
55.00	05500 RADI OLOGY-THE	RAPEUTI C	2, 550, 146	109, 201			3, 679, 636	
57. 00 58. 00	05700 CT SCAN 05800 MRI		2, 071, 561 824, 968	25, 255 12, 586			2, 359, 145 990, 183	57. 00 58. 00
59.00	05900 CARDI AC CATHE	TERI ZATI ON	2, 441, 622	129, 408			3, 470, 539	
60.00	06000 LABORATORY	TUO. 001 041	12, 703, 548	151, 978			14, 520, 028	
60. 01 62. 00	06001 LABORATORY-PA	THOLOGICAL PACKED RED BLOOD CELL	1, 794, 824 764, 712	16, 949 5, 985			1, 964, 159 801, 649	1
65.00	06500 RESPIRATORY T		4, 477, 869	110, 488			5, 359, 352	1
66.00	06600 PHYSI CAL THER		6, 404, 537	8, 614			6, 502, 457	66.00
67. 00 68. 00	06700 OCCUPATI ONAL 06800 SPEECH PATHOL		2, 387, 951 960, 728	3, 090 0			2, 417, 990 1, 045, 530	67. 00 68. 00
69. 00	06900 ELECTROCARDI O	LOGY	1, 274, 882	19, 550	265, 663	260, 062	1, 820, 157	69. 00
70. 00 71. 00	07000 ELECTROENCEPH	ALOGRAPHY IES CHARGED TO PATIENT	1, 219, 342 7, 780, 546	0			1, 435, 251 7, 780, 546	70. 00 71. 00
71.00	07200 I MPL. DEV. CH		8, 758, 504	0		0	8, 758, 504	•
73. 00	07300 DRUGS CHARGED		24, 994, 971	0	· ·	0	24, 994, 971	
74. 00 76. 00	07400 RENAL DI ALYSI 03020 ACUPUNCTURE	S	817, 533	0			817, 533 0	74. 00 76. 00
76. 97	07697 CARDI AC REHAB	ILITATION	395, 891	22, 109			508, 296	
	OUTPATIENT SERVICE				Г			
88. 00 89. 00	08800 RURAL HEALTH	CLINIC LIFIED HEALTH CENTER	0	0			0	
90.00	09000 CLI NI C		2, 071, 255	100, 937			2, 743, 006	90.00
90. 01	09001 DI ABETES CENT	ER	0	0	0	0	140 530	90. 01
90. 02 90. 03	09002 NEUROPSYCH 09003 WOUND CENTER		130, 112 1, 633, 519	1, 147 0	l		169, 538 1, 814, 929	90. 02 90. 03
90. 04	09004 HYPERBARIC OX		260, 707	0	151	44, 908	305, 766	90. 04
90.05	09005 VI MCARE CLI NI		637, 102	59, 502			891, 333 256, 517	
90. 06 91. 00	09006 MEDICATION MG 09100 EMERGENCY	INT CLINIC	251, 109 10, 467, 943	12, 823 252, 482			356, 517 13, 028, 105	90. 06 91. 00
92. 00	1 1	EDS (NON-DISTINCT PART					0	1

lealth Financial Systems	COLUMBUS REGIO				u of Form CMS-2	<u> 2552-1</u>
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/30/2023 8:4	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
OTHER RELIGIOUS AND SHOOT OFFITERS	0	1. 00	2. 00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	3, 201, 010	112, 320	214, 51	3 867, 002	4, 394, 845	05.0
99. 10 09910 CORF	3, 201, 010	112, 320	214, 51	0 807,002	4, 374, 645	1
101.00 10100 HOME HEALTH AGENCY	0	0			- 1	101.0
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	101.0
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109. 0
110.00 11000 INTESTINAL ACQUISITION	o	0		o o	0	110.0
111.00 11100 ISLET ACQUISITION	0	0		0 0	0	111.0
113.00 11300 INTEREST EXPENSE						113.0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	318, 665, 327	9, 993, 522	12, 472, 93	29, 860, 948	316, 316, 958	118. 0
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	43, 646	37, 981	18		95, 851	
194. 00 07950 WELLNESS COMMUNITY	313, 596	0	3, 38	3 65, 140	382, 119	
194. 01 07951 BUILDING RENTALS	187, 572	10.075		0	187, 572	
94. 02 07952 H0SPI CE 94. 03 07953 OUTREACH CLI NI CS	109, 892	13, 075			122, 967	194. 0
94. 04 07954 SPEECH - HEARING ALDS	226, 075	0			226, 075	
94. 05 07955 NONALLOWABLE MARKETING	515, 569	0			515, 569	
94. 06 07956 CRH FOUNDATION	54, 478	26, 891		0 17, 188	98, 557	
94. 07 07957 HEALTHY COMMUNITIES	54, 476	20, 091		0 17, 188	·	194. 0
94. 08 07958 CRHP	3, 520, 599	108, 348	1, 459, 02	9 594, 418	5, 682, 394	
94. 09 07959 NEUROPSYCH_PART_B	0, 320, 377	7, 565	1, 437, 02		8, 692	
200.00 Cross Foot Adjustments		,, 303	1, 12			200.0
201.00 Negative Cost Centers		0		ol ol		201.0
202.00 TOTAL (sum lines 118 through 201)	323, 636, 754	10, 187, 382	13, 936, 65	5 30, 551, 734	323, 636, 754	

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/inme Prepared:

54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 544, 500 208, 330 00640 ULTRA SOUND 06404 ULTRA SOUND 288, 774 093, 225 00 20, 288 00 20, 288 00640 ULTRA SOUND 288, 774 093, 225 00 20, 288 00640 ULTRA SOUND 020, 288 00640 ULTRA SOUND 288, 774 093, 225 00 20, 288 00640 ULTRA SOUND 05, 200 05, 200 00640 ULTRA SOUND 200, 288 00, 200 00640 ULTRA SOUND 200, 288 006 00640 ULTRA SOUND 12, 200, 288 006 00640 ULTRA SOUND 12, 200, 288 006 00640 ULTRA SOUND 12, 200, 288 006 00640 ULTRA SOUND 12, 200, 288 006 00640 ULTRA SOUND 12, 200, 288 006 006 006 00640 ULTRA SOUND 12, 200, 288 006 006 006 006 006 006 006 00640 ULTRA SOUND 12, 200, 288 006 006 006 006 006 006 006 006 006 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 0 11. 00 0 13. 00 0 14. 00
CEMBERAL SERVICE COST CENTERS 1.00	2.00 4.00 5.00 7.00 8.00 9.00 515 10.00 0 11.00 0 13.00 0 14.00
GENERAL SERVICE COST CENTERS 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0	2.00 4.00 5.00 7.00 8.00 9.00 515 10.00 0 11.00 0 13.00 0 14.00
2.00	2.00 4.00 5.00 7.00 8.00 9.00 515 10.00 0 11.00 0 13.00 0 14.00
1.00 00000 EMPLOYEE BENEFITS DEPARTMENT	4.00 5.00 7.00 8.00 9.00 515 10.00 0 11.00 0 13.00 0 14.00
5.00 00500 ADMINISTRATIVE & GENERAL 57, \$20, 766	5.00 7.00 8.00 9.00 10.00 0 11.00 0 13.00 0 14.00
1.00 00700 00700 00FART 00 00 00 00 00 00 00	7.00 8.00 9.00 515 10.00 0 11.00 0 13.00 0 14.00
8. 00 0.0600 LAUNDRY & LI NEN SERVICE 180, 415 49, 992 1, 064, 185 7, 00 0.0700 10	8. 00 9. 00 515 10. 00 0 11. 00 0 13. 00 0 14. 00
10.00 01000 01000 01000 01000 01000 01000 0100 01000 01000 01000 01000 01000 01000 01000 01000 01100 01000 01100 01000 01100 01100 01000 011000 01000 01000 01000 01000 01000 01000 01000 0100 010000 010000 010000 010000 010000 010000 010000 0100000 01000000 0100000000	515 10.00 0 11.00 0 13.00 0 14.00
111.00 O1100 CAFETERIA 412.861 383, 127 0 83.688 14.00	0 11.00 0 13.00 0 14.00
13. 00 01300 OURSING ADMIN ISTRATION 1,933,359 622,698 0 14,371	0 13.00 0 14.00
14. 00 O1400 CENTRAL SERVICES & SUPPLY 305, 435	0 14.00
15. 00 O1500 PHARMACY 1, 636, 301 297, 526 0 35, 504	
16.00 01600 MEDICAL RECORDS & LIBRARY 449, 375 226, 430 0 5, 917 0 0 23.00 02300 PARMED ED PRGM 0 0 0 0 0 0 0 0 0	0 15.00
23.00 02300 PARMIED ED PROM 176, B38 21, 695 0 1, 691 23.01 02302 PHARMACY RESI DENCY PROG 100, 907 23, 306 0 2, 536 1, 691 23.02 2302 PHARMACY RESI DENCY PROG 100, 907 23, 306 0 2, 536 1, 702, 495 2, 522 231.00 03000 ADULTS & PEDI ATRIC CS 10, 308, 956 4, 814, 843 350, 676 1, 702, 495 2, 522 231.00 03100 INTENSI VE CARE UNI T 2, 228, 210 679, 290 44, 636 252, 754 282 230.00 23000 CORONARY CARE UNI T 0 0 0 0 0 0 0 0 0	0 16.00
23.01 C3201 XRAY EDUCATION	0 17.00
23.302 PARMACY RESI DENCY PROG 100, 907 23, 306 0 2,536	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS 10, 308, 956	0 23.01
30.00 03000 ADULTS & PEDIATRICS 10, 308, 956 4, 814, 843 350, 676 1, 702, 495 2, 522 32.00 03100 INTENSIVE CARE UNIT 2, 228, 210 679, 290 44, 636 252, 754 282 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0	_0 23.02
32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	147 30. OC
33.00 03300 BURN INTENSIVE CARE UNI T 0 0 0 0 0 0 0 0 0	31.00
34. 00 03400 SUBRGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 32.00
40.00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 41.00 04100 SUBPROVI DER - I RF 716,760 687,100 43,323 136,944 253 42.00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0	0 33.00
41.00 04100 SUBPROVI DER - I RF 716, 760 687, 100 43, 323 136, 944 253 42.00 04200 SUBPROVI DER 0 0 0 0 0 43.00 04300 NURSERY 466, 393 36, 137 14, 443 1, 691 44.00 04400 SKI LLED NURSI NG FACILITY 0 0 0 NO 05000 OPERATI NG ROOM 5, 172, 357 2, 468, 662 230, 214 756, 572 17 51.00 05100 RECOVERY ROOM 441, 180 197, 421 46, 959 104, 821 52.00 05200 DELI VERY ROOM & LABOR ROOM 630, 215 237, 339 15, 949 72, 699 54.00 05300 ANESTHESI OLOGY 32, 286 7, 376 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 565, 189 526, 622 77, 304 110, 739 1 54.01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 544, 500 208, 330 0 61, 709 54.02 05404 ULTRA SOUND 288, 774 93, 225 0 20, 288 54.03 05405 MAMMOGRAPHY 325, 893 6, 260 4, 212 20, 288 54.03 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 55.00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57.00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58.00 05800 MRI 214, 027 55, 786 0 5, 917 60.01 06001 LABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 60.00 06000 LABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 60.00 06000 CABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 60.00 06000 CABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 60.00 06000 CABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 60.00 06000 CABORATORY-PATHOLOGY 225, 990 0 0 0 60.00 06000 CABORATORY-PATHOLOGY 225, 990 0 0 0 60.00 06000 CABORATORY-PATHOLOGY 393, 425 86, 655 0 1, 691 60.00 06000 CABORATORY-PATHOLOGY 393, 425 86, 655 0 1, 691 60.00 06000 CABORATORY-PATHOLOGY 393, 425 86, 655 0 1, 691 60.00 06000 CABORATORY-PATHOLOGY 393, 425 86, 655 0 1, 691 60.00 06000 CABORATORY-PATHOLOGY 393, 425 86, 655 0 1,	0 34.00
42. 00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0	
44. 00 04400 SKI LLED NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0	0 42.00
ANCILLARY SERVICE COST CENTERS	0 43.00
50.00 05000 OPERATING ROOM 5, 172, 357 2, 468, 662 230, 214 756, 572 17	0 44.00
51. 00	DOD FO 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 630, 215 237, 339 15, 949 72, 699 53. 00 05300 ANESTHESI OLOGY 32, 286 7, 376 0 0 54. 00 05400 RADI OLOGY - DI AGNOSTI C 565, 189 526, 622 77, 304 110, 739 1 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 544, 500 208, 330 0 61, 709 54. 02 05404 ULTRA SOUND 288, 774 93, 225 0 20, 288 55. 00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 77, 771 60, 60	988 50. 00 0 51. 00
53. 00 05300 ANESTHESI OLOGY 32, 286 7, 376 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 565, 189 526, 622 77, 304 110, 739 1 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 544, 500 208, 330 0 61, 709 54. 02 05404 ULTRA SOUND 288, 774 93, 225 0 20, 288 54. 03 05405 MAMMOGRAPHY 325, 893 6, 260 4, 212 20, 288 55. 00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 01 O6001 LABORATORY 3, 138, 490 673, 649 0 77, 771 0	0 52.00
54. 01	0 53.00
54. 02 05404 ULTRA SOUND 288, 774 93, 225 0 20, 288 54. 03 05405 MAMMOGRAPHY 325, 893 6, 260 4, 212 20, 288 55. 00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 77, 771 60. 01 06001 LABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 173, 276 26, 529 0 2, 536 65. 00 06500 RESPI RATORY THERAPY 1, 405, 500 38, 183 26, 263 1, 691	54.00
54. 03 05405 MAMMOGRAPHY 325, 893 6, 260 4, 212 20, 288 55. 00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 77, 771 6 60, 73, 649 0 77, 771 60, 00 </td <td>0 54.01</td>	0 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 795, 350 484, 038 13, 292 80, 307 12 57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 77, 771 771 771 771 771 772 772 773, 649 0 773, 771 774	0 54.02 0 54.03
57. 00 05700 CT SCAN 509, 927 111, 944 0 12, 680 58. 00 05800 MRI 214, 027 55, 786 0 5, 917 59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY - PATHOLOGI CAL 424, 551 75, 125 0 77, 771 60. 01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 173, 276 26, 529 0 2, 536 65. 00 06500 RESPI RATORY THERAPY 1, 158, 419 489, 741 0 86, 224 66. 00 06600 PHYSI CAL THERAPY 1, 405, 500 38, 183 26, 263 1, 691 67. 00 06700 OCCUPATI ONAL THERAPY 522, 646 13, 699 11, 506 0 68. 00 06800 SPECH PATHOLOGY 225, 990 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 393, 425 86, 655 0 1, 691 70. 00 0700 ELECTROENCEPHALOGRAPHY 310, 228 0 1, 054 121, 728 <td></td>	
59. 00 05900 CARDI AC CATHETERI ZATI ON 750, 154 573, 606 62, 813 129, 336 6 60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 777, 771 0 0 777, 771 0 0 077, 771 0 0 0 0 777, 771 0 0 0 0 0 777, 771 0 0 0 0 0 0 777, 771 0 0 0 0 0 0 777, 771 0 0 0 0 0 4, 227 0 0 4, 227 0 0 2, 536 0 0 4, 227 0 2, 536 0 0 2, 536 0 0 0 0 0 2, 536 0	0 57.00
60. 00 06000 LABORATORY 3, 138, 490 673, 649 0 77, 771 60. 01 06001 LABORATORY-PATHOLOGI CAL 424, 551 75, 125 0 4, 227 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 173, 276 26, 529 0 2, 536 65. 00 06500 RESPI RATORY THERAPY 1, 158, 419 489, 741 0 86, 224 66. 00 06600 PHYSI CAL THERAPY 1, 405, 500 38, 183 26, 263 1, 691 67. 00 06700 OCCUPATI ONAL THERAPY 522, 646 13, 699 11, 506 0 06800 SPEECH PATHOLOGY 225, 990 0 0 0 0 0 0 0 0 0	0 58.00
60. 01	381 59.00
62. 00	0 60.00
65. 00 06500 RESPIRATORY THERAPY 1, 158, 419 489, 741 0 86, 224 66. 00 06600 PHYSI CAL THERAPY 1, 405, 500 38, 183 26, 263 1, 691 67. 00 06700 OCCUPATI ONAL THERAPY 522, 646 13, 699 11, 506 0 0 0 0 0 0 0 0 0	0 60.01
66. 00 06600 PHYSI CAL THERAPY 1, 405, 500 38, 183 26, 263 1, 691 67. 00 06700 0CCUPATI ONAL THERAPY 522, 646 13, 699 11, 506 0 0 0 0 0 0 0 0 0	0 65.00
68. 00 06800 SPEECH PATHOLOGY 225, 990 0 0 0 0 0 0 0 0 0	0 66.00
69. 00 06900 ELECTROCARDI OLOGY 393, 425 86, 655 0 1, 691 1, 054 121, 728 1, 000 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 1, 893, 142 0 0 0 0 0 0 0 0 0	0 67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 310, 228 0 1, 054 121, 728 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 1, 681, 757 0 0 0 0 0 0 0 0 0	0 68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1,681,757 0 0 0 0 0 0 0 0 0	0 69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,893,142 0 0 0 0 0 0 0 0 0	0 70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 5, 402, 638 0 0 0	0 72.00
	0 73.00
74. 00 07400 RENAL DI ALYSI S 176, 709 0 0 0	0 74.00
76. 00 03020 ACUPUNCTURE 0 0 0 0 0	0 76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 109, 868 97, 998 0 2, 536	0 76. 97
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0	0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0	0 89.00
	346 90.00
90. 01 09001 DI ABETES CENTER 0 0 0	0 90.01
90. 02 09002 NEUROPSYCH 36, 645 5, 083 0 1, 691	0 90.02
90. 03 09003 WOUND CENTER 392, 295 0 1, 567 0	0 90.03
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 66, 091 0 65 0 90. 05 09005 VI MCARE CLI NI C 192, 661 263, 745 5, 756 248, 528	0 90.04
90. 05 09005 VI MCARE CLI NI C 192, 661 263, 745 5, 756 248, 528 90. 06 09006 MEDI CATI ON MGMT CLI NI C 77, 061 56, 840 0 12, 680	0 90.06
	967 91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 949, 941 497, 861 0 0	0 95.00
99. 10 09910 CORF 0 0 0 0 0 0 0 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 001.	0 99.10
101. DOLIVE TOUR TEALITY AVENUET UI UI UI UI UI UI	01101.00

			To	12/31/2022	Date/Time Prepared: 5/30/2023 8:40 am
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	E & GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10.00
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113. 00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	55, 938, 598	17, 983, 791	1, 064, 185	4, 797, 260	3, 152, 515 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	20, 718	168, 350	0	0	0 190.00
194. 00 07950 WELLNESS COMMUNITY	82, 595	0	0	0	0 194.00
194. 01 07951 BUILDING RENTALS	40, 544	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	26, 579	57, 956	0	1, 691	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	48, 866	0	0	0	0 194.04
194. 05 07955 NONALLOWABLE MARKETING	111, 440	0	0	0	0 194.05
194. 06 07956 CRH FOUNDATION	21, 303	119, 196	0	30, 432	0 194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 194. 07
194. 08 07958 CRHP	1, 228, 244	480, 257	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	1, 879	33, 534	0	0	0 194. 09
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	57, 520, 766	18, 843, 084	1, 064, 185	4, 829, 383	3, 152, 515 202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				10	12/31/2022	Date/lime Pre 5/30/2023 8:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO5OO ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	2 700 752					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	2, 789, 753 202, 115	11, 717, 109				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	34, 160	212, 816	2, 499, 785			14.00
15. 00	01500 PHARMACY	88, 247	549, 988	0	10, 177, 813		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	99, 634	0	0	0	2, 860, 362	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00 23. 01	O2300 PARAMED ED PRGM O2301 XRAY EDUCATION	19, 927	0	0	0	0	23. 00 23. 01
	02302 PHARMACY RESIDENCY PROG	8, 540	56, 353	0	0	0	23. 01
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	3, 5.5	337 333	<u> </u>	<u> </u>		20.02
30.00	03000 ADULTS & PEDIATRICS	600, 652	3, 757, 935	45, 266	15, 445	303, 084	30. 00
31.00	03100 NTENSI VE CARE UNI T	65, 474	408, 621	1, 195	6, 113	52, 113	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T		0	0	0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	0	Ō	ō	0	40.00
41.00	04100 SUBPROVI DER - I RF	56, 934	365, 894	0	1, 541	23, 437	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	37, 007	228, 616 0	0	2	10, 693 0	ı
44.00	ANCI LLARY SERVI CE COST CENTERS	١	U	U	<u> </u>	0	44.00
50.00	05000 OPERATI NG ROOM	290, 362	1, 828, 001	2, 300, 982	75, 497	352, 455	50.00
51.00	05100 RECOVERY ROOM	34, 160	208, 185	0	112	28, 713	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54, 087	346, 520	21, 014	0	16, 304	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	27 007	0	14 207	30, 709	54, 856 22, 615	
54. 00	05402 NUCLEAR MEDICINE-DI AGNOSTI C	37, 007 17, 080	0	16, 387 0	17, 561 134, 582	43, 601	54.00
54. 02	05404 ULTRA SOUND	14, 233	0	Ö	765	24, 707	54. 02
54. 03	05405 MAMMOGRAPHY	28, 467	0	0	470	19, 655	54.03
55. 00	05500 RADI OLOGY-THERAPEUTI C	22, 773	0	0	733	74, 606	55.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	25, 620	0	0	54, 704 30, 405	134, 442 33, 411	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	14, 233 54, 087	337, 576	17, 544	19, 068	105, 127	59.00
60.00	06000 LABORATORY	213, 502	007, 070	0	43	263, 163	1
60. 01	06001 LABORATORY-PATHOLOGI CAL	14, 233	0	0	38	25, 190	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 847	0	0	0	11, 726	•
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	68, 320 11, 387	430, 160 0	193 17, 428	771 977	112, 771	1
67 00	06700 OCCUPATI ONAL THERAPY	2, 847	0	17, 420	9//	62, 313 22, 515	
	06800 SPEECH PATHOLOGY	8, 540	0	Ö	Ö	7, 119	
	06900 ELECTROCARDI OLOGY	25, 620	168, 079	0	114, 975	46, 717	1
	07000 ELECTROENCEPHALOGRAPHY	22, 773	0	0	0	28, 619	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	108, 100 58, 631	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS		0	0	9, 638, 796	406, 591	
	07400 RENAL DIALYSIS	l o	Ö	Ö	4, 610	10, 544	ı
	03020 ACUPUNCTURE	0	0	0	o	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	8, 540	56, 104	0	14	6, 401	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	O	0	٥	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
	09000 CLI NI C	68, 320	298, 389	7, 095	4, 378	28, 168	•
90. 01	09001 DI ABETES CENTER	0	0	0	O	0	90. 01
	09002 NEUROPSYCH	11, 387	0	0	0	596	1
90. 03	09003 WOUND CENTER	19, 927	128, 746	67, 167	4, 546	32, 458	1
90. 04 90. 05	O9004 HYPERBARI C OXYGEN THERAPY O9005 VI MCARE CLI NI C	2, 847 28, 467	20, 981 183, 596	0	384	2, 244 5, 320	1
	09006 MEDICATION MGMT CLINIC	5, 693	28, 877	0	0	2, 465	1
91.00	09100 EMERGENCY	239, 122	1, 264, 146	5, 514	8, 495	277, 243	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS	100 70	007 501	5	44	44 / 40	05 00
	09500 AMBULANCE SERVI CES 09910 CORF	133, 794 0	837, 526 0	0	11, 551 0	41, 649 0	1
	10100 HOME HEALTH AGENCY	0	0	0	0	-	101.00
	1	1			-1		

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared:

			10	12/31/2022	5/30/2023 8:40 am	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 0	0
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110. 0	0
111.00 11100 I SLET ACQUISITION	0	0	0	0	0 111.00	0
113.00 11300 INTEREST EXPENSE					113. 00	0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 692, 965	11, 717, 109	2, 499, 785	10, 177, 285	2, 860, 362 118. 0	0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 847	0	0	0	0 190. 0	0
194. 00 07950 WELLNESS COMMUNITY	8, 540	0	0	0	0 194. 0	0
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0 194. 0	1
194. 02 07952 HOSPI CE	0	0	0	528	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	2, 847	0	0	0	0 194. 0	6
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 194. 0	7
194. 08 07958 CRHP	82, 554	0	0	0	0 194. 0	8
194. 09 07959 NEUROPSYCH PART B	0	0	0	0	0 194. 0	9
200.00 Cross Foot Adjustments					200. 0	0
201.00 Negative Cost Centers	0	0	0	0	0 201. 0	0
202.00 TOTAL (sum lines 118 through 201)	2, 789, 753	11, 717, 109	2, 499, 785	10, 177, 813	2, 860, 362 202. 0	0

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0112

				1	5 12/31/2022	Date/lime Pre 5/30/2023 8:4	
	Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	
		SERVI CE	PRGM	EDUCATI ON	RESI DENCY PROG		
		17. 00	23. 00	23. 01	23. 02	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 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
13. 00	01300 NURSI NG ADMI NI STRATI ON						11.00
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	0					17.00
23. 00 23. 01	02300 PARAMED ED PRGM 02301 XRAY EDUCATION	0	0	l			23. 00 23. 01
	02302 PHARMACY RESIDENCY PROG			1, 038, 282	658, 482		23.01
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			000, 102		20.02
30.00		0	0	0	0	72, 114, 976	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	14, 329, 691	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	
34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	34.00
40. 00	04000 SUBPROVI DER – I PF		0	Ö	Ö	0	40.00
41.00	04100 SUBPROVI DER - I RF	O	0	0	0	5, 601, 706	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0		0	2, 952, 722	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	U U	0	0	0	0	44.00
50. 00	05000 OPERATING ROOM	O	0	0	0	37, 422, 679	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	3, 102, 642	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	4, 309, 778	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	274, 598	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0	1, 038, 282 0	0	5, 028, 165 3, 528, 898	1
54. 02	05404 ULTRA SOUND	0	0	0	0	1, 777, 989	1
54. 03	05405 MAMMOGRAPHY	0	0	0	0	1, 912, 967	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	5, 162, 936	55.00
57. 00	05700 CT SCAN	0	0	0	0	3, 208, 462	1
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	1, 343, 962 5, 526, 231	1
60.00	06000 LABORATORY		0		0	18, 886, 646	
60. 01	06001 LABORATORY-PATHOLOGI CAL	Ö	0	Ö	Ö	2, 507, 523	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1, 018, 563	
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	7, 705, 951	1
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	0	8, 066, 199 2, 991, 203	
	06800 SPEECH PATHOLOGY		0] 0 0	0	2, 991, 203 1, 287, 179	
	06900 ELECTROCARDI OLOGY		0	Ö	Ö	2, 657, 319	
	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	1, 919, 653	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	9, 570, 403	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	450 402	10, 710, 277	1
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0	658, 482 0	41, 101, 478 1, 009, 396	1
76. 00			0	Ö	Ö	0	1
76. 97		0	0	0	0	789, 757	76. 97
	OUTPATIENT SERVICE COST CENTERS				-1		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	09000 CLINIC		0	0	0	4, 353, 593	
90. 01	09001 DI ABETES CENTER	o	0	0	Ö	0	1
	09002 NEUROPSYCH	O	0	0	0	224, 940	1
	09003 WOUND CENTER	0	0	0	0	2, 461, 635	
	09004 HYPERBARI C OXYGEN THERAPY	0	0	0	0	397, 994	1
90.05	09005 VI MCARE CLINI C 09006 MEDICATION MGMT CLINI C	0	0	0	0	1, 819, 790 540, 133	1
	09100 EMERGENCY		0	l 0	n	19, 260, 857	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART					,,	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0		0	6, 867, 167	1
	09910 CORF 10100 HOME HEALTH AGENCY		0		0	0	99. 10 101. 00
	J. S. SS NOME TIENETT NOCHOT	<u> </u>	0	1 0	<u> </u>	0	1.01.00

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

				To 12/31/2022	Date/Time Prepa 5/30/2023 8:40	
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	aiii
	SERVI CE	PRGM	EDUCATI ON	RESI DENCY		
				PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	(0	0 10	9. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0	0 11	10.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0	0 11	11.00
113. 00 11300 INTEREST EXPENSE					11	13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1, 038, 282	2 658, 482	313, 746, 058 11	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(0	287, 766 19	
194. 00 07950 WELLNESS COMMUNITY	0	0	(0	473, 254 19	94.00
194. 01 07951 BUI LDI NG RENTALS	0	0	(0	228, 116 19	
194. 02 07952 HOSPI CE	0	0	(0	209, 721 19	
194. 03 07953 OUTREACH CLINICS	0	0	(0		94. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	(0	274, 941 19	94.04
194. 05 07955 NONALLOWABLE MARKETING	0	0	(0	627, 009 19	94. 05
194. 06 07956 CRH FOUNDATION	0	0	(0	272, 335 19	94.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	(0	0 19	94. 07
194. 08 07958 CRHP	0	0	(0	7, 473, 449 19	94. 08
194. 09 07959 NEUROPSYCH PART B	0	0	(0	44, 105 19	94. 09
200.00 Cross Foot Adjustments		0	(0		00.00
201.00 Negative Cost Centers	0	0	(0	0 20	01.00
202.00 TOTAL (sum lines 118 through 201)	0	0	1, 038, 282	658, 482	323, 636, 754 20	02.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0112

				To 12/31/2022 Date/Time Pre 5/30/2023 8:4	
	Cost Center Description	Intern & Residents Cost & Post	Total	J7 307 2023 U. 4	+O alli
		Stepdown Adjustments			
		25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00	00200 CAP REL COSTS-BEDG & TTAT				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY				13.00
	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
	01700 SOCIAL SERVICE				17.00
23. 00 23. 01	O2300 PARAMED ED PRGM O2301 XRAY EDUCATION				23. 00
	I I				23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	72, 114, 976		30.00
	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0 0	14, 329, 691 0		31. 00 32. 00
	03300 BURN INTENSIVE CARE UNIT	O	o		33.00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
40.00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0 0	5, 601, 706 0		41. 00 42. 00
43. 00	04300 NURSERY	O	2, 952, 722		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44.00
FO 00	ANCI LLARY SERVI CE COST CENTERS		27 422 470		F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	37, 422, 679 3, 102, 642		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	O	4, 309, 778		52.00
53. 00	05300 ANESTHESI OLOGY	0	274, 598		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 028, 165		54.00
54. 01 54. 02	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND	0	3, 528, 898 1, 777, 989		54. 01 54. 02
54. 03	05405 MAMMOGRAPHY	o o	1, 912, 967		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	5, 162, 936		55.00
57. 00	05700 CT SCAN	0	3, 208, 462		57.00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	1, 343, 962 5, 526, 231		58. 00 59. 00
60. 00	06000 LABORATORY	O	18, 886, 646		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	2, 507, 523		60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 018, 563		62.00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	7, 705, 951 8, 066, 199		65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	o	2, 991, 203		67.00
	06800 SPEECH PATHOLOGY	0	1, 287, 179		68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	2, 657, 319		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 919, 653 9, 570, 403		70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	O	10, 710, 277		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	41, 101, 478		73.00
	07400 RENAL DI ALYSI S	0	1, 009, 396		74.00
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0	0 789, 757		76. 00 76. 97
. 0. 77	OUTPATIENT SERVICE COST CENTERS		, , , , , , ,] ' ' ' '
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	4 252 502		89.00
90. 00 90. 01	09000 CLINIC 09001 DI ABETES CENTER	0	4, 353, 593 0		90.00
90. 02	09002 NEUROPSYCH	o o	224, 940		90. 02
	09003 WOUND CENTER	0	2, 461, 635		90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	397, 994		90.04
90. 05 90. 06	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	0	1, 819, 790 540, 133		90. 05 90. 06
91. 00	09100 EMERGENCY	0	19, 260, 857		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
05 00	OTHER REIMBURSABLE COST CENTERS	ما	6 067 167		OF CO
90.00	09500 AMBULANCE SERVICES	0	6, 867, 167		95.00

Health Financial Systems C	COLUMBUS REGIONA	AL HOSPITAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	N: 15-0112	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/30/2023 8:40 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00			
99. 10 09910 CORF	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	o	o			101.00
SPECIAL PURPOSE COST CENTERS	•				
109. 00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.00
113. 00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	313, 746, 058			118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	287, 766			190. 00
194. 00 07950 WELLNESS COMMUNITY	0	473, 254			194. 00
194. 01 07951 BUI LDI NG RENTALS	0	228, 116			194. 01
194. 02 07952 HOSPI CE	0	209, 721			194. 02
194. 03 07953 OUTREACH CLINICS	0	0			194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	274, 941			194. 04
194. 05 07955 NONALLOWABLE MARKETING	o	627, 009			194. 05
194. 06 07956 CRH FOUNDATION	o	272, 335			194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0			194. 07
194. 08 07958 CRHP	0	7, 473, 449			194. 08
194. 09 07959 NEUROPSYCH PART B	0	44, 105			194. 09
200.00 Cross Foot Adjustments	0	0			200. 00
201.00 Negative Cost Centers	ol	o			201.00
202.00 TOTAL (sum lines 118 through 201)	o	323, 636, 754			202. 00

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

				10	12/31/2022	5/30/2023 8: 4	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs	1.00	2.00	24	4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	155, 614	4, 908	160, 522	160, 522	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 464, 456	801, 816		9, 163, 208	30, 610	5.00
7.00	00700 OPERATION OF PLANT	102, 685	4, 978, 864	323, 662	5, 405, 211	5, 745	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 787	11, 075		12, 862	67	8. 00
9. 00	00900 HOUSEKEEPI NG	5, 927	72, 633		211, 503	3, 783	9. 00
10.00	01000 DI ETARY	9, 253	109, 970		128, 320	1, 831	10.00
11.00	01100 CAFETERI A	1/ 050	86, 435		98, 683	2, 466	11.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	16, 058 3, 476	140, 484 106, 237		186, 828 167, 099	10, 142 17	13. 00 14. 00
15. 00	01500 PHARMACY	5, 339	67, 123		307, 876	5, 750	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	12, 174	51, 084	1, 303	64, 561	2, 315	16.00
17. 00	01700 SOCI AL SERVI CE	0	0.7001	0	0 1, 00 1	0	17. 00
23.00	02300 PARAMED ED PRGM	0	0	O	o	0	23. 00
23. 01	02301 XRAY EDUCATION	10, 010	4, 894	8, 327	23, 231	1, 050	23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	0	5, 258	8, 514	13, 772	522	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30.00	03000 ADULTS & PEDIATRICS	156, 492	1, 086, 252		1, 433, 434	30, 267	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	17, 236	153, 251 0	80, 739	251, 226	3, 991 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00	04000 SUBPROVI DER – I PF	0	0	l o	ol	0	40.00
41.00	04100 SUBPROVI DER - I RF	44, 977	155, 013	10, 494	210, 484	3, 050	41.00
42.00	04200 SUBPROVI DER	0	0	0	o	0	42.00
43.00	04300 NURSERY	770	8, 153	14, 011	22, 934	2, 251	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 124 010	FF4 042	1 (02 4(2	2 2/2 424	2.072	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	1, 124, 019 2, 910	556, 942 44, 539		3, 363, 424 50, 799	2, 072 14	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 910	53, 545		73, 721	2, 802	52.00
53. 00	05300 ANESTHESI OLOGY	557	1, 664		4, 414	2, 002	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 582	118, 808		290, 817	1, 941	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	87, 275	47, 000	149, 546	283, 821	946	54. 01
54. 02	05404 ULTRA SOUND	3, 044	21, 032		41, 723	749	54.02
54. 03	05405 MAMMOGRAPHY	168, 693	1, 412		354, 242	1, 066	54.03
55. 00	05500 RADI OLOGY-THERAPEUTI C	7, 186	109, 201		913, 846	1, 171	55.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	39, 397 180, 664	25, 255 12, 586		90, 997 210, 313	1, 240 712	57. 00 58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	16, 003	129, 408		470, 451	3, 018	59.00
60.00	06000 LABORATORY	25, 031	151, 978		460, 830	7, 254	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 578	16, 949		51, 272	629	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	5, 985	2, 970	8, 955	147	62.00
65.00	06500 RESPI RATORY THERAPY	15, 562	110, 488		212, 885	3, 594	
66. 00	06600 PHYSI CAL THERAPY	382, 959	8, 614		403, 250	408	66.00
67.00	06700 OCCUPATI ONAL THERAPY	136, 781	3, 090		145, 894	110	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	57, 221 2, 449	19, 550	16, 683 265, 663	73, 904 287, 662	358 1, 366	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI	186, 495	19, 550 O	5, 931	192, 426	1, 103	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3, 731	172, 420	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	o	0	74.00
76. 00	03020 ACUPUNCTURE	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 012	22, 109	1, 833	24, 954	465	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS				ام		00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	0	100, 937	20, 747	121, 684	2, 890	90.00
90.00	09001 DI ABETES CENTER		100, 737	20, 747	121, 004 0	2, 840	90.00
90. 02	09002 NEUROPSYCH	1, 007	1, 147	171	2, 325	200	90.02
90. 03	09003 WOUND CENTER	81, 866	0	3, 917	85, 783	932	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	101, 146	0	151	101, 297	236	90. 04
90. 05	09005 VI MCARE CLI NI C	2, 751	59, 502		68, 311	991	90.05
90.06	09006 MEDICATION MGMT CLINIC	0	12, 823		20, 559	446	90.06
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 319	252, 482	95, 654	353, 455 0	11, 621	91. 00 92. 00
12.00	10.200 OBOLINATION DEDO (NON-DISTINCI FARI	1		ı	٥Į		1 /2.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Peri od: From 01/01/2022	Worksheet B

ALECCATION OF CAPITAL RELATED COSTS		Provider Co	F	rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre 5/30/2023 8:4	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2, 00	2A	4. 00	
OTHER REIMBURSABLE COST CENTERS				'		
95. 00 09500 AMBULANCE SERVICES	25, 592	112, 320	214, 513	352, 425	4, 555	95.00
99. 10 09910 CORF	0	0	0	0	0	, ,,
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	_	_	_	1 -1		
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	U		O O	0	111.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 511, 739	9, 993, 522	12, 472, 932	26, 978, 193	156, 893	113.00
NONREI MBURSABLE COST CENTERS	4, 311, 739	9, 993, 322	12, 472, 932	20, 970, 193	100, 093	1110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	37, 981	184	38, 165	74	190. 00
194. 00 07950 WELLNESS COMMUNITY	64, 560		3, 383			194.00
194. 01 07951 BUI LDI NG RENTALS	31, 509		O	31, 509		194. 01
194. 02 07952 HOSPI CE	0	13, 075	O	13, 075	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	o	0	194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	0	0	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	C	0		194. 05
194. 06 07956 CRH FOUNDATION	0	26, 891	0	26, 891		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0		194. 07
194. 08 07958 CRHP	438, 968	•				194. 08
194. 09 07959 NEUROPSYCH PART B	0	7, 565	1, 127	8, 692	0	194. 09
200.00 Cross Foot Adjustments		_	_	0	_	200.00
201.00 Negative Cost Centers	F 04/ 77/	0	10.00/ /55	0 170 010		201.00
202.00 TOTAL (sum lines 118 through 201)	5, 046, 776	10, 187, 382	13, 936, 655	29, 170, 813	160, 522	1202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/30/2023 8:40 am | |

			'	0 12/31/2022	5/30/2023 8: 4	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0 100 010					4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	9, 193, 818 535, 289	5, 946, 245				5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	28, 836	15, 492	57, 257			8.00
9. 00 00900 HOUSEKEEPI NG	128, 046	101, 596		444, 928		9.00
10. 00 01000 DI ETARY	73, 931	153, 822	0	5, 763	363, 667	10.00
11. 00 01100 CAFETERI A	65, 989	120, 902	0	7, 710	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	309, 017	196, 503	0	.,	0	13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	48, 819	148, 599 93, 889	0	-,	0	14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	261, 537 71, 825	71, 454	0	- '	0	15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	Ö	0	0	17.00
23. 00 02300 PARAMED ED PRGM	0	0	0	O	0	23. 00
23. 01 02301 XRAY EDUCATI ON	28, 265	6, 846	0	156	0	23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	16, 128	7, 355	0	234	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS	1 (47 750	1 510 401	10.0//	15/ 04/	200, 040	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	1, 647, 759 356, 144	1, 519, 401 214, 361	18, 866 2, 402		290, 949 32, 601	30.00
32. 00 03200 CORONARY CARE UNIT	0	214, 301	2,402	25, 200	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	Ö	o	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	114, 563	216, 826	2, 331	12, 617	29, 270	1
42. 00 04200 SUBPROVI DER	74 544	11 404	0	0	0	42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	74, 546 0	11, 404 0	777	156	0	
ANCILLARY SERVICE COST CENTERS	<u> </u>	0	<u> </u>	J		1 44.00
50. 00 05000 OPERATING ROOM	826, 719	779, 027	12, 386	69, 703	2, 075	50.00
51.00 05100 RECOVERY ROOM	70, 516	62, 299		9, 657	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	100, 730	74, 896	1	6, 698	0	52.00
53. 00 05300 ANESTHESI OLOGY	5, 160	2, 328	0	10, 202	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	90, 337 87, 030	166, 184 65, 742	4, 159 0	10, 202 5, 685	190 0	54. 00 54. 01
54. 02 05404 ULTRA SOUND	46, 156	29, 419	0	1, 869	0	
54. 03 05405 MAMMOGRAPHY	52, 089	1, 976	227	1, 869	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	127, 124	152, 746	715	7, 399	1, 407	55.00
57.00 05700 CT SCAN	81, 504	35, 326	0	, , , , , ,	0	57.00
58. 00 05800 MRI	34, 209	17, 604	0	545	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	119, 900 501, 638	181, 011 212, 581	3, 380	11, 916 7, 165	736 0	59. 00 60. 00
60. 00 06000 LABORATORY	67, 858	23, 707		389	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	27, 695	8, 372	0	234	0	62.00
65. 00 06500 RESPIRATORY THERAPY	185, 155	154, 546	0	7, 944	0	65.00
66. 00 06600 PHYSI CAL THERAPY	224, 647	12, 049		156	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	83, 537	4, 323	619	0	0	
68. 00 06800 SPEECH PATHOLOGY	36, 121	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	62, 883 49, 585	27, 345	57	156	0	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	268, 802	0	0	11, 215	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	302, 589	0	Ö	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	863, 526	0	0	0	0	73.00
74. 00 07400 RENAL DIALYSIS	28, 244	0	0	0	0	74.00
76. 00 03020 ACUPUNCTURE	0	0	0	- 1	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	17, 561	30, 925	0	234	0	76. 97
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C		0	0	ام	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLINIC	94, 765	141, 186	2, 393	7, 243	4, 712	
90. 01 09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02 09002 NEUROPSYCH	5, 857	1, 604	0	156	0	90. 02
90. 03 09003 WOUND CENTER	62, 702	0	84	0	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY 90. 05 09005 VI MCARE CLI NI C	10, 564	0 00 000	4 310	0	0	90.04
90. 05 09005 VI MCARE CLI NI C 90. 06 09006 MEDI CATI ON MGMT CLI NI C	30, 794 12, 317	83, 229 17, 937		22, 897 1, 168	0	90. 05 90. 06
91. 00 09100 EMERGENCY	450, 095	353, 161	3, 749	l	1, 727	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	155, 575	333, 101]	55,551	1, 121	92.00
OTHER REIMBURSABLE COST CENTERS]
95. 00 09500 AMBULANCE SERVICES	151, 833	157, 108		-	0	
99. 10 09910 CORF	0	0	0	l I	0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20

	_				5/30/2023 8: 4	iO am
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
SPECIAL PURPOSE COST CENTERS	_					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SITION	0	0	0	0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 940, 936	5, 675, 081	57, 257	441, 968	363, 667	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	3, 311	53, 126	0	0	0	190.00
194.00 07950 WELLNESS COMMUNITY	13, 201	0	0	0	0	194.00
194. 01 07951 BUI LDI NG RENTALS	6, 480	0	0	0	0	194. 01
194. 02 07952 HOSPI CE	4, 248	18, 289	0	156	0	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194.03
194.04 07954 SPEECH - HEARING AIDS	7, 810	0	0	0	0	194.04
194. 05 07955 NONALLOWABLE MARKETING	17, 812	0	0	0	0	194. 05
194.06 07956 CRH FOUNDATION	3, 405	37, 614	0	2, 804	0	194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0	194. 07
194. 08 07958 CRHP	196, 315	151, 553	0	0	0	194. 08
194.09 07959 NEUROPSYCH PART B	300	10, 582	0	0	0	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	9, 193, 818	5, 946, 245	57, 257	444, 928	363, 667	202. 00

					5/30/2023 8: 4	0 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	
	11. 00	N 13. 00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 000800 LAUNDRY & LINEN SERVICE 000800 CANNON CONTROL CANNON CONT						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	295, 750 21, 427 3, 621 9, 355 10, 562	725, 241 13, 172	387, 168 0 0	715, 720 0	221, 262	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
17. 00 01700 SOCIAL SERVICE 23. 00 02300 PARAMED ED PRGM 23. 01 02301 XRAY EDUCATION	0 0 2, 112		0	0	0	17. 00 23. 00 23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	905	3, 488	0	0	0	23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	63, 679	232, 602	7, 011	1, 086	23, 447	30. 00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN INTENSI VE CARE UNI T 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	6, 941 0 0	25, 292 0 0	185 0 0	430 0 0	4, 031 0 0	31. 00 32. 00 33. 00 34. 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	6, 036	0 22, 647	0	0 108	0 1, 813	40. 00 41. 00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 3, 923	0 14, 150	0	0	0 827	42. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0		0	0	0	44. 00
50. 00 05000 OPERATING ROOM	30, 782	113, 146	356, 377	5, 309	27, 266	50. 00
51. 00 05100 RECOVERY ROOM	3, 621	12, 886	0	8	2, 221	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	5, 734 0	21, 448	3, 255	0 2, 159	1, 261 4, 244	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 923		2, 538	1, 235	1, 749	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	1, 811	O	0	9, 464	3, 373	54. 01
54. 02 05404 ULTRA SOUND	1, 509	0	0	54	1, 911	54. 02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 018 2, 414	0	0	33 52	1, 520 5, 772	54. 03 55. 00
57. 00 05700 CT SCAN	2, 716	o	Ö	3, 847	10, 400	57. 00
58. 00 05800 MRI	1, 509		0	2, 138	2, 585	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	5, 734 22, 634		2, 717	1, 341 3	8, 133 20, 358	59. 00 60. 00
60. 01 06001 LABORATORY-PATHOLOGI CAL	1, 509		Ö	3	1, 949	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	302		0	0	907	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	7, 243 1, 207		30 2, 699	54 69	8, 724 4, 821	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	302		0	0	1, 742	67. 00
68. 00 06800 SPEECH PATHOLOGY	905		0	0	551	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 716 2, 414		0	8, 085 0	3, 614 2, 214	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		Ö	Ö	8, 363	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	(77.01/	4, 536	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 74. 00 07400 RENAL DLALYSES	0	0	0	677, 816 324	31, 436 816	73. 00 74. 00
76. 00 03020 ACUPUNCTURE	Ö	Ö	Ö	0	0	76. 00
76. 97 O7697 CARDI AC REHABILITATION	905	3, 473	0	1	495	76. 97
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	O	O	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	О	0	0	0	89. 00
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES CENTER	7, 243	18, 469	1, 099	308	2, 179	90.00
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	1, 207		0	0	0 46	90. 01 90. 02
90. 03 09003 WOUND CENTER	2, 112	7, 969	10, 403	320	2, 511	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	302		0	0	174	90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	3, 018 604		0	27 0	412 191	90. 05 90. 06
91. 00 09100 EMERGENCY	25, 350		854	597	21, 448	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	14, 184	51, 839	0	812	3, 222	95. 00
99. 10 09910 CORF	14, 184		0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	o	0	o	0	101. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20/2023 | Prepared: | From 20

					5/30/2023 8:40 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI O	SERVICES &		RECORDS &
		N	SUPPLY		LI BRARY
	11. 00	13. 00	14.00	15. 00	16. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	285, 489	725, 241	387, 168	715, 683	221, 262 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	302	0	0	0	0 190. 00
194.00 07950 WELLNESS COMMUNITY	905	0	0	0	0 194. 00
194. 01 07951 BUILDING RENTALS	0	0	0	0	0 194. 01
194. 02 07952 HOSPI CE	0	0	0	37	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194.04 07954 SPEECH - HEARING AIDS	0	0	0	o	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 194.05
194. 06 07956 CRH FOUNDATION	302	0	0	0	0 194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 194. 07
194. 08 07958 CRHP	8, 752	0	0	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	0	0	0	o	0 194.09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0	o	o	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	295, 750	725, 241	387, 168	715, 720	221, 262 202. 00
202. 00 TOTAL (Sam Times The through 201)	275, 750	1 /25, 241	307, 100	713, 720	221, 202 202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | P Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

				To	12/31/2022	Date/Time Pre 5/30/2023 8:4	
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY PROG	Subtotal	
		17. 00	23. 00	23. 01	23. 02	24. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00 8. 00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0					17. 00
23. 00	02300 PARAMED ED PRGM	0	0				23.00
23. 01	02301 XRAY EDUCATION	0		61, 660			23. 01
23. 02	O2302 PHARMACY RESIDENCY PROG	0			42, 404		23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O				5, 425, 347	30.00
31. 00	03100 NTENSI VE CARE UNI T	0				920, 890	1
32.00	1	0				0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0				0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0				0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0				0 619, 745	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0				019, 743	1
43. 00	04300 NURSERY	Ö				130, 968	
44.00	04400 SKILLED NURSING FACILITY	0				0	44.00
	ANCILLARY SERVICE COST CENTERS			1		5 500 007	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0				5, 588, 286	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				214, 548 291, 403	1
53. 00	05300 ANESTHESI OLOGY	Ö				18, 305	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0				573, 275	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0				457, 872	1
54. 02	05404 ULTRA SOUND	0				123, 390	1
54. 03 55. 00	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	0				416, 040 1, 212, 646	1
57. 00	05700 CT SCAN	0				227, 198	1
58. 00	05800 MRI	0				269, 615	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				829, 232	1
60.00	06000 LABORATORY	0				1, 232, 463	1
60. 01 62. 00	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				147, 316 46, 612	1
65. 00	06500 RESPIRATORY THERAPY	0				606, 800	1
	06600 PHYSI CAL THERAPY	Ö				650, 719	
67.00	06700 OCCUPATI ONAL THERAPY	0				236, 527	
	06800 SPEECH PATHOLOGY	0				111, 839	1
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0				404, 230 259, 014	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				277, 165	
	07200 I MPL. DEV. CHARGED TO PATIENTS	o				307, 125	
	07300 DRUGS CHARGED TO PATIENTS	0				1, 572, 778	1
		0				29, 384	
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0				0 79, 013	
70. 77	OUTPATIENT SERVICE COST CENTERS	0				77,013	70. 77
88. 00	08800 RURAL HEALTH CLINIC	0				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
	09000 CLINIC	0				404, 171	1
90. 01	09001 DI ABETES CENTER 09002 NEUROPSYCH	0				11 305	
90. 02	09002 NEUROPSYCH 09003 WOUND CENTER					11, 395 172, 816	
90. 04		o				113, 876	1
90. 05	09005 VI MCARE CLI NI C	0				221, 353	90. 05
	09006 MEDICATION MGMT CLINIC	0				55, 009	1
91.00		0				1, 338, 853	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	O				735, 978	95.00
99. 10	09910 CORF	0				0	99. 10
101.00	10100 HOME HEALTH AGENCY	0				0	101.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0112	Peri od: From 01/01/2022	Worksheet B Part II

				rom 01/01/2022		
				Γο 12/31/2022	Date/Time Pre 5/30/2023 8:4	
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	T alli
cost center bescription	SERVI CE	PRGM	EDUCATI ON	RESI DENCY	Subtotal	
	JERVI CE	1 KOW	LDOCATION	PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
SPECIAL PURPOSE COST CENTERS	17.00	20.00	20.01	20.02	21.00	
109. 00 10900 PANCREAS ACQUISITION	0				0	109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0					110.00
111. 00 11100 SLET ACQUISITION	0				l .	111.00
113. 00 11300 NTEREST EXPENSE	Ŭ					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	(0	26, 333, 196	
NONREI MBURSABLE COST CENTERS	<u> </u>	J		<u>, </u>	20/000/170	1.10.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0				94, 978	190. 00
194. 00 07950 WELLNESS COMMUNITY	0					194.00
194. 01 07951 BUI LDI NG RENTALS	0					194. 01
194. 02 07952 HOSPI CE	0					194. 02
194. 03 07953 OUTREACH CLINICS	0					194. 03
194. 04 07954 SPEECH - HEARING AIDS	0					194.04
194. 05 07955 NONALLOWABLE MARKETING	0					194. 05
194. 06 07956 CRH FOUNDATION	0					194.06
194. 07 07957 HEALTHY COMMUNITIES	0					194. 07
194. 08 07958 CRHP	0				2, 366, 088	1
194. 09 07959 NEUROPSYCH PART B	0					194. 09
200.00 Cross Foot Adjustments	-	0	61, 660	42, 404		1
201.00 Negative Cost Centers	0	0	(0		201.00
202.00 TOTAL (sum lines 118 through 201)	o	0	61, 660	42, 404		1
	-1	-1		,,	, , , , , , , ,	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part Provider CCN: 15-0112

			10 12/31/2022	2 Date/lime Prepared: 5/30/2023 8:40 am
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown Adjustments			
	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				
1. 00 00100 CAP REL COSTS-BLDG & FLXT				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL				4. 00 5. 00
7.00 OO700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE				8.00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13. 00 01300 NURSING ADMINISTRATION				13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY				14.00
15. 00 01500 PHARMACY				15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE				16. 00 17. 00
23. 00 02300 PARAMED ED PRGM				23.00
23. 01 02301 XRAY EDUCATION				23. 01
23. 02 02302 PHARMACY RESIDENCY PROG				23. 02
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	0	5, 425, 347		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	920, 890		31.00
32. 00 03200 CORONARY CARE UNIT	0	0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF		0		40.00
41. 00 04100 SUBPROVI DER - RF		619, 745		41.00
42. 00 04200 SUBPROVI DER	o	0		42.00
43. 00 04300 NURSERY	0	130, 968		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
ANCILLARY SERVICE COST CENTERS	1	5 500 004		50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	5, 588, 286		50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	214, 548 291, 403		51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY		18, 305		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	l o	573, 275		54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	o	457, 872		54. 01
54.02 05404 ULTRA SOUND	0	123, 390		54. 02
54. 03 05405 MAMMOGRAPHY	0	416, 040		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 212, 646		55.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	227, 198		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	269, 615 829, 232		59.00
60. 00 06000 LABORATORY		1, 232, 463		60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	o	147, 316		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	46, 612		62.00
65. 00 06500 RESPIRATORY THERAPY	0	606, 800		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	650, 719		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	236, 527		67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		111, 839 404, 230		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		259, 014		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	277, 165		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	307, 125		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 572, 778		73. 00
74. 00 07400 RENAL DI ALYSI S	0	29, 384		74.00
76. 00 03020 ACUPUNCTURE	0	0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	79, 013		76. 97
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	O	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		o o		89.00
90. 00 09000 CLI NI C	o	404, 171		90.00
90. 01 09001 DI ABETES CENTER	0	0		90. 01
90. 02 09002 NEUROPSYCH	0	11, 395		90. 02
90. 03 09003 WOUND CENTER	0	172, 816		90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	113, 876		90.04
90. 05 09005 VI MCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	0	221, 353 55, 009		90.05
91. 00 09100 EMERGENCY	0	1, 338, 853		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 000, 000		92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	735, 978		95.00

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/30/2023 8:40 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total		
99. 10 09910 CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	o	o		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 through 117)	o	26, 333, 196		118.00
NONREI MBURSABLE COST CENTERS		•		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	94, 978		190. 00
194. 00 07950 WELLNESS COMMUNITY	0	82, 391		194. 00
194. 01 07951 BUILDING RENTALS	0	37, 989		194. 01
194. 02 07952 HOSPI CE	0	35, 805		194. 02
194. 03 07953 OUTREACH CLINICS	O	o		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	7, 810		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	17, 812		194. 05
194. 06 07956 CRH FOUNDATION	0	71, 106		194. 06
194. 07 07957 HEALTHY COMMUNITIES	o	0		194. 07
194. 08 07958 CRHP	o	2, 366, 088		194. 08
194. 09 07959 NEUROPSYCH PART B	o	19, 574		194. 09
200.00 Cross Foot Adjustments	o	104, 064		200. 00
201.00 Negative Cost Centers	o	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	29, 170, 813		202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2022 Provi der CCN: 15-0112

					' T	o 12/31/2022	Date/Time Pre 5/30/2023 8:4	
			CAPITAL RELA	ATED COSTS			3/30/2023 8.4	U alli
		Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DEPR)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			1. 00	2. 00	(GROSS SAL) 4.00	5A	5. 00	
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	720 501					1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT	728, 501	13, 667, 402				1. 00 2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11, 128	4, 813	94, 974, 938			4.00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	57, 338	6, 763, 687	18, 103, 868		266, 115, 988	5. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	356, 039 792	317, 409 0	3, 399, 539 39, 522		15, 494, 059 834, 678	8.00
9. 00	00900	HOUSEKEEPI NG	5, 194	130, 375	2, 238, 674	0	3, 706, 318	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	7, 864 6, 181	8, 921 12, 011	1, 083, 644 1, 458, 926	0	2, 139, 962 1, 910, 077	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	10, 046	29, 701	6, 001, 222	0	8, 944, 566	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7, 597	56, 277	10, 093		1, 413, 077	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	4, 800 3, 653	230, 866 1, 278	3, 402, 477 1, 369, 835	0	7, 570, 247 2, 079, 006	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	0	0		2,077,000	17. 00
23. 00	1	PARAMED ED PRGM	0	0	0	-	0	23.00
23. 01 23. 02	1	XRAY EDUCATION PHARMACY RESIDENCY PROG	350 376	8, 166 8, 350	621, 490 308, 607	0	818, 131 466, 840	23. 01 23. 02
20.02	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0.0			_		20.02
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	77, 678 10, 959	187, 006 79, 179			47, 693, 477	30. 00 31. 00
31. 00 32. 00		CORONARY CARE UNIT	10, 939	79, 179	2, 361, 382 0		10, 308, 674 0	32.00
33. 00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	1	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00		SUBPROVI DER - I RF	11, 085	10, 291	1, 804, 815		3, 316, 045	41.00
42.00		SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	583	13, 740 0	1, 331, 932 0		2, 157, 740 0	43. 00 44. 00
11.00	ANCI L	LARY SERVICE COST CENTERS	<u> </u>		<u> </u>			11.00
50.00		OPERATING ROOM	39, 827	1, 649, 959	1, 226, 276		23, 929, 589	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	3, 185 3, 829	3, 285 19, 786	8, 539 1, 658, 093		2, 041, 091 2, 915, 651	51. 00 52. 00
53.00		ANESTHESI OLOGY	119	2, 151	0	0	149, 371	53.00
54.00		RADI OLOGY-DI AGNOSTI C	8, 496	164, 192	1, 148, 804		2, 614, 813	
54. 01 54. 02		NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	3, 361 1, 504	146, 657 17, 306	559, 472 442, 961	0	2, 519, 096 1, 335, 997	54. 01 54. 02
54.03	05405	MAMMOGRAPHY	101	180, 580	630, 687	0	1, 507, 722	54.03
55. 00 57. 00		RADI OLOGY-THERAPEUTI C CT SCAN	7, 809 1, 806	782, 053 25, 836	692, 704 733, 593	0	3, 679, 636 2, 359, 145	55. 00 57. 00
58. 00	05800	l e e e e e e e e e e e e e e e e e e e	900	25, 636 16, 733	733, 593 421, 430		990, 183	58.00
59. 00		CARDI AC CATHETERI ZATI ON	9, 254	318, 760	1, 785, 828		3, 470, 539	
60. 00 60. 01		LABORATORY LABORATORY-PATHOLOGI CAL	10, 868 1, 212	278, 338 32, 112	4, 292, 069 371, 922		14, 520, 028 1, 964, 159	
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	428	2, 913	86, 987		801, 649	
65.00		RESPIRATORY THERAPY	7, 901	85, 157	2, 126, 820		5, 359, 352	65.00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	616	11, 451 5, 907	241, 323 65, 053		6, 502, 457 2, 417, 990	66. 00 67. 00
68. 00	06800	SPEECH PATHOLOGY	0	16, 361	211, 759	0	1, 045, 530	
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 398	260, 531 5, 816	808, 444 652, 751	0	1, 820, 157 1, 435, 251	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	o	0,010	032, 731	0	7, 780, 546	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8, 758, 504	
73. 00 74. 00	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0	0	0	24, 994, 971 817, 533	73. 00 74. 00
76. 00	1	ACUPUNCTURE	o o	0	0		017,333	76.00
76. 97		CARDI AC REHABI LI TATI ON	1, 581	1, 798	275, 002	0	508, 296	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 90. 01		CLINIC DIABETES CENTER	7, 218	20, 346 0	1, 709, 971 0	0	2, 743, 006 0	90. 00 90. 01
90. 01		NEUROPSYCH	82	168	118, 464	0	169, 538	90.01
90. 03	1	WOUND CENTER	0	3, 841	551, 765		1, 814, 929	90.03
90. 04 90. 05	1	HYPERBARIC OXYGEN THERAPY VIMCARE CLINIC	4, 255	148 5, 941	139, 604 586, 514	0	305, 766 891, 333	90. 04 90. 05
90.06	09006	MEDICATION MGMT CLINIC	917	7, 587	263, 768		356, 517	90.06
91.00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	18, 055	93, 806	6, 876, 436	0	13, 028, 105	91. 00 92. 00
7Z. UU		TODGET VALUE OF THE CHARLES AND THE COLUMN T	ı					72.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2022	Worksheet B-1	
				To 12/31/2022	Date/Time Pre 5/30/2023 8:4	
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
	(SQ FEET)	(DEPR)	BENEFI TS	n	E & GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SAL)			

						5/30/2023 8:4	<u>o am</u>
		CAPITAL REL	ATED COSTS				
Co	ost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
55	set conten becompanien	(SQ FEET)	(DEPR)	BENEFITS	n	E & GENERAL	
		,	` ′	DEPARTMENT		(ACCUM. COST)	
				(GROSS SAL)			
		1. 00	2.00	4. 00	5A	5. 00	
	EIMBURSABLE COST CENTERS						
	MBULANCE SERVICES	8, 032	210, 369	2, 695, 214	0	4, 394, 845	
99. 10 09910 C0		0	0	0	0	0	, , ,
	DME HEALTH AGENCY	0	0	0	0	0	101.00
	PURPOSE COST CENTERS						
	ANCREAS ACQUISITION	0	0	0	0		109. 00
	ITESTINAL ACQUISITION	0	0	0	0		110.00
	SLET ACQUISITION	0	0	0	0	0	111. 00
	ITEREST EXPENSE						113.00
	JBTOTALS (SUM OF LINES 1 through 117)	714, 638	12, 231, 958	92, 827, 519	-57, 520, 766	258, 796, 192	118. 00
	BURSABLE COST CENTERS				_		
	FT FLOWER COFFEE SHOP & CANTEEN	2, 716	180	43, 646		95, 851	
	ELLNESS COMMUNITY	0	3, 318	202, 497	0	382, 119	
194. 01 07951 BU		0	0	0	0	187, 572	
194. 02 07952 H0		935	0	0	0	122, 967	
194. 03 07953 0U		0	0	0	0		194. 03
	PEECH - HEARING AIDS	0	0	0	0	226, 075	
194. 05 07955 NO	ONALLOWABLE MARKETING	1, 923	0	53, 432	0	515, 569	194. 05
	EALTHY COMMUNITIES	1, 923	0	53, 432	0		194.06
194. 07 07957 HE		7, 748	1, 430, 841	1, 847, 844	0	1	
	EUROPSYCH PART B	541	1, 430, 841	1,047,044	0		194.00
	ross Foot Adjustments	341	1, 103	0	U	0,092	200.00
	egative Cost Centers						201.00
	ost to be allocated (per Wkst. B,	10, 187, 382	13, 936, 655	30, 551, 734		57, 520, 766	
	art I)	10, 107, 302	13, 730, 033	30, 331, 734		37, 320, 700	202.00
	nit cost multiplier (Wkst. B, Part I)	13. 984033	1. 019700	0. 321682		0. 216149	203 00
	ost to be allocated (per Wkst. B,	101701000		160, 522		9, 193, 818	
	art II)			100,022		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20 11 00
	nit cost multiplier (Wkst. B, Part			0. 001690		0. 034548	205.00
11							
206. 00 NA	AHE adjustment amount to be allocated						206. 00
	per Wkst. B-2)						
207. 00 NA	AHE unit cost multiplier (Wkst. D,						207. 00
Pa	arts III and IV)						

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/30/2023 8: 40 am

						5/30/2023 8: 4	0 am
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (TIME SPT)	DI ETARY (MEALS)	CAFETERI A (FTES)	
		(SQ FEET) 7.00	(LDRY LBS) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 17. 00 23. 00 23. 01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	303, 996 792 5, 194 7, 864 6, 181 10, 046 7, 597 4, 800 3, 653 0 0	2, 049, 410 0 0 0 0 0 0 0 0 0	5, 713 74 99 17 75 42 7 0 0	185, 775 0 0 0 0 0 0 0	980 71 12 31 35 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 23. 00 23. 01
23. 02	02302 PHARMACY RESIDENCY PROG	376	0	3	0	3	23. 02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	77 (70	/75 00/	0.014	440 (00	044	00.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY	77, 678 10, 959 0 0 0 11, 085 0 583	85, 960 0 0 0 0 83, 432 0 27, 814	2, 014 299 0 0 0 162 0 2	148, 628 16, 654 0 0 0 14, 952 0 0	211 23 0 0 0 0 20 0 13	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
F0 00		20.007	440.044	005	1 0/0	100	
71. 00 72. 00 73. 00 74. 00 76. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABILI TATI ON OUTPATI ENT SERVI CE COST CENTERS	39, 827 3, 185 3, 829 119 8, 496 3, 361 1, 504 101 7, 806 900 9, 254 10, 868 1, 212 428 7, 901 616 221 0 1, 398 0 0 0 0 0 1, 581	30, 714 0 148, 872 0 8, 111 25, 597 0 0 120, 966 0 0 0 50, 577 22, 158	895 124 86 0 131 73 24 24 95 15 7 153 92 5 3 102 2 0 0 0 0 0	1, 060 0 0 0 97 0 0 719 0 376 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102 12 19 0 13 6 5 10 8 8 9 5 19 75 5 1 1 24 4 1 3 9 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 59. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 97
90. 00 90. 01 90. 02 90. 03 90. 04 90. 05	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 DIABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARIC OXYGEN THERAPY 09005 VI MCARE CLINIC 09006 MEDICATION MGMT CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 7, 218 0 82 0 0 4, 255 917 18, 055	0 85, 645 0 0 3, 018 126 11, 085	0 93 0 2 0 0 294 15 495	0 0 2, 407 0 0 0 0 0 0 882	0 0 24 0 4 7 1 10 2 84	88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	8, 032	0	0	0	47	95. 00
99. 10	09910 CORF 10100 HOME HEALTH AGENCY	0 0	0	0	0	0	1
			'	,	<u> </u>		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (TIME SPT) (MEALS) (FTES) (SQ FEET) (LDRY LBS) 9.00 10.00 11.00 7 00 8 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 ol 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 Ω 0 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 290, 133 2, 049, 410 5, 675 185, 775 946 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 1 190. 00 2,716 0 0 194. 00 07950 WELLNESS COMMUNITY 0 3 194.00 194. 01 07951 BUI LDI NG RENTALS 0 0 0 0 0 194. 01 0 194. 02 07952 HOSPI CE 935 2 0 194. 02 0 0 194.03 194. 03 07953 OUTREACH CLINICS 0 0 194. 04 07954 SPEECH - HEARING AIDS 0 0 0 0 0 194.04 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 0 194.05 0 194.06 07956 CRH FOUNDATION 1 194.06 1, 923 0 36 194. 07 07957 HEALTHY COMMUNITIES 0 0 0 0 194. 07 194. 08 07958 CRHP 7,748 0 29 194. 08 0 194. 09 07959 NEUROPSYCH PART B 0 194.09 541 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 4, 829, 383 2, 789, 753 202. 00 Cost to be allocated (per Wkst. B, 18, 843, 084 1,064,185 3, 152, 515 Part I) 61. 984645 0. 519264 16. 969533 2, 846. 686735 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 845. 332225 204.00 Cost to be allocated (per Wkst. B, 5, 946, 245 57, 257 444, 928 363, 667 295, 750 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 19.560274 0.027938 77.879923 1.957567 301. 785714 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

	ALLOCATION - STATISTICAL BASIS	COLUMBOS REGIO	Provi der CO	CN: 15-0112 F	Peri od:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/30/2023 8: 4 SOCI AL	O am
	Cost Center Description	ADMI NI STRATI O	SERVICES &	(DRG COST)	RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY	(TIME SPT)	
		(NURS HRS)	(STER SUP)		(GROSS		
		13. 00	14. 00	15. 00	CHARGES) 16.00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00							10.00
11. 00	01100 CAFETERI A						11.00
13.00		1, 363, 773	(4.022				13.00
14. 00 15. 00		24, 770 64, 014	64, 833 0	25, 974, 849)		14. 00 15. 00
16. 00		0	0	23, 77 1, 3 17 C	903, 305, 588		16.00
17. 00	1	0	0	C		0	
23. 00	1	0	0		_	0	
23. 01 23. 02		6, 559	0			0	
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30.00	1	437, 392	1, 174			0	
31. 00 32. 00		47, 560 0	31 ₀	15, 602	16, 454, 922	0	
33. 00	1	O	0	Č	o o	Ö	1
34.00		0	0	C	0	0	01.00
40. 00 41. 00		0	0	2 023	0 7, 400, 339	0	
42.00		42, 587 0	0	3, 933 C		0	1
43.00	04300 NURSERY	26, 609	0	5	3, 376, 431	0	43.00
44. 00		0	0	C	0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	212, 764	59, 677	192, 676	111, 289, 949	0	50.00
51.00		24, 231	0			0	
52.00		40, 332	545			0	02.00
53. 00 54. 00		0	0 425	78, 372 44, 818		0	
54. 00		0	0	343, 467		0	1
54. 02		0	0	1, 952		0	
54. 03 55. 00		0	0	1, 200 1, 870		0	
57. 00		0	0	139, 611		0	I
58. 00	05800 MRI	o	0	77, 598		0	58.00
		39, 291	455			0	
60. 00 60. 01		0	0	110 98		0	
62. 00	1	- 1	0	ć		0	1
65. 00		50, 067	5	1, 967		0	
66. 00 67. 00	1 1	0	452	2, 494	19, 675, 668 7, 109, 159	0	66. 00 67. 00
68. 00	1 1	0	0			0	68.00
69. 00		19, 563	0	293, 428	14, 751, 188	0	1
70.00	1	0	0	C	9, 036, 609	0	70.00
71. 00 72. 00	1 1	ENT O	0	1	34, 133, 137 18, 512, 970	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	O	0	24, 599, 219		0	l
74. 00		0	0	11, 764		0	
76. 00 76. 97	1	6, 530	0	C 36		0	
70. 77	OUTPATIENT SERVICE COST CENTERS	0, 330	<u> </u>		2,021,133	<u> </u>	70.77
88. 00		0	0	C	0	0	
89. 00 90. 00	1	R 0 34, 730	0	11 17/	0 004 157	0	
90. 00	1	34, 730	184 0	11, 174 C	8, 894, 157 0	0	1
90. 02	09002 NEUROPSYCH	0	0	C	188, 179	0	90. 02
90. 03	1	14, 985	1, 742	11, 603		0	
90. 04 90. 05		2, 442 21, 369	O	980	708, 639 1, 679, 714	0	90. 04 90. 05
90.06	1	3, 361	0	780	778, 235	0	90.06
91.00	09100 EMERGENCY	147, 136	143	21, 680		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PARTIES OF THE REIMBURSABLE COST CENTERS	AKI					92.00
95. 00	09500 AMBULANCE SERVICES	97, 481	0	29, 479	13, 151, 082	0	95.00
	•		- 1				

Usalah Fisassial Costana	COLUMBUS DECLO	NAL HOCDITAL		la lia		2552 10
Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	COLUMBUS REGIO	Provi der CO		Period: From 01/01/2022 To 12/31/2022	u of Form CMS- Worksheet B-1 Date/Time Pre 5/30/2023 8:4	epared:
Cost Center Description	NURSI NG ADMI NI STRATI O N (NURS HRS)	CENTRAL SERVICES & SUPPLY (STER SUP)	PHARMACY (DRG COST)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPT)	
	13. 00	14. 00	15. 00	16. 00	17. 00	
99. 10 09910 CORF	0	0		0	0	1 , , ,
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		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	0	111. 00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 363, 773	64, 833	25, 973, 50	1 903, 305, 588	0	118. 00
NONREI MBURSABLE COST CENTERS	1					
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190.00
194. 00 07950 WELLNESS COMMUNITY	0	0		0		194. 00
194. 01 07951 BUILDING RENTALS	0	0		0		194. 01
194. 02 07952 HOSPI CE	0	0	1, 34			194. 02
194. 03 07953 OUTREACH CLINICS	0	0		0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0		0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0		194. 05
194. 06 07956 CRH FOUNDATION	0	0		0		194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0		0		194. 07
194. 08 07958 CRHP	0	0		0		194. 08
194. 09 07959 NEUROPSYCH PART B	U	U		U U	U	194. 09 200. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	11 717 100	2 400 705	10 177 01	2 040 242	0	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	11, 717, 109					
203.00 Unit cost multiplier (Wkst. B, Part I)		38. 557293			0. 000000	
204.00 Cost to be allocated (per Wkst. B,	725, 241	387, 168	715, 72	0 221, 262	0	204. 00

0. 531790

5. 971774

0. 027554

0.000245

0. 000000 205. 00

206. 00

207.00

Part II)

11)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

205.00

206.00 207.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112

				'	o 12/31/2022 Date/lime Pr 5/30/2023 8:	
	Cost Center Description	PARAMED ED	XRAY	PHARMACY		
		PRGM (PERCENT)	EDUCATION (PERCENT)	RESI DENCY PROG		
		(= =)	(* =***=***)	(PERCENT)		
	GENERAL SERVICE COST CENTERS	23. 00	23. 01	23. 02		
1. 00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY					14.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE					17. 00
23. 00	02300 PARAMED ED PRGM	0				23. 00
23. 01	02301 XRAY EDUCATION		100			23. 01
23. 02	02302 PHARMACY RESIDENCY PROG INPATIENT ROUTINE SERVICE COST CENTERS			100	J	23. 02
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	(30.00
	03100 INTENSIVE CARE UNIT	0	0			31.00
	03200 CORONARY CARE UNIT	0	0	(32.00
	03300 BURN INTENSIVE CARE UNIT	0	0	(33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0			34. 00 40. 00
	04100 SUBPROVI DER – I RF		0			41.00
42. 00	04200 SUBPROVI DER	0	0	Ċ		42.00
43.00	04300 NURSERY	0	0	(43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0)	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0			50.00
	05100 RECOVERY ROOM		0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	Ċ		52.00
53.00	05300 ANESTHESI OLOGY	0	0	(53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	100	(54.00
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	0	0	(54. 01 54. 02
54. 02	05405 MAMMOGRAPHY		0			54.02
	05500 RADI OLOGY-THERAPEUTI C	0	0	C		55.00
57. 00	05700 CT SCAN	0	0	(D	57.00
58. 00	05800 MRI	0	0	(58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		0			59. 00 60. 00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	Ö			60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C		62.00
	06500 RESPI RATORY THERAPY	0	0	(65.00
	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0	(66. 00 67. 00
	06800 SPEECH PATHOLOGY		0			68.00
	06900 ELECTROCARDI OLOGY	0	0	Ċ		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	100		72. 00 73. 00
	07400 RENAL DIALYSIS		0	100		74.00
	03020 ACUPUNCTURE	0	0	Ċ		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	()	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00 89. 00
	09000 CLINIC		0			90.00
90. 01	09001 DI ABETES CENTER		0			90. 01
	09002 NEUROPSYCH	0	0	(D	90. 02
	09003 WOUND CENTER	0	0	(90.03
	O9004 HYPERBARI C OXYGEN THERAPY O9005 VI MCARE CLINI C		0			90. 04 90. 05
	09006 MEDICATION MGMT CLINIC		0			90.06
91.00	09100 EMERGENCY		O			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
0E 00	OTHER REIMBURSABLE COST CENTERS					05 00
	09500 AMBULANCE SERVICES 09910 CORF	0	0			95. 00 99. 10
	11-2000	1 9	<u> </u>	1	-1	1 // 15

| Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				10	5/30/2023 8	
	Cost Center Description	PARAMED ED	XRAY	PHARMACY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		PRGM	EDUCATI ON	RESI DENCY		
		(PERCENT)	(PERCENT)	PROG		
				(PERCENT)		
101 00 10100	LIGHT HEALTH ACENOV	23. 00	23. 01	23. 02		101 00
	HOME HEALTH AGENCY	0	0	0		101.00
	AL PURPOSE COST CENTERS PANCREAS ACQUISITION		0			109, 00
	INTESTINAL ACQUISITION	0	0	0		1109.00
	ISLET ACQUISITION	0	0	0		111.00
	INTEREST EXPENSE	U	U	U		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	100	100		118.00
	IMBURSABLE COST CENTERS	<u> </u>	100	100		110.00
	GIFT FLOWER COFFEE SHOP & CANTEEN	O	0	0		190.00
	WELLNESS COMMUNITY	0	0	0		194.00
	BUILDING RENTALS	0	0	0		194. 01
194. 02 07952		o	0	0		194. 02
194. 03 07953	OUTREACH CLINICS	O	0	0		194. 03
194. 04 07954	SPEECH - HEARING AIDS	0	0	0		194.04
194. 05 07955	NONALLOWABLE MARKETING	0	0	0		194. 05
194. 06 07956	CRH FOUNDATION	0	0	0		194. 06
194. 07 07957	HEALTHY COMMUNITIES	0	0	0		194. 07
194. 08 07958	CRHP	0	0	0		194. 08
194. 09 07959	NEUROPSYCH PART B	0	0	0		194. 09
200. 00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	0	1, 038, 282	658, 482		202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	10, 382. 820000			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	61, 660	42, 404		204. 00
205 00	Part II)	0.000000	/1/ /00000	40.4.040000		205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	616. 600000	424. 040000		205. 00
206. 00	NAHE adjustment amount to be allocated	0	0	0		206, 00
200.00	(per Wkst. B-2)		0			200.00
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000		207. 00
237.30	Parts III and IV)	3.000000	2. 000000	3.000000		[00
"	,	. '	'		ı	

Date/Time Prepared: 12/31/2022 5/30/2023 8:40 am Hospi tal Title XVIII PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 114, 976 72, 114, 976 253, 658 72, 368, 634 30.00 03100 INTENSIVE CARE UNIT 14, 329, 691 14, 329, 691 31.00 14, 329, 691 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 0 33 00 0 0 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 04000 SUBPROVIDER - IPF 40 00 0 0 0 0 40 00 04100 SUBPROVI DER - I RF 0 5, 601, 706 5, 601, 706 41.00 5, 601, 706 41.00 04200 SUBPROVI DER 0 42.00 \cap Λ 42.00 43.00 04300 NURSERY 2, 952, 722 2, 952, 722 0 2, 952, 722 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 37, 422, 679 37, 422, 679 86, 907 37, 509, 586 50 00 05100 RECOVERY ROOM 3, 102, 642 3, 102, 642 51.00 3, 102, 642 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 309, 778 4, 309, 778 0 4, 309, 778 52.00 05300 ANESTHESI OLOGY 274, 598 5.508 53 00 274 598 280, 106 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 028, 165 5, 028, 165 6, 078 5, 034, 243 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 3, 528, 898 3, 528, 898 0 3, 528, 898 54.01 05404 ULTRA SOUND 1, 777, 989 1, 777, 989 1, 777, 989 54.02 54.02 0 05405 MAMMOGRAPHY 54.03 1, 912, 967 1, 912, 967 1, 912, 967 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 5, 162, 936 5, 162, 936 19, 117 5, 182, 053 55.00 57.00 05700 CT SCAN 3, 208, 462 3, 208, 462 3, 208, 462 57.00 58 00 05800 MRI 1 343 962 1 343 962 1, 343, 962 58 00 05900 CARDI AC CATHETERI ZATI ON 59.00 5, 526, 231 5, 526, 231 11, 988 5, 538, 219 59.00 18, 886, 646 18, 886, 646 06000 LABORATORY 18, 886, 646 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 2, 507, 523 2, 507, 523 2, 544, 807 60.01 37.284 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 1, 018, 563 62.00 1,018,563 1, 018, 563 62.00 65.00 06500 RESPIRATORY THERAPY 7, 705, 951 7, 705, 951 16, 038 7, 721, 989 65.00 66.00 06600 PHYSI CAL THERAPY 8,066,199 8, 066, 199 23, 766 8,089,965 66.00 67 00 06700 OCCUPATIONAL THERAPY 2 991 203 2 991 203 2 991 203 67 00 06800 SPEECH PATHOLOGY 68.00 1, 287, 179 1, 287, 179 0 1, 287, 179 68.00 06900 ELECTROCARDI OLOGY 2, 657, 319 2, 657, 319 0 2, 657, 319 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 919, 653 1, 919, 653 ol 1, 919, 653 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 9, 570, 403 9, 570, 403 9, 570, 403 71 00 0 10, 710, 277 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 710, 277 10, 710, 277 72.00 07300 DRUGS CHARGED TO PATIENTS 41, 101, 478 0 41, 101, 478 73.00 41, 101, 478 73.00 74.00 07400 RENAL DIALYSIS 1,009,396 1,009,396 0 1, 009, 396 74.00 03020 ACUPUNCTURE 0 76.00 0 0 76.00 07697 CARDIAC REHABILITATION 789, 757 789, 757 789, 757 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 C 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89 00 90.00 09000 CLI NI C 4, 353, 593 4, 353, 593 0 4, 353, 593 90.00 90 01 09001 DI ABETES CENTER 0 90 01 09002 NEUROPSYCH 224, 940 90.02 224, 940 224, 940 90.02 0 09003 WOUND CENTER 90.03 2, 461, 635 2, 461, 635 26, 317 2, 487, 952 90.03 09004 HYPERBARIC OXYGEN THERAPY 397, 994 397, 994 976 398, 970 90.04 90.04 90.05 09005 VIMCARE CLINIC 1, 819, 790 1, 819, 790 0 1, 819, 790 90.05 09006 MEDICATION MGMT CLINIC 90.06 540.133 540, 133 0 540, 133 90.06 91.00 09100 EMERGENCY 19, 260, 857 19, 260, 857 56, 686 19, 317, 543 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 266, 235 7, 266, 235 7, 266, 235 92 00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 6, 867, 167 6, 867, 167 1.434 6, 868, 601 95 00 09910 CORF 99.10 99. 10 0 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109, 00

0

0

321, 012, 293

313, 746, 058

7, 266, 235

0

0

545, 757

545, 757

321, 012, 293

313, 746, 058

7, 266, 235

0

0 110.00

01111.00

321, 558, 050 200. 00

314, 291, 815 202. 00

7, 266, 235 201. 00

113.00

110.00 11000 INTESTINAL ACQUISITION

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

111.00 11100 I SLET ACQUISITION

113. 00 11300 INTEREST EXPENSE

200.00

201.00

202.00

Provider CCN: 15-0112

						5/30/2023 8: 4	0 am
				XVIII	Hospi tal	PPS	
			Charges	1			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
		6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00	03000 ADULTS & PEDI ATRI CS	80, 656, 829		80, 656, 829)		30.00
31. 00	03100 INTENSIVE CARE UNIT	16, 454, 922		16, 454, 922			31.00
32.00	03200 CORONARY CARE UNIT	0		(32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		(33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		()		34.00
40.00	04000 SUBPROVI DER - I PF	0		()		40.00
41.00	04100 SUBPROVI DER - I RF	7, 400, 339		7, 400, 339			41.00
42.00	04200 SUBPROVI DER	0		(42.00
43.00	04300 NURSERY	3, 376, 431		3, 376, 43			43.00
44.00	04400 SKILLED NURSING FACILITY	0)		44. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	20.770.024	00 F11 012	111 200 040	0.224242	0.000000	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	28, 778, 936 2, 443, 807	82, 511, 013 6, 622, 533			0. 000000 0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 138, 181	9, 772			0. 000000	
53. 00	05300 ANESTHESI OLOGY	5, 495, 517	11, 825, 697			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 820, 023	5, 320, 656			0. 000000	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	953, 054	12, 814, 089			0. 000000	
54.02	05404 ULTRA SOUND	1, 581, 277	6, 219, 979			0.000000	
54.03	05405 MAMMOGRAPHY	1, 315	6, 204, 741	6, 206, 056	0. 308242	0.000000	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	367, 415	23, 190, 017	23, 557, 432	0. 219164	0. 000000	55.00
57.00	05700 CT SCAN	12, 735, 508	29, 715, 324	42, 450, 832	0. 075581	0. 000000	
58.00	05800 MRI	2, 688, 576	7, 861, 180			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	20, 419, 884	12, 774, 554			0. 000000	
60.00	06000 LABORATORY	26, 904, 219	56, 191, 256			0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	853, 045	7, 100, 967			0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 152, 939	1, 549, 756			0.000000	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	29, 443, 713	6, 164, 406			0. 000000 0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	5, 231, 245 3, 887, 050	14, 444, 423 3, 222, 109			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	902, 383	1, 345, 435			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	5, 813, 732	8, 937, 456			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	657, 639	8, 378, 970			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 488, 293	14, 644, 844			0.000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 493, 235	11, 019, 735			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	39, 782, 763	88, 730, 172	128, 512, 935	0. 319824	0. 000000	73.00
74.00	07400 RENAL DI ALYSI S	3, 329, 228	0	3, 329, 228	0. 303192	0. 000000	74.00
76.00	03020 ACUPUNCTURE	0	0	١ .		0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	13, 146	2, 007, 987	2, 021, 133	0. 390750	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	0	0	(88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	U 45 117	0 020 040	0 004 15	0. 489489	0 000000	89. 00 90. 00
90. 00 90. 01	09000 CLINIC 09001 DIABETES CENTER	65, 117	8, 829, 040	8, 894, 157		0. 000000 0. 000000	1
	09002 NEUROPSYCH	5, 310	182, 869			0. 000000	
	09003 WOUND CENTER	104, 686	10, 144, 103				
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	708, 639			0. 000000	1
90. 05	09005 VI MCARE CLINI C	5, 413	1, 674, 301			0. 000000	
90.06	09006 MEDICATION MGMT CLINIC	2, 897	775, 338			0. 000000	1
91.00	09100 EMERGENCY	25, 938, 954	61, 602, 305			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	15, 043, 819	15, 043, 819	0. 483005	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	17, 384	13, 133, 698	13, 151, 082	0. 522175	0. 000000	
	09910 CORF	0	0				99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	()		101.00
100.00	SPECIAL PURPOSE COST CENTERS						100.00
	10900 PANCREAS ACQUISITION	0	0				109. 00 110. 00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION		0	(111.00
	111300 NTEREST EXPENSE		Ü		Ί		113.00
200.00		362, 404, 405	540, 901, 183	903, 305, 588	3		200.00
201.00		,,	2 . 2 , 7 3 . 7 7 0 0				201.00
202.00		362, 404, 405	540, 901, 183	903, 305, 588	3		202.00
50	1			,,,,	1	1	

Heal th Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0112

Period:
From 01/01/2022
Part I

To 12/31/2022
Date/Time Prepared:

5/30/2023 8:40 am Title XVIII Hospi tal PPS Cost Center Description PPS Inpatient Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31 00 31 00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40 00 40 00 41.00 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.337044 50.00 05100 RECOVERY ROOM 0. 342215 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.837183 52.00 53.00 05300 ANESTHESI OLOGY 0.016171 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.705009 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0. 256328 54.01 05404 ULTRA SOUND 54 02 0.227911 54 02 54.03 05405 MAMMOGRAPHY 0.308242 54.03 05500 RADI OLOGY-THERAPEUTI C 55.00 0. 219975 55.00 05700 CT SCAN 0.075581 57.00 57.00 58.00 05800 MRI 0. 127393 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.166842 59.00 06000 LABORATORY 60.00 0.227289 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 0. 319940 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.275087 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 0. 216860 65.00 66.00 06600 PHYSI CAL THERAPY 0.411166 66,00 06700 OCCUPATI ONAL THERAPY 67.00 0. 420753 67.00 06800 SPEECH PATHOLOGY 0.572635 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 180143 69.00 07000 ELECTROENCEPHALOGRAPHY 0.212431 70.00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 280385 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.578528 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 319824 73.00 07400 RENAL DIALYSIS 74.00 0.303192 74.00 76.00 03020 ACUPUNCTURE 0.000000 76.00 07697 CARDIAC REHABILITATION 76.97 0. 390750 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0. 489489 90.00 09001 DI ABETES CENTER 90 01 0.000000 90 01 90.02 09002 NEUROPSYCH 1. 195351 90.02 90. 03 09003 WOUND CENTER 0. 242756 90.03 09004 HYPERBARI C OXYGEN THERAPY 0.563009 90.04 90.04 09005 VIMCARE CLINIC 90 05 1.083393 90.05 90.06 09006 MEDICATION MGMT CLINIC 0.694049 90.06 09100 EMERGENCY 91.00 0. 220668 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0. 483005 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 522284 95.00 99. 10 09910 CORF 99. 10 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION l111. 00 113.00 11300 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

					T	o 12/31/2022	Date/Time Pre 5/30/2023 8:4	
				Ti tl	e XIX	Hospi tal	PPS	
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst. B, Part I,	Adj .		Di sal I owance		
			col. 26)					
			1. 00	2.00	3.00	4. 00	5. 00	
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	72, 114, 976		72, 114, 976		72, 368, 634	30.00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	14, 329, 691		14, 329, 691	0	14, 329, 691 0	31. 00 32. 00
33.00		BURN INTENSIVE CARE UNIT	0			0	0	1
34. 00		SURGICAL INTENSIVE CARE UNIT	Ö		ا	o	0	34.00
40.00		SUBPROVIDER - IPF	0		0	0	0	40.00
41. 00		SUBPROVI DER - I RF	5, 601, 706		5, 601, 706		5, 601, 706	1
42. 00		SUBPROVI DER	0		0	0	0	42.00
43.00	1	NURSERY	2, 952, 722	l .	2, 952, 722	0	2, 952, 722	1
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0		0	0	0	44.00
50.00		OPERATING ROOM	37, 422, 679		37, 422, 679	86, 907	37, 509, 586	50.00
51. 00		RECOVERY ROOM	3, 102, 642	l .	3, 102, 642		3, 102, 642	1
52.00	05200	DELIVERY ROOM & LABOR ROOM	4, 309, 778		4, 309, 778	0	4, 309, 778	52.00
53.00		ANESTHESI OLOGY	274, 598		274, 598		280, 106	
54.00		RADI OLOGY-DI AGNOSTI C	5, 028, 165		5, 028, 165		5, 034, 243	1
54. 01 54. 02	1	NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND	3, 528, 898 1, 777, 989	l .	3, 528, 898 1, 777, 989		3, 528, 898 1, 777, 989	1
54. 02		MAMMOGRAPHY	1, 777, 969	l .	1, 912, 967	0	1, 777, 967	54.02
55. 00		RADI OLOGY-THERAPEUTI C	5, 162, 936	l .	5, 162, 936	19, 117	5, 182, 053	1
57.00		CT SCAN	3, 208, 462		3, 208, 462		3, 208, 462	57.00
58.00	05800		1, 343, 962		1, 343, 962		1, 343, 962	58. 00
59.00		CARDI AC CATHETERI ZATI ON	5, 526, 231		5, 526, 231	11, 988	5, 538, 219	59.00
60.00	1	LABORATORY PATHOLOGICAL	18, 886, 646		18, 886, 646		18, 886, 646	1
60. 01 62. 00		LABORATORY-PATHOLOGICAL WHOLE BLOOD & PACKED RED BLOOD CELL	2, 507, 523 1, 018, 563	l .	2, 507, 523 1, 018, 563		2, 544, 807 1, 018, 563	60. 01 62. 00
65. 00		RESPIRATORY THERAPY	7, 705, 951			16, 038	7, 721, 989	1
66. 00	1	PHYSI CAL THERAPY	8, 066, 199	l .			8, 089, 965	1
67.00		OCCUPATI ONAL THERAPY	2, 991, 203	0	2, 991, 203		2, 991, 203	67.00
68. 00		SPEECH PATHOLOGY	1, 287, 179	l .	1, 287, 179		1, 287, 179	68. 00
69.00		ELECTROCARDI OLOGY	2, 657, 319		2, 657, 319		2, 657, 319	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 919, 653 9, 570, 403	l .	1, 919, 653 9, 570, 403	0	1, 919, 653 9, 570, 403	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	10, 710, 277	l .	10, 710, 277	o	10, 710, 277	72.00
73.00		DRUGS CHARGED TO PATIENTS	41, 101, 478	l .	41, 101, 478	0	41, 101, 478	1
74.00	1	RENAL DIALYSIS	1, 009, 396		1, 009, 396		1, 009, 396	1
76. 00		ACUPUNCTURE	0		0	0	0	76. 00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	789, 757		789, 757	0	789, 757	76. 97
88. 00		RURAL HEALTH CLINIC	0		T 0	O	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		ĺ		0	
90.00	09000	CLINIC	4, 353, 593		4, 353, 593	0	4, 353, 593	90.00
		DI ABETES CENTER	0		0	0		90. 01
		NEUROPSYCH	224, 940	l .	224, 940		224, 940	1
90. 03 90. 04		WOUND CENTER HYPERBARIC OXYGEN THERAPY	2, 461, 635 397, 994		2, 461, 635 397, 994		2, 487, 952 398, 970	
90. 05		VIMCARE CLINIC	1, 819, 790		1, 819, 790		1, 819, 790	
90.06		MEDICATION MGMT CLINIC	540, 133		540, 133		540, 133	1
91.00	09100	EMERGENCY	19, 260, 857		19, 260, 857	56, 686	19, 317, 543	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART	7, 266, 235		7, 266, 235		7, 266, 235	92.00
05 00		REI MBURSABLE COST CENTERS		T		1		
		AMBULANCE SERVICES	6, 867, 167	l .	6, 867, 167	1, 434	6, 868, 601 0	1
99. 10		HOME HEALTH AGENCY	0	l .			-	99. 10 101. 00
101.00		AL PURPOSE COST CENTERS						1101.00
109.00		PANCREAS ACQUISITION	0		0		0	109. 00
		INTESTINAL ACQUISITION	0		0			110.00
	1	I SLET ACQUISITION	0		0			111.00
		INTEREST EXPENSE	221 012 202		221 012 202	E 4 E 7 E 7		113.00
200. 00 201. 00		Subtotal (see instructions) Less Observation Beds	321, 012, 293 7, 266, 235	l .	321, 012, 293 7, 266, 235		321, 558, 050 7, 266, 235	
201.00	1	Total (see instructions)	313, 746, 058	l .			314, 291, 815	
50	1	,		'	,		,,	

Peri od: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112

				'	0 12/31/2022	5/30/2023 8: 4	
			Ti tl	e XIX	Hospi tal	PPS	
			Charges	1			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
		4 00	7. 00	8.00	9. 00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00	8.00	9.00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	80, 656, 829		80, 656, 829			30.00
31. 00	03100 INTENSIVE CARE UNIT	16, 454, 922		16, 454, 922			31.00
32. 00	03200 CORONARY CARE UNIT	0		0			32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40.00	04000 SUBPROVI DER - I PF	0		0			40.00
41.00	04100 SUBPROVI DER - I RF	7, 400, 339		7, 400, 339			41.00
42.00	04200 SUBPROVI DER	0		0			42.00
43.00	04300 NURSERY	3, 376, 431		3, 376, 431			43.00
44. 00	04400 SKILLED NURSING FACILITY	0		0			44.00
F0 00	ANCILLARY SERVICE COST CENTERS		00 511 010	111 000 010	0.004040		
50.00	05000 OPERATING ROOM	28, 778, 936	82, 511, 013			0.000000	
51. 00 52. 00	05100 RECOVERY ROOM	2, 443, 807	6, 622, 533			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	5, 138, 181 5, 495, 517	9, 772 11, 825, 697			0. 000000 0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 820, 023	5, 320, 656			0. 000000	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	953, 054	12, 814, 089			0. 000000	
54. 02	05404 ULTRA SOUND	1, 581, 277	6, 219, 979			0. 000000	
54. 03	05405 MAMMOGRAPHY	1, 315	6, 204, 741			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	367, 415	23, 190, 017			0. 000000	
57.00	05700 CT SCAN	12, 735, 508	29, 715, 324	1		0. 000000	
58.00	05800 MRI	2, 688, 576	7, 861, 180	10, 549, 756	0. 127393	0. 000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 419, 884	12, 774, 554	33, 194, 438	0. 166481	0. 000000	59.00
60.00	06000 LABORATORY	26, 904, 219	56, 191, 256			0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	853, 045	7, 100, 967			0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 152, 939	1, 549, 756			0. 000000	
65.00	06500 RESPI RATORY THERAPY	29, 443, 713	6, 164, 406			0.000000	
66. 00 67. 00	06600 PHYSI CAL THERAPY	5, 231, 245	14, 444, 423			0.000000	
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 887, 050 902, 383	3, 222, 109 1, 345, 435	1		0. 000000 0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	5, 813, 732	8, 937, 456			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	657, 639	8, 378, 970			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 488, 293	14, 644, 844			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 493, 235	11, 019, 735			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	39, 782, 763	88, 730, 172			0. 000000	
74.00	07400 RENAL DI ALYSI S	3, 329, 228	0	3, 329, 228	0. 303192	0. 000000	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0. 000000	0. 000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	13, 146	2, 007, 987	2, 021, 133	0. 390750	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0			0. 000000	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 000 040	0 004 457		0.000000	
90.00	09000 CLINIC	65, 117	8, 829, 040			0.000000	
	09001 DI ABETES CENTER	5, 310	102.040	100 170		0. 000000 0. 000000	
	09002 NEUROPSYCH 09003 WOUND CENTER	104, 686	182, 869 10, 144, 103				
90. 03	09004 HYPERBARI C OXYGEN THERAPY	104, 000	708, 639			0. 000000	
90. 05	09005 VI MCARE CLINIC	5, 413	1, 674, 301			0. 000000	
90. 06	09006 MEDICATION MGMT CLINIC	2, 897	775, 338			0. 000000	
91.00	09100 EMERGENCY	25, 938, 954	61, 602, 305	1		0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	15, 043, 819			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	'					
95.00	09500 AMBULANCE SERVICES	17, 384	13, 133, 698	13, 151, 082	0. 522175	0. 000000	95.00
	09910 CORF	0	0	l .			99. 10
101.00	10100 HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS			1			
	10900 PANCREAS ACQUISITION	0	0			0.000000	
	11000 INTESTINAL ACQUISITION	0	0			0.000000	
	11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	0	Ü	0	0. 000000	0. 000000	
200.00		362, 404, 405	540, 901, 183	903, 305, 588			113. 00 200. 00
200.00	1 1	302, 404, 405	540, 901, 183	703, 303, 388			200.00
202.00		362, 404, 405	540, 901, 183	903, 305, 588			202.00
_52.00	1.014. (000 111011 4011 0115)	1 332, 134, 403	5.5,751,105	, , , , , , , , , , , , , , , , , , , ,	1		,_52.00

Health Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0112
From 01/01/2022
To 12/31/2022
To 12/31/2023 8: 40 am

				5/30/2023 8: 4	10 am
Occident Decident Decident	DDC 1	Ti tle XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
INDATIENT DOUTINE SERVICE COST CENTERS	11. 00				
30.00 O3000 ADULTS & PEDIATRICS					30.00
31. 00 03100 NTENSI VE CARE UNI T					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT					33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T					34.00
40. 00 04000 SUBPROVI DER - I PF					40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 337044				50.00
51.00 05100 RECOVERY ROOM	0. 342215				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 837183				52.00
53. 00 05300 ANESTHESI OLOGY	0. 016171				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 705009				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 256328				54. 01
54. 02 05404 ULTRA SOUND	0. 227911				54. 02
54. 03 05405 MAMMOGRAPHY	0. 308242				54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 219975				55.00
57. 00 05700 CT SCAN	0. 075581				57.00
58. 00 05800 MRI	0. 127393				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 166842				59.00
60. 00 06000 LABORATORY	0. 227289				60.00
60. 01 06001 LABORATORY - PATHOLOGI CAL	0. 319940				60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 275087				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 216860				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 411166				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 420753				67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 572635				68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 180143 0. 212431				69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 212431				71.00
72. 00 07100 MEDICAL SOLVETES CHARGED TO PATIENTS	0. 578528				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 319824				73.00
74. 00 07400 RENAL DI ALYSI S	0. 303192				74.00
76. 00 03020 ACUPUNCTURE	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 390750				76. 97
OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90. 00 09000 CLI NI C	0. 489489				90.00
90. 01 09001 DI ABETES CENTER	0. 000000				90. 01
90. 02 09002 NEUROPSYCH	1. 195351				90. 02
90. 03 09003 WOUND CENTER	0. 242756				90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 563009				90. 04
90. 05 09005 VI MCARE CLI NI C	1. 083393				90. 05
90.06 O9006 MEDICATION MGMT CLINIC	0. 694049				90.06
91. 00 09100 EMERGENCY	0. 220668				91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART	0. 483005				92. 00
OTHER REIMBURSABLE COST CENTERS	0.50000				05.00
95. 00 09500 AMBULANCE SERVI CES	0. 522284				95.00
99. 10 09910 CORF					99. 10
101. 00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	0.000000				100 00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0. 000000 0. 000000				109. 00 110. 00
111. 00 111000 I NIESTINAL ACQUISITION	0.000000				111.00
113. 00 11300 NTEREST EXPENSE	0.000000				113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

						5/30/2023 8: 4	<u>0 am</u>
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	'	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col . 1 -		Amount	
			/	col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	37, 422, 679	5, 588, 286	31, 834, 393	0	0	50.00
	DO RECOVERY ROOM	3, 102, 642				0	51.00
	DO DELIVERY ROOM & LABOR ROOM	4, 309, 778				0	1
	OO ANESTHESI OLOGY	274, 598				0	1
	DO RADI OLOGY-DI AGNOSTI C	5, 028, 165				0	1
	D2 NUCLEAR MEDICINE-DIAGNOSTIC	3, 528, 898					1
	04 ULTRA SOUND	1, 777, 989				0	1
	D5 MAMMOGRAPHY	1, 912, 967	416, 040				1
	DO RADI OLOGY-THERAPEUTI C	5, 162, 936				0	1
	DO CT SCAN	3, 208, 462				0	1
	DO MRI	1, 343, 962				0	58.00
	OO CARDI AC CATHETERI ZATI ON	5, 526, 231	829, 232			0	
	DO LABORATORY	18, 886, 646				0	1
	D1 LABORATORY-PATHOLOGI CAL	2, 507, 523			_	0	
							1
	DO WHOLE BLOOD & PACKED RED BLOOD CELL	1, 018, 563				0	1
	DO RESPIRATORY THERAPY	7, 705, 951	606, 800				
	OO PHYSI CAL THERAPY	8, 066, 199				0	
	OO OCCUPATI ONAL THERAPY	2, 991, 203				0	
	DO SPEECH PATHOLOGY	1, 287, 179				0	68.00
	DO ELECTROCARDI OLOGY	2, 657, 319				0	
	DO ELECTROENCEPHALOGRAPHY	1, 919, 653				0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 570, 403				0	
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	10, 710, 277				0	
	DO DRUGS CHARGED TO PATIENTS	41, 101, 478				0	
	DO RENAL DI ALYSI S	1, 009, 396				0	
	20 ACUPUNCTURE	0				0	
	97 CARDIAC REHABILITATION	789, 757	79, 013	710, 744	0	0	76. 97
	PATIENT SERVICE COST CENTERS	T _	1 -		1 _	_	
	OO RURAL HEALTH CLINIC	0	ł .			0	1
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	1
	DO CLINIC	4, 353, 593				0	
	DI ABETES CENTER	0	0			0	
	D2 NEUROPSYCH	224, 940				0	
	03 WOUND CENTER	2, 461, 635				0	
	D4 HYPERBARIC OXYGEN THERAPY	397, 994				0	90.04
	D5 VI MCARE CLI NI C	1, 819, 790				0	
	D6 MEDICATION MGMT CLINIC	540, 133				0	1
	DO EMERGENCY	19, 260, 857				0	1
	OO OBSERVATION BEDS (NON-DISTINCT PART	7, 266, 235	544, 735	6, 721, 500	0	0	92.00
	REIMBURSABLE COST CENTERS						
	DO AMBULANCE SERVICES	6, 867, 167	735, 978			0	
99. 10 0991		0					
	DO HOME HEALTH AGENCY	0	0	C	0	0	101.00
	CIAL PURPOSE COST CENTERS		_		_	_	
	PANCREAS ACQUISITION	0					109.00
	OO INTESTINAL ACQUISITION	0					110.00
	DO I SLET ACQUI SI TI ON	0	0	C	0	0	111.00
	DO INTEREST EXPENSE					_	113. 00
200.00	Subtotal (sum of lines 50 thru 199)	226, 013, 198					200.00
201.00	Less Observation Beds	7, 266, 235					201.00
202. 00	Total (line 200 minus line 201)	218, 746, 963	19, 236, 246	199, 510, 717	0	0	202. 00

					5/30/2023 8:40 am
		Ti tl	e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to		
	Operating	Part I,	Charge Ratio		
	Cost	column 8)	(col . 6 /		
	Reducti on		col. 7)		
	6. 00	7. 00	8.00		
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00		
50. 00 05000 OPERATI NG ROOM	37, 422, 679	111, 289, 949	0. 336263		50.00
51. 00 05100 RECOVERY ROOM	3, 102, 642	9, 066, 340			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 309, 778	5, 147, 953			52. 00
	274, 598	17, 321, 214			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 028, 165	7, 140, 679			54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 528, 898	13, 767, 143	0. 256328		54. 0
54. 02 05404 ULTRA SOUND	1, 777, 989	7, 801, 256	0. 227911		54. 02
54. 03 05405 MAMMOGRAPHY	1, 912, 967	6, 206, 056	0. 308242		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 162, 936	23, 557, 432			55.00
57.00 05700 CT SCAN	3, 208, 462	42, 450, 832			57.00
58. 00 05800 MRI	1, 343, 962	10, 549, 756	0. 127393		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 526, 231	33, 194, 438	0. 166481		59.00
60. 00 06000 LABORATORY	18, 886, 646	83, 095, 475	0. 227289		60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	2, 507, 523	7, 954, 012	0. 315253		60.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 018, 563	3, 702, 695			62.00
65. 00 06500 RESPIRATORY THERAPY	7, 705, 951	35, 608, 119			65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 066, 199	19, 675, 668			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 991, 203	7, 109, 159			67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 287, 179	2, 247, 818			68.00
69. 00 06900 SPEECH PATHOLOGY	2, 657, 319	14, 751, 188			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 919, 653	9, 036, 609			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	9, 570, 403	34, 133, 137			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	10, 710, 277	18, 512, 970			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	41, 101, 478	128, 512, 935			73. 00
74. 00 07400 RENAL DI ALYSI S	1, 009, 396				74.00
76. 00 03020 ACUPUNCTURE	0	0	0.00000		76.00
76. 97 O7697 CARDIAC REHABILITATION	789, 757	2, 021, 133	0. 390750		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	0.000000		89.00
90. 00 09000 CLI NI C	4, 353, 593	8, 894, 157	0. 489489		90.00
90. 01 09001 DI ABETES CENTER	0	0	0.000000		90.0
90. 02 09002 NEUROPSYCH	224, 940	188, 179	1. 195351		90. 02
90. 03 09003 WOUND CENTER	2, 461, 635	10, 248, 789			90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	397, 994	708, 639			90.04
90. 05 09005 VI MCARE CLI NI C	1, 819, 790				90. 05
90. 06 09006 MEDICATION MGMT CLINIC	540, 133	778, 235			90.00
91. 00 09100 EMERGENCY	19, 260, 857	87, 541, 259			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 266, 235	15, 043, 819			92.00
	1, 200, 233	15,045,619	0.463003		92.00
OTHER REIMBURSABLE COST CENTERS	. 0/7 4/7	40 454 000	0 500475		05.00
95. 00 09500 AMBULANCE SERVICES	6, 867, 167	13, 151, 082			95. 00
99. 10 09910 CORF	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0. 000000		101. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0. 000000		110.00
111.00 11100 ISLET ACQUISITION	0	0	0. 000000		111.00
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (sum of lines 50 thru 199)	226, 013, 198	795, 417, 067			200. 00
201.00 Less Observation Beds	7, 266, 235				201. 00
202.00 Total (line 200 minus line 201)	218, 746, 963				202. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, , , , , , , , , , , , , , , , , , , ,			1=12.00

Heal th Fi nancial Systems COLUMBUS REGIONAL HOSPITAL Hospital Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-0112 Part Date/Time Prepared: 5/30/2023 8: 40 am Provider CCN: 15-012 Part Date/Time Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30/2023 8: 40 am Prepared: 5/30
Title XVIII Hospital Per Diem (col. 3 / col. 4) Per Diem (col. 3 / col. 4) Per Diem (col. 26) Per Diem
Title XVIII Hospital PPS Total Patient Days Col. 3 / Col. 4 Days Col. 4 Days Col. 3 / Col. 4 Days Col. 4 Col. 1 - Col. 2 Col. 2 Col. 2 Col. 2 Col. 2 Col. 2 Col. 2 Col. 4 Col. 5 Col. 4 Col. 5 Col. 4 Col. 5
Title XVIII
Title XVIII
Cost Center Description
Related Cost (from Wkst. B, Part II, col 26)
Col. 4 Col. 26 Col. 1 - Col. 26 Col. 2 Col. 4 Col. 4 Col. 26 Col. 26 Col. 20 Col.
B, Part II, col. 26) Col. 1 - col. 2) Col. 2) Col. 20 Col. 2) Col. 20 Co
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS
31. 00 INTENSI VE CARE UNI T 920, 890 920, 890 3, 846 239. 44 31. 00 32. 00 33. 00 BURN I NTENSI VE CARE UNI T 0 0 0 0. 00 33. 00 34. 00 SUBPROVI DER - I PF 0 0 0 0. 00 34. 00 41. 00 SUBPROVI DER - I RF 619, 745 0 619, 745 3, 453 179. 48 41. 00 42. 00 SUBPROVI DER 0 0 0 0 0. 00 42. 00 43. 00 NURSERY 130, 968 130, 968 3, 018 43. 40 43. 00
32. 00 CORONARY CARE UNIT 0 0 0 0. 00 32. 00 33. 00 34. 00 34. 00 50 50 50 50 50 50 50
33. 00 BURN INTENSIVE CARE UNIT 0 0 0 0 0.00 33. 00 34. 00 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0 0 0.00 34. 00 40. 00 SUBPROVI DER - I PF 0 0 0 0 0 0 0 0. 00 41. 00 SUBPROVI DER - I RF 0 619, 745 0 619, 745 3, 453 179. 48 41. 00 42. 00 SUBPROVI DER 0 0 0 0 0 0 0. 00 42. 00 43. 00 NURSERY 130, 968 3, 018 43. 40 43. 00
34. 00 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0.00 34.00 40. 00 SUBPROVI DER - I PF 0 0 0 0 0 40.00 41. 00 SUBPROVI DER - I RF 619, 745 0 619, 745 3, 453 179. 48 41. 00 42. 00 SUBPROVI DER 0 0 0 0 0.00 42. 00 43. 00 NURSERY 130, 968 130, 968 3, 018 43. 40 43. 00
40. 00 SUBPROVI DER - I PF 0 0 0 0 0.00 40.00 41. 00 SUBPROVI DER - I RF 619, 745 0 619, 745 3, 453 179. 48 41. 00 42. 00 SUBPROVI DER 0 0 0 0 0.00 42. 00 43. 00 NURSERY 130, 968 130, 968 3, 018 43. 40 43. 00
41. 00 SUBPROVI DER - I RF 619, 745 0 619, 745 3, 453 179, 48 41, 00 42. 00 SUBPROVI DER 0 0 0 0 0 42, 00 43. 00 NURSERY 130, 968 130, 968 3, 018 43, 40 43, 00
41. 00 SUBPROVI DER - I RF 619, 745 0 619, 745 3, 453 179, 48 41, 00 42. 00 SUBPROVI DER 0 0 0 0 0 42, 00 43. 00 NURSERY 130, 968 130, 968 3, 018 43, 40 43, 00
42. 00 SUBPROVI DER 0 0 0 0 42. 00 43. 00 130, 968 3, 018 43. 40 43. 00
43. 00 NURSERY 130, 968 130, 968 3, 018 43. 40 43. 00
44.00 SKILLED NURSING FACILITY 0 0 0 0.00 44.00
200.00 Total (lines 30 through 199) 7,096,950 7,096,950 47,994 200.00
Cost Center Description Inpatient Inpatient
Program days Program
Capital Cost
(col. 5 x
col. 6)
6.00 7.00
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 ADULTS & PEDI ATRI CS 12, 310 1, 772, 640 30. 00
31.00 INTENSIVE CARE UNIT 856 204, 961 31.00
32.00 CORONARY CARE UNIT 0 0 32.00
33.00 BURN INTENSIVE CARE UNIT 0 0 33.00
34.00 SURGICAL INTENSIVE CARE UNIT 0 0 34.00
40.00 SUBPROVI DER - PF 0 0 40.00
41.00 SUBPROVI DER - I RF 1,899 340,833 41.00
42. 00 SUBPROVI DER 0 0 42. 00
43.00 NURSERY 0 0 43.00
44.00 SKILLED NURSING FACILITY 0 0 44.00
200.00 Total (lines 30 through 199) 15,065 2,318,434 200.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITA	،L	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS Provide	r CCN: 15-0112 Peri od:	Worksheet D

From 01/01/2022 To 12/31/2022 Part II Date/Time Prepared: 5/30/2023 8:40 am Title XVIII Hospi tal **PPS** Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 0.050214 50 00 05000 OPERATING ROOM 5, 588, 286 111, 289, 949 9, 399, 954 472,009 214, 548 05100 RECOVERY ROOM 9,066,340 0.023664 814, 961 51.00 51.00 19, 285 05200 DELIVERY ROOM & LABOR ROOM 5, 147, 953 52.00 291, 403 0.056606 10, 157 575 52.00 05300 ANESTHESI OLOGY 18, 305 17, 321, 214 0.001057 53.00 1, 872, 723 1.979 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 573, 275 7, 140, 679 0.080283 779, 109 62, 549 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 457, 872 13, 767, 143 0.033258 379, 833 12,632 54.01 54.02 05404 ULTRA SOUND 123, 390 7, 801, 256 0.015817 532, 261 8, 419 54.02 54 03 05405 MAMMOGRAPHY 416, 040 6, 206, 056 0.067038 786 53 54 03 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 212, 646 23, 557, 432 0.051476 121, 374 6, 248 55.00 57.00 05700 CT SCAN 227, 198 42, 450, 832 0.005352 4, 983, 663 26, 673 57.00 58.00 05800 MRI 10, 549, 756 0.025557 1,007,172 269, 615 25.740 58.00 05900 CARDI AC CATHETERI ZATI ON 829, 232 33, 194, 438 59.00 0.024981 5, 472, 461 136, 708 59 00 60.00 06000 LABORATORY 1, 232, 463 83, 095, 475 0.014832 9, 381, 729 139, 150 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 147, 316 7, 954, 012 0.018521 270, 339 5,007 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 702, 695 0.012589 744,820 9, 377 62.00 46,612 62.00 65.00 06500 RESPIRATORY THERAPY 606,800 35, 608, 119 0.017041 11, 042, 970 188, 183 65.00 06600 PHYSI CAL THERAPY 650, 719 19, 675, 668 1, 424, 924 66.00 0.033072 47, 125 66.00 06700 OCCUPATI ONAL THERAPY 236, 527 7, 109, 159 899, 168 29, 916 67.00 0.033271 67.00 111, 839 6, 100 68.00 06800 SPEECH PATHOLOGY 2, 247, 818 0.049754 122, 594 68.00 69.00 06900 ELECTROCARDI OLOGY 404, 230 14, 751, 188 0.027403 2, 370, 340 64, 954 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 259, 014 9, 036, 609 0.028663 291, 891 8, 366 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 277, 165 34, 133, 137 0.008120 7, 119, 173 57,808 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 307, 125 18, 512, 970 0.016590 3, 317, 440 55,036 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 572, 778 128, 512, 935 0.012238 13, 748, 909 168, 259 73.00 07400 RENAL DIALYSIS 74.00 29, 384 3, 329, 228 0.008826 1, 122, 347 9,906 74.00 03020 ACUPUNCTURE 76 00 0.000000 76.00 0 76.97 07697 CARDIAC REHABILITATION 79,013 2,021,133 0.039093 3, 140 123 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 0 89 00 90.00 09000 CLI NI C 404, 171 8, 894, 157 0.045442 34, 286 1,558 90.00 09001 DI ABETES CENTER 0.000000 90.01 90.01 90.02 09002 NEUROPSYCH 11.395 188. 179 0.060554 90.02 0 09003 WOUND CENTER 172, 816 10, 248, 789 52, 920 892 90.03 0.016862 90.03 90.04 09004 HYPERBARIC OXYGEN THERAPY 113, 876 708, 639 0.160697 90.04 0 90.05 09005 VIMCARE CLINIC 221, 353 1, 679, 714 0.131780 2,667 351 90.05 09006 MEDICATION MGMT CLINIC 55.009 0.070684 1, 430 90.06 90.06 778, 235 101 09100 EMERGENCY 10, 051, 757 153, 732 91.00 1, 338, 853 87, 541, 259 0.015294 91.00 544, 735 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 15, 043, 819 0.036210 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 200.00 Total (lines 50 through 199) 19, 045, 003 782, 265, 985 87, 377, 298 1, 718, 814 200. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS		F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 8:4	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1, 00	2A	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Total Patient Days	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 200.00
	Amount (see instructions)	1 through 3, minus col. 4)	(00	col . 6)	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5.00	6. 00	7. 00	8. 00	
30. 00	0	0 0 0 0	37, 677 3, 846	0. 00 0. 00 0. 00	856 0 0	31. 00 32. 00 33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF	0	0	(0.00		34. 00 40. 00

40. 00 04000 SUBPROVI DER - I PF	0	0	0	0.00	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 453	0.00	1, 899	41.00
42. 00 04200 SUBPROVI DER	0	o	0	0.00	0	42.00
43. 00 04300 NURSERY		o	3, 018	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		o	0	0. 00	0	44.00
200.00 Total (lines 30 through 199)		o	47, 994		15, 065	200.00
Cost Center Description	Inpatient				·	
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
	1					•

				To 12/31/2022	Date/Time Pre 5/30/2023 8:4	
		Title	e XVIII	Hospi tal	PPS	U alli
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
, , , , , , , , , , , , , , , , , , ,	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0	0	50.00
51.00 05100 RECOVERY ROOM	0	0)	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	1, 038, 282	54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0)	0	0	54. 01
54. 02 05404 ULTRA SOUND	0	0)	0	0	54. 02
54. 03 05405 MAMMOGRAPHY	0	0)	0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0)	0 0	0	55.00
57. 00 05700 CT SCAN	0	0)	0	0	57.00
58. 00 05800 MRI	0	0)	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 0	0	59.00
60. 00 06000 LABORATORY	0	0)	0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0)	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0)	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0]	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0]	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0]	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0]	0	658, 482	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	<u>'</u>	0	0	74.00
76. 00 03020 ACUPUNCTURE	0			0 0		76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0)	0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS				0 0		00 00
88. 00 08800 RURAL HEALTH CLINIC	0			-		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	0	0	•	0 0	0	89. 00 90. 00
90. 00 09000 CLINI C 90. 01 09001 DI ABETES CENTER	0		(90.00
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	0		(0 0	0	90.01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	0					90.02
90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARI C OXYGEN THERAPY	0		()	0 0	0	90.03
90. 04 09004 HTPERBARTC OXTGEN THERAPT	0		(0	0	90.04
90. 06 09006 MEDICATION MGMT CLINIC				0	0	90.06
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	١	1	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				O _I	<u> </u>	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	O		0 0	1, 696, 764	
1	1	١ -	1	-1	.,,	, ,

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0112	Period: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

	66575			Т	o 12/31/2022	Date/Time Pre 5/30/2023 8:4	pared: O am
			Title	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			_			
50.00	05000 OPERATI NG ROOM	0	0	-	, - , ,	0. 000000	
51. 00	05100 RECOVERY ROOM	0	0			0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	-, ,	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	,,	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 038, 282			0. 145404	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	C	,,	0.000000	54. 01
54. 02	05404 ULTRA SOUND	0	0		.,,	0.000000	54. 02
54. 03	05405 MAMMOGRAPHY	0	0	1	0, 200, 000	0.000000	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			0.000000	55. 00
57.00	05700 CT SCAN	0	0	C	,,	0.000000	57.00
58.00	05800 MRI	0	0		.,	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C		0.000000	59.00
60.00	06000 LABORATORY	0	0	C	83, 095, 475	0.000000	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	C	7, 954, 012	0.000000	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	3, 702, 695	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	35, 608, 119	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	19, 675, 668	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	7, 109, 159	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	2, 247, 818	0.000000	68.00
	06900 ELECTROCARDI OLOGY	0	0	C	14, 751, 188	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	9, 036, 609	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	34, 133, 137	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	18, 512, 970	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	658, 482	658, 482	128, 512, 935	0.005124	73.00
74.00	07400 RENAL DIALYSIS	0	0	C	3, 329, 228	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	0	C	0	0.000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	2, 021, 133	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0.000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	C	8, 894, 157	0.000000	90.00
90. 01	09001 DI ABETES CENTER	o	0	l c	o	0.000000	90. 01
90. 02	09002 NEUROPSYCH	o	0	l c	188, 179	0.000000	90. 02
90. 03	09003 WOUND CENTER	o	0	l c	10, 248, 789	0.000000	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	o	0	l c	708, 639	0.000000	90. 04
90.05	09005 VI MCARE CLI NI C	o	0	l c	1, 679, 714	0.000000	90. 05
90.06	09006 MEDICATION MGMT CLINIC	ol	0		778, 235	0.000000	90.06
91.00	09100 EMERGENCY	ol	0	l c	87, 541, 259	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	C		0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS			•	'		
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	o	1, 696, 764	1, 696, 764	782, 265, 985		200. 00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

			10) 12/31/2022	5/30/2023 8:4	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	3	Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	9, 399, 954	0	20, 026, 944	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	814, 961	0	1, 132, 640	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	10, 157	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 872, 723	O	2, 457, 912	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 145404	779, 109		1, 043, 884	151, 785	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	379, 833		4, 318, 607	0	54. 01
54. 02 05404 ULTRA SOUND	0. 000000	532, 261	0	1, 074, 860	0	54. 02
54. 03 05405 MAMMOGRAPHY	0. 000000	786	0	515, 222	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	121, 374		6, 773, 705	0	55. 00
57. 00 05700 CT SCAN	0. 000000	4, 983, 663		6, 429, 991	0	57.00
58. 00 05800 MRI	0. 000000	1, 007, 172		1, 756, 092	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 472, 461	0	3, 589, 797	0	59.00
60. 00 06000 LABORATORY	0. 000000	9, 381, 729	-	4, 244, 134	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	270, 339		1, 571, 401	0	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	744, 820		223, 753	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	11, 042, 970		1, 428, 159	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 424, 924		32, 997	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	899, 168		13, 914	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	122, 594		127, 047	0	68.00
69. 00 06900 SPEECH PATHOLOGY	0. 000000	2, 370, 340	-	2, 930, 772	0	69.00
70. 00 07000 ELECTROCARDI OLOGT	0. 000000	2, 370, 340	0	1, 480, 519	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	7, 119, 173		2, 900, 198	0	70.00
	1				0	71.00
	0.000000	3, 317, 440		3, 312, 094	_	
	0. 005124	13, 748, 909		29, 470, 931	151, 009	73.00
	0.000000	1, 122, 347	0	U	0	74.00
76. 00 03020 ACUPUNCTURE	0.000000	2 140	0	005 001	0	76.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 000000	3, 140	0	825, 031	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0	O	O	0	00 00
	0.000000	0	-	0	0	88.00
	0.000000	24 204	0	2 017 514	-	89.00
90. 00 09000 CLI NI C	0.000000	34, 286		3, 017, 514	0	90.00
90. 01 09001 DI ABETES CENTER	0. 000000	0	0	4 7 (0	0	90. 01
90. 02 09002 NEUROPSYCH	0. 000000	50.000	0	4, 760	0	90. 02
90. 03 09003 WOUND CENTER	0. 000000	52, 920	0	4, 504, 332	0	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	164, 772	0	90.04
90. 05 09005 VI MCARE CLI NI C	0. 000000	2, 667		1, 972	0	90.05
90.06 09006 MEDICATION MGMT CLINIC	0. 000000	1, 430		0	0	90.06
91. 00 09100 EMERGENCY	0. 000000	10, 051, 757	0	6, 146, 924	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	2, 501, 892	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		87, 377, 298	183, 735	114, 022, 770	302, 794	200. 00

From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/30/2023 8:40 am Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 336263 20, 026, 944 6, 734, 320 50.00 05100 RECOVERY ROOM 0 1, 132, 640 51.00 0.342215 0 51.00 387, 606 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.837183 52.00 53.00 05300 ANESTHESI OLOGY 0.015853 2, 457, 912 0 0 38, 965 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.704158 1, 043, 884 0 0 735, 059 54.00 Ol 4, 318, 607 0 1, 106, 980 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 256328 54 01 0 54.02 05404 ULTRA SOUND 0. 227911 1,074,860 0 244, 972 54.02 54.03 05405 MAMMOGRAPHY 0.308242 515, 222 0 158, 813 54.03 0 0 05500 RADI OLOGY-THERAPEUTI C 0. 219164 6, 773, 705 55.00 1, 484, 552 55.00 0 0. 075581 05700 CT SCAN 485, 985 57 00 6, 429, 991 57 00 58.00 05800 MRI 0.127393 1, 756, 092 0 223, 714 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0.166481 3, 589, 797 597, 633 59.00 06000 LABORATORY 0 60 00 0 227289 4 244 134 170 964, 645 60 00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 0. 315253 1, 571, 401 0 495, 389 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.275087 223, 753 0 0 61, 552 62.00 62.00 06500 RESPIRATORY THERAPY 0 65.00 0. 216410 1, 428, 159 0 309,068 65.00 06600 PHYSI CAL THERAPY 32, 997 0 0 0 409958 13, 527 66 00 66 00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 0.420753 13, 914 5,854 67.00 06800 SPEECH PATHOLOGY 0.572635 127, 047 72, 752 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.180143 2, 930, 772 527, 958 69.00 0 o 07000 ELECTROENCEPHALOGRAPHY 0.212431 1, 480, 519 314, 508 70 00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 280385 2, 900, 198 0 813, 172 71.00 1, 916, 139 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0.578528 3, 312, 094 72.00 07300 DRUGS CHARGED TO PATIENTS 160, 709 73.00 0.319824 29, 470, 931 0 9, 425, 511 73.00 07400 RENAL DIALYSIS 0 74.00 0.303192 C 0 74 00 76.00 03020 ACUPUNCTURE 0.000000 0 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 0.390750 825, 031 0 0 322, 381 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0.489489 3, 017, 514 0 1, 477, 040 90.00 09001 DI ABETES CENTER 0 90.01 0.000000 0 0 90.01 90.02 09002 NEUROPSYCH 1. 195351 4,760 0 5,690 90.02 90 03 09003 WOUND CENTER 0. 240188 4, 504, 332 0 0 1, 081, 886 90.03 0 09004 HYPERBARIC OXYGEN THERAPY 0 92, 541 90.04 90.04 0.561632 164, 772 09005 VIMCARE CLINIC 0 90.05 1.083393 1, 972 2, 136 90.05 90.06 09006 MEDICATION MGMT CLINIC 0.694049 0 0 90.06 91.00 09100 EMERGENCY 0. 220020 6, 146, 924 0 1, 352, 446 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2<u>, 501, 892</u> 92.00 0 1, 208, 426 0.483005 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 522175 0 200.00 Subtotal (see instructions) 114, 022, 770 161, 287 32, 661, 220 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

114, 022, 770

0

161, 287

32, 661, 220 202. 00

202.00

Net Charges (line 200 - line 201)

In Lieu of Form CMS-2552-10 Health Financial Systems COLUMBUS REGIONAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0112 Peri od: Worksheet D From 01/01/2022 Part V

12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 137 50.00 05100 RECOVERY ROOM 0 51.00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0000000000000000000000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0 54.01 54.02 05404 ULTRA SOUND 0 54.02 54.03 05405 MAMMOGRAPHY 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MRI 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 60 00 39 60 00 60.01 06001 LABORATORY-PATHOLOGI CAL 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 51, 399 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 76.00 03020 ACUPUNCTURE 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 90.00 00000000 90.01 09001 DI ABETES CENTER 90.01 0 90.02 09002 NEUROPSYCH 90.02 90.03 09003 WOUND CENTER 0 90.03 09004 HYPERBARI C OXYGEN THERAPY 90.04 0 90.04 09005 VIMCARE CLINIC 0 90.05 90.05 90.06 09006 MEDICATION MGMT CLINIC 0 90.06 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 200.00 Subtotal (see instructions) 51, 575 200.00

51, 575

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	COLUMBUS REGIO	INAL HOSPLTAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.		Provi der C	CN: 15-0112 CCN: 15-T112	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
		Title	: XVIII	Subprovi der - I RF	PPS	o diii
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)	ŕ	,			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 588, 286	111, 289, 949	0. 05021	31, 116	1, 562	50.00
51.00 05100 RECOVERY ROOM	214, 548	9, 066, 340	0. 02366	2, 765	65	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	291, 403	5, 147, 953	0. 05660	06	0	52.00
53. 00 05300 ANESTHESI OLOGY	18, 305	17, 321, 214	0. 00105	6, 390	7	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	573, 275	7, 140, 679	0. 08028	15, 914	1, 278	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	457, 872	13, 767, 143	0. 03325	8, 366	278	54. 01
54. 02 05404 ULTRA SOUND	123, 390	7, 801, 256	0. 0158	13, 161	208	54. 02
54. 03 05405 MAMMOGRAPHY	416, 040	6, 206, 056	0.06703	38	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 212, 646			76 0	0	55.00
57. 00 05700 CT SCAN	227, 198				237	57.00
58. 00 05800 MRI	269, 615				l .	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	829, 232		1	·	66	59.00
60. 00 06000 LABORATORY	1, 232, 463				4, 077	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	147, 316				7	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46, 612				261	
65. 00 06500 RESPI RATORY THERAPY	606, 800					
66. 00 06600 PHYSI CAL THERAPY	650, 719			1	31, 646	1
67. 00 06700 OCCUPATI ONAL THERAPY	236, 527			·	· ·	
68. 00 06800 SPEECH PATHOLOGY	111, 839					
69. 00 06900 ELECTROCARDI OLOGY	404, 230				651	
70. 00 07000 ELECTROENCEPHALOGRAPHY	259, 014				0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	277, 165		1		786	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	307, 125					
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 572, 778					
74. 00 07400 RENAL DI ALYSI S	29, 384		1		685	
76. 00 03020 ACUPUNCTURE	27,304	0, 327, 220	0. 00000			
76. 97 07697 CARDI AC REHABI LI TATI ON	79, 013	2, 021, 133	1			
OUTPATIENT SERVICE COST CENTERS	77,013	2,021,100	0.0370	75 0		70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ł	1			
90. 00 09000 CLINIC	404, 171	1	1			
90. 01 09001 DI ABETES CENTER	101,171	0,071,107	i			
90. 02 09002 NEUROPSYCH	11, 395	188, 179				
90. 03 09003 WOUND CENTER	172, 816	•	1			
90. 04 09004 HYPERBARI C OXYGEN THERAPY	113, 876				_	90.04
90. 05 09005 VI MCARE CLI NI C	221, 353					
90. 06 09006 MEDICATION MGMT CLINIC	55, 009				_	
91. 00 09100 EMERGENCY	1, 338, 853				200	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 336, 633					1
OTHER REIMBURSABLE COST CENTERS		15,045,019	0.00000	,o _l 0		1 72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	18, 500, 268	782, 265, 985		3, 955, 881	105, 585	1
200.00 Total (Tries 50 till ough 177)	10, 300, 200	1 702, 200, 900	1	3, 755, 001	100, 303	₁ 200.00

Hoal +b	Financial Systems	COLUMBUS REGIO	MAL HOSDITAL			In Lio	u of Form CMS-:	2552 10
	<u>Financial Systems</u> TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			^N: 15_∩112	Peri od		Worksheet D	2332-10
	GH COSTS	KVIOL OTTEK TAS	J TTOVICE O	SN. 13 0112		1/01/2022		
			Component (CCN: 15-T112	To 1	2/31/2022		
			Titlo	XVIII	Subpr	ovi der -	5/30/2023 8: 4 PPS	o am
			11110	ZVIII		IRF	113	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Alli	ed Heal th	Allied Health	
		Anesthetist	Program	Program		-Stepdown		
		Cost	Post-Stepdown		Adj	ustments		
		1.00	Adjustments	0.00		0.4	2 22	
	ANCILLARY CERVICE COST CENTERS	1. 00	2A	2. 00		3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	O	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM		0		0	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	0	
53.00	05300 ANESTHESI OLOGY		0		0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0	0	1, 038, 282	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		0		0	0	0 1,000,202	1
54. 02	05404 ULTRA SOUND	0	0		0	0	Ö	
54. 03	05405 MAMMOGRAPHY	o	0		0	0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MRI	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0	0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0		0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0	Ö	658, 482	
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	1
76.00	03020 ACUPUNCTURE	0	0		0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
	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	
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 90. 05	O9004 HYPERBARI C OXYGEN THERAPY O9005 VI MCARE CLI NI C		0		0	0	0	90. 04 90. 05
90.05	09006 MEDICATION MGMT CLINIC		0		0	0	0	90.05
91.00	09100 EMERGENCY		0		0	0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		U		0	U	0	1
, 00	OTHER DELMBHREADLE COST CENTERS	٠			٠,			1 .2.00

92.00 95.00

1, 696, 764 200. 00

0

Heal th	Financial Systems	COLUMBUS REGIO	NAI HOSPITAI		In lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0112	Peri od:	Worksheet D	2002 10
	GH COSTS	WIOL OTHER TAG	i i i ovi dei o	011. 10 0112	From 01/01/2022		
	555.5			CCN: 15-T112	To 12/31/2022	5/30/2023 8: 4	
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum o		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 111, 289, 949	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 9, 066, 340	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 5, 147, 953	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0 17, 321, 214	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 038, 282	1, 038, 2			54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 13, 767, 143		
54. 02	05404 ULTRA SOUND	o o	Ö	1	0 7, 801, 256		
54. 03	05405 MAMMOGRAPHY	0	0	1	0 6, 206, 056	l .	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 23, 557, 432		
		0	0	1			
57.00	05700 CT SCAN	0	_		0 42, 450, 832		
58. 00	05800 MRI		0		0 10, 549, 756		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 33, 194, 438		
60.00	06000 LABORATORY	0	0	l .	0 83, 095, 475		
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	1	0 7, 954, 012		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 3, 702, 695		
65.00	06500 RESPI RATORY THERAPY	0	0	1	0 35, 608, 119	l .	
66.00	06600 PHYSI CAL THERAPY	0	0	1	0 19, 675, 668	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 7, 109, 159	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 2, 247, 818	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0)	0 14, 751, 188	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 9, 036, 609	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 34, 133, 137	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 512, 970		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	658, 482	658, 4			
74.00	07400 RENAL DIALYSIS	0	0		0 3, 329, 228		
76. 00	03020 ACUPUNCTURE	o O	Ö	1	0 0	l .	
76. 97	07697 CARDI AC REHABI LI TATI ON	o O	Ö	1	0 2, 021, 133		
, 0, ,,	OUTPATIENT SERVICE COST CENTERS	J	<u> </u>		0 2/02///00	0.00000	70.77
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	Ö	1	0 0		
90.00	09000 CLINIC	o o	Ö	1	0 8, 894, 157		
90.00	09001 DI ABETES CENTER	0		1	0 8,874,137	0.000000	
90.01	09001 DIABETES CENTER	0		1	0		
		-	0	1			
90. 03	09003 WOUND CENTER	0	0	1	0 10, 248, 789		
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0	1	0 708, 639		
90. 05	09005 VI MCARE CLI NI C	0	0	1	0 1, 679, 714	l .	1
90. 06	09006 MEDICATION MGMT CLINIC	0	0	l .	0 778, 235		
91. 00	09100 EMERGENCY	0	0	1	0 87, 541, 259		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 15, 043, 819	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	1, 696, 764	1, 696, 7	782, 265, 985		200.00

Health Financial Systems	COLUMBUS REGION	JAI HOSPITAI		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS		Provider C	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet D Part IV Date/Time Pre	
		· ·			5/30/2023 8: 4	0 am
		Title	· XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7) 9.00	10. 00	x col. 10)	12.00	x col . 12)	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11. 00	12.00	13. 00	
50. 00 05000 OPERATING ROOM	0. 000000	31, 116	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	2, 765	0		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2, 709	ĺ		0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	6, 390	Ö		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 145404	15, 914	2, 314	0	0	1
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	8, 366	0	0	0	54. 01
54.02 05404 ULTRA SOUND	0. 000000	13, 161	0	0	0	54.02
54. 03 05405 MAMMOGRAPHY	0. 000000	0	0		0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0		0	
57.00 05700 CT SCAN	0. 000000	44, 313	0		0	
58. 00 05800 MRI	0. 000000	13, 305	0		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 655	0		0	
60. 00 06000 LABORATORY	0. 000000	274, 857	0		0	
60. 01 06001 LABORATORY-PATHOLOGICAL	0. 000000	391	0		0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	20, 747	0		0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 000000 0. 000000	658, 958	0 0		0	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	956, 881 926, 569			0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	312, 600			0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	23, 771			0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	23, 7, 1	ĺ		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	96, 767	l o		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 219	Ö		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 005124	445, 433	2, 282	0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	77, 651	0	0	0	74.00
76. 00 03020 ACUPUNCTURE	0. 000000	0	0		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0			0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	•		0	
90. 00 09000 CLINIC	0.000000	0			0	
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	0. 000000 0. 000000	0	0		0	
90. 03 09003 WOUND CENTER	0. 000000	0			0	1
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0		0	1
90. 05 09005 VI MCARE CLI NI C	0. 000000	0	-	-	0	
90. 06 09006 MEDICATION MGMT CLINIC	0. 000000	0			0	1
91. 00 09100 EMERGENCY	0. 000000	13, 052	-		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	Ō		0	1
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		3, 955, 881	4, 596	60	0	200. 00

Health Financial Systems	COLUM	BUS REGIONAL HOSPI	ΓAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACC	INE COST Provid	ler CCN: 15-0112	Peri od: From 01/01/2022	Worksheet D Part V
		Compor	nent CCN: 15-T112	To 12/31/2022	Date/Time Prepared:

			'			5/30/2023 8: 4	O am
			Title	XVIII	Subprovi der -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi ces (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.001010		1			
	O5000 OPERATING ROOM	0. 336263	0	1	0		
	05100 RECOVERY ROOM	0. 342215	0	1	0		1
	05200 DELIVERY ROOM & LABOR ROOM	0. 837183	0		0	_	
	D5300 ANESTHESI OLOGY	0. 015853	0		0	_	
	05400 RADI OLOGY-DI AGNOSTI C	0. 704158	0	l .	0	1	1
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 256328	0	1	0	0	
	05404 ULTRA SOUND	0. 227911	0		0	0	
54. 03	D5405 MAMMOGRAPHY	0. 308242	0	1	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 219164	0	1	0	0	55.00
	D5700 CT SCAN	0. 075581	0	1	0	0	57.00
58.00	05800 MRI	0. 127393	0)	0 0	0	58. 00
59.00	D5900 CARDIAC CATHETERIZATION	0. 166481	0		0	0	59.00
60.00	06000 LABORATORY	0. 227289	0		0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 315253	0)	0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 275087	0	1	0 0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 216410	0	1	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 409958	0	1	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 420753	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY	0. 572635	O		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 180143	0		o o	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 212431	0		o o	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 280385	0		o o	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 578528	0		0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0. 319824	0		0	0	1
	07400 RENAL DIALYSIS	0. 303192	Ö	1	0	o o	1
	03020 ACUPUNCTURE	0. 000000	0		o o	o o	1
	07697 CARDI AC REHABI LI TATI ON	0. 390750	Ö	1	o o		
_	OUTPATIENT SERVICE COST CENTERS	0.070700		l	<u> </u>		10.77
	08800 RURAL HEALTH CLINIC						88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
	09000 CLINIC	0. 489489	0		o	0	1
	09001 DI ABETES CENTER	0. 000000		1	0	Ö	
	09002 NEUROPSYCH	1. 195351		1	0 0	Ö	1
	09003 WOUND CENTER	0. 240188		1	0 0		1
	09004 HYPERBARI C OXYGEN THERAPY	0. 561632			0 0		1
1	09005 VIMCARE CLINIC	1		1			
	09006 MEDICATION MGMT CLINIC	1. 083393		1	0		1
		0. 694049	-		0	0	
	09100 EMERGENCY	0. 220020	60		0 0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 483005	0		0 0		92.00
	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0. 522175		I	ol		95.00
200.00		0. 5221/5	40	1		12	
	Subtotal (see instructions)		60		0 0] 13	200.00
201. 00	Less PBP Clinic Lab. Services-Program				0		201.00
202.00	Only Charges (Line 200 Line 201)		/_			10	202 00
202. 00	Net Charges (line 200 - line 201)	1	60	1	0 0	13	202.00

	Financial Systems	COLUMBUS REGIO				u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der (CCN: 15-0112	Peri od: From 01/01/2022	Worksheet D Part V	
			Component	CCN: 15-T112		Date/Time Pr 5/30/2023 8:	epared:
			Ti tl	e XVIII	Subprovi der -	PPS	40 alli
		Cos	sts		IRF		
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To Ded. & Coins.	Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	•	1			50.00
	05100 RECOVERY ROOM	0					51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	l ·	1			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		l .				54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		1	1			54. 01
54. 02	05404 ULTRA SOUND	0	1	- 1			54. 02
54.03	05405 MAMMOGRAPHY	0					54. 03
	05500 RADI OLOGY-THERAPEUTI C	0	•	1			55. 00
57. 00	05700 CT SCAN	0	•	1			57.00
58.00	05800 MRI	0					58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	l .				59. 00 60. 00
60. 00	06001 LABORATORY-PATHOLOGI CAL		1	- 1			60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		l .	1			62.00
65.00	06500 RESPIRATORY THERAPY	0					65.00
66.00	06600 PHYSI CAL THERAPY	0) ()			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	1			67.00
68. 00	06800 SPEECH PATHOLOGY	0	1				68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1	- 1			69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1	1			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS			- 1			72.00
	07300 DRUGS CHARGED TO PATIENTS	0					73.00
74.00	07400 RENAL DIALYSIS	0					74.00
76.00	03020 ACUPUNCTURE	0	1				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0) ()			76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		1	1			88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLINIC	0					90.00
90. 01	09001 DI ABETES CENTER	0	l .				90. 01
90. 02	09002 NEUROPSYCH	0					90. 02
90. 03	09003 WOUND CENTER	0	1	- 1			90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	1				90. 04
90.05	09005 VI MCARE CLI NI C	0	•	1			90.05
90. 06 91. 00	09006 MEDICATION MGMT CLINIC	0	l .	1			90.06
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0		1			91.00
72.00	OTHER REIMBURGARIE COST CENTERS		1	1			J 72.00

0

0

95.00

200.00

202.00

09100 EMERGENCY
09200 OBSERVATION BEDS (NON-DISTINCT PART
OTHER REI MBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

95.00

200. 00 201. 00

202.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Pre 5/30/2023 8:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)		Per Diem (col. 3 / col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 42. 00 SUBPROVIDER 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199) Cost Center Description	5, 425, 347 920, 890 0 0 0 0 619, 745 0 130, 968 0 7, 096, 950 Inpatient Program days	0 0 0	5, 425, 34 920, 89 619, 74 130, 96 7, 096, 95	3, 846 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	144. 00 239. 44 0. 00 0. 00 0. 00 0. 00 179. 48 0. 00 43. 40 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	961 115 0 0 0 101 0 246 0 1, 423	0 0 0 18, 127 0 10, 676				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 200. 00

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

From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am Title XIX Hospi tal PPS Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent (column 3 x to Charges Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 0.050214 50 00 05000 OPERATING ROOM 5, 588, 286 111, 289, 949 3, 858, 175 193, 734 214, 548 05100 RECOVERY ROOM 9,066,340 0.023664 348, 796 51.00 51.00 8, 254 05200 DELIVERY ROOM & LABOR ROOM 5, 147, 953 52.00 291, 403 0.056606 1, 869, 094 105, 802 52.00 05300 ANESTHESI OLOGY 18, 305 17, 321, 214 0.001057 762, 543 53.00 806 53.00 05400 RADI OLOGY-DI AGNOSTI C 15, 559 54.00 573, 275 7, 140, 679 0.080283 193, 801 54.00 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 457, 872 13, 767, 143 0.033258 75, 011 2, 495 54.01 54.02 05404 ULTRA SOUND 123, 390 7, 801, 256 0.015817 250, 405 3, 961 54.02 54 03 05405 MAMMOGRAPHY 416, 040 6, 206, 056 0.067038 Ω 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 212, 646 23, 557, 432 0.051476 62, 238 3, 204 55.00 57.00 05700 CT SCAN 227, 198 42, 450, 832 0.005352 1, 705, 470 9, 128 57.00 58.00 05800 MRI 10, 549, 756 0.025557 438, 715 269, 615 11, 212 58.00 05900 CARDI AC CATHETERI ZATI ON 829, 232 33, 194, 438 1, 879, 827 59.00 0.024981 46, 960 59 00 60.00 06000 LABORATORY 1, 232, 463 83, 095, 475 0.014832 4, 526, 231 67, 133 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 147, 316 7, 954, 012 0.018521 128, 822 2, 386 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 702, 695 0.012589 289.345 62.00 46,612 3,643 62.00 65.00 06500 RESPIRATORY THERAPY 606,800 35, 608, 119 0.017041 3, 408, 659 58,087 65.00 06600 PHYSI CAL THERAPY 650, 719 19, 675, 668 66.00 0.033072 327, 471 10,830 66.00 06700 OCCUPATI ONAL THERAPY 236, 527 7, 109, 159 268, 946 67.00 0.033271 8,948 67.00 111, 839 905 68.00 06800 SPEECH PATHOLOGY 2, 247, 818 0.049754 18, 184 68.00 69.00 06900 ELECTROCARDI OLOGY 404, 230 14, 751, 188 0.027403 665, 214 18, 229 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 259, 014 9, 036, 609 0.028663 90,644 2,598 70.00 1, 905, 444 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 277, 165 34, 133, 137 0.008120 15, 472 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 307, 125 18, 512, 970 0.016590 584, 273 9,693 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 572, 778 128, 512, 935 0.012238 6, 158, 146 75, 363 73.00 07400 RENAL DIALYSIS 74.00 29, 384 3, 329, 228 0.008826 698, 461 6, 165 74.00 03020 ACUPUNCTURE 76 00 0.000000 76.00 0 76.97 07697 CARDIAC REHABILITATION 79,013 2,021,133 0.039093 1,596 62 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89 00 0 89 00 90.00 09000 CLI NI C 404, 171 8, 894, 157 0.045442 5, 347 243 90.00 09001 DI ABETES CENTER 0.000000 90.01 90.01 90.02 09002 NEUROPSYCH 11.395 188. 179 0.060554 1.062 90.02 64 90.03 09003 WOUND CENTER 172, 816 10, 248, 789 59 90.03 0.016862 3, 475 90.04 09004 HYPERBARIC OXYGEN THERAPY 113, 876 708, 639 0.160697 0 90.04 90.05 09005 VIMCARE CLINIC 221, 353 1, 679, 714 0.131780 1,663 219 90.05 09006 MEDICATION MGMT CLINIC 90.06 55.009 0.070684 90.06 778, 235 0 09100 EMERGENCY 91.00 1, 338, 853 87, 541, 259 0.015294 4, 330, 361 66, 229 91.00 544, 735 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 15, 043, 819 0.036210 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 200.00 Total (lines 50 through 199) 19, 045, 003 782, 265, 985 34, 857, 419 747, 443 200.00

Health Financial Systems		CO	LUMBUS REG	I ONAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIEN	T ROUTINE SERVICE	OTHER PASS	THROUGH C	0STS	Provi der (Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/30/2023 8:4	
					Ti t	le XIX	Hospi tal	PPS	
Cost Center I	escri pti on		Nursi ng		Nursi ng	Allied Healt	Allied Health	All Other	

				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health		All Other	
oost conten beschiptron	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown	i i ogi alli	Adjustments	0031	Educati on	
	Adjustments		Aujustillerits		Cost	
	1A	1. 00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
					1 0	
30. 00 03000 ADULTS & PEDI ATRI CS	0		(
31.00 03100 INTENSIVE CARE UNIT	0		(-	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	(0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	(0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0	(0	41.00
42. 00 04200 SUBPROVI DER	0	o o	7		Ö	42.00
	0	0			0	
		1		-	U	43.00
44.00 04400 SKILLED NURSING FACILITY	0		(-		44.00
200.00 Total (lines 30 through 199)	0	0	(,		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient		Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				*		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	37, 67	0.00	961	30.00
31. 00 03100 I NTENSI VE CARE UNI T	_	o	3, 846			31.00
32. 00 03200 CORONARY CARE UNIT		o o	(0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0			-	33.00
		1	-			1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	-	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0	(0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	1	3, 453			41.00
42. 00 04200 SUBPROVI DER	0	0	(0.00	0	42.00
43. 00 04300 NURSERY		0	3, 018	0.00	246	43.00
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	0	44.00
200.00 Total (lines 30 through 199)		0	47, 994	1	1, 423	200.00
Cost Center Description	Inpatient		,	•	., .==	
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
	0					20.00
		l .				30.00
31.00 03100 INTENSIVE CARE UNIT	0	l .				31.00
32.00 O3200 CORONARY CARE UNIT	0	l .				32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	l .				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
42. 00 04200 SUBPROVI DER	o o					42.00
43. 00 04300 NURSERY	0					43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0					44.00
200.00 Total (lines 30 through 199)	l 0	l				200. 00

THROUGH COSTS				To 12/31/2022	Date/Time Pre 5/30/2023 8:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	O alli
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
'	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
ANOULL ARV. OF DIVI OF COOT, OF NITERO	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			ı		_	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	ľ	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0		0	1, 038, 282	54. 00 54. 01
		0		0	0	
54. 02 05404 ULTRA SOUND 54. 03 05405 MAMMOGRAPHY		0		0		54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57. 00 05700 CT SCAN		0		0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 LABORATORY - PATHOLOGI CAL		0		0 0	0	60.00
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	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0			Ö	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	Ö	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	l ő	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	658, 482	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76. 00 03020 ACUPUNCTURE	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	l	76. 97
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90. 00 09000 CLI NI C	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 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	90. 04
90. 05 09005 VI MCARE CLI NI C	0	0		0 0	0	90. 05
90.06 O9006 MEDICATION MGMT CLINIC	0	0		0 0	0	90.06
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	1, 696, 764	200.00

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared:

THROUG	in COSTS				o 12/31/2022	Date/Time Pre 5/30/2023 8:4	
-			Ti tl	e XIX	Hospi tal	PPS	o ani
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
	, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			ĺ	and 4)	,	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	0	111, 289, 949	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	.,	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	5, 147, 953	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	17, 321, 214	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 038, 282	1, 038, 282	7, 140, 679	0. 145404	54.00
54. 01	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0	0	, ,	0. 000000	54. 01
54.02	05404 ULTRA SOUND	0	0	0	7,001,200	0.000000	54.02
54.03	05405 MAMMOGRAPHY	0	0	0	6, 206, 056	0.000000	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	23, 557, 432	0.000000	55.00
57.00	05700 CT SCAN	0	0	C	42, 450, 832	0.000000	57.00
58.00	05800 MRI	0	0	C	10, 549, 756	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	33, 194, 438	0.000000	59.00
60.00	06000 LABORATORY	0	0	C	83, 095, 475	0.000000	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0	C	7, 954, 012	0.000000	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	3, 702, 695	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	35, 608, 119	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	19, 675, 668	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	7, 109, 159	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2, 247, 818	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	14, 751, 188	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	9, 036, 609	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	34, 133, 137	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18, 512, 970	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	658, 482	658, 482	128, 512, 935	0. 005124	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	3, 329, 228	0.000000	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0.000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	2, 021, 133	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	C	8, 894, 157	0.000000	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0.000000	90. 01
90. 02	09002 NEUROPSYCH	0	0	0	188, 179	0.000000	90. 02
90. 03	09003 WOUND CENTER	0	0	0	10, 248, 789	0.000000	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0	0	708, 639	0.000000	90.04
90.05	09005 VI MCARE CLI NI C	0	0	0	1, 679, 714	0.000000	90.05
90.06	09006 MEDICATION MGMT CLINIC	0	0	O	778, 235	0. 000000	90.06
91.00	09100 EMERGENCY	0	0	0	87, 541, 259	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	15, 043, 819	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	1, 696, 764	1, 696, 764	782, 265, 985		200. 00

Health Financial Systems	COLUMBUS REGIONA	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPA THROUGH COSTS	FIENT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2022	Worksheet D Part IV Date/Time Prepared:

			To	12/31/2022	Date/Time Pre 5/30/2023 8:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	o diii
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	-	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	3, 858, 175	0	0	0	
51.00 05100 RECOVERY ROOM	0. 000000	348, 796	0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1, 869, 094	0	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	762, 543	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 145404	193, 801	28, 179	0	0	1
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	75, 011	0	0	0	
54. 02 05404 ULTRA SOUND	0. 000000	250, 405	0	0	0	
54. 03 05405 MAMMOGRAPHY	0. 000000	0	0	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	62, 238	0	0	0	
57. 00 05700 CT SCAN	0. 000000	1, 705, 470	0	0	0	
58. 00 05800 MRI	0. 000000	438, 715	0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 879, 827	0	0	0	
60. 00 06000 LABORATORY	0. 000000	4, 526, 231	0	0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	128, 822	0	0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	289, 345	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 408, 659	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	327, 471	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	268, 946	0	o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	18, 184	0	o	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	665, 214	0	o	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	90, 644	0	o	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 905, 444	0	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	584, 273	0	0	0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 005124	6, 158, 146	31, 554	0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	698, 461	0	0	0	1
76. 00 03020 ACUPUNCTURE	0. 000000	0	0	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	1, 596	0	0	0	
OUTPATIENT SERVICE COST CENTERS		.,,,,,,	-1			1
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	5, 347	0	0	0	90.00
90. 01 09001 DI ABETES CENTER	0. 000000	0	0	O	0	90. 01
90. 02 09002 NEUROPSYCH	0. 000000	1, 062	0	0	0	90.02
90. 03 09003 WOUND CENTER	0. 000000	3, 475	0	o	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	o	0	90.04
90. 05 09005 VI MCARE CLI NI C	0. 000000	1, 663	0	o	0	
90.06 09006 MEDICATION MGMT CLINIC	0. 000000	0	0	o	0	90.06
91. 00 09100 EMERGENCY	0. 000000	4, 330, 361	0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	o	0	
OTHER REIMBURSABLE COST CENTERS	1. 111300		,	<u> </u>		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		34, 857, 419	59, 733	0	0	200.00
	•					

 Heal th Financial Apportionment of Apportion
 Systems
 COLUMBUS REGIO

 Apportion
 OTHER HEALTH SERVICES AND VACCINE COST
 | Peri od: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time | Prepared: Provider CCN: 15-0112

				1	0 12/31/2022	5/30/2023 8:4	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	'	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	1	0. 336263	0			0	
51.00		0. 342215	0			0	51.00
52.00	I I	0. 837183	0	-,		0	
53.00	05300 ANESTHESI OLOGY	0. 015853	0		0	0	53.00
54.00		0. 704158	0			0	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 256328	0	.,,		0	54. 01
54. 02	05404 ULTRA SOUND	0. 227911	0			0	54. 02
54. 03	05405 MAMMOGRAPHY	0. 308242	0			0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 219164	0	_,,		0	55.00
57.00	05700 CT SCAN	0. 075581	0	-, ,		0	57.00
58. 00	1	0. 127393	0			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 166481	0			0	59. 00
60.00	06000 LABORATORY	0. 227289	0	,,		0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 315253	0			0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 275087	0		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 216410	0	.,	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 409958	0	_, _,,	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 420753	0			0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 572635	0			0	68. 00
69.00		0. 180143	0	.,		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 212431	0			0	
71. 00		0. 280385	0	_,,		0	71.00
72.00	I I	0. 578528	0	,		0	72.00
73.00	I I	0. 319824	0		0	0	
74.00		0. 303192	0		0	0	74. 00
76.00	03020 ACUPUNCTURE	0. 000000	0			0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 390750	0	76, 022	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	1		1	1		
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLI NI C	0. 489489	0			0	1
90. 01	09001 DI ABETES CENTER	0. 000000	0	1	0	0	90. 01
90. 02	09002 NEUROPSYCH	1. 195351	0	0,		0	90.02
90. 03	09003 WOUND CENTER	0. 240188	0	.,,		0	90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0. 561632	0	1	-	0	90. 04
90. 05	09005 VI MCARE CLI NI C	1. 083393	0			0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 694049	0			0	90.06
91.00	09100 EMERGENCY	0. 220020	0			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 483005	0	3, 510, 152	0	0	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0 5004==1		0.000.5:-			05.00
95.00	1	0. 522175	0			_	95.00
200.00			0			0	200.00
201.00				0	0		201. 00
202.00	Only Charges		^	00 010 017		_	202 20
202.00	Net Charges (line 200 - line 201)	1	0	99, 013, 917	0	0	202. 00

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 8: 40 am

						5/30/2023 8: 40	am
			Ti tl e	e XIX	Hospi tal	PPS	
		Cost	S				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. D	ed. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 049, 510	0				50.00
51. 00	05100 RECOVERY ROOM	417, 920	0				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 141	o				52. 00
53. 00	05300 ANESTHESI OLOGY	31, 254	o				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	791, 037	0				54. 00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	338, 869	0				54. 01
54. 01	05404 ULTRA SOUND	373, 478	0				54. 02
54. 02	05405 MAMMOGRAPHY	183, 999	0				54. 02
55.00	05500 RADI OLOGY-THERAPEUTI C		0				55.00
	l	656, 643					
57.00	05700 CT SCAN	510, 417	0				57.00
58.00	05800 MRI	176, 962	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	200, 693	0				59. 00
60.00	06000 LABORATORY	2, 843, 070	0				60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	289, 883	0				60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	68, 937	0				62.00
65.00	06500 RESPI RATORY THERAPY	237, 796	0				65.00
66.00	06600 PHYSI CAL THERAPY	823, 114	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	176, 098	0				67.00
68.00	06800 SPEECH PATHOLOGY	312, 274	0				68.00
69.00	06900 ELECTROCARDI OLOGY	183, 984	O				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	402, 438	o				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	623, 545	ol				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	521, 286	ol				72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 692, 989	0				73.00
74. 00	07400 RENAL DI ALYSI S	0	0				74. 00
76. 00	03020 ACUPUNCTURE		o				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	29, 706	o				76. 97
10. 11	OUTPATIENT SERVICE COST CENTERS	27, 700	O _I				10. 71
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	592, 842	0				90.00
90.00		392, 642	- 1				90.00
	09001 DI ABETES CENTER	0.722	0				
90. 02	09002 NEUROPSYCH	9, 733	0				90.02
90. 03	09003 WOUND CENTER	340, 961	0				90. 03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	0				90. 04
90. 05	09005 VI MCARE CLI NI C	1, 081, 976	0				90. 05
90.06	09006 MEDICATION MGMT CLINIC	29, 287	0				90.06
91.00	09100 EMERGENCY	4, 667, 642	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 695, 421	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 531, 207					95.00
200.00	Subtotal (see instructions)	27, 888, 112	0			2	200.00
201.00	Less PBP Clinic Lab. Services-Program	0				2	201.00
	Only Charges						
202.00		27, 888, 112	0			2	202.00

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0112	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022		
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days	.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 3				1.00
2.00 Inpatient days (including private room days,					2.00
3.00 Private room days (excluding swing-bed and o	observation bed da	ys). If you have only p	rivate room days,	0	3. 00

	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	37, 677	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	37, 677	
3. 00	do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	33, 894	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
7.00	report ing period	١	/
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	10 210	9.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	12, 310	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT		
17. 00		0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	72, 368, 634	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)	ا	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) 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)	72, 368, 634	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	72, 368, 634	1
	27 minus line 36)]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 020 7/	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 920. 76 23, 644, 556	1
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	23, 044, 330	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	23, 644, 556	41.00

	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	0	7. 00
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)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	12, 310	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	72, 368, 634 0	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	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)	0	25. 00
26. 00 27. 00		0 72, 368, 634	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	
29. 00	Pri vate room charges (excluding swing-bed charges)	Ö	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
34. 00 35. 00			34. 00 35. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	36.00
37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost 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)	1, 920. 76	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	23, 644, 556	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	23, 644, 556	41.00

alth Financial Systems CO MPUTATION OF INPATIENT OPERATING COST	JLUMBUS REGION	Provider C		<u>In Lie</u> Period: Trom 01/01/2022	u of Form CMS-2 Worksheet D-1	
		Title	Т	o 12/31/2022	Date/Time Pre 5/30/2023 8:4	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1. 00	2.00	3. 00	4.00	5. 00 0	42.
Intensive Care Type Inpatient Hospital Units						
. OO INTENSIVE CARE UNIT . OO CORONARY CARE UNIT	14, 329, 691	3, 846 0			3, 189, 345 0	1
. OO BURN INTENSIVE CARE UNIT	0	0			0	45.
. OO SURGICAL INTENSIVE CARE UNIT	Ö	0			0	
. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1. 00	
.00 Program inpatient ancillary service cost (Wkst					22, 946, 419	
0.01 Program inpatient cellular therapy acquisition				column 1)	0	
1.00 Total Program inpatient costs (sum of lines 41 PASS THROUGH COST ADJUSTMENTS	through 48.0	1) (See Thistru	ctions)		49, 780, 320	49.
.00 Pass through costs applicable to Program inpat	ient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 977, 601	50.
				6.5	4 000 540	
.00 Pass through costs applicable to Program inpat and IV)	ment ancillar	y services (f	rom Wkst. D, s	um of Parts II	1, 902, 549	51.
.00 Total Program excludable cost (sum of lines 50	and 51)				3, 880, 150	52.
.00 Total Program inpatient operating cost excludi	ng capital re	lated, non-ph	ysician anesth	etist, and	45, 900, 170	53.
medical education costs (line 49 minus line 52 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
.00 Program discharges					0	54.
.00 Target amount per discharge					0. 00	55.
.01 Permanent adjustment amount per discharge					0. 00	
.02 Adjustment amount per discharge (contractor us .00 Target amount (line 54 x sum of lines 55, 55.0					0.00	55. 56.
.00 Difference between adjusted inpatient operatir			line 56 minus	line 53)	0	57
.00 Bonus payment (see instructions)	.g	, g			0	58
.00 Trended costs (lesser of line 53 ÷ line 54, or	line 55 from	the cost rep	orting period	endi ng 1996,	0. 00	59.
updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, c	or line 55 fro	m nrior vear	rost renort II	ndated by the	0. 00	60
market basket)	, TTHE 33 TTO	iii piror year	cost report, u	paarea by the	0.00	00.
.00 Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the lesse 53) are less than expected costs (lines 54 x 6 enter zero. (see instructions)	er of 50% of t	he amount by	which operatin	g costs (line	0	61.
.00 Relief payment (see instructions)					0	62.
. 00 Allowable Inpatient cost plus incentive paymer	nt (see instru	ctions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST .00 Medicare swing-bed SNF inpatient routine costs	through Dece	mber 31 of the	e cost renorti	na period (See	0	64.
instructions)(title XVIII only)	in ough bood		5 5551 1 5pc. 1.	g po ou (000		"
.00 Medicare swing-bed SNF inpatient routine costs	after Decemb	er 31 of the	cost reporting	period (See	0	65.
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient routine	costs (line	64 plus line	65)(title XVII	l only)· for	0	66.
CAH, see instructions	(11110	o. p. do	00) (11 11 0 711 1			
.00 Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost re	porting period	0	67.
(line 12 x line 19) 1.00 Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost reno	rting period	0	68.
(line 13 x line 20)				g p		
.00 Total title V or XIX swing-bed NF inpatient ro					0	69.
PART III - SKILLED NURSING FACILITY, OTHER NUR Skilled nursing facility/other nursing facilit						70.
.00 Adjusted general inpatient routine service cos	st per diem (I					71.
.00 Program routine service cost (line 9 x line 71	•	(lin- 11 '	ino 25)			72.
.00 Medically necessary private room cost applicat .00 Total Program general inpatient routine servic		•	•			73.
.00 Capital-related cost allocated to inpatient ro				art II, column		75.
26, line 45)	0)					l _,
00 Per diem capital-related costs (line 75 ÷ line 70 Program capital-related costs (line 9 x line 70 Program capital-related costs (line 9 x line 70 Program capital-related costs (line 9 x line 70 Program capital-related costs (line 75 ÷ line 70 Program capital-related costs (line 75 ÷ line 70 Program capital-related costs (line 75 ÷ line 70 Program capital-related costs (line 75 + line 70 Pro						76.
00 Inpatient routine service cost (line 74 minus	•					78
.00 Aggregate charges to beneficiaries for excess	costs (from p					79.
Total Program routine service costs for compar		ost limitatio	n (line 78 min	us line 79)		80
.00 Inpatient routine service cost per diem limita .00 Inpatient routine service cost limitation (lir)				81.
.00 Reasonable inpatient routine service costs (se		•				83
.00 Program inpatient ancillary services (see inst		•				84
.00 Utilization review - physician compensation (s						85
.00 Total Program inpatient operating costs (sum of PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.
.00 Total observation bed days (see instructions)	THROUGH CUST				3, 783	87.
.00 Adjusted general inpatient routine cost per di	(1: 27	1: 2)			1, 920. 76	1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 0 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88)	(see instructions))			7, 266, 235	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	UGH COST					
90.00 Capital-related cost	5, 425, 347	72, 368, 634	0. 07496	7, 266, 235	544, 735	90.00
91.00 Nursing Program cost	o	72, 368, 634	0. 00000	7, 266, 235	0	91.00
92.00 Allied health cost	0	72, 368, 634	0. 00000	7, 266, 235	0	92.00
93.00 All other Medical Education	0	72, 368, 634	0. 00000	7, 266, 235	0	93. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0112		Worksheet D-1
	Component CCN: 15-T112	From 01/01/2022 To 12/31/2022	
	Title XVIII	Subprovi der -	PPS
		IRF	

			I RF		
	Cost Center Description			4 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			3, 453	1.00
2.00	Inpatient days (including private room days, excluding swing-be			3, 453	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). It you have only pr	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	d days)		3, 453	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room	n days) through Decembe	r 31 of the cost	0	5. 00
4 00	reporting period	dovo) after December	21 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 899	9.00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent			_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar yea			O	13.00
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0. 00	17. 00
	reporting period	Ü			
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			5, 601, 706	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line		22.00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)		3 1 1		
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		5, 601, 706	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	ua lina 22) (aaa inatrua	+: 000)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line	, ,	tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	, 01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	5, 601, 706	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 622. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		3, 080, 691	39. 00
40.00	Medically necessary private room cost applicable to the Program			2 090 601	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	- ITTIE 40 <i>)</i>		3, 080, 691	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	COLUMBUS REGIO		CN: 15-0112	Peri od:	wof Form CMS-2 Worksheet D-1	
				CCN: 15-T112	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared
			Title	: XVIII	Subprovi der -	5/30/2023 8: 4 PPS	O am
	Cost Contor Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	Cost Center Description	Inpatient Cost	I npati ent Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
2. 00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4. 00 00 0	5.00	42.0
1	ntensive Care Type Inpatient Hospital Units						
- 1	INTENSIVE CARE UNIT	0					43.0
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	_	1		l .	
	SURGI CAL INTENSI VE CARE UNI T	0				Ö	1
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wk					1, 413, 102	48.
	Program inpatient cellular therapy acquisiti				D, column 1)	0	
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	ctions)		4, 493, 793	49.
	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sı	um of Parts I and	340, 833	50.
	III)	-+:+:!!		W+ D		110 101	
	Pass through costs applicable to Program inp and IV)	atient ancillai	ry services (f	ιυπ WKST. D,	sum or Parts II	110, 181	51.
2. 00	Total Program excludable cost (sum of lines					451, 014	52.
	Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	thetist, and	4, 042, 779	53.
	medical education costs (line 49 minus line FARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	54.
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)				0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55)			0.00	
	Difference between adjusted inpatient operat			line 56 minus	s line 53)	0	1
	D Bonus payment (see instructions)						
	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	m the cost rep	orting period	d ending 1996,	0.00	59.
0. 00							60.
1. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61.
	Relief payment (see instructions)					0	62.
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	63.
1. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64.
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See						65.
5. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.
7. 00	on, see histractions Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost i	reporting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after l	December 31 of	the cost rep	porting period	0	68.
Ī	Total title V or XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY		0	69.
- 1	Skilled nursing facility/other nursing facil	,		•	7)		70.
- 1	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		iine /o - iine	۷)			71. 72.
3. 00	Medically necessary private room cost applic	abĺe to Program					73.
5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•		•	Part II, column		74. 75.
	26, ille 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
. 00	Program capital-related costs (line 9 x line	76)					77.
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		nrovider recor	ds)			78. 79.
	Aggregate charges to beneficialies for exces Total Program routine service costs for comp				nus line 79)		80
. 00	Inpatient routine service cost per diem limi	tati on		,	,		81
- 1	Inpatient routine service cost limitation (I						82.
- 1	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83. 84.
1	Utilization review - physician compensation		ons)				85.
	Total Program inpatient operating costs (sum		hrough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2022 To 12/31/2022		pared: 0 am
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 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)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		· ·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	619, 745	5, 601, 706	0. 11063	5 0	0	90.00
91.00 Nursing Program cost	0	5, 601, 706	0.00000	0	0	91.00
92.00 Allied health cost	0	5, 601, 706	0.00000	0	0	92.00
93.00 All other Medical Education	0	5, 601, 706		0	0	93.00
·		·		•		

Heal th	Financial Systems COLUMBUS REGIONAL	_ HOSPITAL	In Lie	u of Form CMS-2	2552-10	
COMPUT	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-0112	Peri od:	Worksheet D-1		
			From 01/01/2022	D. L. (T' D.		
			To 12/31/2022	Date/Time Pre 5/30/2023 8:4		
		Title XIX	Hospi tal	PPS	J alli	
	Cost Center Description	THE MIX	1103pt tui	110		
	occi conton pocon per on			1. 00		
	PART I - ALL PROVIDER COMPONENTS			11.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		37, 677	1.00	
2. 00	Inpatient days (including private room days, excluding swing-			37, 677	2.00	
3.00	Private room days (excluding swing-bed and observation bed days	ys). If you have only p	rivate room days,	0	3.00	
	do not complete this line.					
4.00	0 Semi-private room days (excluding swing-bed and observation bed days)					
5.00						
	reporting period					
6.00	.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0					
	reporting period (if calendar year, enter 0 on this line)				l	
7. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7. 00	
	reporting period					
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	5 (
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	961	9. 00	
10. 00	newborn days) (see instructions) 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 00 10					
10.00	through December 31 of the cost reporting period (see instruc		i ooiii days)	U	10.00	
11 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, e		100m days) arter	0	11.00	
12.00			te room days)	0	12.00	
12.00	through December 31 of the cost reporting period	x only (merdaring priva	to room days)		12.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room davs)	0	13.00	
	after December 31 of the cost reporting period (if calendar y				-	
14.00	Medically necessary private room days applicable to the Progr			0	14.00	
15.00	Total nursery days (title V or XIX only)	- 0	- '	3, 018	15.00	
16 00	00 Nursery days (title V or XIX only)					

COMPUTA	TION OF INPATIENT OPERATING COST		NAL HOSPITAL Provider Co	CN: 15-0112	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 To 12/31/2022		
			Ti +I	e XIX	Hospi tal	5/30/2023 8: 4 PPS	0 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
	·	I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 2, 952, 722	2. 00 3, 018	3. 00 978. 3	4. 00 37 246	5. 00 240, 679	42.00
	Intensive Care Type Inpatient Hospital Units	2, 732, 722	3,010	770.	240	240, 079	42.00
	INTENSIVE CARE UNIT	14, 329, 691	3, 846	3, 725. 8	37 115	428, 475	43.00
	CORONARY CARE UNIT	0	0	0. (0	
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0.0		0	
	OTHER SPECIAL CARE (SPECIFY)	0	0	0. (00 0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III lino 10	column 1)	10, 024, 264 0	1
	Total Program inpatient costs (sum of lines				, corumir r)	12, 539, 268	1
	PASS THROUGH COST ADJUSTMENTS	Tr tim dugit to	77 (000 111011 4	21. 0.10)		12/00//200	17.0
	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, su	m of Parts I and	176, 596	50.0
) 	ationt ancilla	ny sorvi sos (fi	com Wkst D	cum of Dorte II	007 174	51.00
	Pass through costs applicable to Program inp and IV)	atrent anciria	y services (11	OIII WKSt. D,	Sum of Parts II	807, 176	31.00
	Total Program excludable cost (sum of lines	50 and 51)				983, 772	52.00
	Total Program inpatient operating cost exclu	0 .	elated, non-phy	ysician anest	hetist, and	11, 555, 496	53.0
	medical education costs (line 49 minus line FARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program discharges					0	54. 0
	Target amount per discharge						55.0
	Permanent adjustment amount per discharge					0. 00	55.0
1	Adjustment amount per discharge (contractor	J ,				0.00	55.0
1	Target amount (line 54 x sum of lines 55, 55				50)	0	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (1	ine 56 minus	Tine 53)	0	57. C
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost repo	orting period	endina 1996	0.00	1
	updated and compounded by the market basket)						
	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report,	updated by the	0. 00	60.0
	market basket) Continuous improvement bonus payment (if lin	o 53 ± lino 54	ie lose than	the lowest of	linge 55 nlue	0	61.0
	55.01, or line 59, or line 60, enter the les					0	01.0
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)					0	/2 0
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)				62. 0 63. 0
⊢	PROGRAM INPATIENT ROUTINE SWING BED COST	(222	,				
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.0
	instructions)(title XVIII only)	to after Decemb	or 21 of the	oost roportin	a ported (Soc	0	65.0
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter beceili	bei 31 01 the t	Lost reportin	ig perrou (see	0	05.0
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.0
	CAH, see instructions		D 1 01	6.11			
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 (or the cost r	eporting period	0	67.0
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	0	68.0
	(line 13 x line 20)						
-	Total title V or XIX swing-bed NF inpatient		•			0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.0
1	Adjusted general inpatient routine service c	,			,		71.0
72.00	Program routine service cost (line 9 x line	71)					72.0
	Medically necessary private room cost applic						73.0
1	Total Program general inpatient routine serv	•			Dart II column		74.0
	Capital-related cost allocated to inpatient 26, line 45)	TOUTTHE SELVICE	custs (IIUIII I	WOI KSHEEL D,	rait II, CUIUIIII		75.0
1	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7. 00	Program capital-related costs (line 9 x line	76)					77. C
	Inpatient routine service cost (line 74 minu		anno di deservici	40)			78.0
1	Aggregate charges to beneficiaries for exces				nue lino 70)		79.0
1	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST TIME LATEOU	ι (ιιιις /δ MI	nus iille /9)		80. 0 81. 0
1	Inpatient routine service cost limitation (1)				82.0
	Reasonable inpatient routine service costs (* .				83.0
34. 00	Program inpatient ancillary services (see in	structions)					84.0
	Utilization review - physician compensation						85.0
	Total Program inpatient operating costs (sum PART IV – COMPUTATION OF OBSERVATION BED PASS		irougn 85)				86.0
	Total observation bed days (see instructions					3, 783	87. C
57. UU I						1, 920. 76	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			7, 266, 235	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 425, 347	72, 368, 634	0. 07496	7, 266, 235	544, 735	90.00
91.00 Nursing Program cost	0	72, 368, 634	0.00000	7, 266, 235	0	91.00
92.00 Allied health cost	0	72, 368, 634	0.00000	7, 266, 235	0	92.00
93.00 All other Medical Education	0	72, 368, 634	0. 00000	7, 266, 235	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 01/01/2022	Worksheet D-1
	Component CCN: 15-T112	To 12/31/2022	Date/Time Prepared: 5/30/2023 8:40 am
	Title XIX	Subprovi der -	
		IRE	

			I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS		I.	1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 453	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	3, 453 0	3.0
3. 00	do not complete this line.	ys). It you have omly pr	Tvate room days,	O	3.0
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 453	4.0
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6.0
6.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	31 OF the Cost	U	0.0
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	100	7.0
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8.0
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (evoluding	swing_bed and	101	9.00
7. 00	newborn days) (see instructions)	o the frogram (excruding	3wi ng-bed and	101	7.0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.0
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.0
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.0
12.00	through December 31 of the cost reporting period	A only (Therdaring privat	e room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.0
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.0
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			3, 018	16.0
10.00	SWING BED ADJUSTMENT			240	10.0
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	f the cost	0. 00	17.0
	reporting period	Ü			
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 0
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Dosombor 21 of	the cost	0.00	19.0
17.00	reporting period	s thi dugit beceiliber 31 of	the cost	0.00	19.0
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.0
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			5, 601, 706	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 0
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23.0
	x line 18)]	_	
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.0
05.00	7 x line 19)	21 . 6 . 11		0	05.0
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	3) of the cost reporting	period (line 8	0	25. 0
26. 00	Total swing-bed cost (see instructions)			0	26.0
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 601, 706	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 0 30. 0
31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11110 20)		0. 00	32.0
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00	34.0
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private seem cost di	fforontial (1)	0 E 401 704	36.0
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	rrenentiai (IINe	5, 601, 706	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 622. 27	1
39.00	Program general inpatient routine service cost (line 9 x line			163, 849	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	•		0 163, 849	ı
		T 1 1 11C 407		10.5 649	1 41. い

	ancial Systems ON OF INPATIENT OPERATING COST	COLUMBUS REGION		CN: 15-0112	In Lie	worksheet D-1	
JOINI OTATIC	on of the Attent of Electrical Cost			CCN: 15-T112	From 01/01/2022 To 12/31/2022	!	
						5/30/2023 8: 4	
			Ti tl	e XIX	Subprovi der - I RF		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
	SERY (title V & XIX only) ensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.0
3. 00 I NT	ENSIVE CARE UNIT	0	C				
	ONARY CARE UNIT N INTENSIVE CARE UNIT	0	C				
1	GICAL INTENSIVE CARE UNIT	0	C	•			1
7. 00 OTH	ER SPECIAL CARE (SPECIFY)						47. (
	Cost Center Description					1. 00	
	gram inpatient ancillary service cost (WH				2 1 1	364, 097	
	gram inpatient cellular therapy acquisiti al Program inpatient costs (sum of lines				D, column 1)	0 527, 946	
PAS	S THROUGH COST ADJUSTMENTS		,				
0.00 Pas	s through costs applicable to Program inp Ն	oatient routine	services (fro	m Wkst. D, sı	um of Parts I and	18, 127	50.0
1) s through costs applicable to Program inp	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.0
	IIV) al Program excludable cost (sum of lines	EO and E1)				18, 127	52.
	al Program inpatient operating cost exclu	,	lated, non-ph	ysician anes	thetist, and	509, 819	
	ical education costs (line 49 minus line	52)	·				
	GET AMOUNT AND LIMIT COMPUTATION gram discharges					T 0	54.
5. 00 Tan	get amount per discharge					0.00	55.
	manent adjustment amount per discharge ustment amount per discharge (contractor	use only)				0. 00 0. 00	
	get amount (line 54 x sum of lines 55, 59					0.00	1
1	ference between adjusted inpatient opera	ting cost and ta	irget amount (line 56 minus	s line 53)	0	1
	us payment (see instructions) ended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	ortina perio	d endina 1996.	0.00	
upd	ated and compounded by the market basket))	•	0 .		0.00	
	.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.
	tinuous improvement bonus payment (if lir					0	61.
	01, or line 59, or line 60, enter the less are less than expected costs (lines 54)						
ent	er zero. (see instructions)		and the gat a		,,		
	<pre>ief payment (see instructions) owable Inpatient cost plus incentive payr</pre>	ment (see instru	ıctions)			0 0	1 .
PR0	GRAM INPATIENT ROUTINE SWING BED COST						
	licare swing-bed SNF inpatient routine cos tructions)(title XVIII only)	sts through Dece	ember 31 of th	e cost repor	ting period (See	0	64.
	licare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reporti	ng period (See	0	65.
1	tructions)(title XVIII only) al Medicare swing-bed SNF inpatient routi	no costs (lino	64 plus lino	45) (+i +l o VVI	II only). for	0	66.
I	ar medicare swring-bed swrimpatrent routh , see instructions	THE COSTS (TITLE	04 prus rine	bs)(title xvi	TT OHLY), TO		00.
	le V or XIX swing-bed NF inpatient routing	ne costs through	December 31	of the cost i	reporting period	0	67.
	ne 12 x line 19) le V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost re	porting period	0	68.
1 7	ne 13 x line 20)	routing costs (line 67 . U.	e 68)		0	69.
PAR ³	al title V or XIX swing-bed NF inpatient T III – SKILLED NURSING FACILITY, OTHER N	JURSING FACILITY	, AND ICF/IID	ONLY			09.
	lled nursing facility/other nursing facil				7)		70.
, ,	usted general inpatient routine service of gram routine service cost (line 9 x line	,	ine /U ÷ iine	2)			71. 72.
3.00 Med	ically necessary private room cost applic	cable to Program					73.
	al Program general inpatient routine servital-related cost allocated to inpatient				Part II column		74. 75.
	line 45)	Toutine Service		worksneet b,	rait II, corumi		, 5.
	diem capital-related costs (line 75 ÷ li						76. 77.
	gram capital-related costs (line 9 x line atient routine service cost (line 74 minu	*					78.
9. 00 Agg	regate charges to beneficiaries for exces	ss costs (from p			11 · · · - 70`		79.
1	al Program routine service costs for compatient routine service cost per diem limi		ost IImitatio	n (line 78 mi	nus line 79)		80.
2. 00 I np	atient routine service cost limitation (I	ine 9 x line 81					82.
	sonable inpatient routine service costs gram inpatient ancillary services (see in		ıs)				83. 84.
	gram inpatient ancillary services (see in Lization review - physician compensation		ons)				85.
6. 00 <u>Tot</u>	al Program inpatient operating costs (sur	of lines 83 th					86.
	T IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component	CCN: 15-T112	From 01/01/2022 To 12/31/2022		pared: O am
		Ti tl	e XIX	Subprovi der -		
Overland Development of the control				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per					0. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	0	0	0. 00000	00	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	0	92.00
93.00 All other Medical Education	0	0	0. 00000		o l	93.00
	1			1		

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od: From 01/01/2022	Worksheet D-3	
				To 12/31/2022	Date/Time Pre 5/30/2023 8:4	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					1 2)	

					5/30/2023 8: 4	0 am
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
	·		To Charges	Program	Program Costs	
			J	Charges	(col. 1 x	
				3	col . 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			2.00	0.00	
30.00	03000 ADULTS & PEDIATRICS			26, 787, 142		30.00
31. 00	03100 I NTENSI VE CARE UNI T			5, 111, 501		31.00
32. 00	03200 CORONARY CARE UNIT			0, 111, 301		32.00
				-		
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T			0		34.00
40.00	04000 SUBPROVI DER - I PF			0		40. 00
41.00	04100 SUBPROVI DER - I RF			0		41. 00
	04200 SUBPROVI DER			0		42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 337044			50.00
51.00	05100 RECOVERY ROOM		0. 342215	814, 961	278, 892	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 837183	10, 157	8, 503	52.00
53.00	05300 ANESTHESI OLOGY		0. 016171	1, 872, 723	30, 284	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 705009	779, 109	549, 279	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 256328			54. 01
54.02	05404 ULTRA SOUND		0. 227911		121, 308	54. 02
54. 03	05405 MAMMOGRAPHY		0. 308242			54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 219975		26, 699	55.00
57. 00	05700 CT SCAN		0. 075581		376, 670	57.00
58. 00	05800 MRI		0. 127393		128, 307	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 166842		913, 036	59.00
60.00						
	06000 LABORATORY		0. 227289			60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL		0. 319940			60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 275087			62.00
65. 00	06500 RESPI RATORY THERAPY		0. 216860			65.00
66. 00	06600 PHYSI CAL THERAPY		0. 411166			66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 420753			67. 00
68.00	06800 SPEECH PATHOLOGY		0. 572635	122, 594	70, 202	68. 00
69.00	06900 ELECTROCARDI OLOGY		0. 180143	2, 370, 340	427, 000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 212431	291, 891	62, 007	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 280385	7, 119, 173	1, 996, 109	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 578528		1, 919, 232	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 319824	13, 748, 909		73.00
	07400 RENAL DI ALYSI S		0. 303192		340, 287	74.00
76.00	03020 ACUPUNCTURE		0.000000			76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 390750		_	76. 97
	OUTPATIENT SERVICE COST CENTERS			2,	.,	
88. 00	08800 RURAL HEALTH CLINIC		0.000000		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		Ö	89. 00
	09000 CLINIC		0. 489489		_	90.00
90. 01	09001 DI ABETES CENTER		0. 000000		0	90.01
90. 01	09002 NEUROPSYCH		1. 195351		0	90.01
						90.02
	09003 WOUND CENTER		0. 242756			
	09004 HYPERBARI C OXYGEN THERAPY		0. 563009		0	
	09005 VI MCARE CLI NI C		1. 083393		2, 889	
90.06	09006 MEDICATION MGMT CLINIC		0. 694049			
91.00	09100 EMERGENCY		0. 220668		2, 218, 101	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 483005	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES					95.00
200.00				87, 377, 298		
201.00		(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			87, 377, 298		202. 00

	Financial Systems COLUMBUS REGIONA ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0112		eriod: com 01/01/2022	Worksheet D-3	
		Component	CCN: 15-T112	To		Date/Time Pre 5/30/2023 8:4	
		Titl∈	e XVIII	5	Subprovi der - I RF	PPS	
	Cost Center Description	<u> </u>	Ratio of Cos		I npati ent	Inpati ent	
			To Charges		Program Charges	Program Costs (col. 1 x	
			1.00		2. 00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		2.00	0.00	
0. 00 1. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT						30.
2. 00	03200 CORONARY CARE UNIT						32.
3.00	03300 BURN INTENSIVE CARE UNIT						33.
4.00	03400 SURGICAL INTENSIVE CARE UNIT						34.
0.00	O4000 SUBPROVI DER - I PF O4100 SUBPROVI DER - I RF		•		4, 065, 051		40. 41.
2. 00	04200 SUBPROVI DER				1, 000, 001		42.
3.00	04300 NURSERY						43.
0 00	ANCILLARY SERVICE COST CENTERS		0.2270	4.4	21 11/	10 407	
0.00	O5000 OPERATING ROOM O5100 RECOVERY ROOM		0. 3370 0. 3422		31, 116 2, 765	10, 487 946	1
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 8371	- 1	2, 703	0	1
3. 00	05300 ANESTHESI OLOGY		0. 0161	71	6, 390	103	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 7050	- 1	15, 914	11, 220	1
4. 01 4. 02	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND		0. 2563 0. 2279	- 1	8, 366 13, 161	2, 144 3, 000	1
4. 03	05405 MAMMOGRAPHY		0. 3082	- 1	13, 101	0,000	1
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 2199		0	0	1
7.00	05700 CT SCAN		0. 0755		44, 313	3, 349	1
8. 00 9. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON		0. 1273 0. 1668		13, 305 2, 655	1, 695 443	1
0.00	06000 LABORATORY		0. 1008		2, 055 274, 857	62, 472	1
0. 01	06001 LABORATORY-PATHOLOGI CAL		0. 3199		391	125	1
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2750		20, 747	5, 707	1
5. 00 6. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 2168 0. 4111		658, 958 956, 881	142, 902 393, 437	1
7. 00	06700 OCCUPATI ONAL THERAPY		0. 4111		926, 569	389, 857	
8. 00	06800 SPEECH PATHOLOGY		0. 5726		312, 600	179, 006	1
9. 00	06900 ELECTROCARDI OLOGY		0. 1801		23, 771	4, 282	1
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 2124		0 7.7	0	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2803 0. 5785	- 1	96, 767 10, 219	27, 132 5, 912	
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3198	- 1	445, 433	142, 460	1
4. 00	07400 RENAL DIALYSIS		0. 3031	- 1	77, 651	23, 543	1
6.00	03020 ACUPUNCTURE		0.0000		0	0	
6. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		0. 3907	50	0	0	76.
8. 00	08800 RURAL HEALTH CLINIC		0.0000	00		0	88.
9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	- 1		0	
0.00	09000 CLINIC		0. 4894	- 1	0	0	1
0. 01 0. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH		0. 0000 1. 1953		0	0	1
0. 02	09003 WOUND CENTER		0. 2427		o	0	1
0. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 5630	09	0	0	
0.05	09005 VI MCARE CLI NI C		1. 0833		0	0	90.
0.06	09006 MEDICATION MGMT CLINIC 09100 EMERGENCY		0. 6940 0. 2206		0 13, 052	0 2, 880	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2200		13,052	2, 880	1
	OTHER REIMBURSABLE COST CENTERS						
5.00	09500 AMBULANCE SERVICES			T			95.
00. 00 01. 00		s (lino 61)			3, 955, 881	1, 413, 102	200. 201.
	Net charges (line 200 minus line 201)	s (11116 01)	1		3, 955, 881		201.

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		From 01/01/2022	Worksheet D-3 Date/Time Prepared:
	Ti +Lo VIV	Hooni tal	5/30/2023 8: 40 am

				To 12/31/2022		
-		Ti tl	e XIX	Hospi tal	5/30/2023 8: 4 PPS	U alli
	Cost Center Description		Ratio of Cost		I npati ent	
	'		To Charges	Program	Program Costs	
				Charges	(col . 1 x	
					col . 2)	
	DATI ENT DOUTINE OFFICE OF COOT OFFITEDS		1. 00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS			47.74/.5/0		00.00
	000 ADULTS & PEDIATRICS			17, 716, 568		30.00
	100 INTENSIVE CARE UNIT 200 CORONARY CARE UNIT			2, 360, 704		31. 00 32. 00
	300 BURN INTENSIVE CARE UNIT			0		33.00
4	400 SURGI CAL INTENSI VE CARE UNI T			0		34. 00
	000 SUBPROVI DER - I PF			0		40.00
	100 SUBPROVI DER - I RF			0		41.00
	200 SUBPROVI DER			0		42.00
43.00 043	300 NURSERY			2, 011, 622		43.00
	CILLARY SERVICE COST CENTERS					
	000 OPERATING ROOM		0. 33704			50.00
	100 RECOVERY ROOM		0. 34221		119, 363	51.00
	200 DELIVERY ROOM & LABOR ROOM		0. 83718		1, 564, 774	52.00
1	300 ANESTHESI OLOGY		0. 01617		12, 331	53.00
1	400 RADI OLOGY-DI AGNOSTI C		0. 70500		136, 631	54.00
	402 NUCLEAR MEDICINE-DIAGNOSTIC 404 ULTRA SOUND		0. 25632 0. 22791		19, 227 57, 070	54. 01 54. 02
	405 MAMMOGRAPHY		0. 30824		37,070	54. 02
	500 RADI OLOGY-THERAPEUTI C		0. 21997		13, 691	55.00
	700 CT SCAN		0. 07558			57. 00
	800 MRI		0. 12739			58. 00
59.00 059	900 CARDI AC CATHETERI ZATI ON		0. 16684		313, 634	59.00
60.00 060	000 LABORATORY		0. 22728	9 4, 526, 231	1, 028, 763	60.00
60. 01 060	001 LABORATORY-PATHOLOGI CAL		0. 31994	128, 822	41, 215	60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 27508	7 289, 345	79, 595	62.00
	500 RESPI RATORY THERAPY		0. 21686			65.00
	600 PHYSI CAL THERAPY		0. 41116		134, 645	66.00
	700 OCCUPATI ONAL THERAPY		0. 42075			67.00
	800 SPEECH PATHOLOGY		0. 57263		10, 413	68.00
	900 ELECTROCARDI OLOGY		0. 18014		119, 834	69.00
1	000 ELECTROENCEPHALOGRAPHY		0. 21243		19, 256	70. 00 71. 00
1	100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS		0. 28038 0. 57852			71.00
4	300 DRUGS CHARGED TO PATIENTS		0. 31982			73.00
	400 RENAL DIALYSIS		0. 30319		211, 768	74.00
4	020 ACUPUNCTURE		0. 00000			76.00
	697 CARDIAC REHABILITATION		0. 39075		624	76. 97
OU ⁻	TPATIENT SERVICE COST CENTERS					
	800 RURAL HEALTH CLINIC		0. 00000		0	88.00
	900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
	000 CLINIC		0. 48948		2, 617	90.00
	001 DI ABETES CENTER		0.00000		0	90. 01
1	002 NEUROPSYCH		1. 19535			90. 02
	003 WOUND_CENTER 004 HYPERBARIC_OXYGEN_THERAPY		0. 24275		844	90. 03 90. 04
	005 VIMCARE CLINIC		0. 56300 1. 08339		1, 802	90. 04 90. 05
	006 MEDICATION MGMT CLINIC		0. 69404		1, 802	90.05
	100 EMERGENCY		0. 22066		955, 572	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48300			92.00
	HER REIMBURSABLE COST CENTERS		30300			00
	500 AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			34, 857, 419		200. 00
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			34, 857, 419		202. 00

Health Financial Systems COLUMBUS REGIONAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0112	Peri od:	eu of Form CMS-: Worksheet D-3	
THE THE PARTY SERVICE GOOD THE OWN DAME.		CCN: 15-T112	From 01/01/2022 To 12/31/2022	2	epared:
	Ti tl	e XIX	Subprovi der - I RF		
Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3.00	
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04200 SUBPROVIDER 44.00 04200 SUBPROVIDER 45.00 04200 SUBPROVIDE			1, 036, 975		30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
ANCILLARY SERVICE COST CENTERS 50. 00 50. 00 50. 00 51. 00 52. 00 52. 00 52. 00 52. 00 52. 00 53. 00 54. 00 54. 00 54. 01 55. 00		0. 3370 0. 3422 0. 8371 0. 0161 0. 7050 0. 2563 0. 2279 0. 3082 0. 2199 0. 0755 0. 1273 0. 1668 0. 2272 0. 3199 0. 2750 0. 2168 0. 4111 0. 4207 0. 5726 0. 1801 0. 2124 0. 2803 0. 5785 0. 3198 0. 3031 0. 0000 0. 3907	15	663 0 38 3, 345 0 741 0 0 741 0 0 17, 679 0 18, 891 110, 165 97, 727 59, 992 895 0 0 42, 992 0 0	51. 00 52. 00 54. 00 54. 01 54. 02 54. 03 55. 00 57. 00 59. 00 60. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARIC OXYGEN THERAPY 90. 05 09005 VI MCARE CLINIC 90. 06 09006 MEDI CATION MGMT CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 0000 0. 0000 0. 4894 0. 0000 1. 1953 0. 2427 0. 5630 1. 0833 0. 6940 0. 2206 0. 4830	00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 212 0 0 0 0 0	89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00
95.00 O9500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net charges (line 200 minus line 201)	s (line 61)		964, 668 964, 668		95. 00 200. 00 201. 00 202. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/30/2023 8:40 am

	Title XVIII Hospital	PPS	<u> </u>
		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 occurring prior to October 1 (see	23, 314, 607	1. 01
4 00	instructions)	0 407 (44	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	8, 497, 641	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1.03
	1 (see instructions)		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1.04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2.00
2. 01	Outlier reconciliation amount	0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	683, 918	2. 03
2. 04	Outlier payments for discharges occurring on or after October 1 (see instructions)	42, 201	2.04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)	20, 066, 111 212. 64	3. 00 4. 00
4.00	Indirect Medical Education Adjustment	212.04	4.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	0.00	5.00
	or before 12/31/1996. (see instructions)		1
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0. 00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0. 00	6. 26
0.20	the CAA 2021 (see instructions)	0.00	0.20
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00	7. 01
7 00	cost report straddles July 1, 2011 then see instructions.	0.00	7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0. 00	7. 02
	and 87 FR 49075 (August 10, 2022) (see instructions)		ł
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		ł
	1998), and 67 FR 50069 (August 1, 2002).	2 22	
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0. 00	8. 02
0.02	under § 5506 of ACA. (see instructions)	0.00	0.02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
	instructions)	2.00	
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0. 00	10.00
11. 00	FTE count for residents in dental and podiatric programs.		11.00
12.00	Current year allowable FTE (see instructions)	0. 00	12.00
13. 00	Total allowable FTE count for the prior year.		13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
16. 00	Adjustment for residents in initial years of the program (see instructions)		16.00
17. 00	Adjustment for residents displaced by program or hospital closure		17.00
18.00	Adjusted rolling average FTE count	0.00	18. 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	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 000000 0	21.00
22. 00	IME payment adjustment (see instructions)	0	22. 00
22.0.	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0. 00	23. 00
	(f)(1)(i v)(C).		
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	1
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0. 00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	U	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 89	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	24. 12	•
32. 00	Sum of lines 30 and 31	30. 01	
33. 00	Allowable disproportionate share percentage (see instructions)	13. 97	33. 00

	51			6.5. 040.6	
	Financial Systems COLUMBUS REGIONA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2023 8: 40 PPS	o am
				1. 00	
34. 00	Disproportionate share adjustment (see instructions)			1, 111, 043	34.00
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
35. 01 35. 02		enter zero on this line	0. 000453542 3, 261, 880	0. 000450068 3, 093, 946	35. 01 35. 02
35. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental UC	CP (see instructions)	2, 439, 707	779, 845	35. 03
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	,	3, 219, 552		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges (see instructions)	scharges (lines 40 throu	gh 46) 0		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruc-		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 (see instructions)	ry for adjustment)	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 47 Subtotal (see instructions)	1. 01)	36, 868, 962		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instructions	•		36, 868, 962	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			2, 658, 424 0	50. 00 51. 00
52.00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			58, 295	53.00
54. 01					
	Islet isolation add-on payment			23, 878 0	54. 00 54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of	69)		23, 878 0 0	54. 00 54. 01 55. 00
55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (Cellular therapy acquisition cost (see instructions)			23, 878 0 0 0	54. 00 54. 01 55. 00 55. 01
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into	ructions)	hrough 35).	23, 878 0 0	54. 00 54. 01 55. 00
55. 01 56. 00 57. 00 58. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Indicillary service other pass through costs from Wkst. D, Pt. Indicillary service other pass through costs from Wkst. D, Pt.	ructions) III, column 9, lines 30 t	hrough 35).	23, 878 0 0 0 0 0 0 183, 735	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00
55. 01 56. 00 57. 00 58. 00 59. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Indical (sum of amounts on lines 49 through 58)	ructions) III, column 9, lines 30 t	hrough 35).	23, 878 0 0 0 0 0 0 183, 735 39, 793, 294	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00
55. 01 56. 00 57. 00 58. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Indicillary service other pass through costs from Wkst. D, Pt. Indicillary service other pass through costs from Wkst. D, Pt.	ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	23, 878 0 0 0 0 0 0 183, 735	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. In Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	23, 878 0 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	23, 878 0 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	23, 878 0 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intrough costs of physicians' services in a teaching hospital (see intrough costs of the pass through costs from Wkst. D, Pt. In an acquisition of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	23, 878 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 63. 00 64. 00 65. 00 66. 00 67. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introduction of service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)		23, 878 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intrough costs of physicians' services in a teaching hospital (see intrough costs of the pass through costs from Wkst. D, Pt. In an acquisition of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s	ee instructions)	23, 878 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introduction of physicians' services in a teaching hospital (see introduction of the pass through costs (from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through the pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the period of the pass through costs (line 59 minus) Deductible so tilled to program beneficiaries (line 59 minus) Dedu	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0	54. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough costs of physicians' services in a teaching hospital (see intrough costs from Wkst. D, Pt. In accordance of the pass through costs from Wkst. D, Pt. In accordance of the pass through costs from Wkst. D, Pt. In accordance of the pass through services of the program beneficiaries (line 59 minus deductibles billed to program beneficiaries (line 59 minus deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s	ee instructions) s)	23, 878 0 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introduction of physicians' services in a teaching hospital (see introduction of the pass through costs (from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the pass through the pt. Indeed of the person of the pass through costs from Wkst. D, Pt. Indeed of the pass through costs from Wkst. D, Pt. Indeed of the person of the person of the person of the person pass through costs from Wkst. D, Pt. Indeed of the person of th	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0	54. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introverse) Routine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 70. 00 70. 50 70. 75 70. 88 70. 89	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introduction of the pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons) Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 67. 00 70. 50 70. 75 70. 88 70. 89
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 70. 00 70. 50 70. 75 70. 88 70. 89	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introverse) Routine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1 Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 92 70. 93	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough costs of physicians' services in a teaching hospital (see intrough costs of physicians' service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1) Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount (see instructions) Demonstration payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0 0 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93
55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 50 70. 75 70. 87 70. 88 70. 90 70. 91 70. 93 70. 94	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. 1) Ancillary service other pass through costs from Wkst. D, Pt. 1 Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s (For SCH see instruction) tration) adjustment (see	ee instructions) s)	23, 878 0 0 0 183, 735 39, 793, 294 38, 705 39, 754, 589 3, 515, 596 208, 958 299, 922 194, 949 109, 347 36, 224, 984 0 0 0 0 0 0 0 0 0 0 0	54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

	REGIONAL HOSPITAL	ON 45 0440		u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0112	Peri od: From 01/01/2022	Worksheet E Part A	
			To 12/31/2022	Date/Time Pre	
	T: +1 -	- V() (1.1.1	11: +-1	5/30/2023 8: 4	0 am
		XVIII FEV	Hospi tal	PPS Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy)	(Enter in column 0		0		70. 96
the corresponding federal year for the period prior to					
70.97 Low volume adjustment for federal fiscal year (yyyy)			0	0	70. 97
the corresponding federal year for the period ending 70.98 Low Volume Payment-3	on or arter 10/1)			0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus	s lines 69 & 70)			36, 203, 984	
71.01 Sequestration adjustment (see instructions)				456, 170	71.01
71.02 Demonstration payment adjustment amount after sequest				0	
71.03 Sequestration adjustment-PARHM or CHART pass-throughs				05 044 474	71.03
72.00 Interim payments 72.01 Interim payments-PARHM or CHART				35, 266, 671	72. 00 72. 01
73.00 Tentative settlement (for contractor use only)				0	
73.01 Tentative settlement-PARHM or CHART (for contractor	use only)			o .	73. 01
74.00 Balance due provider/program (line 71 minus lines 71.				481, 143	74.00
73)					
74.01 Balance due provider/program-PARHM or CHART (see inst	,			77/ 040	74.01
75.00 Protested amounts (nonallowable cost report items) in CMS Pub. 15-2, chapter 1, §115.2	accordance with			776, 319	75. 00
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		l			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2,	or sum of 2.03			0	90.00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (se 93.00 Capital outlier reconciliation adjustment amount (see				0	92.00 93.00
94.00 The rate used to calculate the time value of money (so				0. 00	
95.00 Time value of money for operating expenses (see instru				0.00	95.00
96.00 Time value of money for capital related expenses (see	•			0	96.00
			Prior to 10/1		
LICD Danier December Assessed			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			١	0	100.00
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see ins	tructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
					i
			0.0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus payment (see inst		uotmont.	0.0000		103. 00 104. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A	Demonstration) Adju			0	104. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration	Demonstration) Adju			0	104. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A	Demonstration) Adju			0	
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt.	Demonstration) Adjustation period under			0	104. 00 200. 00 201. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstr. Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions)	Demonstration) Adjustation period under			0	104. 00 200. 00 201. 00 202. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions)	Demonstration) Adjuration period under	the 21st	0	0	104. 00 200. 00 201. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation	Demonstration) Adjuration period under	the 21st	0	0	104. 00 200. 00 201. 00 202. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation period)	Demonstration) Adjuration period under	the 21st	0	0 tration	104. 00 200. 00 201. 00 202. 00 203. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation period) 204.00 Medicare target amount	Demonstration) Adjustion period under	the 21st	0	tration	104. 00 200. 00 201. 00 202. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 206.00 Medicare inpatient routine cost cap (line 202 times l	Demonstration) Adjustion period under II, line 49) (N/A in first year 204) ine 205)	the 21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation period) Case-mix adjustment factor (see instructions) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 206.00 Medicare inpatient routine cost cap (line 202 times ladjustment to Medicare Part A Inpatient Reimbursement	Demonstration) Adjuration period under II, line 49) (N/A in first year 204) ine 205)	the 21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
104.00 HRR adjustment amount for HSP bonus payment (see inst Rural Community Hospital Demonstration Project (§410A 200.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation period) 204.00 Medicare target amount 205.00 Case-mix adjustment factor (see instructions) 206.00 Case-mix adjusted target amount (line 203 times line 206.00 Medicare inpatient routine cost cap (line 202 times I Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions)	Demonstration) Adjuration period under II, line 49) (N/A in first year 204) ine 205) see instructions)	the 21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
200.00 Is this the first year of the current 5-year demonstr. Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 202.00 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 206.00 Medicare inpatient routine cost cap (line 202 times l	Demonstration) Adjustion period under III, line 49) (N/A in first year 204) ine 205) see instructions) Pt. A, line 59)	the 21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00

210.00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

211.00 Total adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

Comparision of PPS versus Cost Reimbursement

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

213.00 Low-volume adjustment (see instructions)

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

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 8:40 am

2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 10.00 Organ acquisitions	824 3.00 127 4.00 0 4.01 000 5.00 0 6.00 .00 7.00 0 8.00 794 9.00 0 10.00 575 11.00 287 12.00 0 13.00
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 2.8, 024, 4.00 Outlier payment (see instructions) 2.10, 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 51, COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	426 2.00 824 3.00 127 4.00 000 5.00 0 6.00 .00 7.00 0 8.00 794 9.00 0 10.00 575 11.00
2.00 Medical and other services reimbursed under OPPS (see instructions) 3.01	426 2.00 824 3.00 127 4.00 000 5.00 0 6.00 .00 7.00 0 8.00 794 9.00 0 10.00 575 11.00
3.00 OPPS payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 51, COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	824 3.00 127 4.00 0 4.01 000 5.00 0 6.00 0 7.00 0 8.00 794 9.00 0 10.00 575 11.00
4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 10.00 Organ acquisitions 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Ancillary service charges (sum of lines 1 2 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	127
4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 51, COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 4. 01 000 5. 00 0 6. 00 . 00 7. 00 0 8. 00 794 9. 00 10. 00 575 11. 00 287 12. 00 0 13. 00
6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 0.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 6.00 7.00 7.00 0 8.00 794 9.00 10.00 575 11.00 287 12.00 0 13.00
7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	7. 00 0 8. 00 794 9. 00 0 10. 00 575 11. 00 287 12. 00 0 13. 00
8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 161, 170 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 8.00 794 9.00 10.00 575 11.00 287 12.00 0 13.00
9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 302, 0rgan acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	794 9.00 0 10.00 575 11.00 287 12.00 0 13.00
10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 10.00 575 11.00 287 12.00 0 13.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	287 12.00 0 13.00
Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 13.00
12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 161, Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 13.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 13.00
Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	287 14.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0 15.00
	0 15.00 0 16.00
inda dadi. paymont boon mado in addordando mith iz din 3710. 10(0)	0 10.00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000	•
18.00 Total customary charges (see instructions) 161,	•
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 109, instructions)	712 19.00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0 20.00
instructions)	
	575 21.00
22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions)	0 22.00 0 23.00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 28,537,	•
COMPUTATION OF REIMBURSEMENT SETTLEMENT	
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)	0 25.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5,070, 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 23,518,	
instructions)	442 27.00
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
30.00 Subtotal (sum of lines 27 through 29) 23,518, 31.00 Primary payer payments	442 30.00 808 31.00
31.00 Primary payer payments 5, 32.00 Subtotal (line 30 minus line 31) 23,512,	
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) 453, 35.00 Adjusted reimbursable bad debts (see instructions) 294,	•
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	
37.00 Subtotal (see instructions) 23,807,	128 37.00
	-45 38.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 39.00
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions)	39. 50 0 39. 75
39.97 Demonstration payment adjustment amount before sequestration	0 39.97
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)	0 39. 98
39. 99 RECOVERY OF ACCELERATED DEPRECIATION	0 39.99
40.00 Subtotal (see instructions) 23,807, 40.01 Sequestration adjustment (see instructions) 299,	•
40.01 Sequestration adjustment (see histractions) 40.02 Demonstration payment adjustment amount after sequestration	970 40. 01 0 40. 02
40. 03 Sequestration adjustment-PARHM or CHART pass-throughs	40. 03
41.00 Interim payments 23,548,	
41.01 Interim payments-PARHM or CHART	41. 01
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only)	0 42.00 42.01
43.00 Balance due provider/program (see instructions) -41,	•
43.01 Balance due provider/program-PARHM (see instructions)	43. 01
	820 44.00
§115. 2 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
	001 00 00
93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)	. 00 92. 00
7.1.00 1.010. (Sum of 11100 71 Glid 70)	0 93.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/30/2023 8:	40 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od:	Worksheet E	
	Component CCN: 15-T112	From 01/01/2022 To 12/31/2022	Date/Time Pre	
	·		5/30/2023 8: 4	O am
	Title XVIII	Subprovi der -	PPS	
		I RF		

	I RF		
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions) OPPS payments	13 41	2. 00 3. 00
4. 00	Outlier payment (see instructions)	0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)	0.00	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	0	11. 00
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges	0	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)	0.00000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	0.000000	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		19. 00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)	ol	21. 00
	Interns and residents (see instructions)	l ő	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	41	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	ő	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	41	27. 00
20.00	instructions)		20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0 0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)	41	30.00
31.00		0	31.00
32. 00	Subtotal (line 30 minus line 31)	41	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34.00		ő	34.00
	Adjusted reimbursable bad debts (see instructions)	0	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	41 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	l ol	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0 0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	41	40.00
40. 01	Sequestration adjustment (see instructions)	0	40.01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02 40. 03
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments	40	41. 00
41. 01	Interim payments-PARHM or CHART		41.0
42. 00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.0
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	1	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2 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
	The rate used to calculate the Time Value of Money	l	92.0
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	93. 00 94. 00
	1.22. (25 2. 1.100 / 6.0 / 6/	۱ ۷۱	

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0112	Peri od:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-T112	To 12/31/2022		
				5/30/2023 8: 4	lÖ am
		Title XVIII	Subprovi der -	PPS	
			IRF		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Peri od: Worksheet E-1 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/30/2023 8:40 am Provider CCN: 15-0112

Interim payments payable on individual bills, either						5/30/2023 8: 40	o am
Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 2.00 3.00 4.00 1.00 1.00 2.00 3.00 4.00 1.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 2.00 3.00 2.00							
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.3, 548, 442 1.00 2.3, 548, 442 1.00 2.00 2.00 2.3, 548, 442 1.00 2			Inpatien	t Part A	Par	⁻t B	
Total interim payments paid to provider 35, 239, 871 23, 548, 442 1			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either services rendered in the cost reporting period. If none, write "NoNE" or enter a zero			1.00	2.00	3. 00	4.00	
Interim payments payable on individual bills, either services rendered in the cost reporting period. If none, write "NoNE" or enter a zero	1. 00	Total interim payments paid to provider		35, 239, 87		23, 548, 442	1. 00
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 09/14/2022 26,800 0 0 3 3 3 3 3 3 3	2.00)	0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment and unbrased on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NOME" or enter a zero. (1)		services rendered in the cost reporting period. If none,					
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)		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00	List separately each retroactive lump sum adjustment					3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider		for the cost reporting period. Also show date of each					
3.01 ADJUSTMENTS TO PROVIDER							
3.02 0 0 3 3 3 3 3 3 3 3							
3.03		ADJUSTMENTS TO PROVIDER	09/14/2022				3. 01
3.04 0							3. 02
3.05 Provider to Program				(O		3.03
Provider to Program						I I	3.04
3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3 3 5 5 5 5 5 5 5 5	3. 05			(O .	0	3.05
3.51 0							
3.52 0 0 0 0 3 3		ADJUSTMENTS TO PROGRAM					3. 50
3.53 3.54 0 0 0 3 3 3 54 3 99 3 54 54 54 54 54 54 54							3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 26,800 0 3 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 35,266,671 23,548,442 4 4 4 4 4 4 4 4 4							3. 52
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98					-	1 -1	3. 53
3.50-3.98) 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 appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 6.55 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 481,143 6.66,671 23,548,442 4 4 4 4 4 4 4 4 4 4 4 4						1 -1	3. 54
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 appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 6.51 0 0 0 0 0 5 5.52 0 0 0 0 0 5 5.52 0 0 0 0 0 5 5.52 0 0 0 0 0 6 5.50 0 0 0 0 0 6 5.50 0 0 0 0 0 6 5.50 0 0 0 0 0 0 6 5.50 0 0 0 0 0 0 6 5.50 0 0 0 0 0 0 0 6 5.50 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 0 5.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 99			26, 800	O	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		/		05 044 47	_	00 540 440	
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			35, 266, 67	1	23, 548, 442	4. 00
TO BE COMPLÉTED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 TENTATIVE TO PROVIDER 5. 02 5. 03 Provider to Program 5. 50 TENTATIVE TO PROGRAM 5. 50 TENTATIVE TO PROGRAM 5. 50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99 Compared to Program 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER 5. 50 - SPROVIDER 6. 00 5. 50 - SPROVIDER 6. 00 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	E 00				1		5. 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
5. 01 TENTATI VE TO PROVIDER							
5. 02 5. 03 Provi der to Program 5. 50 ENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM O O O O S S S S S S S S S	5 01			()	0	5. 01
5. 03 Provider to Program		TENTITIVE TO TROVIDER					5. 02
Provider to Program						1	5. 03
5. 50 TENTATIVE TO PROGRAM 0 0 5 5. 51 0 0 0 5 5. 52 0 0 0 5 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 0 5 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 481, 143 0 6	0.00	Provider to Program			~1		0.00
5. 52 0 0 5 5 5 9 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 0 0 5 5 50-5. 98) 0 0 0 5 5 50-5. 98) 0 0 0 0 0 0 0 0 0	5. 50			()	0	5.50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 5 6 6 6 7 7 8 8 9 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 6 7 9 5 9 6 9 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	5. 51			()	o	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 481,143 0 6	5. 52			()	o	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	o	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 481,143 0 6		5. 50-5. 98)					
6. 01 SETTLEMENT TO PROVI DER 481, 143 0 6	6.00	Determined net settlement amount (balance due) based on					6.00
6 02 SETTLEMENT TO DDOCDAM	6. 01	SETTLEMENT TO PROVIDER		481, 143	3	0	6.01
0. 02 SETTE ENDERNITED PROGRAMM U 41, 239 0	6. 02	SETTLEMENT TO PROGRAM		(O	41, 239	6.02
	7.00	Total Medicare program liability (see instructions)		35, 747, 814	4		7.00
Contractor NPR Date							
Number (Mo/Day/Yr)							
0 1.00 2.00			()	1. 00	2. 00	
8.00 Name of Contractor 8	8. 00	Name of Contractor					8. 00

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provi der CCN: 15-0112	Peri od: From 01/01/2022	Worksheet E-1 Part I
		Component CCN: 15-T112	To 12/31/2022	Date/Time Prepared: 5/30/2023 8:40 am

Title XVIII Subprovi der PPS **IRF** Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1. 00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 3, 829, 289 1.00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. 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 ADJUSTMENTS TO PROVIDER 3.01 3.01 0 3.02 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 0 3.53 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 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 3, 829, 289 4.00 40 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) 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 PROVIDER 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 n 5.51 0 0 5.51 5. 52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 59, 975 6.01 6.02 SETTLEMENT TO PROGRAM 0 6.02 3, 889, 264 Total Medicare program liability (see instructions) 41 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor 8. 00

Heal th	Financial Systems COLUMBUS REGION	IAL HOSPITAL	In Lie	u of Form CMS-:	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0112 Period: From 01/01/2022 Part II To 12/31/2022 Date/Time P 5/30/2023 8					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				1	
1. 00	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 lin	e 14		1.00 2.00	
	2.00 Medicare days (see instructions)					
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	4.00 Total inpatient days (see instructions)					
5.00	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200					
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	.00 Sequestration adjustment amount (see instructions)					
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00	
					•	

	Financial Systems COLUMBUS REGIO ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-T112	From 01/01/2022 To 12/31/2022	Part III Date/Time Pre 5/30/2023 8:4	pared:
		Title XVIII	Subprovi der - I RF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1.00	Net Federal PPS Payment (see instructions)			3, 534, 722	1.00
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0270	2.00
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			196, 531	3.00
. 00	Outlier Payments			222, 436	4.0
. 00	Unweighted intern and resident FTE count in the most recen	t cost reporting period e	nding on or prior	0.00	5.00
	to November 15, 2004 (see instructions)				l
01	Cap increases for the unweighted intern and resident FTE c	ount for residents that we	re displaced by	0.00	5. 0°
	program or hospital closure, that would not be counted wit	hout a temporary cap adjus	tment under 42		l
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				l
00	New Teaching program adjustment. (see instructions)			0.00	6.00
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth	period of a "new	0.00	7.00
	teaching program" (see instructions)				
00	OO Current year's unweighted I&R FTE count for residents within the new program growth period of a "new				
	teaching program" (see instructions)				1
00	Intern and resident count for IRF PPS medical education ad	justment (see instructions)	0. 00	
. 00	Average Daily Census (see instructions)			9. 460274	
. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
2. 00	Teaching Adjustment (see instructions)			0	
3. 00	Total PPS Payment (see instructions)			3, 953, 689	
1. 00	Nursing and Allied Health Managed Care payments (see instr	ucti on)		0	
. 00	Organ acquisition (DO NOT USE THIS LINE)				15.0
6. 00	Cost of physicians' services in a teaching hospital (see i	nstructi ons)		0	
7. 00	Subtotal (see instructions)			3, 953, 689	
3. 00	Primary payer payments			0	
9. 00	Subtotal (line 17 less line 18).			3, 953, 689	
0. 00	Deducti bl es			23, 052	
. 00	Subtotal (line 19 minus line 20)			3, 930, 637	1
2. 00	Coinsurance			0	
3. 00	Subtotal (line 21 minus line 22)			3, 930, 637	
4. 00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		5, 632	
5. 00	Adjusted reimbursable bad debts (see instructions)			3, 661	1
5. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructi ons)		5, 632	
7. 00	Subtotal (sum of lines 23 and 25)			3, 934, 298	
3. 00	Direct graduate medical education payments (from Wkst. E-4	, line 49)		0	
9. 00	Other pass through costs (see instructions)			4, 596	
0.00	Outlier payments reconciliation			0	
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1.50	Proneer ACO demonstration payment adjustment (see instruct	i ons)		0	
1. 98	Recovery of accelerated depreciation.	an		0	
1. 99	Demonstration payment adjustment amount before sequestration	UH		0	
2. 00	Total amount payable to the provider (see instructions)			3, 938, 894	
2. 01	Sequestration adjustment (see instructions)	_		49, 630	
2. 02	Demonstration payment adjustment amount after sequestratio	n		2 020 200	
3.00	Interim payments			3, 829, 289	
4.00	Tentative settlement (for contractor use only) Balance due provider/program (line 32 minus lines 32.01. 3	2 02 22 and 24)		0 59. 975	
5.00		2 HZ 33 200 3/11		54 4/5	1 KD ()

Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)

99.01 | Calculated Teaching Adjustment Factor for the current year. (see instructions)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.

FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE

36.00

50.00

52.00

53.00

99.00

222, 436

0.000000

0 51.00

0.000000 99.01

0.00

36.00

53.00

TO BE COMPLETED BY CONTRACTOR

Time Value of Money (see instructions)

50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4

51.00 Outlier reconciliation adjustment amount (see instructions)

The rate used to calculate the Time Value of Money

Health Financial Systems	COLUMBUS REGIONAL HOSPIT	AL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provid	er CCN: 15-0112	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2023 8:40 am
		Ti +Lo VIV	Hospi tal	DDC

		1	o 12/31/2022	Date/lime Pre 5/30/2023 8:4	
		Title XIX	Hospi tal	PPS	o um
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	KVI OLO I OK III I LLO V OK XII	C OLICTIOLS		
1. 00	Inpatient hospital/SNF/NF services		0		1.00
2. 00	Medical and other services		ı	27, 888, 112	2.00
3. 00	Organ acquisition (certified transplant programs only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		0		4.00
5. 00	Inpatient primary payer payments		0	27,000,112	5.00
6. 00	Outpatient primary payer payments		U	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	-	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		U	27, 888, 112	7.00
	Reasonable Charges				
0.00					0 00
8. 00	Routine service charges		04 057 410	00 010 017	8.00
9.00	Ancillary service charges		34, 857, 419	99, 013, 917	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		04 057 440	00 040 047	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		34, 857, 419	99, 013, 917	12.00
40.00	CUSTOMARY CHARGES				40.00
13. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
44.00	basis			,	
14. 00	Amounts that would have been realized from patients liable fo		0	0	14.00
45.00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000		15.00
16. 00	Total customary charges (see instructions)		34, 857, 419	99, 013, 917	16.00
17. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	34, 857, 419	71, 125, 805	17.00
	line 4) (see instructions)			· _ '	
18. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18. 00
	16) (see instructions)		_	_ '	
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst		0	-	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		0	27, 888, 112	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	_	22.00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	· '	24.00
25. 00	Capital exception payments (see instructions)		0	· '	25.00
26. 00	Routine and Ancillary service other pass through costs		59, 733	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		59, 733		27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		59, 733	27, 888, 112	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	59, 733	27, 888, 112	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	59, 733	27, 888, 112	36.00
37.00	TO ZERO OUT MEDICALD		-59, 733	-27, 888, 112	37.00
38.00	Subtotal (line 36 ± line 37)		o	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	- I	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2.	0	0	43.00
	chapter 1, §115.2	•		1	
			'	'	•

Health Financial Systems COLUMBUS REGI	u of Form CMS-2	552-10		
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0112	Peri od: From 01/01/2022	Worksheet E-5	
		To 12/31/2022	Date/Time Prep 5/30/2023 8:40	oared:) am
	Title XVIII		PPS	
	1. 00			
TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or	0	1.00		
2.00 Capital outlier from Wkst. L, Pt. I, line 2	0	2.00		
3.00 Operating outlier reconciliation adjustment amount (see i	0	3.00		
4.00 Capital outlier reconciliation adjustment amount (see instructions)				4.00
5.00 The rate used to calculate the time value of money (see instructions)				5.00
6.00 Time value of money for operating expenses (see instructi	0	6.00		
7.00 Time value of money for capital related expenses (see instructions)				7.00

Health Financial Systems

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

oni y)					5/30/2023 8: 4	0 am
		General Fund	Specific	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	25, 210, 269	1 1	0	0	1.00
2. 00 3. 00	Temporary investments	205, 344	0	0	0	2. 00 3. 00
4. 00	Notes recei vabl e Accounts recei vabl e	83, 073, 062	- 1	0	0	4.00
5. 00	Other recei vable	1, 884, 225		ő	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		1 1	0	0	6.00
7.00	Inventory	6, 566, 355	0	0	0	7. 00
8.00	Prepai d expenses	7, 414, 082	1 1	0	0	8. 00
9.00	Other current assets	3, 270, 025		0	0	9.00
10. 00 11. 00	Due from other funds	02 522 744	0	0	0	10.00 11.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	92, 532, 764	1 0	<u>U</u>	0	11.00
12. 00	Land	1, 792, 375	0	0	0	12.00
13.00	Land improvements	21, 019, 398		0	0	13.00
14.00	Accumulated depreciation	-13, 864, 472		0	0	14.00
15. 00	Bui I di ngs	211, 501, 218	1 1	0	0	15.00
16.00	Accumulated depreciation	-160, 420, 894	1 1	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	9, 631, 299	1	0	0	18. 00 19. 00
20. 00	Accumulated depreciation	-8, 677, 288		0	0	20.00
21. 00	Automobiles and trucks	2, 130, 917	1 1	Ö	0	21.00
22. 00	Accumul ated depreciation	-1, 479, 370	1 1	0	0	22. 00
23. 00	Major movable equipment	167, 385, 946	0	0	0	23. 00
24. 00	Accumulated depreciation	-114, 328, 507	1	0	0	24.00
25. 00	Minor equipment depreciable	0	0	0	0	25.00
26. 00 27. 00	Accumulated depreciation	0	0	0	0	26. 00 27. 00
28. 00	HIT designated Assets Accumulated depreciation		0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	114, 690, 622	0	0		30.00
	OTHER ASSETS					
31.00	Investments	151, 786, 973	1 1	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	15, 036, 546	0	0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	166, 823, 519	1 1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	374, 046, 905		Ö	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	21, 372, 890	1 1	0	0	37.00
38. 00	Salaries, wages, and fees payable	12, 170, 084		0	0	38.00
39.00	Payroll taxes payable (chart tarm)	2, 534, 122	1 1	0	0	39. 00 40. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	1, 245, 000	0	0	0	41.00
42. 00	Accel erated payments	0		Ŭ	O	42.00
43. 00	Due to other funds	Ö	0	0	0	43.00
44.00	Other current liabilities	12, 888, 030	0	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	50, 210, 126	0	0	0	45. 00
	LONG TERM LIABILITIES		1			
46. 00	Mortgage payable	35, 731, 163	1	0	0	46.00
47. 00 48. 00	Notes payable Unsecured Loans	0	0	0	0	47. 00 48. 00
49. 00	Other long term liabilities		0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35, 731, 163	1	ő	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	85, 941, 289	1 1	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	288, 105, 616	1 1			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
55. 00 56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	288, 105, 616	1 1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	374, 046, 905	0	0	0	60.00
	[59]	I	I I	l		I

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0112

Peri od: Worksheet G-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

5/30/2023 8:40 am General Fund Special Purpose Fund Endowment Fund 1. 00 3.00 4.00 5.00 2.00 1.00 Fund balances at beginning of period 360, 641, 735 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -27, 465, 477 2.00 2.00 3 00 Total (sum of line 1 and line 2) 333, 176, 258 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 5.00 0 0 0 0 0 6.00 0 6.00 0 7.00 Ω 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 333, 176, 258 0 11.00 11.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 45, 070, 647 12.00 0 12.00 13.00 0 0 13.00 14.00 0 0 0 14.00 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 45, 070, 647 18.00 Total deductions (sum of lines 12-17) 18.00 0 Fund balance at end of period per balance 19.00 288, 105, 611 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 10.00 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 C Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 Health Financial Systems CCC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0112

			To 12/31/2022		
	Cost Center Description	Inpatient	Outpati ent	5/30/2023 8: 4 Total	o alli
	cost center bescription	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	3.00	
	General Inpatient Routine Services				
1.00	Hospi tal	89, 399, 03	9	89, 399, 039	1.00
2. 00	SUBPROVI DER - I PF		0	0	2.00
3.00	SUBPROVIDER - IRF	7, 410, 63	-	7, 410, 635	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)	96, 809, 67	4	96, 809, 674	10.00
	Intensive Care Type Inpatient Hospital Services	107001701			
11.00	INTENSIVE CARE UNIT	16, 665, 92	6	16, 665, 926	11. 00
12.00	CORONARY CARE UNIT		o	0	12.00
13.00	BURN INTENSIVE CARE UNIT		o	0	13.00
14.00	SURGI CAL INTENSI VE CARE UNIT		o	0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	16, 665, 92	6	16, 665, 926	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	113, 475, 60	o	113, 475, 600	17.00
18.00	Ancillary services	222, 414, 40	6 465, 460, 457	687, 874, 863	18.00
19.00	Outpatient services	25, 763, 28		87, 242, 201	19.00
20.00	RURAL HEALTH CLINIC		o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o o	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	15, 05	1 13, 162, 049	13, 177, 100	23.00
24.00	CMHC				24.00
24. 10	CORF		o o	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27.00	LEVEL II NURSERY	3, 387, 11	1 0	3, 387, 111	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	365, 055, 45	4 540, 101, 421	905, 156, 875	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		359, 055, 536		29. 00
30.00	PROVISION FOR BAD DEBT	6, 138, 76			30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00		1	0		34.00
35. 00			0		35.00
36.00	Total additions (sum of lines 30-35)		6, 138, 762		36.00
37. 00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38.00
39. 00			0		39. 00
40.00		1	0		40.00
41.00	Total 101 011 000 (0 0 0 0 11 0 0 0 0 7 45)		0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		365, 194, 298		43.00
	to Wkst. G-3, line 4)	1	1		l

111 45	Figure in Contains	COLUMBUC DECLONAL	HOCDITAL	la lia		NEE 2 4 0
	Financial Systems	COLUMBUS REGIONAL			u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0112	Peri od: From 01/01/2022	Worksheet G-3	
					Date/Time Pre	pared:
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part				905, 156, 875	1.00
2.00	Less contractual allowances and discounts or	n patients' account	S		543, 374, 692	2.00
3.00	Net patient revenues (line 1 minus line 2)				361, 782, 183	3.00
4.00	Less total operating expenses (from Wkst. G-		13)		365, 194, 298	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-3, 412, 115	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				582, 221	6.00
7.00	Income from investments				3, 321, 284	7.00
8.00	Revenues from telephone and other miscellane	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				45, 868	10.00
11. 00	Rebates and refunds of expenses				46, 128	11.00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	ests			794, 552	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su	upplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pat	tients			33, 158	17.00
18.00	Revenue from sale of medical records and abs	stracts			5, 776	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			34, 072	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				150	21.00
22.00	Rental of hospital space				75, 011	22.00
23.00	Governmental appropriations				0	23.00
24.00	UNREALIZED INVESTMENT INCOME				-36, 306, 890	24.00
24. 01	JV INCOME				64, 204	24. 01
24. 02	WELLNESS REVENUE				-314, 967	24. 02
24. 03	CRHP REVENUE				5, 002, 476	24. 03
24.04	OTHER OPERATING INCOME				1, 053, 124	24.04
24. 50	COVI D-19 PHE Fundi ng				858, 553	24.50
24. 51	FEMA GRANT FUNDING				1, 265, 272	24. 51
	T-t-1 -th ! (6 ! (24)				22 440 000	

24.51 FEMA GRANT FUNDING
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 LOSS ON DISPOSAL
27.01 OTHER NON-OPERATING EXPENSES
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

-23, 440, 008 25. 00 -26, 852, 123 26. 00 -780, 324 27. 00

1, 393, 678 27. 01 613, 354 28. 00 -27, 465, 477 29. 00

Heal th	Financial Systems COLUMBUS RE	GIONAL HOSPITAL	In lie	u of Form CMS-2	2552_10	
CALCUL	Worksheet L Parts I-III Date/Time Pre 5/30/2023 8:4	pared:				
	PPS					
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier			2, 393, 664	1.00	
1. 00	Model 4 BPCI Capital DRG other than outlier			2, 393, 004	1.00	
2. 00	Capital DRG outlier payments			114, 677	2.00	
2. 01	Model 4 BPCI Capital DRG outlier payments			0		
3. 00	Total inpatient days divided by number of days in the co	ost reporting period (see ins	tructions)	104. 25	3.00	
4. 00	Number of interns & residents (see instructions)	ior reper in a period (core in a	,	0.00	4.00	
5. 00	Indirect medical education percentage (see instructions))		0.00	5.00	
6.00	Indirect medical education adjustment (multiply line 5 kg		1, columns 1 and	0	6.00	
	1.01) (see instructions)					
7. 00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	rt A patient days (Worksheet	E, part A line	5. 89	7. 00	
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		24. 12	8. 00	
9.00	Sum of lines 7 and 8			30. 01	9. 00	
10.00	Allowable disproportionate share percentage (see instruc	ctions)		6. 27	10.00	
11. 00	Disproportionate share adjustment (see instructions)	150, 083 2, 658, 424				
12. 00	12.00 Total prospective capital payments (see instructions)					
	DART II DAVAIENT UNDER REACCOURT COOT			1. 00		
1 00	PART II - PAYMENT UNDER REASONABLE COST			0	1.00	
1. 00 2. 00	Program inpatient routine capital cost (see instructions Program inpatient ancillary capital cost (see instructions			0	2.00	
3. 00	Total inpatient program capital cost (see Instruction Total inpatient program capital cost (line 1 plus line 2			0	3.00	
4. 00	Capital cost payment factor (see instructions)	-)		0	4.00	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0		
0.00	Trotal Tipati one program capital cost (Time c x Time T)				0.00	
				1. 00		
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0	1.00	
2.00	Program inpatient capital costs for extraordinary circum			0	2.00	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions)	2)		0. 00	3. 00 4. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4	1)		0.00	5.00	
6. 00	Percentage adjustment for extraordinary circumstances (s	,		0.00		
7. 00	Adjustment to capital minimum payment level for extraord	,	v line 6)	0.00		
8. 00	Capital minimum payment level (line 5 plus line 7)	arnary crrcumstances (rine 2	X TITIC 0)	0	8.00	
9. 00					9.00	
10.00					10.00	
11. 00	Carryover of accumulated capital minimum payment level of Worksheet L. Part III, line 14)			0	11. 00	
12. 00	Net comparison of capital minimum payment level to capit	tal navments (line 10 nlus li	ne 11)	0	12.00	
13. 00	Current year exception payment (if line 12 is positive,			0	13.00	
14. 00	Carryover of accumulated capital minimum payment level of	0				
50	(if line 12 is negative, enter the amount on this line)	· ·	55			
15.00	1,	ee instructions)		0	15.00	
16.00		,		0	16.00	
17.00	Current year exception offset amount (see instructions)			0	17. 00	