COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0112 Worksheet S Peri od. From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: То 5/24/2022 10:23 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2022 Time: 10:23 am]Manually prepared cost report use only 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 [1] As Submitted
 7. Contractor No.

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 10. NPR Date:

 (11. Contractor's Vendor Code:
 4

 (12. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11. Contractor's Code:

 (13. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11.

 [N] Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) MISREPRESENTATION OF 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 01/01/2021 and ending 12/31/2021 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 ADMINIS	TRATOR CHECKBOX	ELECTRONI C						
	1		1 2		SI GNATURE 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					

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	593, 631	-148, 821	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	50, 800	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	644, 431		0		200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI CATI ON DATA	Provio	ler CCN: 1		Period: From 01/01/ To 12/31/	2021 2021	Workshe Part I Date/Ti 5/24/20	me Pre	pare
	1.00	2.00		3.00		L	. 00			
~~	Hospital and Hospital Health Care Co	-								1
00 00	Street: 2400 EAST 17TH STREET City: COLUMBUS	PO Box: State: IN	Zin Cod	e: 47201-	Count	y: BARTHOLO	1EW			1. 2.
00	CTTY. COLOMBOS	Component Name	CCN	CBSA	Provi der	Date		nt Syste	em (P	<u> </u>
			Number	Number	Type	Certi fi ed		0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componer	nt Identification:								
00	Hospi tal	COLUMBUS REGIONAL HOSPITAL	150112	18020	1	07/01/1966	Ν	Р	Р	3.
00 00	Subprovi der – IPF Subprovi der – IRF	COLUMBUS REGIONAL REHAB	15T112	18020	5	01/01/1984	N	Р	N	4. 5.
		UNI T								
00	Subprovider - (Other)									6
00	Swing Beds - SNF									7
00	Swing Beds - NF									8
00	Hospital-Based SNF									9
. 00	Hospital-Based NF									10.
. 00	Hospital-Based OLTC									11.
. 00	Hospital-Based HHA									12
. 00	Separately Certified ASC									13
. 00	Hospital-Based Hospice									14
00	Hospital-Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
10	Hospital-Based (CORF) I									17
00	Renal Dialysis									18
00	Other					From:		To:		19
00						1.00	224	2.0		0.5
	Cost Reporting Period (mm/dd/yyyy)					01/01/20)21	12/31/	2021	20
00	Type of Control (see instructions)					8				21
					1.00	2.00		3.0	0	1
	Inpatient PPS Information				1.00	2.00		5.0		
00	Does this facility qualify and is it	currently receiving pay	ments fo	r	Y	N				22
	disproportionate share hospital adju	istment, in accordance wi	th 42 CF							
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle ame								
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim ur	compensated care payment			Y	Y				22
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			cost						
0.5	reporting period occurring on or aft									
02	Is this a newly merged hospital that				N	N				22
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th October 1.	le cost reporting period	ULUL AL							
03	Did this hospital receive a geograph	ic reclassification from	urban +	0	Ν	N		N		22
00	rural as a result of the OMB standar							IN IN		~~
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
				as						
	Does this hospital contain at least									
	Does this hospital contain at least counted in accordance with 42 CFR 41	2.105)? Enter in column								
		2.105)? Enter in column			Ν	N		Ν		22
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	ic reclassification from			IN IN	1				
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME	íc reclassification from 8 delineations for statis	stical ar	eas	IN					1
04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in	ic reclassification from delineations for statis column 1, "Y" for yes or	tical ar "N" for	eas no	IN .					
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04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th	stical ar "N" for er 1. Ent ne cost	eas no	N					
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	S REGI ONAL	Provider CC	N: 15-0112		eri od:	In Lie	1		et S-2	
				Fr Tc	om 01/0 12/3	1/2021	Part Date 5/24	: e/Tir 1/202	ne Pre 22 10:	pared: 23 am
	In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	S Mea eli ui	ut-of tate di cai d gi bl e npai d	Medica HMO da	ays	Medi da	her caid iys	
4.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00		4.00	5.00	312	6.	163	24.00
 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 5.00 If this provider is an IRF, enter the in-state 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 	26			-	0	,,	231		105	25. 00
HMO paid and eligible but unpaid days in column 5.					Urban/Ri	ural S	Date	of	Geogr	
			ni na ne		1.0	10		2.00)	26.00
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo	or rural.		0 0			1				20.00
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c enter the effective date of the geographic reclassif (5.00 If this is a sole community hospital (SCH), enter th	or"2" for r fication in	rural. If a column 2.	pplicable,			1				27.00 35.00
effect in the cost reporting period.		perrous 5				0				33.00
					Begi nn 1. 0		E	ndi n 2. 00		
6.00 Enter applicable beginning and ending dates of SCH s		script line	36 for num	ber				2. 0.	-	36.00
of periods in excess of one and enter subsequent dat 7.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for t	er the numbe			us		0				37.00 37.01
accordance with FY 2016 OPPS final rule? Enter "Y" f instructions) 8.00 If line 37 is 1, enter the beginning and ending date	for yes or " es of MDH st	N" for no. atus. If I	(see ine 37 is							38.00
greater than 1, subscript this line for the number of										
enter subsequent dates.	n periods i	n excess o	r one and							
		n excess o	r one and	-	Y/I			Y/N		
99.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	il payment a), (ii), or the mileage	ndjustment (iii)? En e requireme	for low vol ter in colu nts in	imn	<u>Y/1</u> 1.0 N	0		Y/N 2.00 N		39.00
enter subsequent dates. 39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet	il payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	djustment (iii)? En e requireme in column ht? Enter " er "Y" for	for low vol ter in colu nts in 2 "Y" for y Y" for yes	mn res or	1.0	0		<u>2.00</u> N)	39. 00 40. 00
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 enter subsequent dates. 9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS 8.00 Is the facility electing full federal capital paymer Teaching Hospitals 	il payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Ente . (see inst ent for disp ception for st. L, Pt. I capital? E t? Enter "	idjustment (iii)? En e requireme in column ht? Enter " er "Y" for rructions) proportiona extraordin II and Wks Enter "Y fo Y" for yes	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for	mn res or for acc tanc l = (no.	1.0 N Y cordance ces through pr no.	0 1.00 N N N N) 2. N	2.00 N N 11 000	XI X 3. 00 N N	40.00 45.00 46.00 47.00 48.00
 enter subsequent dates. 39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 10.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 15.00 Does this facility qualify and receive Capital paymed with 42 CFR Section §412.320? (see instructions) 16.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 17.00 Is this a new hospital under 42 CFR §412.300(b) PPS 18.00 Is the facility electing full federal capital paymer Teaching Hospitals 16.00 Is this a nospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in colum 	al payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Ente . (see inst ent for disp ception for st. L, Pt. I capital? E tr? Enter " n approved (se to column crograms in cable CRs) olumn 2.	idjustment (iii)? En e requireme in column er "Y" for er "Y" for eructions) proportiona extraordin II and Wks enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment	mn res or for i acc itanc i acc itanc i acc i accc i acc i acc i acc i acc i a	1.0 N Y cordance ces through or no. or yes o spi tal mate ducti on?	0 1.00 N N N N N	D 2.	2.00 N N 11 000	XI X 3. 00 N N	40. 00 45. 00 46. 00 47. 00 48. 00 56. 00
 enter subsequent dates. 9.00 Does this facility qualify for the inpatient hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment excorpursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS 8.00 Is the facility electing full federal capital paymer Teaching Hospitals 6.00 Is this a new hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in col for the respons trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is " 	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter ber 1. Enter cont for disp ception for st. L, Pt. I capital? Enter " n approved (ce to column programs in cable CRs) olumn 2. period duri or yes or "N th of this Y", complet	adjustment (iii)? En requireme in column er "Y" for ructions) proportiona extraordin II and Wks Enter "Y fo Y" for yes ME program A lis "Y", the prior MA direct ng which r " for no i cost repor	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	mn res or for i acc i accc i accc i accc i accc i accc i accc i accc i acc	1.0 N V Cordance ces through or no. Dr yes of spi tal mate ducti on? coroved col umn	0 V 1.00 N N N N N N 1	D 2.	2.00 N N 11 000	XI X 3. 00 N N	40. 00 45. 00 46. 00 47. 00 48. 00 56. 00
 enter subsequent dates. 39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 10.00 Is this hospital subject to the HAC program reductic "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1 15.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 16.00 Is this a new hospital under 42 CFR §412.300(b) PPS 1s this a new hospital under 42 CFR §412.300(b) PPS 1s the facility electing full federal capital paymer Teaching Hospitals 16.00 Is this a new hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in colum 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in colum 1. For respons the first cost reporting GME programs trained at this facility? Enter "Y" for yes; otherwise, enter "N" for no in colum 1. For respons the first cost reporting GME programs trained at this facility? Enter "Y" for yes; therwise, enter "N" for no in colum 1. For colum 1. For respons the first cost reporting GME programs trained at this facility? Enter "Y" for yes; therwise, enter "N" for no in colum 1. For colum 1. For respons the first cost reporting fulle programs trained at this facility? Enter "Y" for yes; therwise, enter "N" for no in colum 1. For colum 1. For respons the first cost reporting fulle programs trained at this facility? Enter "Y" for yes; therwise, enter "N" for no in colum 1. For colum 1. For colum 2. If the respons the first cost reporting fulle p	al payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter . (see inst ent for disp ception for st. L, Pt. I capital? E tt? Enter " n approved (se to column programs in cable CRs) olumn 2. period duri or yes or "N oth of this Y", complet 1, if appli	adjustment (iii)? En e requireme in column er "Y" for er "Y" for erructions) oroportiona extraordin II and Wks enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable. for physici	for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	mn res or for i acc ttanc l'" fc ttanc l'" fc to hos ulti '' rec lf ?? [colur	1.0 N V Cordance Ces through or no. Or yes o spital mate duction? Cordumn Enter "Y nn 2 is	0 V 1.00 N N N N N N 1	D 2.	2.00 N N 11 000	XI X 3. 00 N N	40.00 45.00 46.00 47.00 48.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		NAL HOSPITAL Provider C		eri od:	Worksheet S-2	2552-10
			T.	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/24/2022 10:	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in col	85? (umn 1. CR) NAH	see If column 1	1.00 Y	2.00 Y	3.00	60.00
0.01 If line 60 is yes, complete columns 2 and 3 for each instructions)	progra			23. 01		60.01
0.02 f line 60 is yes, complete columns 2 and 3 for each instructions)	progra	m. (see	Direct GME	23. 02	1 Direct GME	60.02
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	1.00 N	2.00	3.00	4.00	5.00 0.00	61.00
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.03
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.0
 instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being 						61.0
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		1.00	2.00	3.00	4.00	61.1(
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital	trai ne	d in this cost		iod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	a Teach gram. (ing Health Cer see instructio		your hospital	0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se			cost reporting	period? Enter	N	63.00

OSPI 1	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP	EX IDENTIFICATION DA	ATA Provider C		eriod:	Worksheet S-2	2
				Fr To	rom 01/01/2021 0 12/31/2021	Part I Date/Time Pre 5/24/2022 10:	
				Unwei ghted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
	period that begins on or after J	uly 1, 2009 and befo	ore June 30, 2010.		2		
4.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.0
	or (cordinin r drvrded by (cordinin	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTËs Nonprovider	FTEs in Hospital	3/ (col . 3 + col . 4))	
		1.00	2.00	Site	4.00	F 00	-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 0
	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)			Unweighted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
	Section 5504 of the ACA Current	Voar ETE Docidante !	n Nonnrovidor Cattin	1.00	2.00	3.00	
	beginning on or after July 1, 20		n Nonprovider Settin	gsEffective i	or cost report	rng perious	
5. 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	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1.00	2.00	Si te 3.00	4.00	5.00	-
7.00	Enter in column 1, the program	1.00	2.00	0.00			67.0
	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						

Heal th	Financial Systems COLUMBUS REGIONAL HOSPITAL	ı I	n Lieu	of For	m CMS-2	2552-10
HOSPI T		Period: From 01/01/ To 12/31/	2021 2021	Workshe Part I Date/Ti	me Pre	pared:
				2.00		23 am
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF su	bprovi der?	N	2.00	0.00	70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in		N	N	0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new tea program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reporti (see instructions)	no. (see ching no.	N		0	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program ir	the most	N	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordanc CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions	e with 42 Y,				
		,	-	1.0	0	-
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reportir "Y" for yes and "N" for no.	g period? I	Enter	N		80.00 81.00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti		no.	N		85.00 86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under sectior 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l		Ν		87.00
		V 1.00		XI 2. 0		
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. C N		95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 N		0. C Y	0	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wks1 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column			Ν		98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title VIX	N		Ν		98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance or Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i column 2 for title XIX.			Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Ν		Y		98.06
105 00	Rural Providers Does this hospital qualify as a CAH?	N	1			105.00
	If this facility qualify as a CAH, has it elected the all-inclusive method of paymer for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Ν				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

	OLUMBUS REGION	IAL HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICA	TION DATA	Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet S- Part I Date/Time Pr 5/24/2022 10	repared:
				V	XI X	_
108.00 Is this a rural hospital qualifying for an exc	ception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or	"N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
		1. 00	2.00	Speech 3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost therapy services provided by outside supplier? for yes or "N" for no for each therapy.		N	N	N	Ν	109.00
110 00 Did this boosital participate in the Dural Car		- Domonotroti	on project (\$4	104	1.00 N	110.00
110.00 Did this hospital participate in the Rural Com Demonstration) for the current cost reporting p complete Worksheet E, Part A, lines 200 throug applicable.	eriod? Enter "	'Y" for yes or	"N" for no. I	f yes,	N	110.00
				1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it pa Health Integration Project (FCHIP) demonstrati "Y" for yes or "N" for no in column 1. If the integration prong of the FCHIP demo in which t Enter all that apply: "A" for Ambulance servic for tele-health services.	on for this co response to co his CAH is par	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
			1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylva demonstration for any portion of the current of Enter "Y" for yes or "N" for no in column 1. in column 2, the date the hospital began parti demonstration. In column 3, enter the date the participation in the demonstration, if application	cost reporting If column 1 is cipating in th ne hospital cea	period? s "Y", enter ne	N	2.00	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter	"Y" for ves or	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the met in column 2. If column 2 is "E", enter in colu for short term hospital or "98" percent for lo psychiatric, rehabilitation and long term hosp the definition in CMS Pub.15-1, chapter 22, §2	hod used (A, E umn 3 either "9 ong term care (oitals provider 2208.1.	3, or E only) 93" percent (includes rs) based on				
116.00 Is this facility classified as a referral cent "N" for no.	er? Enter "Y"	for yes or	Y			116.00
117.00 Is this facility legally-required to carry mal	practice insur	rance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or if the policy is claim-made. Enter 2 if the po			1			118.00
			Premiums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid	Losses:		1.00	2.00	3.00	0118.01
						_
118.02 Are malpractice premiums and paid losses repor Administrative and General? If yes, submit su and amounts contained therein.				1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the C §3121 and applicable amendments? (see instruct "N" for no. Is this a rural hospital with < 10 Hold Harmless provision in ACA §3121 and appli	ions) Enter in 00 beds that qu	ר column 1, "א ualifies for t	(" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for h patients? Enter "Y" for yes or "N" for no.	nigh cost impla	antable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare relate Act?Enter "Y" for yes or "N" for no in column the Worksheet A line number where these taxes	1. If column 1			N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center		or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) 126.00 f this is a Medicare certified kidney transpl		nter the certi	fication date			126.00
in column 1 and termination date, if applicabl	e, in column 2	2.				
127.00 If this is a Medicare certified heart transplation in column 1 and termination date, if applicabl			ication date			127.00
128.00 If this is a Medicare certified liver transpla in column 1 and termination date, if applicabl			fication date			128.00
129.00 If this is a Medicare certified lung transplar column 1 and termination date, if applicable,	nt center, ente		cation date in			129.00

alth Financial Systems COLUMBUS REGION SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN	15 0112	Peri od:		u of Form CMS- Worksheet S-:	
SPITAL AND HUSPITAL HEALTH CAKE COMPLEX IDENTIFICATION DATA	Provider con	. 15-0112	From 01	/01/2021 2/31/2021	Part I	epared
				1.00	2.00	-
0.00 If this is a Medicare certified pancreas transplant center,		fi cati on				130.0
date in column 1 and termination date, if applicable, in co 1.00 If this is a Medicare certified intestinal transplant cente		tificatio	n İ			131.0
date in column 1 and termination date, if applicable, in co	olumn 2.					
2.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column		ation date	e			132.0
3.00 Removed and reserved						133.0
4.00 If this is an organ procurement organization (0P0), enter t and termination date, if applicable, in column 2. All Providers	he OPO number ir	n column 1				134. (
0.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number	yes, and home of	office cos	ts	Y		140.0
1.00 2.00 If this facility is part of a chain organization, enter on	0 lines 141 throug	ĺ.	name an	3.00 d address	of the home	
office and enter the home office contractor name and contra 1.00 Name: Contractor's Name:	actor number.	Contrac	tor's Nu	mber		141.0
2.00 Street: PO Box:						142.0
3. 00 Ci ty: State:		Zip Cod	e:			143.0
					1.00	
4.00 Are provider based physicians' costs included in Worksheet	A?				Y	144.
				1.00	2.00	-
5.00 If costs for renal services are claimed on Wkst. A, line 74				Y		145. (
inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	n column 1. If co n for this cost r	eporting				
6.00 Has the cost allocation methodology changed from the previo Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.			lf	Ν		146.
has a star the engine of date (my/dd//) in adjume 2						
yes, enter the approval date (mm/dd/yyyy) in column 2.					1 00	-
7.00Was there a change in the statistical basis? Enter "Y" for					1.00 N	147.
7.00Was there a change in the statistical basis? Enter "Y" for 8.00Was there a change in the order of allocation? Enter "Y" fo	or yes or "N" for	no.			N N	148.
7.00Was there a change in the statistical basis? Enter "Y" for	or yes or "N" for	no.		tle V	N	
7.00Was there a change in the statistical basis? Enter "Y" for 8.00Was there a change in the order of allocation? Enter "Y" fo 9.00Was there a change to the simplified cost finding method? E	or yes or "N" for Enter "Y" for yes Part A 1.00	no. or "N" fo Part B 2.00	Ti	3.00	N N Title XIX 4.00	148.
7.00Was there a change in the statistical basis? Enter "Y" for 8.00Was there a change in the order of allocation? Enter "Y" fo 9.00Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an	or yes or "N" for inter "Y" for yes Part A 1.00 n exemption from	no. or "N" fo Part B 2.00 the appli	cation o	3.00 f the low	N N Title XIX 4.00 er of costs	148.
7.00 Was there a change in the statistical basis? Enter "Y" for 8.00 Was there a change in the order of allocation? Enter "Y" fo 9.00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5.00 Hospital	or yes or "N" for inter "Y" for yes Part A 1.00 exemption from nent for Part A a N	r no. <u>5 or "N" fo</u> <u>Part B</u> <u>2.00</u> the appli and Part B N	cation o	3.00 f the low 2 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	148. 149. 155.
7.00 Was there a change in the statistical basis? Enter "Y" for 8.00 Was there a change in the order of allocation? Enter "Y" fo 9.00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5.00 Hospital 6.00 Subprovider - IPF	r yes or "N" for nter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N	no. <u>sor "N" fo</u> <u>Part B</u> <u>2.00</u> the appli and <u>Part B</u> N N	cation o	3.00 f the low 2 CFR §41 N N	N N Title XIX 4.00 er of costs 3.13) N N	148. 149. 155. 155.
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7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF	r yes or "N" for Ther "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N	no. no. Part B 2.00 the appli and Part B N N N	cation o	3.00 f the low 2 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N	148. 149. 155. 155. 156. 157. 158. 159.
7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY	or yes or "N" for Enter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N	no. <u>sor "N" fo</u> <u>Part B</u> <u>2.00</u> the appli and Part B N N N N N	cation o	3.00 f the low 2 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N	148. 149. 155. 155. 156. 157. 158. 159. 160.
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7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF	r yes or "N" for The "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N	no. or "N" fo Part B 2.00 the appli and Part B N N N N N N N N N	cati on o . (See 4	3.00 f the low <u>2 CFR §41</u> N N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
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7. 00 Was there a change in the statistical basis? Enter "Y" for 3. 00 Was there a change in the order of allocation? Enter "Y" for 5. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF Multicampus 5. 00 Is this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no. Name	r yes or "N" for inter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	no. or "N" for Part B 2.00 the appli and Part B N N N N N N N N Ses in diff	ferent CI	3.00 f the low 2 <u>CFR §41</u> N N N N N N SSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N T.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF 6. 00 If this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no. Name 0 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3,	r yes or "N" for nter "Y" for yes Part A 1.00 nexemption from nent for Part A a N N N N N N N N N	no. or "N" for Part B 2.00 the appli and Part B N N N N N N N N Ses in dif	ferent CI	3.00 f the low 2 <u>CFR §41</u> N N N N N N N SSAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N T.00 N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.
7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF Multicampus 5. 00 15 this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no. 0 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	r yes or "N" for inter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	no. or "N" for Part B 2.00 the appli and Part B N N N N N N N N Ses in diff	ferent CI	3.00 f the low 2 <u>CFR §41</u> N N N N N N SSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N T.00 N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.
7. 00 Was there a change in the statistical basis? Enter "Y" for 8. 00 Was there a change in the order of allocation? Enter "Y" for 9. 00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF 6. 00 If line 165 is yes, for each campus hospital that has on Enter "Y" for yes or "N" for no. 0 6. 00 If line 165 is yes, for each campus hospital that has on County in column 1, state in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	r yes or "N" for inter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	no. or "N" for Part B 2.00 the appli nd Part B N N N N N N N N N N State Z 2.00	ferent Cl	3.00 f the low 2 <u>CFR §41</u> N N N N N N SSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N T.00 N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.
7. 00Was there a change in the statistical basis? Enter "Y" for 8. 00Was there a change in the order of allocation? Enter "Y" fo 9. 00Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5. 00Hospital 6. 00Subprovider - 1PF 7. 00Subprovider - 1RF 8. 00SUBPROVIDER 9. 00SNF 0. 00HOME HEALTH AGENCY 1. 00CMHC 1. 10CORF Multicampus 5. 00 If this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no. Mame 0 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in the Americ 7. 00 Is this provider a meaningful user under §1886(n)? Enter "	r yes or "N" for inter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the appli nd Part B N N N N N N N N N N Ses in diff State Z 2.00 Reinvestm " for no.	ferent CI i p Code 3.00	3.00 f the low 2 CFR §41 N N N N N N N BSAs? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165. 0166.
7.00 Was there a change in the statistical basis? Enter "Y" for 8.00 Was there a change in the order of allocation? Enter "Y" for 9.00 Was there a change to the simplified cost finding method? E Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each compon 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 COMPC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no. 0 6.00 If line 165 is yes, for each campus in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	r yes or "N" for inter "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the appli and Part B N N N N N N N N N N N N N	ferent Cl ip Code 3.00	3.00 f the low 2 CFR §41 N N N N N N N SSAs? CBSA 4.00 CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161.

Health Financial Systems					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112				2
				Part I	narod
			10 12/31/2021	Date/Time Pre 5/24/2022 10:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provid	ler have any days for indi	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans rep	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	nter the number of section	n		
1876 Medicare days in column 2. (see	e instructions)				

10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/24/2022 10:	epared
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esnonses Ent	1.00	2.00	
	mm/dd/yyyy format.		coponecor 2m			
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation	haalaalaa af	+h+	N		1 1 0
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N N		1.0
	rieportring period. In yes, enter the date of the enange in e	01 41111 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
8. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe	ffices, drug er or its f the board	Y			3.0
	relationships? (see instructions)		Y/N	Turpo	Dato	_
			1.00	Type 2.00	Date 3.00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	04/29/2022	4. C
5.00	Are the cost report total expenses and total revenues diffe		Y			5.0
	those on the filed financial statements? If yes, submit rec			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6.0
7.00 3.00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during th	Y N		7. C 8. C
9.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.0
	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10.0
11.00	cost reporting period? If yes, see instructions. 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	Ν		11. (
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12.0 13.0
	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? I	fyes, see ir	nstructions.	Ν	14.0
	Bed Complement Did total beds available change from the prior cost reporti				Y	15.0
		Par Y/N	t A Date	Par Y/N	t B Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Y	04/03/2022	Y	04/03/2022	16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/03/2022	Y	04/03/2022	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

Heal th	Financial Systems COLUMBUS REG	I ONAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		eriod:	Worksheet S-2	2
				rom 01/01/2021 o 12/31/2021	Part II Date/Time Pro	enared
					5/24/2022 10	: <u>23 am</u>
			iption	Y/N	Y/N	
20,00	If line 16 or 17 is yes, were adjustments made to PS&R	MGD CARE PART		1.00 Y	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:	DAYS		Т	IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					_
	Have assets been relifed for Medicare purposes? If yes, s			++	N	22.00
23.00	Have changes occurred in the Medicare depreciation expensions reporting period? If yes, see instructions.	ng the cost	N	23.00		
24.00	Were new leases and/or amendments to existing leases enter	ered into durina	this cost rep	orting period?	Y	24.00
	If yes, see instructions					
25.00	Have there been new capitalized leases entered into durin	ng the cost repo	rting period?	lfyes, see	N	25.00
o (o o	instructions.					
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost report	ing period? IT	yes, see	N	26.00
27.00	Has the provider's capitalization policy changed during t	the cost reporti	na period? If	ves. submit	N	27.00
	copy.			,,		
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit	entered into du	ring the cost	reporti ng	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/o	or bond funds (D	obt Sorvico Po	corvo Eund)	Y	29.00
29.00	treated as a funded depreciation account? If yes, see ins		ebt Service Re	serve runu)	T	29.00
30.00	Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see	N	30.00
	instructions.	-				
31.00	Has debt been recalled before scheduled maturity without	issuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					-
32.00	Have changes or new agreements occurred in patient care s	servi ces furni sh	ed through con	tractual	N	32.00
02.00	arrangements with suppliers of services? If yes, see inst		ou thi ough oon	in dottal.		02.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 a	applied pertaini	ng to competit	ive bidding? If		33.00
	no, see instructions.					_
24 00	Provider-Based Physicians Are services furnished at the provider facility under an	arrangement wit	h providor bas	od physicians?	Y	34.00
34.00	If yes, see instructions.	arrangement with		eu physicians?	T	34.00
35.00	If line 34 is yes, were there new agreements or amended e	existing agreeme	nts with the p	rovi der-based	Y	35.00
	physicians during the cost reporting period? If yes, see	instructions.				
				Y/N	Date	
	Home Office Costs			1.00	2.00	_
36.00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been	prepared by the	home office?			37.00
	lf yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of					38.00
39.00	the provider? If yes, enter in column 2 the fiscal year e If line 36 is yes, did the provider render services to ot					39.00
57.00	see instructions.		nents: 11 yes,			37.00
40.00	If line 36 is yes, did the provider render services to the	ne home office?	lf yes, see			40.00
	instructions.					
			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,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report	BKD, LLP				42.00
43 00	preparer. Enter the telephone number and email address of the cost	317-383-4000		KBEJARANO@BKD.	COM	43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems COLU	JMBUS REGION	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	ONNAI RE	Provider (Period:	Worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
				10 12/01/2021	5/24/2022 10:	<u>23 am</u>
		3.	. 00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/pos		I RECTOR				41.00
held by the cost report preparer in columns 1, 2,	2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost report	ort					42.00
preparer.						
43.00 Enter the telephone number and email address of	the cost					43.00
report preparer in columns 1 and 2, respectively.	r.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COLUMBUS REGIO	Provi der CO	CN: 15-0112	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/24/2022 10:	
						I/P Days /	2.5 am
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	221	80, 6	65 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						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		221	80, 6	65 0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	26	9,4	90 0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0		0 0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		247	90, 1	55 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	19	6, 9		0	17.00
18.00	SUBPROVI DER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00 21.00
21.00	HOME HEALTH AGENCY	101.00				0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	22.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.00
25.00	CMHC - CMHC	00.00					25.00
25.10	CMHC - CORF	99, 10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		266				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges				1		33.01

	<u>Financial Systems</u> AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COLUMBUS REGION	Provi der CO		Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2021 To 12/31/2021		narod
					10 12/31/2021	5/24/2022 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
1 00		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	10, 868	936	30, 70	0		1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	7, 277	7, 762				2.00
3.00	HMO IPF Subprovi der	, 2, 7	, , , 02				3.00
4.00	HMO I RF Subprovi der	533	279				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.0
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation	10, 868	936	30, 70	0		7.00
	beds) (see instructions)	.,					
8.00	INTENSIVE CARE UNIT	810	115	3, 97	2		8.00
9.00	CORONARY CARE UNIT	0	0		0		9.0
10.00	BURN INTENSIVE CARE UNIT	0	0		0		10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T	0	0		0		11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY		246	2,84	2		13.0
14.00	Total (see instructions)	11, 678	1, 297	37, 51	4 0.00	1, 185. 00	14.0
15.00	CAH visits	0	0		0		15.0
16.00	SUBPROVIDER - IPF	0	0		0 0.00	0.00	
17.00	SUBPROVIDER - IRF	1, 234	26	2,83			
8.00	SUBPROVI DER		0		0 0.00		
9.00	SKILLED NURSING FACILITY	0	0		0 0.00	0.00	
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPI CE				~		24.0
24.10	HOSPICE (non-distinct part)				0		24.1
25.00	CMHC - CMHC		0		0 0 00	0.00	25.0
25.10	CMHC - CORF	0	0		0 0.00		
26.00	RURAL HEALTH CLINIC	0	0		0 0.00 0 0.00		
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00 0.00 0.00		
28.00	Total (sum of lines 14-26) Observation Bed Days		855	3, 55		1, 203. 00	27.0
29.00	Ambulance Trips	3, 799	600	5,00	0		29.0
0.00	Employee discount days (see instruction)	3, 799			0		30.0
31.00	Employee discount days (see fistruction)				0		31.0
32.00	Labor & delivery days (see instructions)	0	163	31			32.0
32.00	Total ancillary labor & delivery room	U U	105		0		32.0
22.01	outpatient days (see instructions)				Ĭ		02.0
33.00	LTCH non-covered days	О					33.0
	LTCH site neutral days and discharges	o					33.0

HOSPLT	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COLUMBUS REGIONA	Provider C	CN· 15-0112	Peri od:	u of Form CMS-2 Worksheet S-3	
103111				GN. 10 0112	From 01/01/2021 To 12/31/2021	Part I Date/Time Prej 5/24/2022 10:2	
		Full Time		Di s	charges	0/21/2022 10.1	20 411
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	component	Workers	nue v		II LIE XIX	Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0			9, 199	1.00
	8 exclude Swing Bed, Observation Bed and					,	
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 50	62 0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
0.00	beds) (see instructions)						0.00
8.00 9.00							8.00 9.00
	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
11.00 12.00							11.00 12.00
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00
14.00	Total (see instructions)	0.00	0	2,8	2, 021	9, 199	14.00
15.00	CAH visits	0.00	0	2,0	2,021	, , , , , , , , , , , , , , , , , , , ,	15.00
16.00	SUBPROVIDER - IPF	0, 00	0		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	1 .	83 28	200	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			1			21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00 30.00	Ambulance Trips Employee discount days (see instruction)						29.00 30.00
30.00	Employee discount days (see fistruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)						31.00
32.00	Total ancillary labor & delivery room						32.00
JZ. UT	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days				0		33.00
					0		

SPI T	Financial Systems AL WAGE INDEX INFORMATION			Provider C		Peri od:	Worksheet S-3	3
						From 01/01/2021 To 12/31/2021		epar
		Wkst. A Line Number	Amount Reported	Recl assi fi cat i on of Sal ari es	Adjusted Salaries (col.2 ± col.		5/24/2022 10: Average Hourly Wage (col. 4 ÷	23
				(from Wkst. A-6)	3)	col. 4	col. 5)	
	PART II – WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	-
	SALARI ES			1	I	I		
0	Total salaries (see instructions)	200.00	90, 443, 917	-831, 376	89, 612, 541	2, 473, 238. 00	36. 23	8 1
0	Non-physician anesthetist Part		0	0	C	0.00	0.00	
0	A Non-physician anesthetist Part		0	о	(0.00	0.00	
0	B Physician-Part A -		0	0	(0.00	0.00	
	Administrative							
1 0	Physicians - Part A - Teaching Physician and Non		0 2, 796, 854	0	2, 796, 854	0.00 12,136.00		
0	Physician-Part B Non-physician-Part B for		214, 098	0	214, 098	4, 160. 00	51.47	6
	hospital-based RHC and FQHC services		214, 070	0	214,070	4, 100. 00	51.47	
0	Interns & residents (in an approved program)	21.00	0	0	C	0.00	0.00	
)1	Contracted interns and residents (in an approved		C	0	C	0.00	0.00	
0	programs) Home office and/or related organization personnel		0	0	C	0.00	0.00	6
00 00	SNF	44.00	0	1 010 270	7 152 454	0.00		
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		6, 142, 077	1, 010, 379	7, 152, 456	230, 715. 00	31.00	
00	Contract Labor: Direct Patient Care		32, 620, 671	0	32, 620, 671	420, 467. 00	77. 58	3 11
00	Contract Labor: Top Level management and other management and administrative		981, 569	275, 705	1, 257, 274	4 22, 428. 00	56.06	12
00	services Contract Labor: Physician-Part		6, 580, 163	0	6, 580, 163	58, 318. 00	112.83	3 13
00	A - Administrative Home office and/or related organization salaries and		0	0	C	0.00	0.00	14
01	wage-related costs Home office salaries		0	0	(0.00	0.00	1
02	Related organization salaries		4, 247, 648	0	4, 247, 648			
00	Home office: Physician Part A - Administrative		0	0	(0.00	0.00	15
00	Home office and Contract		0	0	C	0.00	0.00	16
01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	16
02	- Teaching Home office contract		0	0	(0.00		
	Physicians Part A - Teaching WAGE-RELATED COSTS		-					
00	Wage-related costs (core) (see		25, 699, 877	0	25, 699, 877	7		17
00	instructions) Wage-related costs (other)							18
00	(see instructions) Excluded areas		2, 289, 500	0	2, 289, 500	þ		19
00	Non-physician anesthetist Part A		0	0	()		20
	Non-physician anesthetist Part B		0	0	(2'
00	Physician Part A - Administrative		0	0				22
01	Physician Part A - Teaching		0	0	(0	-	22
00 00	Physician Part B Wage-related costs (RHC/FQHC)		963, 806 0		963, 806 (23
	Interns & residents (in an		0	0	(Ď		25
50	approved program) Home office wage-related		0	0	(25
51	(core) Related organization		1, 546, 658	0	1, 546, 658	3		25
52	wage-related (core) Home office: Physician Part A		0	0	()		25
	- Administrative - wage-related (core)							

Heal th	Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/24/2022 10:	pared:
		Wkst. A Line		Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(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	FC						
26.00		4.00	181, 461	-176, 430	5, 03	1 86.00	58, 50	26.00
26.00	Employee Benefits Department Administrative & General	4.00						
			21, 685, 743					
28.00	Administrative & General under		8, 513, 369	0	8, 513, 36	9 97, 308. 00	87.49	28.00
29.00	contract (see inst.) Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
29.00 30.00	Operation of Plant	7.00	2, 935, 708	112, 492	3, 048, 20			
30.00		8.00	2,935,708 38,870					
	Laundry & Linen Service							31.00
32.00	Housekeepi ng	9.00	2,031,865	88, 787	2, 120, 65			
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
34.00	(see instructions) Dietary	10.00	2, 125, 548	-1, 218, 351	907, 19	7 43, 076. 00	21 04	34.00
34.00	Dietary under contract (see	10.00	2, 125, 548	-1, 218, 351	907, 19	0 43,078.00 0 0.00		
35.00	instructions)		0	0		0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1, 295, 804	1, 295, 80	4 61, 948. 00	20.02	36.00
37.00	Maintenance of Personnel	12.00	0	1, 295, 804	1, 295, 60	0 01, 948.00		
37.00	Nursing Administration	13.00	4, 946, 496	238, 059	5, 184, 55			
39.00	Central Services and Supply	13.00	4, 940, 490					
40.00	Pharmacy	14.00	3, 373, 685	,				
40.00	Medical Records & Medical	16.00	1, 796, 005					40.00
41.00	Records Library	10.00	1, 790, 005	-1,000,203	/30,74	22, 110.00	32. 31	41.00
42.00	Social Service	17.00	0	n -		0 0.00	0.00	42.00
	Other General Service	17.00	0			0 0.00		42.00
+5.00		1 10.00	0	0	I	0.00	0.00	13.00

Heal th	Financial Systems		COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/24/2022 10:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY			-			
1.00	Net salaries (see		95, 946, 334	-831, 376	95, 114, 95	8 2, 554, 250. 00	37.24	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 142, 077	1, 010, 379	7, 152, 45	6 230, 715. 00	31.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		89, 804, 257	-1, 841, 755	87, 962, 50	2 2, 323, 535. 00	37.86	3.00
	minus line 2)							
4.00	Subtotal other wages & related		44, 430, 051	275, 705	44, 705, 75	6 539, 545. 00	82.86	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		27, 246, 535	0	27, 246, 53	5 0.00	30. 98	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		161, 480, 843	-1, 566, 050	159, 914, 79	3 2, 863, 080. 00	55.85	6.00
7.00	Total overhead cost (see		47, 628, 829	-3,067,440	44, 561, 38	9 1, 079, 203. 00	41.29	7.00
	instructions)							
							I	

Heal th	Financial Systems	COLUMBUS REGIONA	L HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				3, 812, 425	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contril	buti on			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see in:	structions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla				0	6.00
7.00	Employee Managed Care Program Administration	n 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 Thi				0	8.01
8.02	Health Insurance (Self Funded with a Third	Party Administrate	or)		16, 711, 782	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				352, 712	10.00
11.00	Life Insurance (If employee is owner or ben	efi ci ary)			45, 063	11.00
12.00	Accident Insurance (If employee is owner or				0	
13.00	Disability Insurance (If employee is owner of				1, 281, 634	13.00
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary	y)		0	14.00
15.00	'Workers' Compensation Insurance				77, 748	15.00
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	aordinary accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				6, 473, 809	
18.00	Medicare Taxes - Employers Portion Only				0	18.00
19.00	Unemployment Insurance				79, 903	19.00
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost H	Reported on lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				118, 107	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23))			28, 953, 183	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th	Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0112	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Pre 5/24/2022 10:	pared:
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Ident					
1.00	Total facility's contract labor and benefit	t cost		32, 620, 671		
2.00	Hospi tal			32, 620, 671	28, 953, 183	
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF					9.00
	Hospi tal -Based OLTC					10.00
	Hospi tal -Based HHA			0	0	
	Separately Certified ASC					12.00 13.00
	Hospital -Based Hospice			0	0	
	Hospital-Based Health Clinic RHC			0	0	14.00 15.00
	Hospital-Based Health Clinic FQHC			0	0	
	Hospital -Based-CMHC			_	0	16.00 16.10
	Hospital-Based-CMHC 10			0	0	
	Renal Dialysis			0	0	
18.00	Other			0	0	18.00

Heal th	Financial Systems COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
		Provider CC		Period:	Worksheet S-1	
				From 01/01/2021	Data /Tima Dra	norod.
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: 23 am
					0/21/2022 101	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 colum	18)	0. 327610	1.00
0.00	Medicaid (see instructions for each line)				04 500 000	0.00
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				26, 520, 928 Y	2.00 3.00
3.00 4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal navmont	ts from Medic	ui d2	N N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	1 5		in u :	2, 969, 828	5.00
6.00	Medi cai d charges		u		139, 954, 899	6.00
7.00	Medicaid cost (line 1 times line 6)				45, 850, 624	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of lin	es 2 and 5; if		8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	or each lin	ne)			
9.00	Net revenue from stand-al one CHIP				0	9.00
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(ling 11 mi	nus lino 0. i	f < zero then		12.00
12.00	enter zero)		nus rine 7, i	I < Zero then	0	12.00
	Other state or local government indigent care program (see inst	tructions f	For each line)		1	
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	e program ((Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 1			45 1 11	0	15.00
16.00	Difference between net revenue and costs for state or local ind	digent care	e program (III	ie 15 minus line	9 0	16.00
	<u>13; if < zero then enter zero)</u> Grants, donations and total unreimbursed cost for Medicaid, CHI	P and stat	te/local india	ent care progra	ams (see	
	instructions for each line)			chi care progra		
17.00	Private grants, donations, or endowment income restricted to fu	unding char	rity care		0	17.00
18.00	Government grants, appropriations or transfers for support of I	hospital op	perations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	l indigent	care programs	s (sum of lines	16, 359, 868	19.00
	8, 12 and 16)		Uni nsured	Incurred	Tatal (agl 1	
			patients	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)	I				
20.00	Charity care charges and uninsured discounts for the entire fac	cility	14, 270, 48	4, 058, 083	18, 328, 563	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	4, 675, 15	4, 058, 083	8, 733, 235	21.00
22.00	instructions) Payments received from patients for amounts previously written	off oc		o o	0	22.00
22.00	charity care	on as		0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		4, 675, 15	4, 058, 083	8, 733, 235	23.00
		l				
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien		yond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond the start limit	he indigent	t care program	's length of	0	25.00
26.00	stay limit Total bad debt expense for the entire hospital complex (see in:	structions)	,		8, 709, 418	26 00
28.00	Medicare reimbursable bad debts for the entire hospital complex (see his				536, 981	
27.00	Medicare allowable bad debts for the entire hospital complex (826, 125	
28.00	Non-Medicare bad debt expense (see instructions)		- /		7, 883, 293	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	pense (see	instructions)		2, 871, 790	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				11, 605, 025	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ine 30)			27, 964, 893	31.00

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet A Date/Time Pre	nared·
						5/24/2022 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See	Reclassified Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		21 775 420	21 775 420	11 002 444	0 072 072	1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		21, 775, 438 0		-11, 902, 466 13, 681, 585	9, 872, 972 13, 681, 585	1.00 2.00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	181, 461	32, 340, 737		-1, 970, 593	30, 551, 605	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	21, 685, 743	52, 460, 509		-8, 072, 273	66, 073, 979	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 935, 708 38, 870	7, 605, 957 810, 821		2, 555, 047- 2, 432-	7, 986, 618 852, 123	7.00 8.00
9.00	00900 HOUSEKEEPI NG	2, 031, 865	522, 271		88, 787	2, 642, 923	9.00
10.00		2, 125, 548	1, 004, 628		-1, 809, 277	1, 320, 899	
11.00		0	0	0	1,886,730	1, 886, 730	
13.00 14.00		4, 946, 496	850, 707 722, 510		242, 954 229, 547	6, 040, 157 952, 136	13.00 14.00
15.00		3, 373, 685	2, 114, 476		-195, 468	5, 292, 693	
16.00		1, 796, 005	320, 552		-1,081,228	1, 035, 329	16.00
17.00		0	0	0	0	0	17.00
23.00 23.01		0 136, 027	0 1, 450	0 137, 477	0 353, 095	0 490, 572	23.00 23.0
23.01		229, 935	8, 568		147, 343	385, 846	•
201.02	INPATIENT ROUTINE SERVICE COST CENTERS	22,7,700	0,000	200,000	1177010	0007010	20101
30.00		16, 788, 653	9, 611, 473		-1, 193, 700	25, 206, 426	30.00
31.00		2, 299, 748	5, 027, 358		-159, 930	7, 167, 176	31.00
32.00 33.00		0	0	0	0	0	32.00 33.00
34.00		0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00		1, 472, 014	179, 672	1, 651, 686	256, 962	1, 908, 648	
42.00		1 120 107	192.076	0	15 905	1 224 049	42.00
43.00 44.00		1, 138, 187	182, 976 0		15, 805 0	1, 336, 968 0	
	ANCILLARY SERVICE COST CENTERS				0		
50.00		980, 351	26, 648, 329		-6,033,465	21, 595, 215	
51.00 52.00		11, 276	1,082,069	1, 093, 345	318, 522	1, 411, 867	51.00 52.00
52.00		0	53, 173	-	1, 937, 407 60, 000	1, 937, 407 113, 173	52.00
54.00		1, 567, 071	384, 156		-43, 263	1, 907, 964	
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	510, 036	1, 367, 041		199, 112	2, 076, 189	54. 0 ⁻
54.02		516, 810	82, 458		96, 750	696, 018	
54.03 55.00		509, 609 706, 472	294, 424 1, 289, 656		189, 535 816, 369	993, 568 2, 812, 497	54.0 55.0
57.00		781, 826	431, 331		345, 044	1, 558, 201	•
58.00		343, 412	36, 547	379, 959	139, 133		
59.00		1, 694, 233	5, 080, 968		-4, 363, 897	2, 411, 304	
50.00 50.01		4, 183, 682 371, 974	7,637,615		424, 979	12, 246, 276	60.0
50. 01 52. 00	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	371, 974	707, 983 628, 770		252, 261 83, 111	1, 332, 218 711, 881	60.0 [°] 62.00
65.00		2, 036, 170	543, 721		44, 994	2, 624, 885	65.0
66.00		234, 481	5, 395, 763		-170, 796	5, 459, 448	66.0
67.00		53, 224	1, 186, 792		813, 323	2,053,339	67.0
68.00 69.00		206, 779 695, 878	804, 326 172, 965		-120, 431 20, 110	890, 674 888, 953	68.0 69.0
70.00		682, 451	184, 066		170, 948	1, 037, 465	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		6, 970, 123	6, 970, 123	71.0
72.00		0	0	-	7, 339, 047	7, 339, 047	
73.00		0	25, 149, 633		0	25, 149, 633	
76.00		0	822, 564 0		0	822, 564 0	74.0
76.97		200, 929	59, 634	, °	10, 377	270, 940	
	OUTPATIENT SERVICE COST CENTERS	· · ·		· ·	· · · · · · · · · · · · · · · · · · ·		
88.00		0	0		0	0	88.00
89.00 90.00		0	0	-	0 65, 029	0 1, 805, 565	89.0 90.0
90.00 90.01	09000 CETNIC 09001 DI ABETES CENTER	1, 478, 367 0	262, 169 0		65, U29 0	1, 805, 565	90.0
90.02		302, 168	11, 428	-	8, 523	322, 119	90.0
90.03		666, 623	901, 592		9, 008	1, 577, 223	90.0
90.04		0	0	-	248, 143	248, 143	90.0
90.05 90.06		535, 143	39, 225		35,657	610, 025	90.0
90.06 91.00		231, 464 5, 459, 363	2, 964 1, 278, 149		2, 733 2, 826, 661	237, 161 9, 564, 173	90.0 91.0
92.00		0, 707, 303	1,270,147	0, 101, 012	2, 020, 001	7, 304, 173	92.0
	OTHER REIMBURSABLE COST CENTERS			P			
	09500 AMBULANCE SERVI CES	2, 880, 029	363, 507	3, 243, 536	242, 893	3, 486, 429	

Health Financial Systems	COLUMBUS REGIONA	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider C		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/24/2022 10:	23 am
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	00.10
99. 10 09910 CORF	0	0		0 0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
101.00 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1.00.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	700,000	700.00	0 700 000		111.00
113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	00 010 045	788, 908				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	89, 019, 845	219, 232, 029	308, 251, 87	114, 290	308, 366, 164	1118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 39, 167	20 167	190.00
194. 00 07950 WELLNESS COMMUNITY	0	0		0 298, 869		
194. 01 07951 BUI LDI NG RENTALS	0	1, 942, 331	1, 942, 33			•
194. 02/07952/HOSPI CE	0	108, 830			108, 830	•
194. 03 07953 OUTREACH CLINICS	0	100,000	100,00	0 0		194.03
194. 04 07954 SPEECH - HEARING AI DS	0	0		0 203, 832		
194. 05 07955 NONALLOWABLE MARKETING	0	0		0 559, 921	559, 921	•
194. 06 07956 CRH FOUNDATI ON	46, 865	1,012	47, 87			194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0		0 0		194.07
194. 08 07958 CRHP	1, 377, 207	1, 206, 879	2, 584, 08	503, 116	3, 087, 202	194.08
194.0907959 NEUROPSYCH PART B	0	0		0 0	0	194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	90, 443, 917	222, 491, 081	312, 934, 99	0 8	312, 934, 998	200.00

LLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-01	12 Period: From 01/01/2021	Worksheet A
					Date/Time Prepare
	Cost Center Description	Adjustments	Net Expenses		5/24/2022 10:23 a
		(See A-8)	For		
			Allocation		
		6.00	7.00		
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	-4, 472, 984	5, 399, 988		1.
00	00200 CAP REL COSTS-MVBLE EQUIP	-704, 725			2.
00	00300 OTHER CAP REL COSTS	0	1		3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-423, 994	30, 127, 611		4.
00	00500 ADMINI STRATI VE & GENERAL	-25, 147, 088			5.
00	00700 OPERATION OF PLANT	-445, 178			7.
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0			8.
	01000 DI ETARY	-1, 627	-/ - /		10.
	01100 CAFETERI A	-698, 053			11.
	01300 NURSING ADMINISTRATION	0			13.
	01400 CENTRAL SERVICES & SUPPLY	0	952, 136		14.
	01500 PHARMACY	-43, 267			15
	01600 MEDICAL RECORDS & LIBRARY	-2, 813			16.
	01700 SOCIAL SERVICE	0			17.
	02300 PARAMED ED PRGM 02301 XRAY EDUCATI ON	-32,060			23
	02302 PHARMACY RESIDENCY PROG	-32,000			23
	INPATIENT ROUTINE SERVICE COST CENTERS				20
. 00	03000 ADULTS & PEDIATRICS	362, 799	25, 569, 225		30
	03100 I NTENSI VE CARE UNI T	0			31
	03200 CORONARY CARE UNIT	0	-		32
	03300 BURN INTENSIVE CARE UNIT	0	0		33
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF				34 40
	04100 SUBPROVIDER - IRF		1, 908, 648		40
	04200 SUBPROVI DER	0			42
	04300 NURSERY	0	1, 336, 968		43
. 00	04400 SKILLED NURSING FACILITY	0	0		44
	ANCI LLARY SERVICE COST CENTERS	1 0 (0 (1 0			
	05000 OPERATING ROOM	-4, 362, 610			50
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			51
	05300 ANESTHESI OLOGY	-4, 178			53
	05400 RADI OLOGY-DI AGNOSTI C	-74, 423			54
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	2, 076, 189		54
	05404 ULTRA SOUND	0			54
	05405 MAMMOGRAPHY	-10, 308			54
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	-24, 332 -3, 150			55
	05800 MRI	-3, 150			58
	05900 CARDI AC CATHETERI ZATI ON	-11, 988			59
	06000 LABORATORY	-10, 808			60
. 01	06001 LABORATORY-PATHOLOGI CAL	-37, 284	1, 294, 934		60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	-20, 600			62
	06500 RESPI RATORY THERAPY	-16, 843			65
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	-18, 827			66
	06800 SPEECH PATHOLOGY	-10, 667	-/ / /		68
	06900 ELECTROCARDI OLOGY	0,007	888, 953		69
	07000 ELECTROENCEPHALOGRAPHY	0	1, 037, 465		70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 970, 123		71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	7, 339, 047		72
	07300 DRUGS CHARGED TO PATIENTS	0	20/11/0000		73
	07400 RENAL DI ALYSI S	0	822, 564		74
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0	-		76 76
71	OUTPATIENT SERVICE COST CENTERS		210,740		/0
00	08800 RURAL HEALTH CLINIC	0	0		88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89
00	09000 CLI NI C	0	1, 805, 565		90
01	09001 DI ABETES CENTER	0	-		90
	09002 NEUROPSYCH	-214, 098			90
. 03	09003 WOUND CENTER	-25, 604			90
	09004 HYPERBARI C OXYGEN THERAPY	-1, 689			90
	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	0			90 90
	09100 EMERGENCY	-354, 745			90
	09200 OBSERVATION BEDS (NON-DISTINCT PART	554,745	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		92
	OTHER REIMBURSABLE COST CENTERS				/ ²
	OTHER RETINDORS/ BEE COST CERTERS				

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-0112	Peri od:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/24/2022 10:23 am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
	(Allocation			
	6.00	7.00			101.00
101.00 10100 HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS	0	0			100.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0			109.00
110. 00 11000 INTESTINAL_ACQUISITION 111. 00 11100 ISLET_ACQUISITION	0	0			110. 00 111. 00
113. 00 11300 I NTEREST EXPENSE	0	0			113.00
	0 27 002 0F4	271, 283, 110			118.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-37, 083, 054	271, 283, 110			118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	39, 167			190.00
194. 00 07950 WELLNESS COMMUNITY	0	298, 869			190.00
194. 01 07951 BUI LDI NG RENTALS	0	218, 239			194.00
194. 02 07952 HOSPI CE	0	108, 830			194.01
194. 03 07953 OUTREACH CLINICS	0	100, 030			194.03
194. 04 07954 SPEECH - HEARING AI DS	0	203, 832			194.04
194. 05 07955 NONALLOWABLE MARKETING	0	559, 921			194.05
194. 06 07956 CRH FOUNDATION	0	52, 774			194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0			194.07
194. 08 07958 CRHP	-348, 320	2, 738, 882			194.08
194. 09 07959 NEUROPSYCH PART B	0 0 0	0			194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	-37, 431, 374	275, 503, 624			200.00

		(COLUMBUS REGION			ieu of Form CMS-2552-10 Worksheet A-6
					From 01/01/20	21 21 Date/Time Prepared:
		Increases				
		3.00	4.00	5.00		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	605, 625		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18 <u>3, 2</u> 83		2.00
	FILASSIFICATIONS Provider Col: 15.012 Provider Col:					
1 00	ELGLASS IFICATIONS Provider CNI 15-0112 Provider Provider CNI 15-0112 Provider CNI 15-0112 Provider Provider Provider Provider CNI 15-0112 Provider					
			-			
			-			3.00
			0			4.00
	CLASS HI CALL DRS Provider COX 15 - D112 Per dd To 12/3/2021 Per dd					
1 00		F 00	1 142 005	20.045		1.00
EELASSIFICATIONS Provider CD: 15-012						
	LLSS FI CATIONS Provider CDR: 15-012 Provider CDR					
1.00	CLASS/FICATIONS Provider COX: 15-0112 Increases to 100 (a) (b) (b) (b) (b) (b) (b) (b) (b) (b) (b				1.00	
EECLASSIFICATIONS Provider COX 15-0112 Fordigr TO F						
1 00	EECLASS IF I CATIONS Proof der COX 13-0112					
EEGLASS FLICATIONS Provider CN: 15-0112 Period To Period Distribution Period Distributio						
	G - RECLASS WELLNESS		1, 200, 240	570, 720		
1.00		194.00	174, 637	36, 745		1.00
	0		174, 637			
1 6 6						
						1.00
						4.00
			0			5.00
			0			6.00
			0			7.00
	1		0			1
			0			10.00
			0			11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	19, 600		12.00
			0			13.00
			0			
	1		0			
			0			17.00
	0		0			
						1.00
	ADMINISTRATIVE & GENERAL					
5.00						3.00
	Increases Increases a Salary Other b Salary Other c BECLASS INTERST 3.00 4.00 c De RE Int COSTS MULT (TULP 2.00 0 0.40, 55, 65 c DE REL COSTS MULT (TULP 2.00 0 710, 560 c DE REL COSTS MULT (TULP 2.00 0 710, 560 c DE REL COSTS MULT (TULP 2.00 0 1.00, 100 c MELLONST SHUG A FLIXT 1.00 0 2.06 c MELLONST SHUG COST 0 1.012, 095 20, 665 c DE RELASS HUERBARI C THERAFY EXPENSE 1.05, 282 28, 213 c - - 1.02, 024 590, 620 c - - 1.00 1.220, 244 590, 620 c - - 1.02, 02, 44 590, 620 c - - 1.00 1.220, 244 590, 620 c - - 1.00 <td< td=""><td></td></td<>					
						1.00
			-			2.00
			-			
			0			5.00
			0			6.00
			0			7.00
			0			8.00
			0			
			0			11.00
			o			12.00
13.00	WELLNESS COMMUNITY		0			13.00
14.00	<u>CRHP</u>	194.08	0			14.00
			0	1, 724, 092		
1 00			0	140 000		1 00
			~			1.00
	-	NSE				
1.00		2.00				1.00
		CE	0	13, 498, 302		
1 00			0	11 700		1.00
2.00			0			2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	60, 172		3.00
4.00	PHARMACY	15.00	0	36, 969		4.00
	OPERATING ROOM	50.00	0	239, 897		5.00

Health Financial Systems RECLASSIFICATIONS

COLUMBUS REGIONAL HOSPITAL Provider CCN: 15-0112 Period: Erom 01

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SI FI CATI ONS			Provider CCN:	15-0112	Period: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pro	epared:
		Increases					5/24/2022 10	: <u>23 am</u>
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	259, 774				6.00
7.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.01	0	202, 154				7.00
8.00	ULTRA SOUND	54.02	0	89, 268				8.00
9.00	MAMMOGRAPHY	54.03	0	142, 139				9.00
10.00	RADI OLOGY-THERAPEUTI C	55.00	0	723, 033				10.00
11. 00 12. 00	CT SCAN MRI	57.00 58.00	0	352, 840 129, 349				11.00 12.00
12.00	CARDI AC CATHETERI ZATI ON	59.00	0	173, 434				13.00
14.00	LABORATORY	60.00	0	301, 037				14.00
15.00	LABORATORY-PATHOLOGI CAL	60. 01	0	10, 200				15.00
16.00	EMERGENCY	91.00	0	32, 124				16.00
	0		0	2, 768, 985				
	0 - RECLASS DI RECTOR PHARMACY							
1.00	RADI OLOGY-THERAPEUTI C	55.00	29, 144	0				1.00
2.00	RESPI RATORY THERAPY	65.00	34, 972	0				2.00
3.00 4.00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	2, 914 2, 914	0				3.00
4.00 5.00	ELECTROENCEPHALOGRAPHY	70.00	2,914	0				5.00
6.00	CLINIC	90.00	29, 144	0				6.00
7.00	NEUROPSYCH	90, 02	2, 914	0				7.00
8.00	AMBULANCE SERVICES	95.00	34, 972	0				8.00
9.00	CRHP	194.08	46, 630	0				9.00
	0		186, 518	0				
	P - GIFT SHOP			_				
1.00	GIFT FLOWER COFFEE SHOP &	190.00	39, 167	0				1.00
	CANTEEN	├─	39, 167	₀				
	Q - RECLASS XRAY EDUCATION EX		39, 107	U				-
1.00	XRAY EDUCATION	23.01	333, 827	4, 125				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
	0		333, 827	4, 125				
1 00	R - OTHER EXPENSE	104.00	0	21 040				1 00
1.00	CRHP	1 <u>94.</u> 08	0	3 <u>1,049</u> 31,049				1.00
	S - RECLASS NON ALLOW ADVERT	SING COSTS	0	31, 047				
1.00	NONALLOWABLE MARKETING	194.05	0	419, 921				1.00
	0		0	419, 921				
	U - RECLASS CHARGEABLE SUPPL							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	6, 970, 123				1.00
2 00	PATIENT	72.00	0	7 220 047				2 00
2.00	I MPL. DEV. CHARGED TO PATIENTS	72.00	0	7, 339, 047				2.00
3.00	SPEECH - HEARING ALDS	194.04	o	203, 832				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 12. 00		0.00 0.00	0	0				11.00 12.00
12.00		0.00	0	0				12.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00	L	0.00	0	0				18.00
	0		0	14, 513, 002				1
	V - RECL PTO COST FOR STD EL		_1					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	831, 376				1.00
2.00 3.00		0.00 0.00	0	0				2.00 3.00
3.00 4.00		0.00	0	0				4.00
4.00 5.00		0.00		0				4.00
6.00		0.00	0	0				6.00
7.00		0.00	õ	0				7.00
8.00		0.00	Ō	0				8.00
9.00		0.00	О	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00

COLUMBUS REGIONAL HOSPITAL Provider CCN: 15-0112 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

RECLAS	SI FI CATI ONS			Provider CCN:	: 15-0112	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr	
		Increases				· · · ·	5/24/2022 10	: 23 am
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
12.00	2.00	0.00	0	0				12.00
13.00 14.00		0. 00 0. 00	0	0				13.00 14.00
14.00		0.00	0	0				15.00
16.00		0.00	О	0				16.00
17.00 18.00		0. 00 0. 00	0	0				17.00 18.00
19.00		0.00	0	0				19.00
20.00		0.00	О	0				20.00
21.00 22.00		0. 00 0. 00	0	0				21.00 22.00
23.00		0.00	0	0				23.00
24.00		0.00	0	0				24.00
25.00 26.00		0. 00 0. 00	0	0				25.00 26.00
27.00		0.00	Ő	Ő				27.00
28.00		0.00	0	0				28.00
29.00 30.00		0. 00 0. 00	0	0				29.00 30.00
31.00		0.00	0	0				31.00
32.00		0.00	0	0				32.00
33.00	<u> </u>		0	831, 376				33.00
4 05	X - RECLASS OT SALARIES AND							
1.00	OCCUPATIONAL THERAPY		0	_ <u>620, 280</u> 620, 280				1.00
4	Y - LDRP	50.00						
1.00	DELIVERY ROOM & LABOR ROOM	<u>52.00</u>	<u>1, 683, 7</u> 10 1, 683, 710	_ <u>253, 697</u> 253, 697				1.00
	Z - RECLASS LAB BLOOD SUPERV							
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	83, 111	0				1.00
	0		83, 111	<u>0</u>				
1 00	WA - RECLASS CONTRACT LABOR I ADMINISTRATIVE & GENERAL	BENEFITS 5.00	0	420 777				1.00
1.00 2.00	CENTRAL SERVICES & SUPPLY	14.00	0	430, 777 141, 185				2.00
3.00	ADULTS & PEDIATRICS	30.00	О	475				3.00
4.00 5.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	1, 791, 814 274, 362				4.00 5.00
6.00		90.00	0	710				6.00
	O WB - RECLASS SALARIES TO HOM		0	2, 639, 323				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	56, 429				1.00
2.00	OPERATION OF PLANT	7.00	124, 269	0				2.00
3.00 4.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8.00 9.00	2, 432 116, 389	0				3.00 4.00
5.00	DI ETARY	10.00	49, 216	0				5.00
6.00	CAFETERIA NURSING ADMINISTRATION	11.00	70, 298	0				6.00
7.00 8.00	CENTRAL SERVICES & SUPPLY	13.00 14.00	311, 936 14, 448	13, 742				7.00 8.00
9.00	PHARMACY	15.00	158, 397	0				9.00
10. 00 11. 00	MEDICAL RECORDS & LIBRARY XRAY EDUCATION	16. 00 23. 01	94, 361 3, 143	0				10.00 11.00
12.00	PHARMACY RESIDENCY PROG	23.01	2, 602	0				12.00
13.00	ADULTS & PEDIATRICS	30.00	489, 218	0				13.00
14.00 15.00	I NTENSI VE CARE UNI T SUBPROVI DER – I RF	31.00 41.00	64, 687 71, 940	0				14.00 15.00
16.00	NURSERY	41.00	40, 166	0				16.00
17.00	OPERATING ROOM	50.00	216, 601	141, 390				17.00
18. 00 19. 00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	51.00 54.00	25, 287 117, 567	18, 891 0				18.00 19.00
20.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.00	16, 740	0				20.00
21.00	ULTRA SOUND	54.02	15, 513	0				21.00
22.00 23.00	MAMMOGRAPHY RADI OLOGY-THERAPEUTI C	54.03 55.00	29, 856 25, 959	0				22.00 23.00
23.00 24.00	CT SCAN	57.00	25, 273	0				23.00
25.00		58.00	12, 109	0				25.00
26.00 27.00	CARDI AC CATHETERI ZATI ON LABORATORY	59.00 60.00	58, 973 206, 781	0				26.00 27.00
28.00	LABORATORY-PATHOLOGI CAL	60. 01	17, 650	0				28.00
29.00	RESPI RATORY THERAPY	65.00	82, 235	0				29.00
30. 00 31. 00	PHYSICAL THERAPY OCCUPATIONAL THERAPY	66.00 67.00	59, 840 9, 931	0				30.00 31.00
32.00	SPEECH PATHOLOGY	68.00	13, 012	0				32.00
		· · · ·						

Heal th	Financial Systems		COLUMBUS REGIO	NAL HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0112	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/24/2022 10	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
33.00	ELECTROCARDI OLOGY	69.00	24, 110	0				33.00
34.00	ELECTROENCEPHALOGRAPHY	70.00	28, 343	0				34.00
35.00	CARDIAC REHABILITATION	76. 97	10, 377	0				35.00
36.00	CLINIC	90.00	65, 460	0				36.00
37.00	NEUROPSYCH	90.02	5, 609	0				37.00
38.00	WOUND CENTER	90.03	29, 900	0				38.00
39.00	VIMCARE CLINIC	90.05	26, 728	0				39.00
40.00	MEDICATION MGMT CLINIC	90.06	8, 689	0				40.00
41.00	EMERGENCY	91.00	222, 006	0				41.00
42.00	AMBULANCE SERVICES	95.00	161, 781	0				42.00
43.00	WELLNESS COMMUNITY	194.00	11, 443	0				43.00
44.00	CRH FOUNDATION	194.06	4, 897	0				44.00
45.00	CRHP	194.08	25, 369	0				45.00
46.00	ADMINISTRATIVE & GENERAL	5.00	6, 778	0				46.00
	0		3, 178, 319	230, 452				
	WC - RECLASS SEVERANCE PAY							1
1.00	AMBULANCE SERVICES	95.00	13, 088	0				1.00
	0 — — — — — — — — — — — — — — — — — — —		13, 088	0				
500.00	Grand Total: Increases		8, 335, 017	45, 391, 453				500.00
			·					

	Financial Systems	C	OLUMBUS REGION	AL HOSPITAL Provider CC	N: 15-0112 Pe	In Lie eriod:	u of Form CMS-2 Worksheet A-6	
					Fr Tc	om 01/01/2021		pared:
		Decreases					5/24/2022 10:	23 am
	Cost Center	Li ne #	Salary	Other W	kst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
1.00	B - RECLASS INTEREST INTEREST EXPENSE	113.00	0	788, 908	11			1.00
2.00		0.00	0	0	11			2.00
			0	788, 908				
1.00	C - RECLASS INSURANCE ADMINISTRATIVE & GENERAL	5.00	0	1,053,734	12			1.00
2.00		0.00	Ő	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00	<u> </u>	0.00	0	1,053,734	<u>0</u>			4.00
	D - RECLASS BILLING COST		Ÿ	1,000,701				
1.00	MEDI CAL_RECORDS & LI BRARY		1, 142, 095	20, 965	0			1.00
	U E - RECLASS HYPERBARIC THERAF	PY EXPENSE	1, 142, 095	20, 965				
1.00	WOUND CENTER	90.03	105, 283	82, 813	0			1.00
			105, 283	82, 813				
1.00	F - RECLASS CAFETERIA EXPENSE DI ETARY	10.00	1, 250, 246	590, 926	0			1.00
1.00	0		1, 250, 246	590, 926	— — — ĭ			1.00
1 00	G - RECLASS WELLNESS		474 (07	04 745				4 99
1.00	EMPLOYEE BENEFITS DEPARTMENT		_ <u>174, 6</u> 37 174, 637	_ <u>36, 7</u> 45 36, 745	0			1.00
	H - RECLASS PHYSICIAN FEES		174,057	30,743				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 692, 455	0			1.00
2.00 3.00	OPERATING ROOM	50.00 0.00	0	446, 260 0	0			2.00 3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00 7.00		0.00 0.00	0	0	0			6.00 7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10. 00 11. 00		0.00 0.00	0	0	0			10. 00 11. 00
12.00		0.00	0	0	0			12.00
13.00		0.00	0	0	0			13.00
14.00 15.00		0.00 0.00	0	0	0			14.00 15.00
15.00 16.00		0.00	0	0	0			15.00 16.00
17.00	L	0.00	0	0	0			17.00
			0	5, 138, 715				
1.00	J - RECLASS PHARMACY RES PROC EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 884	0			1.00
2.00	PHARMACY	15.00	145, 016	0	0			2.00
3.00	PHARMACY RESIDENCY PROG	23.02	1 45 01 (2, 159	<u>0</u>			3.00
	K - RECLASS RENT EXPENSE		145, 016	4, 043				
1.00	BUILDING RENTALS	194.01	0	1, 724, 092	0			1.00
2.00		0.00	0	0	0			2.00
3.00 4.00		0.00 0.00	0	0	0			3.00 4.00
5.00		0.00	0	Ö	0			5.00
6.00		0.00	0	0	0			6.00
7.00 8.00		0.00 0.00	0	0	0			7.00 8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
11. 00 12. 00		0.00 0.00	0	0	0			11. 00 12. 00
13.00		0.00	Ö	Ő	Ő			13.00
14.00			0	0	0			14.00
	0 L - RECLASS MARKETING EXPENSE	-	0	1, 724, 092				
1.00	OPERATING ROOM	50.00	0	140,000	0			1.00
			0	140,000				
1.00	M - RECLASS DEPRECIATION EXPE	ENSE 1.00	0	13, 498, 302	9			1.00
1.00	TOTALS		- — — ŏ	13, 498, 302	⁷			1.00
	N - RECLASS MAINTENANCE EXPEN		- 1					
1.00 2.00	OPERATION OF PLANT	7.00 0.00	0	2, 768, 985 0	0			1.00 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

COLUMBUS REGIONAL HOSPITAL

Provider CCN: 15-0112 Period

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2021

NE OE IO					5011. 10 0112	From 01/01/2021 To 12/31/2021	Date/Time F 5/24/2022 1	Prepared:
		Decreases					072172022	
	Cost Center	Line #	Sal ary		Wkst. A-7 Ref			
(00	6. 00	7.00	8.00	9.00	10.00	0		(00
6.00 7.00		0.00	0	0 0		0		6.00 7.00
8.00		0.00	Ö	0		0		8.00
9.00		0.00	0	0		o		9.00
10.00		0.00	0	0		0		10.00
11. 00 12. 00		0. 00 0. 00	0	0				11.00 12.00
13.00		0.00	0	0		0		13.00
14.00		0.00	0	0		o		14.00
15.00		0.00	0	0		0		15.00
16.00	<u> </u>			2, 768, 985				16.00
	0 - RECLASS DI RECTOR PHARMAC	Y	<u> </u>	2,100,100	I			
1.00	PHARMACY	15.00	186, 518	0		0		1.00
2.00 3.00		0. 00 0. 00	0	0		0		2.00 3.00
3.00 4.00		0.00	0	0				4.00
5.00		0.00	0	0		0		5.00
6.00		0.00	0	0		0		6.00
7.00 8.00		0. 00 0. 00	0	0		0		7.00 8.00
8.00 9.00		0.00	0	0				9.00
	0		186, 518			1		
1 00	P - GIFT SHOP	F 00	20.1/7		1	0		1 00
1.00	ADMI NI STRATI VE & GENERAL	5.00	<u>39, 167</u> 39, 167	0		0		1.00
	Q - RECLASS XRAY EDUCATION E	XPENSES	077107	0				
1.00	EMPLOYEE BENEFITS DEPARTMENT		0	4, 016		0		1.00
2.00 3.00	ADMI NI STRATI VE & GENERAL RADI OLOGY-DI AGNOSTI C	5.00 54.00	0 333, 588	109 0		0		2.00 3.00
4.00	MAMMOGRAPHY	54.03	211	0		0		4.00
5.00	RESPIRATORY_THERAPY	65.00	28	0		0		5.00
			333, 827	4, 125				_
1.00	R - OTHER EXPENSE ADMI NI STRATI VE & GENERAL	5.00	0	31, 049		0		1.00
	TOTALS		0	31,049				
1 00	S - RECLASS NON ALLOW ADVERT		ol	410 021	1	0		1 00
1.00	ADMI NI STRATI VE & GENERAL	5.00		<u>419, 921</u> 419, 921				1.00
	U - RECLASS CHARGEABLE SUPPL	Y COST	-	,				
1.00	PHARMACY	15.00	0	13, 295		0		1.00
2.00 3.00	ADULTS & PEDIATRICS	30. 00 31. 00	0	225, 560 204, 806		0		2.00 3.00
4.00	SUBPROVI DER – I RF	41.00	Ő	3, 720		0		4.00
5.00	NURSERY	43.00	0	1, 203		o		5.00
6.00	OPERATING ROOM	50.00	0	8, 765, 023		0		6.00
7.00 8.00	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	54.00 54.02	0 0	110, 818 2, 406		0		7.00
9.00	MAMMOGRAPHY	54.03	Ő	142, 174		0		9.00
10.00	RADI OLOGY-THERAPEUTI C	55.00	0	5, 123		o		10.00
11.00	CT SCAN CARDI AC CATHETERI ZATI ON	57.00	0	25, 166		0		11.00
12.00 13.00	RESPIRATORY THERAPY	59.00 65.00	0	4, 635, 020 87, 904				12.00 13.00
14.00	PHYSI CAL THERAPY	66.00	Ő	13, 372		o		14.00
15.00	VIMCARE CLINIC	90.05	0	9, 147		0		15.00
16.00	EMERGENCY AMBULANCE SERVICES	91.00	0	39, 276		0		16.00 17.00
17.00 18.00	SPEECH PATHOLOGY	95.00 68.00	0 0	25, 157 203, 832		0		17.00
	0			14, 513, 002		-		
1 00	V - RECL PTO COST FOR STD EL		/ 7 4 4	-		ol		1 00
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	66, 741 11, 777	0 0		0		1.00
3.00	HOUSEKEEPING	9.00	27, 602	0		0		3.00
4.00	DI ETARY	10.00	17, 321	0		0		4.00
5.00		11.00	24, 740	0		0		5.00
6.00 7.00	NURSING ADMINISTRATION PHARMACY	13.00 15.00	73, 877 46, 005	0 0		0		6.00 7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	12, 529	0		o		8.00
9.00	ADULTS & PEDIATRICS	30.00	198, 017	0		0		9.00
10.00		31.00	19, 811	0 0		0		10.00
11. 00 12. 00	SUBPROVI DER – I RF NURSERY	41.00 43.00	32, 056 23, 158	0		0		11.00 12.00
13.00	OPERATING ROOM	50.00	12, 809	0		0		13.00
14.00	RECOVERY ROOM	51.00	18	0		0		14.00

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	IS

 COLUMBUS REGIONAL HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0112
 Period: From 01/01/2021
 Worksheet A-6

RECLAS	STELCATIONS			Provi der CCN:		From 01/01/2021	worksneet	
		-				To 12/31/2021	Date/Time 5/24/2022	10:23 am
	Cost Center	Decreases Line #	Sal ary	Other Wkst	t. A-7 Ref.	1		
	6.00	7.00	8.00	9.00	10.00	-		
15.00	RADI OLOGY-DI AGNOSTI C	54.00	26, 198	0	(15.00
16.00 17.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01 54. 02	19, 782 5, 625	0	(16.00 17.00
18.00	MAMMOGRAPHY	54.03	4, 718	0	(18.00
19.00	RADI OLOGY-THERAPEUTI C	55.00	1, 644	0	(19.00
20. 00 21. 00	CT SCAN MRI	57.00 58.00	7, 903 2, 325	0	(20.00 21.00
21.00	CARDI AC CATHETERI ZATI ON	59.00	16, 284	0	(21.00
23.00	LABORATORY	60.00	28, 360	0	(23.00
24.00	LABORATORY-PATHOLOGI CAL RESPI RATORY THERAPY	60. 01	589	0	(24.00 25.00
25.00 26.00	ELECTROCARDI OLOGY	65.00 69.00	34, 281 7, 600	0	(25.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	7, 445	0	(27.00
28.00		90.00	30, 285	0	(28.00
29.00 30.00	VIMCARE CLINIC MEDICATION MGMT CLINIC	90. 05 90. 06	1, 924 5, 956	0	(29.00 30.00
31.00	EMERGENCY	91.00	37, 919	Ö	(31.00
32.00	AMBULANCE SERVICES	95.00	25, 507	0	(32.00
33.00	WELLNESS COMMUNITY	1 <u>94.</u> 00	<u>570</u>	0	(33.00
	X - RECLASS OT SALARIES AND (DTHER EXP	031, 370					
1.00	PHYSICAL THERAPY	<u>66.</u> 00	0	620, 280	(2		1.00
	O Y - LDRP		0	620, 280				_
1.00	ADULTS & PEDIATRICS	30.00	1, 683, 710	253, 697	(1.00
	TOTALS		1, 683, 710	253, 697		_		
1 00	Z - RECLASS LAB BLOOD SUPERVI		02 111	0				1.00
1.00	LABORATORY	<u> </u>	<u> </u>	0	(1.00
	WA - RECLASS CONTRACT LABOR I			-		1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	2, 639, 323	(1.00
2.00 3.00		0.00	0	0	(2.00 3.00
4.00		0.00	0	0	(4.00
5.00		0.00	0	0	(5.00
6.00	<u> </u>		<u>0</u>	2,639,323	(6.00
	WB - RECLASS SALARIES TO HOM					1		
1.00 2.00	ADMI NI STRATI VE & GENERAL LABORATORY	5.00 60.00	3, 175, 153 1, 373	230, 452 0	(1.00 2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 793	0	(-		3.00
4.00		0.00	0	0	(4.00
5.00 6.00		0. 00 0. 00	0	0	(5.00 6.00
7.00		0.00	0	0	(7.00
8.00		0.00	0	0	(8.00
9. 00 10. 00		0.00 0.00	0	0	(9.00 10.00
11.00		0.00	0	0 0	(11.00
12.00		0.00	0	0	(12.00
13.00		0. 00 0. 00	0	0	(13.00
14.00 15.00		0.00	0	0	(14.00 15.00
16.00		0.00	0	0	(16.00
17.00		0.00	0	0	(17.00
18. 00 19. 00		0. 00 0. 00	0	0 0	(18.00 19.00
20.00		0.00	0	0	(20.00
21.00		0.00	0	0	(21.00
22.00 23.00		0. 00 0. 00	0	0 0	(22.00 23.00
24.00		0.00	0	0	(24.00
25.00		0.00	0	0	(25.00
26.00 27.00		0. 00 0. 00	0	0 0	(26.00 27.00
28.00		0.00	0	0	(28.00
29.00		0.00	0	0	(29.00
30. 00 31. 00		0. 00 0. 00	0	0	(30.00 31.00
31.00		0.00	0	0	(31.00
33.00		0.00	0	0	(33.00
34.00		0.00	0	0	(34.00
35.00 36.00		0.00 0.00	0	0 0	(35.00 36.00
	1	5. 50	5			1		

Heal th	Financial Systems		COLUMBUS REGION	NAL HOSPITAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-0112	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/24/2022 10	epared:):23 am
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	Ē.		
	6. 00	7.00	8.00	9.00	10.00			
37.00		0.00	0	0		0		37.00
38.00		0.00	0	0		0		38.00
39.00		0.00	0	0		0		39.00
40.00		0.00	0	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	0	0		0		45.00
46.00		0.00	0	0		0		46.00
	0		3, 178, 319	230, 452		7		
	WC - RECLASS SEVERANCE PAY	·	· · ·					
1.00	ADMI NI STRATI VE & GENERAL	5.00	13, 088	0		0		1.00
	0		13, 088			7		
500.00	Grand Total: Decreases		9, 166, 393	44, 560, 077				500.00

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	:N: 15-0112	Period: From 01/01/2021 To 12/31/2021		bared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
. 00	Land	1, 979, 352	0		0 0	106, 977	1.00
2.00	Land Improvements	21, 020, 698	0		0 0	0	2.00
3.00	Buildings and Fixtures	102, 842, 834	1, 376, 280		0 1, 376, 280	578, 931	3.0
I. 00	Building Improvements	106, 828, 165	508, 164		0 508, 164	0	4.0
5.00	Fixed Equipment	9, 579, 494	40, 002		0 40,002	1, 121	5.0
o. 00	Movable Equipment	170, 867, 684	10, 153, 445		0 10, 153, 445	4, 028, 126	6.0
. 00	HIT designated Assets	0	127, 429		0 127, 429		7.0
3. 00	Subtotal (sum of lines 1-7)	413, 118, 227	12, 205, 320		0 12, 205, 320	4, 715, 155	8.0
9.00	Reconciling Items	0	0		0 0	0	9.0
0.00	Total (line 8 minus line 9)	413, 118, 227	12, 205, 320		0 12, 205, 320	4, 715, 155	10.0
	, , , , , , , , , , , , , , , , , , , ,	Endi ng	Fully		· · · ·		
		Bal ance	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
. 00	Land	1, 872, 375	0				1.0
. 00	Land Improvements	21, 020, 698	0				2.0
3.00	Buildings and Fixtures	103, 640, 183	0				3.0
I. 00	Building Improvements	107, 336, 329	0				4.0
5.00	Fixed Equipment	9, 618, 375	0				5.0
6.00	Movable Equipment	176, 993, 003	0				6.0
. 00	HIT designated Assets	127, 429	0				7.0
3. 00	Subtotal (sum of lines 1-7)	420, 608, 392	0				8.0
9.00	Reconciling Items	0	0				9.0
0.00	Total (line 8 minus line 9)	420, 608, 392	0				10.0

Health Financial Systems		COLUMBUS REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10					
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021		pared:			
	SUMMARY OF CAPITAL									
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see				
					(see instructions)	instructions)				
		9.00	10.00	11.00	12.00	13.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2									
1.00	CAP REL COSTS-BLDG & FIXT	21, 775, 438	0		0 0	0	1.00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00			
3.00	Total (sum of lines 1-2)	21, 775, 438			0 0	0	3.00			
		SUMMARY O	F CAPITAL							
	Cost Center Description	Other	Total (1)							
		Capital-Relat	(sum of cols.							
		ed Costs (see	9 through 14)							
		instructions)								
		14.00	15.00							
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2									
1.00	CAP REL COSTS-BLDG & FIXT	0	21, 775, 438				1.00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00			
3.00	Total (sum of lines 1-2)	0	21, 775, 438				3.00			

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021		pared: 23 am	
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPI TAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col. 2)				
	1.00	2.00	3.00	4,00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00		
1.00 CAP REL COSTS-BLDG & FIXT	243, 615, 389	0	243, 615, 389	0. 579198	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	176, 993, 003	0	176, 993, 003	0. 420802	0	2.00	
3.00 Total (sum of lines 1-2)	420, 608, 392		420, 608, 392			3.00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capital-Relat					
		ed Costs	through 7)				
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 CAP REL COSTS-BLDG & FIXT	ENTERS 0			8, 298, 971	0	1.00	
2.00 CAP REL COSTS-BEDG & FIXT	0			13, 583, 885		2.00	
3.00 Total (sum of lines 1-2)	0			21, 882, 856		3.00	
SUMMARY OF CAPITAL							
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
		(see	instructions)	Capi tal -Rel at			
		instructions)		ed Costs (see	9 through 14)		
	11.00	12.00	12.00	instructions)	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 CAP REL COSTS-BLDG & FIXT	-3, 889, 194	990, 211	() 0	5, 399, 988	1.00	
2. 00 CAP REL COSTS-MVBLE EQUIP	-607, 025			0 0		2.00	
3.00 Total (sum of lines 1-2)	-4, 496, 219		0	0	18, 376, 848	3.00	

Heal th	Fi nan	ici a	I Systems
AD.JUST	MENTS	TO	EXPENSES

JUSTMENTS TO EXPENSES		CULUMBUS REGIC	Provi der CCN: 15-0112	Period:	Worksheet A-8	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 10:	pare
			Expense Classification o To/From Which the Amount is			23 4
				ý		
	5 4 40 4					
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
0 Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1
COSTS-BLDG & FIXT (chapter 2) 0 Investment income - CAP REL	В		CAP REL COSTS-MVBLE EQUIP	2.00	11	2
COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3
(chapter 2) D Trade, quantity, and time	В	-47, 876	ADMI NI STRATI VE & GENERAL	5.00	0	4
discounts (chapter 8) 0 Refunds and rebates of expenses (chapter 8)	В	-114, 483	ADMI NI STRATI VE & GENERAL	5.00	0	5
0 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6
0 Telephone services (pay stations excluded) (chapter	А	-190, 273	ADMI NI STRATI VE & GENERAL	5.00	0	7
21) Tel evi si on and radi o servi ce	А	-11, 869	OPERATION OF PLANT	7.00	0	8
(chapter 21) 0 Parking Lot (chapter 21)		0		0.00	0	
00 Provider-based physician adjustment 00 Sale of scrap, waste, etc.	A-8-2	-8, 080, 590		0.00	0	1C
(chapter 23) 00 Related organization	A-8-1	-128, 021		0.00		12
transactions (chapter 10) 00 Laundry and linen service		0		0.00	0	
00 Cafeteria-employees and guests 00 Rental of quarters to employee	В	-582, 233 0	CAFETERI A	11.00 0.00	0 0	
and others 00 Sale of medical and surgical supplies to other than		0		0.00	0	16
patients 00 Sale of drugs to other than		0		0.00	0	17
patients 00 Sale of medical records and abstracts	В	-2, 813	MEDI CAL RECORDS & LI BRARY	16.00	0	18
00 Nursing and allied health education (tuition, fees, books, etc.)	В	-32,060	XRAY EDUCATI ON	23. 01	0	19
00 Vending machines 00 Income from imposition of		0		0.00		
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24
limitation (chapter 14) 00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	* 114.00		25
(chapter 21) 00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
00 Non-physician Anesthetist 00 Physicians' assistant		0	*** Cost Center Deleted ***	* 19.00 0.00	0	28 29
00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30
<pre>limitation (chapter 14) 99 Hospice (non-distinct) (see instructions)</pre>		0	ADULTS & PEDIATRICS	30.00		30

In Lieu of Form CMS-2552-10

Health Financial Systems		COLUMBUS REGIONA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0112	Peri od:	Worksheet A-8	3
				From 01/01/2021	Data /Tima Dra	norod.
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	
			Expense Classification o	n Worksheet A	572472022 10.	25 0
		Т	p/From Which the Amount is			
				· · · · · · · · · · · · · · · · · · ·		
Cost Center Descr	ription Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)				Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech	A-8-3	0 SF	PEECH PATHOLOGY	68.00		31.00
pathology costs in exc	ess of					
limitation (chapter 14						
32.00 CAH HIT Adjustment for		0		0.00	C	32.00
Depreciation and Inter						
33.00 DEPR PAT PHONES NEW EQ	UIP A	-4, 555 CA	AP REL COSTS-MVBLE EQUIP	2.00	9	33.00
34.00 TV DEPR NEW EQUIP	A	-3, 120 CA	AP REL COSTS-MVBLE EQUIP	2.00	ç	34.00
35.00 CAFETERIA VISITORS	A	-115, 820 CA	AFETERI A	11.00	C	35.00
36.00 MEALS TO GO	A		I ETARY	10.00	C	36.00
37.00 OPERATING ROOM OTHER R	EV B	-4, 653 OF	PERATING ROOM	50.00	C	37.00
38.00 BOND AMORTIZATION	A	82, 092 CA	AP REL COSTS-BLDG & FIXT	1.00	ç	38.00
40.00 TELEPHONE SEVICES	В	-353 AI	OMINISTRATIVE & GENERAL	5.00	C	40.00
41.00 LAND RENT MOB	В	-2, 000 AE	DMINISTRATIVE & GENERAL	5.00	c	41.00
42.00 LABORATORY OTHER REV	В	-5, 400 LA	ABORATORY	60.00	C	42.00
43.00 EMPLOY BENEFITS OTHER	REVENUE B	-66, 937 EN	MPLOYEE BENEFITS DEPARTMEN	IT 4.00	C	43.00
44.00 EMERGENCY ROOM OTHER R	EV B	-28, 505 EM	MERGENCY	91.00	C	44.00
44.01 MEDICAL STAFF INCOME	В	-2, 600 AE	OMINISTRATIVE & GENERAL	5.00	(C	44.01
45.00 RADIOLOGY OTHER REVENU	E B	-68, 868 RA	ADI OLOGY-DI AGNOSTI C	54.00	c	45.00
45.01 FACILITIES OTHER REVEN			PERATION OF PLANT	7.00		45.01
45.02 RADIATION ONCOLOGY OTH			ADI OLOGY-THERAPEUTI C	55.00		1
REVENUE		,			-	
45.03 CRHP OTHER REVENUE ADM	IIN B	-3, 703, 652 AF	OMINISTRATIVE & GENERAL	5.00	l c	45.03
45. 04 CRHP OTHER REVENUE BUI		-348, 320 CF		194.08		
RENTALS		010,02001		171100		
45.05 CRHP OTHER REVENUE EMP	LOYEE B	-355 261 FM	MPLOYEE BENEFITS DEPARTMEN	IT 4.00	c c	45.05
BENEFITS		00072012				
45.07 FOOD OTHER REVENUE	В	-1, 627 DI	I FTARY	10.00	l c	45.07
45.08 PROTECTIVE SERV OTHER			PERATION OF PLANT	7.00		1
45.09 PHARMACY OTHER REVENUE		-43, 267 Pł		15.00		
45. 10 HUMAN RESOURCES OTHER			MPLOYEE BENEFITS DEPARTMEN			
45. 11 LACTATION AND PREPARE			OULTS & PEDIATRICS	30.00		1
REVENUE				00100		
45. 12 VOLUNTEER OTHER REVENU	ЕВ	3 847 AF	OMINISTRATIVE & GENERAL	5.00	c	45.12
45. 13 RENTAL PROPERTIES DEPR			AP REL COSTS-BLDG & FIXT	1.00		1
45. 14 LOSS ON DI SPOSAL DEMOL			AP REL COSTS-BLDG & FIXT	1.00		1
45. 15 UNALLOWABLE PHYS RECRU			DMINISTRATIVE & GENERAL	5.00		1
45. 16 DEPRECIATION RELIFED B			AP REL COSTS-BLDG & FIXT	1.00		
45. 17 DEPRECIATION RELIFED E			AP REL COSTS-MVBLE EQUIP	2.00		45.17
45. 18 PRI OR YEAR AUDI T ADJUS			AP REL COSTS-BLDG & FIXT	1.00		
45. 18 PRIOR TEAR AUDIT ADJUS 45. 19 NONALLOWABLE INT EXP 1			AP REL COSTS-BLDG & FIXT	2.00		45.18
BONDS	,,,,, A	-23,00304	A REE COSTS-WIDEL LOUIP	2.00	''	J. 17
	003/2009	62 7/10		2 00	11	15 21
45.21 NONALLOWABLE INT EXP 2 BONDS	.003/2009 A	-03, 74104	AP REL COSTS-MVBLE EQUIP	2.00	''	45.21
		10 10/ 10		E 00		45 22
45. 22 UNALLOWABLE AHA MEMBER	SHIP A	-18, 120 AL	DMINISTRATIVE & GENERAL	5.00		45.22
45. 23 AMBULANCE SERVICES	В	267 226		05.00	l c	45.23
			MBULANCE SERVICES	95.00		
45.24 HAF ADJUSTMENT	A A		DMINISTRATIVE & GENERAL	5.00		
45. 25 OTHER OPERATING REVENU	IE – MISC B	446 AL	OMINISTRATIVE & GENERAL	5.00	C	45.25
SALES					-	45 07
45. 27 AUDI OLOGY - OTHER REVE			PEECH PATHOLOGY	68.00		
45. 28 BUI LDI NG RENT - HOSPI C	E B	-22, 665 AE	OMINISTRATIVE & GENERAL	5.00	C	45.28
PALLIATIVE						
45. 29 ORTHOPEDICS OTHER REVE			DULTS & PEDIATRICS	30.00		
45.30 LUNG INSTITIUTE OTHER			ESPI RATORY THERAPY	65.00		
45.31 BLOOD BANK OTHER REVEN	UE B		HOLE BLOOD & PACKED RED	62.00	C	45.31
			LOOD CELL			
45.32 LAB SPECIMENT PROC OTH	ER B	-5, 408 LA	ABORATORY	60.00	C	45.32
REVENUE						
45.33 X-RAY CT SCAN OTHER RE	VENUE B	-3, 150 CT	T SCAN	57.00	C	45.33
50.00 TOTAL (sum of lines 1	-	-37, 431, 374				50.00
(Transfer to Worksheet	А,					
column 6, line 200.)						
(1) Description all shorter	6		0110 D L 45 4			

(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.

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL	In Lie	u of Form CMS-2	2552-10	
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: <u>23 am</u>
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	s to be Adjusted		
				,		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)				Ref.	
	1.00	2.00	3.00	4.00	5.00	

(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.

Heal th	Financial Systems	COLUMBUS REGI	ONAL HOSPITAL	In Lie	u of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0112	Period: From 01/01/2021	Worksheet A-8	3-1
OFFI CE				To 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANI ZATI ONS OR	CLAI MED HOME	
	OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	4, 706, 816	5, 316, 828	1.00
2.00	30.00	ADULTS & PEDIATRICS	HOSPITAL BASED PHYS PART A S	6 481, 991	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			5, 188, 807	5, 316, 828	5.00
	Transfer column 6, line 5 to				.,	
	Worksheet A-8, column 2,					
	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 not been posted to Worksheet A columns 1 and/or 2, the amount allowable should be indicated in column 4 of this nam

nas not	been posted to worksneet A,	corumns r and/or 2,	the amount allowable	should be indicated in co	rumn 4 or this part.			
				Related Organization(s)	and/or Home Office			
				5 ,				
		N		C Num				
	Symbol (1)	Name	Percentage (of Name	Percentage of			
			Ownership		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

rormour					
6.00	E	J BICKEL	0.00 SI HEALTH MANAGEMENT	0.00	6.00
7.00	E	D TRAPP	0.00 SI HEALTH MANAGEMENT	0.00	7.00
8.00	E	Z ELLI SON	0.00 SI HEALTH MANAGMENT	0.00	8.00
9.00	E	R SHEDD	0.00 SI HEALTH MANAGEMENT	0.00	9.00
10.00	E	S STARK	0.00 SI HEALTH MANAGEMENT	0.00	10.00
10. 01	E	D DOUP	0.00 SI HEALTH MANAGMENT	0.00	10.01
10. 02	E	D MICHAEL	0.00 SI HEALTH MANAGMENT	0.00	10. 02
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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 organizati 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 provider.

Health Financial Systems COLUMBUS REGION	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0112	Period: From 01/01/2021	Worksheet A-8-1
OFFICE COSTS			Date/Time Prepared:

								5/24/20	22 10:	23 am
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS	A RESULT OF	TRANSACTIONS WI	TH RELATED	ORGANI ZATI ONS	OR CLAIMED	HOME	
	OFFICE COSTS:									
1.00	-610, 012	0								1.00
2.00	481, 991	0								2.00
3.00	0	0								3.00
4.00	0	0								4.00
5.00	-128, 021									5.00

* 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.

nus not	been posted to worksheet A,		the amount arrowable should	a be find cated fit cordinit 4 of	tin 3 part.	
	Related Organization(s)					
	and/or Home Office					
	Type of Business					
	51					
	6.00				1	
	B. INTERRELATIONSHIP TO RELATIONSHIP	IED ORGANIZATION(S)	AND/OR HOME OFFICE:			

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

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

6.00 MANAGEMENT COMPANY	6.00
7. 00 MANAGEMENT COMPANY	7.00
8.00 MANAGEMENT COMPANY	8.00
9. 00 MANAGEMENT COMPANY	9.00
10. 00 MANAGEMENT COMPANY	10.00
10. 01 MANAGEMENT COMPANY	10.01
10. 02 MANAGMENT COMPANY	10.02
100.00	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems	COLUMBUS REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	3-2
						From 01/01/2021 To 12/31/2021		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der		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		ADMINISTRATIVE & GENERAL	2, 995, 463	2, 795, 713	199, 750			1.00
2.00		ADULTS & PEDIATRICS	677, 591	0	677, 591			2.00
3.00		SUBPROVIDER – IRF	220, 798	0	220, 798			3.00
4.00		OPERATING ROOM	6, 627, 827	4, 357, 957	2, 269, 870			4.00
5.00		ANESTHESI OLOGY	60, 000	0	60, 000			5.00
6.00		RADI OLOGY-DI AGNOSTI C	50, 000	0	50,000			6.00
7.00		MAMMOGRAPHY	22, 917	0	22, 917			7.00
8.00		RADI OLOGY-THERAPEUTI C	45, 000	0	45,000			8.00
9.00		CARDIAC CATHETERIZATION	55, 000	0	55,000			9.00
10.00		LABORATORY-PATHOLOGI CAL	225, 000	0	225,000			10.00
11.00		RESPI RATORY THERAPY	50, 000	0	50,000			11.00
12.00		PHYSI CAL THERAPY	38, 350	0	38, 350			12.00
13.00		ELECTROCARDI OLOGY	3, 600	0	3,600			13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	19, 600	0	19, 600	211, 500	196	14.00
15.00	90.02	NEUROPSYCH	214, 098	214, 098	C	181, 300	0	15.00
16.00	90.03	WOUND CENTER	65, 769	0	65, 769	211, 500	395	16.00
17.00	90.04	HYPERBARIC OXYGEN THERAPY	4, 231	0	4, 231	211, 500	25	17.00
18.00	90.05	VIMCARE CLINIC	20, 000	0	20, 000	211, 500	356	18.00
19.00	91.00	EMERGENCY	3, 099, 726	326, 240	2, 773, 486	211, 500	27, 578	19.00
20.00	95.00	AMBULANCE SERVICES	13, 125	0	13, 125	211, 500	84	20.00
200.00			14, 508, 095	7, 694, 008	6, 814, 087	,	67, 951	200.00

Heal th	Financial Syst	ems	COLUMBUS REGI	ONAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 01/01/2021 To 12/31/2021		epared: 23 am
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	71, 788			0 0	0	1.00
2.00		ADULTS & PEDIATRICS	561, 899			0 0	0	2.00
3.00		SUBPROVIDER - IRF	970, 968			0 0	0	3.00
4.00		OPERATING ROOM	2, 346, 841	117, 342	(0 0	0	4.00
5.00		ANESTHESI OLOGY	55, 822	2, 791	(0 0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	44, 445	2, 222		0 0	0	6.00
7.00	54.03	MAMMOGRAPHY	12, 609	630	(0 0	0	7.00
8.00		RADI OLOGY-THERAPEUTI C	38, 432	1, 922	(0 0	0	8.00
9.00	59.00	CARDIAC CATHETERIZATION	43, 012	2, 151	(0 0	0	9.00
10.00	60. 01	LABORATORY-PATHOLOGI CAL	187, 716	9, 386	(0 0	0	10.00
11.00	65.00	RESPI RATORY THERAPY	33, 657	1, 683	(0 0	0	11.00
12.00	66.00	PHYSICAL THERAPY	19, 523	976	(0 0	0	12.00
13.00	69.00	ELECTROCARDI OLOGY	3, 661	183	(0 0	0	13.00
14.00		ELECTROENCEPHALOGRAPHY	19, 930	997	(0 0	0	14.00
15.00	90.02	NEUROPSYCH	0	0	(0 0	0	15.00
16.00	90.03	WOUND CENTER	40, 165	2,008	(0 0	0	16.00
17.00	90.04	HYPERBARIC OXYGEN THERAPY	2, 542	127	(0 0	0	17.00
18.00	90.05	VIMCARE CLINIC	36, 199	1, 810	(0 0	0	18.00
19.00		EMERGENCY	2, 804, 205	140, 210	(0 0	0	19.00
20.00	95.00	AMBULANCE SERVICES	8, 541	427	(0 0	0	20.00
200.00			7, 301, 955	365, 097		0 0	0	200.00

Health Financial Systems COLUMBUS REGIONA			ONAL HOSPITAL		In Lie	u of Form CMS	-2552-10	
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-	-8-2
						From 01/01/2021 To 12/31/2021	Date/Time Pr	repared [.]
							5/24/2022 10	
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16,00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	15.00	71, 788				1.00
2.00		ADULTS & PEDIATRICS		561, 899				2.00
3.00		SUBPROVIDER - IRF	0	970, 968				3.00
4.00		OPERATING ROOM	0	2, 346, 841	(4, 357, 957		4.00
5.00		ANESTHESI OLOGY	0	55, 822	4, 178			5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	44, 445				6.00
7.00	54.03	MAMMOGRAPHY	0	12,609				7.00
8.00	55.00	RADI OLOGY-THERAPEUTI C	0	38, 432	6, 568	6, 568		8.00
9.00	59.00	CARDI AC CATHETERI ZATI ON	0	43, 012	11, 988	11, 988		9.00
10.00	60. 01	LABORATORY-PATHOLOGI CAL	0	187, 716	37, 284	37, 284		10.00
11.00	65.00	RESPI RATORY THERAPY	0	33, 657	16, 343	3 16, 343		11.00
12.00	66.00	PHYSI CAL THERAPY	0	19, 523	18, 827	7 18, 827		12.00
13.00	69.00	ELECTROCARDI OLOGY	0	3, 661	(0 0		13.00
14.00		ELECTROENCEPHALOGRAPHY	0	19, 930	(0 0		14.00
15.00		NEUROPSYCH	0	0	(214, 098		15.00
16.00		WOUND CENTER	0	40, 165	25, 604			16.00
17.00		HYPERBARIC OXYGEN THERAPY	0	2, 542	1, 689	9 1, 689		17.00
18.00		VIMCARE CLINIC	0	36, 199	(0 0		18.00
19.00		EMERGENCY	0	2, 804, 205	(326, 240		19.00
20.00		AMBULANCE SERVICES	0	8, 541	4, 584			20.00
200.00			0	7, 301, 955	386, 582	2 8, 080, 590		200.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	COLUMBUS REGIO	NAL HOSPITAL Provider CO		Period:	u of Form CMS-: Worksheet B	2552-10
				rom 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/24/2022 10:	
		CAPI TAL REL	ATED COSTS		10/21/2022 101	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	5, 399, 988	5, 399, 988				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A CAFETERI A CATIONAL C	12, 976, 860 30, 127, 611 40, 926, 891 7, 541, 440 852, 123 2, 642, 923 1, 319, 272 1, 188, 677	82, 486 474, 442 2, 598, 298 5, 871 38, 500 58, 292 45, 816	12, 976, 860 5, 735 6, 906, 121 297, 113 (129, 007 8, 631 12, 330	30, 215, 832 5, 779, 665 1, 064, 523 14, 424 7, 740, 595 316, 820 452, 534	54, 087, 119 11, 501, 374 872, 418 3, 551, 025 1, 703, 015 1, 699, 357	2.00 4.00 5.00 7.00 8.00 9.00 10.00
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	6, 040, 157 952, 136 5, 249, 426 1, 032, 516	74, 466 56, 312 35, 580 27, 078	29, 509 48, 194 178, 732 1, 229	4 9, 872 2 1, 166, 799	7, 954, 733 1, 066, 514 6, 630, 537 1, 317, 766	14.00 15.00
17.00 01700 SOCI AL SERVICE 23.00 02300 PARAMED ED PRGM 23.01 02301 XRAY EDUCATION 23.02 PHARMACY RESIDENCY PROG	0 0 458, 512 385, 846	0 0 741 <u>2, 787</u>	((13, 779 7, 767	0 9 165, 185	0 0 638, 217 528, 253	17.00 23.00 23.01 23.02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	25, 569, 225	581, 426	170, 387	5, 964, 760	32, 285, 798	30.00
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	7, 167, 176 0 0	83, 079 0 0	61, 233 () ()	8 818, 813 0 0 0 0		31.00 32.00 33.00 34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 1, 908, 648	0 76, 578	0 9, 085	-	0 2, 522, 311	40.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 1, 336, 968	0 4, 321	(17, 616	0 0	0 1, 762, 333	42.00 43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	17, 232, 605	295, 216	966, 567	462, 916	18, 957, 304	50.00
51.00 05100 RECOVERY ROOM	1, 411, 867	23, 609	3, 068	3 19, 360	1, 457, 904	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 937, 407 108, 995	28, 330 882	18, 709 2, 885		1, 984, 446 112, 762	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 833, 541 2, 076, 189	62, 984 24, 913	142, 976 118, 856		2, 502, 179 2, 397, 015	•
54. 02 05404 ULTRA SOUND	696, 018	11, 148	44, 872	2 183, 938	935, 976	54.02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	983, 260 2, 788, 165	749 58, 003	161, 163 995, 949			•
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 555, 051 519, 092	13, 328 6, 671	60, 308 9, 520		1, 907, 790 658, 630	
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 399, 316	66, 001	119, 229	606, 585	3, 191, 131	•
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL	12, 235, 468 1, 294, 934	80, 559 8, 984	238, 172 12, 898		14, 048, 072 1, 452, 678	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	691, 281	3, 173	1, 812	2 29, 025	725, 291	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 608, 042 5, 440, 621	58, 566 4, 566	75, 565 17, 564		3, 470, 004 5, 565, 537	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	2, 053, 339 880, 007	1, 638 0	3, 318 18, 355		2, 080, 351 975, 120	
69. 00 06900 ELECTROCARDI OLOGY	888, 953	10, 363	256, 087		1, 404, 190	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 037, 465 6, 970, 123	0	7, 157 (1, 290, 252 6, 970, 123	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 339, 047	0	(7, 339, 047	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	25, 149, 633 822, 564	0	(-	25, 149, 633 822, 564	
76.00 03020 ACUPUNCTURE	0	0	(0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	270, 940	11, 719	3, 655	5 73, 794	360, 108	76.97
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 1, 805, 565	0 54, 126	(19, 735	-	0 2, 408, 000	
90. 01 09001 DI ABETES CENTER	0	0	(0 0	0	90.01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	108, 021 1, 551, 619	645 0	126 3, 326		141, 508 1, 761, 424	90.02 90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	246, 454	0	213	3 36, 768	283, 435	90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	610, 025 237, 161	31, 540 6, 797	6, 213 7, 361		843, 328 333, 108	•
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	9, 209, 428	133, 832	128, 621		11, 442, 743	91.00
72. UU UV72UU UDJERVATI UN BEUS (NUN-DISTINCT PART				1	0	92.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/24/2022 10:	epared: 23 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS					1	
95. 00 09500 AMBULANCE SERVICES	3, 214, 519	59, 537	218, 60	4 1, 057, 955		
99. 10 09910 CORF	0	0		0 0	-	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1.00.00
109.00 10900 PANCREAS ACQUI SI TI ON	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 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 I NTEREST EXPENSE	071 000 110	F 000 0F0	44 550 05	00 (40 700	0/0 000 517	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	271, 283, 110	5, 303, 952	11, 559, 35	2 29, 648, 783	269, 202, 517	118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	39, 167	20, 214	17	2 0		190.00
194. 00 07950 WELLNESS COMMUNITY	298, 869	20, 214	3, 34			1
194. 01 07951 BUI LDI NG RENTALS	218, 239	0	5, 54	ο 	218, 239	
194. 02/07952 HOSPI CE	108, 830	0			108, 830	
194. 03 07953 OUTREACH CLINICS	100,000	0				194.02
194. 04 07954 SPEECH - HEARING AIDS	203, 832	0			203, 832	
194. 05 07955 NONALLOWABLE MARKETING	559, 921	0		0	559, 921	
194. 06 07956 CRH FOUNDATI ON	52, 774	14, 254		18,077		194.06
194. 07 07957 HEALTHY COMMUNI TI ES	02,771	0				194.07
194. 08 07958 CRHP	2, 738, 882	57, 595	1, 413, 21	4 484, 186		
194. 09 07 959 NEUROPSYCH PART B	2,700,002	3, 973				194.09
200.00 Cross Foot Adjustments	Ŭ	5, 770		-		200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	275, 503, 624	5, 399, 988	12, 976, 86	30, 215, 832		

ST AL	LOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021		
	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				1	1	
	DO100 CAP REL COSTS-BLDG & FIXT						1.
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
	20500 ADMINI STRATI VE & GENERAL	54, 087, 119					5.
	DO700 OPERATION OF PLANT	2, 809, 533	14, 310, 907				7.
	DO800 LAUNDRY & LINEN SERVICE	213, 113	37, 427	1, 122, 958			8.
	DO900 HOUSEKEEPI NG	867, 437	245, 449				9
	D1000 DI ETARY	416,009	371, 623				
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	415, 116 1, 943, 166	292, 091 474, 737	0	63, 827 17, 476		
	01400 CENTRAL SERVICES & SUPPLY	260, 526	359,006	0			
	D1500 PHARMACY	1, 619, 694	226, 830	0	37, 992		
00 0	01600 MEDICAL RECORDS & LIBRARY	321, 901	172, 627	0	3, 799	0	16
	01700 SOCIAL SERVICE	0	0	0	0	-	
	D2300 PARAMED ED PRGM	155,000	0	0		0	
	02301 XRAY EDUCATION 02302 PHARMACY RESIDENCY PROG	155, 902 129, 041	4, 726 17, 768	0			
	NPATIENT ROUTINE SERVICE COST CENTERS	127,041	17,700		3,037		- 23
	D3000 ADULTS & PEDIATRICS	7, 886, 651	3, 706, 738	372, 642	1, 822, 101	2,007,454	30
00 0	D3100 I NTENSI VE CARE UNI T	1, 986, 054	529, 649	46, 768		261, 430	31
	D3200 CORONARY CARE UNIT	0	0	0		0	
	D3300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	0	0	0	
	04100 SUBPROVIDER - IRF	616, 145	488, 205	, s			
	04200 SUBPROVI DER	010, 145	400, 209	0			
	04300 NURSERY	430, 499	27, 550	12, 068	0		
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44
	ANCI LLARY SERVICE COST CENTERS	4 (20 050	4 000 07/	0.40.05/	(04.500	10.00/	1 - 0
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	4, 630, 852 356, 134	1, 882, 076 150, 511	242, 956 49, 201	624, 590 53, 949		
	D5200 DELIVERY ROOM & LABOR ROOM	484, 756	180, 614				
	D5300 ANESTHESI OLOGY	27, 545	5, 623				
00 0	D5400 RADI OLOGY-DI AGNOSTI C	611, 227	401, 537	80, 963	107, 138	3, 115	54
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	585, 538	158, 828				
	05404 ULTRA SOUND	228, 638	71,073				
	05405 MAMMOGRAPHY 05500 RADI OLOGY-THERAPEUTI C	325, 341 1, 000, 888	4, 773 369, 781	5, 527 14, 901	43, 311 63, 827		
	05700 CT SCAN	466, 031	84, 967	0			
	05800 MRI	160, 889	42, 531	0	7, 598		
	05900 CARDI AC CATHETERI ZATI ON	779, 523	420, 770	65, 813	72, 945	9, 828	59
	D6000 LABORATORY	3, 431, 635	513, 581	0			
	06001 LABORATORY-PATHOLOGI CAL	354,857	57, 275		.,	-	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	177, 173 847, 646	20, 226 373, 372				
	D6600 PHYSI CAL THERAPY	1, 359, 538	29, 110	-	. = . ,		
	06700 OCCUPATI ONAL THERAPY	508, 184	10, 444				
00 0	D6800 SPEECH PATHOLOGY	238, 200	0	0		0	68
	D6900 ELECTROCARDI OLOGY	343, 013	66, 064	0	.,		
	07000 ELECTROENCEPHALOGRAPHY	315, 180	0	1, 270	-		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 702, 648	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	1, 792, 768 6, 143, 502	0		0		
	07400 RENAL DI ALYSI S	200, 934	0	0	0	0	
	D3020 ACUPUNCTURE	0	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	87, 966	74, 712	0	1, 520	0	76
	DUTPATIENT SERVICE COST CENTERS			-	-	-	
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	
	09000 CLINIC	588, 221	345, 065	-	-		
	D9001 DI ABETES CENTER	0	0 .0, 000	0	0	0	
02 0	09002 NEUROPSYCH	34, 567	4, 111	0	0	0	
	D9003 WOUND CENTER	430, 277	0	3, 237		0	
1	09004 HYPERBARI C OXYGEN THERAPY	69, 237	0	207		0	
	09005 VI MCARE CLI NI C	206,006	201, 076		158, 807		
	D9006 MEDICATION MGMT CLINIC D9100 EMERGENCY	81, 371 2, 795, 210	43, 334 853, 212		13, 677 408, 795		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 173, 210	003,212	/ 3,008	400, 793	1,019	91
	THER REIMBURSABLE COST CENTERS			1		1	1 ′′
	D9500 AMBULANCE SERVICES	1, 111, 615	379, 563	0	0	0	95
10 0	09910 CORF	0	0	0	0		99
	10100 HOME HEALTH AGENCY	0	0	0	0		101

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				rom 01/01/2021	Part I	
				Го 12/31/2021	Date/Time Prep 5/24/2022 10:2	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	
cost center bescription	E & GENERAL		LINEN SERVICE		DILIANI	
	5.00	7.00	8.00	9,00	10.00	
SPECIAL PURPOSE COST CENTERS	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101.00	
109. 00 10900 PANCREAS ACQUISITION	0	0	(0 0	0.	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE	-	-				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	52, 547, 897	13, 698, 655	1, 122, 958	4, 627, 438	2, 535, 478 ⁻	118.00
NONREI MBURSABLE COST CENTERS	· · · ·			· · · · · · · · · · · · · · · · · · ·		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	14, 548	128, 868	(0 0	0	190.00
194.0007950 WELLNESS COMMUNITY	89, 651	0	(0 0	0	194.00
194. 01 07951 BUI LDI NG RENTALS	53, 311	0	(0 0	0	194.01
194. 02 07952 HOSPI CE	26, 585	0	(0 0	0	194.02
194. 03 07953 OUTREACH CLINICS	0	0	(0 0	0	194.03
194. 04 07954 SPEECH - HEARING AIDS	49, 792	0	(0 0	0	194.04
194.0507955NONALLOWABLE MARKETING	136, 776	0	(0 0	0	194.05
194. 06 07956 CRH FOUNDATI ON	20, 789	90, 874	(35, 713	0	194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0	(0 0	0	194.07
194. 08 07958 CRHP	1, 146, 611	367, 181	(0 0	0	194.08
194.0907959 NEUROPSYCH PART B	1, 159	25, 329	(760	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)	54, 087, 119	14, 310, 907	1, 122, 958	4, 663, 911	2, 535, 478	202.00

	Financial Systems	COLUMBUS REGIO				u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/24/2022 10:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	23 am
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 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		2, 470, 391					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	145, 618		1 050 440			13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	28, 102 76, 641		1, 952, 449 0			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	74, 086		C		1, 890, 179	16.00
17.00	01700 SOCIAL SERVICE	0		0	0	0	17.00
23.00	02300 PARAMED ED PRGM	0	0	C	0	0	23.00
23.01	02301 XRAY EDUCATION	17, 883		C		0	23.01
23.02	02302 PHARMACY RESIDENCY PROG	10, 219	58, 024	0	0	0	23.02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	E02 (00	2 752 100	E2 701	13, 204	407 010	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	592, 690 71, 531		53, 781 1, 727	2, 867	427, 213 4, 934	30.00 31.00
32.00	03200 CORONARY CARE UNIT	0		1, 727		4, 734	32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0	0		0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0		C	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	48, 539	298, 899	0	234	3, 701	41.00
42.00		20 (54	104 122	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	30, 656			-	0	43.00 44.00
44.00	ANCI LLARY SERVICE COST CENTERS		0		<u> </u>	0	44.00
50.00	05000 OPERATI NG ROOM	255, 470	1, 621, 511	1, 682, 226	43, 599	964, 619	50.00
51.00	05100 RECOVERY ROOM	30, 656	200, 434	C	98	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-	24, 917	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	U U	0	15, 161	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	40, 875		15, 419 0	16, 108 107, 225	0	54.00 54.01
54.01	05404 ULTRA SOUND	15, 328			305	0	54.01
54.02	05405 MAMMOGRAPHY	20, 438		5, 345		0	54.02
55.00	05500 RADI OLOGY-THERAPEUTI C	20, 438		C	79	0	55.00
57.00	05700 CT SCAN	30, 656	0	C	62, 278	0	57.00
58.00	05800 MRI	10, 219		C	9, 415	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	48, 539		17, 804	33, 304	64, 555	
60. 00 60. 01		194, 157		0	15	0	60.00
62.00	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 773 2, 555			31	0	60.01 62.00
65.00	06500 RESPIRATORY THERAPY	66, 422		329	3, 766	124, 998	65.00
	06600 PHYSI CAL THERAPY	12, 773		70, 927		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 555	0	C	0	0	67.00
	06800 SPEECH PATHOLOGY	7,664		C	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	20, 438		0	36, 084	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 992	0	0	2	225, 736 0	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
		0	0	C	8, 702, 818	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	4, 565	0	74.00
	03020 ACUPUNCTURE	0	0	C	0	0	76.00
76.97		5, 109	39, 004	C	12	0	76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
	09000 CLINIC	56, 203	258, 395	5, 798	1,060	74, 423	90.00
90.01	09001 DI ABETES CENTER	0	200, 375	3,770	1,000	0	90.01
90.02	09002 NEUROPSYCH	2, 555	0	0	0	0	90.02
90.03	09003 WOUND CENTER	17, 883		67, 638	3, 536	0	90.03
		5, 109		C	0	0	90.04
90.05	09005 VI MCARE CLI NI C	25, 547		370	937	0	90.05
	09006 MEDICATION MGMT CLINIC	5, 109			0	0	90.06
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	189, 048	981, 572	6, 168	3, 510	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1			I		/2.00
95.00		132, 844	841, 897	0	9, 171	0	95.00
99.10	09910 CORF	0	0	C		0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre	pared.
				10 12/01/2021	5/24/2022 10:	
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		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 365, 648	10, 535, 730	1, 952, 44	9 9, 071, 112	1, 890, 179	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 555	0		0 0		190.00
194.0007950 WELLNESS COMMUNITY	7,664	0		0 0		194.00
194. 01 07951 BUI LDI NG RENTALS	0	0		0 0		194.01
194. 02 07952 HOSPI CE	0	0		0 591		194.02
194. 03 07953 OUTREACH CLINICS	0	0		0 0		194.03
194.04 07954 SPEECH - HEARING AIDS	0	0		0 0		194.04
194.0507955NONALLOWABLE MARKETING	0	0		0 0		194.05
194. 06 07956 CRH FOUNDATI ON	2, 555	0		0 0		194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0		0 0		194.07
194. 08 07958 CRHP	84, 305	0		0 0		194.08
194.0907959 NEUROPSYCH PART B	7,664	0		0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 470, 391	10, 535, 730	1, 952, 44	9 9, 071, 703	1, 890, 179	202.00

	icial Systems FION - GENERAL SERVICE COSTS	COLUMBUS REGIO	Provi der CC	Fr	eriod: com 01/01/2021	J of Form CMS-: Worksheet B Part I	
				То	0 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY PROG	Subtotal	
OFNED.		17.00	23.00	23.01	23.02	24.00	
1.00 00100 2.00 00200 4.00 00400 5.00 00500 7.00 00700 3.00 00800 9.00 00900 10.00 01000 11.00 01100 13.00 01300	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
5.00 01500 6.00 01600 7.00 01700 3.00 02300 3.01 02301	CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE PARAMED ED PRGM XRAY EDUCATION PHARMACY RESIDENCY PROG	0 0 0 0	0	817, 488	746, 344		14. 0 15. 0 16. 0 17. 0 23. 0 23. 0 23. 0
I NPAT	ENT ROUTINE SERVICE COST CENTERS						
31.00 03100 32.00 03200 33.00 03300 34.00 03400 40.00 04000 41.00 04100 22.00 04200 43.00 04400 44.00 04200	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER NURSERY SKILLED NURSING FACILITY LARY SERVICE COST CENTERS			0 0 0 0 0 0 0 0 0		52, 920, 462 11, 732, 076 0 0 0 4, 416, 826 0 2, 457, 239 0	31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00
i0.00 05000 i1.00 05100 i2.00 05200 i3.00 05300 i4.00 05400 i4.01 05402 i4.02 05404 i4.03 05405 i5.00 05500 i7.00 05700 i8.00 05800 i9.00 05900 i0.01 06001 i2.00 06200 i5.00 06600 i0.00 06600 i0.00 06600 i0.00 06600 i0.00 07000 i1.00 07100 i2.00 07200 i3.00 07300 i4.00 07400 i6.00 03020 i6.07 07407 i6.07 07407	OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC NUCLEAR MEDICINE-DIAGNOSTIC ULTRA SOUND MAMMOGRAPHY RADIOLOGY-THERAPEUTIC CT SCAN MRI CARDIAC CATHETERIZATION LABORATORY LABORATORY-PATHOLOGICAL WHOLE BLOOD & PACKED RED BLOOD CELL RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY ELECTRO			0 0 0 817, 488 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	30, 917, 229 2, 298, 887 2, 747, 865 161, 091 4, 596, 049 3, 323, 962 1, 272, 596 1, 737, 271 5, 580, 353 2, 563, 879 889, 282 5, 007, 555 18, 287, 759 1, 882, 173 928, 284 5, 431, 163 7, 070, 480 2, 613, 406 1, 220, 984 4, 007, 659 1, 964, 849 8, 672, 771 9, 131, 815 40, 742, 297 1, 028, 063 0 568, 431	51.00 52.00 53.00 54.00 54.00 54.00 54.00 54.00 57.00 59.00 60.00 60.00 62.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 74.00 74.00 76.00 7
8.00 08800 9.00 08900 0.01 09001 0.02 09002 0.03 09003 0.04 09003 0.05 09004 0.05 09005 0.06 09006 1.00 09100 2.00 09200	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER CLINIC DIABETES CENTER NEUROPSYCH WOUND CENTER HYPERBARIC OXYGEN THERAPY VIMCARE CLINIC MEDICATION MGMT CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART		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 3, 885, 947 0 182, 741 2, 398, 030 382, 408 1, 599, 096 502, 208 16, 760, 345	89.0 90.0 90.0 90.0 90.0 90.0 90.0 90.0
0THER 05.00 09500 9.10 09910	REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	000000000000000000000000000000000000000	0 0 0	0 0 0	0 0 0	7, 025, 705 0 0	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre	parod:
				10 12/31/2021	5/24/2022 10:	
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	
	SERVI CE	PRGM	EDUCATI ON	RESI DENCY		
	17.00	00.00	00.01	PROG	04.00	
	17.00	23.00	23.01	23.02	24.00	
SPECIAL PURPOSE COST CENTERS						100.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 I NTEREST EXPENSE	0		017 10	744 044	0// 000 00/	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	817, 48	746, 344	266, 909, 236	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN		0			205 525	100.00
194. 00/07950 WELLNESS COMMUNITY	0	0		0 0	205, 525	
194. 01 07950 WELLNESS COMMONT I Y	0	0		0 0	464, 319	
194. 02 07952 HOSPI CE	0	0		0 0	271, 550 136, 006	
194. 02/07952 HOSPICE 194. 03/07953 OUTREACH CLINICS	0	0		0 0		194.02
194. 04/07954 SPEECH - HEARING ALDS	0	0		0 0	253, 624	
194.0507955 NONALLOWABLE MARKETING	0	0		0 0	253, 624 696, 697	
194. 06 07955 NONALLOWABLE MARKETING	0	0		0 0		
194. 07 07957 HEALTHY COMMUNITIES	0	0		0 0	235, 036	194.06
194. 08 07958 CRHP	0	0		0 0	6, 291, 974	
194. 09/07959 NEUROPSYCH PART B	0	0		0 0		194.08
	0	0		0 0		200.00
		0		0 0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0	817, 48	0 8 746, 344	275, 503, 624	
202.00 TOTAL (Sum TIMES THE INFOLIGN 201)	I U	U	817,48	/40, 344	270, 503, 624	202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	COLUMBUS REGION	AL HOSPITAL Provider CCN: 15	5-0112 Period: Wor	Form CMS-2552-10 ksheet B
			From 01/01/2021 Par To 12/31/2021 Dat	e/Time Prepared:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/2	4/2022 10:23 am
	25.00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7. 00 00700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00 9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY				14.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
23.00 02300 PARAMED ED PRGM				23.00
23. 01 02301 XRAY EDUCATION				23.01
23. 02 02302 PHARMACY RESIDENCY PROG I NPATI ENT ROUTI NE SERVI CE COST CENTE	RS			23.02
30. 00 03000 ADULTS & PEDI ATRI CS	0	52, 920, 462		30.00
31.00 03100 INTENSIVE CARE UNIT	0	11, 732, 076		31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		32.00 33.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT		0		33.00
40. 00 04000 SUBPROVIDER - IPF	0	o		40.00
41.00 04100 SUBPROVI DER – I RF	0	4, 416, 826		41.00
42.00 04200 SUBPROVI DER	0	0		42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	2, 457, 239 0		43.00
ANCI LLARY SERVICE COST CENTERS		0		
50. 00 05000 OPERATI NG ROOM	0	30, 917, 229		50.00
51.00 OS100 RECOVERY ROOM	0	2, 298, 887		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	0	2, 747, 865 161, 091		52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 596, 049		54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	3, 323, 962		54.01
54. 02 05404 ULTRA SOUND 54. 03 05405 MAMMOGRAPHY	0	1, 272, 596 1, 737, 271		54.02 54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	5, 580, 353		55.00
57. 00 05700 CT SCAN	0	2, 563, 879		57.00
58.00 05800 MRI	0	889, 282		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	5,007,555		59.00 60.00
60. 01 06001 LABORATORY - PATHOLOGI CAL	0	18, 287, 759 1, 882, 173		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	CELL 0	928, 284		62.00
65.00 06500 RESPI RATORY THERAPY	0	5, 431, 163		65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	7, 070, 480 2, 613, 406		66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 220, 984		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2,007,659		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,964,849		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATENTS	ITENI O	8, 672, 771 9, 131, 815		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	40, 742, 297		73.00
74.00 07400 RENAL DI ALYSI S	0	1, 028, 063		74.00
76.00 03020 ACUPUNCTURE	0	0		76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	568, 431		76.97
88. 00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENT		0		89.00
90. 00 09000 CLINIC	0	3, 885, 947		90.00
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	0	0 182, 741		90.01 90.02
90. 02 09002 NEOROPSYCH 90. 03 09003 WOUND CENTER	0	2, 398, 030		90.02
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	382, 408		90.04
90. 05 09005 VI MCARE CLINIC	0	1, 599, 096		90.05
90. 06 09006 MEDICATION MGMT CLINIC	0	502, 208		90.06
91.00 09100 EMERGENCY	0	16, 760, 345		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 0			92.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES	PART 0	7, 025, 705		92.00

Health Financial Systems	COLUMBUS REGIONA	L HOSPI TAL		In Lieu	」 of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared:
					5/24/2022 10:23 am
Cost Center Description	Intern &	Total			
	Residents				
	Cost & Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
99. 10 09910 CORF	0	0			99.10
101.0010100 HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS	1				
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	266, 909, 236			118.00
NONREI MBURSABLE COST CENTERS	r				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	205, 525			190.00
194.0007950 WELLNESS COMMUNITY	0	464, 319			194.00
194. 01 07951 BUI LDI NG RENTALS	0	271, 550			194.01
194. 02 07952 HOSPI CE	0	136, 006			194.02
194. 03 07953 OUTREACH CLINICS	0	0			194.03
194. 04 07954 SPEECH - HEARING AIDS	0	253, 624			194.04
194.0507955NONALLOWABLE MARKETING	0	696, 697			194.05
194.0607956CRH FOUNDATION	0	235, 036			194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0			194.07
194. 08 07958 CRHP	0	6, 291, 974			194.08
194.0907959 NEUROPSYCH PART B	0	39, 657			194.09
200.00 Cross Foot Adjustments	0	0			200.00
201.00 Negative Cost Centers	0	0			201.00
202.00 TOTAL (sum lines 118 through 201)	0	275, 503, 624			202.00

ALLUCA	Financial Systems ATION OF CAPITAL RELATED COSTS	COLUMBUS REGIO	Provider C	CN: 15-0112 P	eri od:	u of Form CMS-2 Worksheet B	2552-10
				F	rom 01/01/2021 p 12/31/2021	Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/24/2022 10:	23 am
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	28	4.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	82, 486	5, 735	88, 221	88, 221	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1,045,365	474, 442	6, 906, 121	8, 425, 928	16, 881	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	97, 867	2, 598, 298 5, 871	297, 113 0	2, 993, 278 5, 871	3, 109 42	1
9.00	00900 HOUSEKEEPI NG	5, 082	38, 500	129, 007	172, 589	2, 163	
10.00	01000 DI ETARY	690	58, 292	8, 631	67, 613	925	
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 9, 773	45, 816 74, 466	12, 330 29, 509	58, 146 113, 748	1, 322 5, 288	•
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 873	56, 312	48, 194	107, 379	29	14.00
15.00	01500 PHARMACY	8, 527	35, 580	178, 732	222, 839	3, 408	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	929	27, 078	1, 229	29, 236	750	
17.00 23.00	01700 SOCIAL SERVICE 02300 PARAMED ED PRGM	0	0	0	0	0	
23.01	02301 XRAY EDUCATION	12,000	741	13, 779	26, 520	482	
23.02	02302 PHARMACY RESIDENCY PROG	0	2, 787	7, 767	10, 554	385	23.02
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	356, 384	581, 426	170, 387	1, 108, 197	17, 393	30.00
31.00	03100 I NTENSI VE CARE UNI T	28, 597	83, 079	61, 233	172, 909	2, 392	
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	
40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	0	0	0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	50, 176	76, 578	9, 085	135, 839	1, 542	
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	1, 819 0	4, 321 0	17, 616 0	23, 756 0	1, 178 0	
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	928, 369	295, 216	966, 567	2, 190, 152	1, 352	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	23, 609 28, 330	3, 068 18, 709	26, 677 47, 039	57 0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	882	2, 885	3, 767	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 022	62, 984	142, 976	208, 982	1, 351	1
54.01 54.02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	31, 938	24, 913 11, 148	118, 856 44, 872	175, 707 56, 020	517 537	•
54.03	05405 MAMMOGRAPHY	155, 795	749	161, 163	317, 707	545	
55.00	05500 RADI OLOGY-THERAPEUTI C	5, 140	58, 003	995, 949	1, 059, 092		55.00
	05700 CT SCAN 05800 MRI	903	13, 328	60, 308	74, 539		
58.00 59.00		0	4 471	0 5 20	14 101		
U7.UU		42, 815	6, 671 66, 001	9, 520 119, 229	16, 191 228, 045	360	58.00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	42, 815 30, 060	66, 001 80, 559	119, 229 238, 172	228, 045 348, 791	360 1, 772 4, 363	58.00 59.00 60.00
60. 00 60. 01	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL	30, 060 1, 021	66, 001 80, 559 8, 984	119, 229 238, 172 12, 898	228, 045 348, 791 22, 903	360 1, 772 4, 363 397	58.00 59.00 60.00 60.01
60. 00 60. 01 62. 00	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30, 060 1, 021 0	66, 001 80, 559 8, 984 3, 173	119, 229 238, 172 12, 898 1, 812	228, 045 348, 791 22, 903 4, 985	360 1, 772 4, 363 397 85	58.00 59.00 60.00 60.01 62.00
60. 00 60. 01	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL	30, 060 1, 021	66, 001 80, 559 8, 984	119, 229 238, 172 12, 898	228, 045 348, 791 22, 903	360 1, 772 4, 363 397	58.00 59.00 60.00 60.01 62.00 65.00
60.00 60.01 62.00 65.00 66.00 67.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	30, 060 1, 021 0 27, 274 356, 936 122, 398	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354	360 1, 772 4, 363 397 85 2, 126 300 64	58.00 59.00 60.00 60.01 62.00 65.00 66.00 67.00
60.00 60.01 62.00 65.00 66.00 67.00 68.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158	360 1, 772 4, 363 397 85 2, 126 300 64 224	58.00 59.00 60.01 62.00 65.00 66.00 67.00 68.00
$\begin{array}{c} 60.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304	360 1, 772 4, 363 397 85 2, 126 300 64 224 727	58.00 59.00 60.01 62.00 65.00 66.00 67.00 68.00 69.00
$\begin{array}{c} 60. \ 00 \\ 60. \ 01 \\ 62. \ 00 \\ 65. \ 00 \\ 66. \ 00 \\ 67. \ 00 \\ 68. \ 00 \\ 69. \ 00 \\ 70. \ 00 \\ 71. \ 00 \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158	360 1, 772 4, 363 397 85 2, 126 300 64 224	58.00 59.00 60.01 62.00 65.00 65.00 67.00 68.00 69.00 70.00 71.00
$\begin{array}{c} 60. \ 00 \\ 60. \ 01 \\ 62. \ 00 \\ 65. \ 00 \\ 66. \ 00 \\ 67. \ 00 \\ 68. \ 00 \\ 69. \ 00 \\ 70. \ 00 \\ 71. \ 00 \\ 72. \ 00 \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 717 0 0	$\begin{array}{c} 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00 \end{array}$
$\begin{array}{c} 60.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06500 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0	58.00 59.00 60.01 62.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00
$\begin{array}{c} 60. \ 00 \\ 60. \ 01 \\ 62. \ 00 \\ 65. \ 00 \\ 66. \ 00 \\ 67. \ 00 \\ 68. \ 00 \\ 69. \ 00 \\ 70. \ 00 \\ 71. \ 00 \\ 72. \ 00 \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 717 0 0	58.00 59.00 60.01 62.00 65.00 65.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00
$\begin{array}{c} 60.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 0 0	58.00 59.00 60.01 62.00 65.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 76.00
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 76.00 76.97	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06700 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03020 ACUPUNCTURE 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0 15, 414	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 216	58.00 59.00 60.01 62.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 76.00
60.00 60.01 62.00 65.00 66.00 67.00 70.00 71.00 72.00 73.00 74.00 76.00 76.97 88.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06700 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03020 ACUPUNCTURE 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 0 0	58.00 59.00 60.01 62.00 65.00 65.00 64.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 76.97 88.00
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 76.97 88.00 89.00 90.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0 15, 414	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 216 0	58.00 59.00 60.01 62.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 76.97 88.00 89.00
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 76.00 76.97 88.00 89.00 90.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 1, 638 0 10, 363 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0 15, 414 0 0 0 0 0 73, 872 0	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 216 0 0 0 0 1, 544 0	58. 00 59. 00 60. 01 62. 00 65. 00 65. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 73. 00 74. 00 76. 97 88. 00 89. 00 90. 00 90. 01
60.00 60.01 62.00 65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 74.00 74.00 76.00 76.97 88.00 89.00 90.01 90.01 90.02	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FIED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER 09002 NEUROPSYCH	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0 0 0 0 0 0 0 0 0	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 216 0 0 1, 544 0 96	58.00 59.00 60.01 62.00 65.00 65.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 74.00 76.97 88.00 89.00 90.00 90.01 90.02
60.00 60.01 62.00 65.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 76.00 76.00 76.97 88.00 89.00 90.00 90.01 90.02 90.03	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 1, 638 0 10, 363 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 0 15, 414 0 0 0 0 0 73, 872 0	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 0 216 0 0 0 0 1, 544 0	58.00 59.00 60.01 62.00 65.00 65.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 73.00 74.00 76.97 88.00 89.00 90.01 90.02 90.03
$\begin{array}{c} 60.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 97\\ 88.\ 00\\ 89.\ 00\\ 90.\ 01\\ 90.\ 02\\ 90.\ 03\\ 90.\ 04\\ 90.\ 05\\ \end{array}$	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY OUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLI NI C	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 3, 655 0 0 19, 735 0 126 3, 326 213 6, 213	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 15, 414 0 73, 872 0 771 158, 701 141, 410 39, 008	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 216 0 0 1, 544 0 96 603 107 571	58.00 59.00 60.01 62.00 65.00 65.00 64.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 74.00 76.97 88.00 89.00 90.01 90.02 90.03 90.04 90.05
60.00 60.01 62.00 65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 74.00 73.00 74.00 76.97 88.00 89.00 90.01 90.02 90.03 90.04 90.05 90.06	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLI NI C	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 0 3, 655 0 126 3, 326 213 6, 213 7, 361	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 0 15, 414 0 771 158, 701 41, 415 39, 008 14, 158	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 0 216 0 0 0 0 0 0 0 0 0 0 0 0 0	59.00 60.01 62.00 65.00 65.00 64.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 73.00 74.00 76.97 88.00 89.00 90.01 90.02 90.03 90.04 90.05 90.06
60.00 60.01 62.00 65.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 76.00 76.00 76.97 88.00 89.00 90.01 90.02 90.03 90.04 90.05 90.06 91.00	06000 LABORATORY 06001 LABORATORY-PATHOLOGI CAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY OUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 DI ABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLI NI C	30, 060 1, 021 0 27, 274 356, 936 122, 398 51, 803 854 146, 920 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 001 80, 559 8, 984 3, 173 58, 566 4, 566 1, 638 0 10, 363 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 229 238, 172 12, 898 1, 812 75, 565 17, 564 3, 318 18, 355 256, 087 7, 157 0 0 0 0 0 3, 655 0 0 19, 735 0 126 3, 326 213 6, 213	228, 045 348, 791 22, 903 4, 985 161, 405 379, 066 127, 354 70, 158 267, 304 154, 077 0 0 0 15, 414 0 73, 872 0 771 158, 701 141, 410 39, 008	360 1, 772 4, 363 397 85 2, 126 300 64 224 727 717 0 0 0 0 0 216 0 0 1, 544 0 96 603 107 571	58.00 59.00 60.00 60.01 62.00 65.00 65.00 64.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 74.00 76.97 88.00 89.00 90.01 90.02 90.03 90.04 90.05 90.06

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/24/2022 10:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
OTHER REIMBURSABLE COST CENTERS	0.000	50 507	010 (0)	000 (57	0.000	1 05 00
95. 00 09500 AMBULANCE SERVICES	24, 316	59, 537	218, 604	302, 457	3, 090	
99. 10 09910 CORF	0	0		0	0	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0	0	101.00
109. 00 10900 PANCREAS ACQUISITION		0	C	0	0	109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0		1109.00
111. 00 11100 I SLET ACQUISITION	0	0		0		111.00
113. 00 11300 I NTEREST EXPENSE	0	0		0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 751, 029	5, 303, 952	11, 559, 352	20, 614, 333	86 565	118.00
NONREI MBURSABLE COST CENTERS		-,,				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	20, 214	173	20, 387	0	190.00
194.0007950 WELLNESS COMMUNITY	60, 922	0	3, 349	64, 271	189	194.00
194. 01 07951 BUI LDI NG RENTALS	61, 134	0	C	61, 134	0	194.01
194. 02 07952 HOSPI CE	0	0	C	0		194.02
194. 03 07953 OUTREACH CLINICS	0	0	C	0	0	194.03
194. 04 07954 SPEECH - HEARING AIDS	0	0	C	0	0	194.04
194.0507955NONALLOWABLE MARKETING	0	0	C	0		194.05
194. 06 07956 CRH FOUNDATI ON	0	14, 254	C	14, 254		194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0	C	0		194.07
194. 08 07958 CRHP	400, 566	57, 595				194.08
194.0907959 NEUROPSYCH PART B	0	3, 973	772	4, 745	0	194.09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	4 070 /54	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	4, 273, 651	5, 399, 988	12, 976, 860	22, 650, 499	88, 221	202.00

LOCA	Financial Systems TION OF CAPITAL RELATED COSTS	COLUMBUS REGIO	Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/24/2022 10:	epared
	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						
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMI NI STRATI VE & GENERAL	8, 442, 809					5.0
00	00700 OPERATION OF PLANT	438, 559	3, 434, 946				7.0
00	00800 LAUNDRY & LINEN SERVICE	33, 266	8, 983				8.0
00	00900 HOUSEKEEPI NG 01000 DI ETARY	135, 404 64, 938	58, 913 89, 198		369, 069 3, 548	226, 222	9.0
. 00	01100 CAFETERI A	64, 798	70, 109		5, 051	0	
. 00	01300 NURSING ADMINISTRATION	303, 322	113, 948	0	1, 383	0	13.
. 00	01400 CENTRAL SERVICES & SUPPLY	40, 667	86, 170			0	
. 00	01500 PHARMACY	252, 829	54, 444	0	3, 006 301	0	
. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	50, 248	41, 434 0	0	301	0	
. 00	02300 PARAMED ED PRGM	0	0	0	0	0	1
. 01	02301 XRAY EDUCATION	24, 336	1, 134		60	0	
. 02	02302 PHARMACY RESIDENCY PROG	20, 143	4, 265	0	241	0	23.
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 231, 064	889, 701	15, 981	144, 188	179, 110	30.
. 00	03100 I NTENSI VE CARE UNI T	310, 017	127, 128			23, 325	
. 00	03200 CORONARY CARE UNI T	0	0	0	0	0	
. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 96, 178	0 117, 180	0 1, 819	0 17, 016	0 16, 180	
. 00	04100 SUBPROVIDER - TRP	90, 178	0	1, 019	0	0 10, 180	
. 00	04300 NURSERY	67, 200	6, 613	518	0	0	
. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.
00	ANCI LLARY SERVICE COST CENTERS	700.0/1	451 740	10,400	40,407	1 072	1 50
. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	722, 861 55, 591	451, 742 36, 126			1, 073 0	
. 00	05200 DELIVERY ROOM & LABOR ROOM	75, 669	43, 351	758		0	
. 00	05300 ANESTHESI OLOGY	4, 300	1, 350	0	0	0	53.
. 00	05400 RADI OLOGY-DI AGNOSTI C	95, 411	96, 378		8, 478	278	
. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	91, 401 35, 690	38, 122 17, 059	0	4, 750 1, 684	0	
. 02	05405 MAMMOGRAPHY	50, 785	1, 146		,	0	
. 00	05500 RADI OLOGY-THERAPEUTI C	156, 235	88, 756	639		1, 170	
. 00	05700 CT SCAN	72, 746	20, 394	0	962	0	
. 00		25, 114	10, 208	0	601	0	
. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	121, 681 535, 667	100, 994 123, 271	2, 823 0	5, 772 7, 937	877 0	
. 01	06001 LABORATORY-PATHOLOGI CAL	55, 392	13, 747			0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	27, 656	4, 855			0	
	06500 RESPI RATORY THERAPY	132, 315	89, 618		9, 861	0	
. 00	06600 PHYSI CAL THERAPY	212, 219	6, 987			0	
. 00 . 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	79, 326 37, 182	2, 507 0	509 0		0	
	06900 ELECTROCARDI OLOGY	53, 543	15, 857	0	120	0	
. 00	07000 ELECTROENCEPHALOGRAPHY	49, 199	0	54	8, 659	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	265, 778	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	279, 845	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	958, 981 31, 365	0		0	0	
		0	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	13, 731	17, 933	0	120	0	
00	OUTPATIENT SERVICE COST CENTERS		-			2	0.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
. 00	09000 CLINIC	91, 819	82, 824		4, 991	3, 577	
. 01	09001 DI ABETES CENTER	0	0	0	0	0	90.
. 02	09002 NEUROPSYCH	5, 396	987	0	0	0	
	09003 WOUND CENTER	67, 165	0	139		0	
. 04 . 05	09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLI NI C	10, 808 32, 157	0 48, 263	9 259	-	0	
	09006 MEDICATION MGMT CLINIC	12, 702	10, 401		1, 082	0	
. 00	09100 EMERGENCY	436, 323	204, 791			632	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
00	OTHER REIMBURSABLE COST CENTERS	173 500	01 104	0		0	OF
	09500 AMBULANCE SERVICES 09910 CORF	173, 520 0	91, 104 0	0	-	0	95. 99.
	10100 HOME HEALTH AGENCY	0	0				101.

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				rom 01/01/2021	Part II	
				o 12/31/2021	Date/Time Pre 5/24/2022 10:	
Cost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	23 811
cost center bescription	E & GENERAL		LINEN SERVICE		DIETART	
	5.00	7.00	8.00	9,00	10.00	
SPECIAL PURPOSE COST CENTERS	3.00	7.00	0.00	7.00	10.00	
109. 00 10900 PANCREAS ACQUISITION	0	0	(0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110,00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 I NTEREST EXPENSE	0	0			0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 202, 542	3, 287, 991	48, 162	366, 183	226, 222	
NONREI MBURSABLE COST CENTERS	072027012	0/20/////	10/102		2207222	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 271	30, 931	(0	0	190.00
194.0007950 WELLNESS COMMUNITY	13, 994	0		0	0	194.00
194. 01 07951 BUILDING RENTALS	8, 322	0		0	0	194.01
194. 02 07952 HOSPI CE	4, 150	0		0	0	194.02
194. 03 07953 OUTREACH CLINICS	0	0		0	0	194.03
194. 04 07954 SPEECH - HEARING AIDS	7, 772	0	0	0 0	0	194.04
194.0507955 NONALLOWABLE MARKETING	21, 350	0	0	0 0	0	194.05
194. 06 07956 CRH FOUNDATI ON	3, 245	21, 812		2, 826	0	194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0		0	0	194.07
194. 08 07958 CRHP	178, 982	88, 132	0	0 0	0	194.08
194.0907959 NEUROPSYCH PART B	181	6, 080	0	60	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	8, 442, 809	3, 434, 946	48, 162	369, 069	226, 222	202.00

	Financial Systems	COLUMBUS REGIO			In Lie	u of Form CMS-2	2552-10
ALLOCAT	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0112 Pe Fr To	eriod: com 01/01/2021 b 12/31/2021	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	5/24/2022 10: MEDI CAL RECORDS &	23 am
		11.00	N 12.00	SUPPLY	15.00	LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
	01100 CAFETERI A	199, 426					11.00
	01300 NURSI NG ADMI NI STRATI ON	11, 755		250 (04			13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	2, 269 6, 187		250, 684 0	567, 746		14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	5, 981		0	0	127, 950	
	01700 SOCIAL SERVICE	0		0	0	0	17.00
	02300 PARAMED ED PRGM	0	u u u u u u u u u u u u u u u u u u u	0	0	0	23.00
	02301 XRAY EDUCATION	1, 444		0	0	0	23.01
H 1	02302 PHARMACY_RESIDENCY_PROG	825	3, 026	0	0	0	23.02
	03000 ADULTS & PEDIATRICS	47, 847	195, 677	6, 905	826	28, 919	30.00
	03100 I NTENSI VE CARE UNI T	5, 774		222	179	334	31.00
	03200 CORONARY CARE UNIT	0	-	0	0	0	32.00
1	03300 BURN I NTENSI VE CARE UNI T	0	, i i i i i i i i i i i i i i i i i i i	0	0	0	33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	, i i i i i i i i i i i i i i i i i i i	0	0	0	34.00 40.00
	04100 SUBPROVIDER - IRF	3, 918		0	15	251	40.00
	04200 SUBPROVI DER	0, 710	0	0	0	0	42.00
43.00	04300 NURSERY	2, 475	10, 124	0	0	0	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	20, 623	84, 563	215, 989	2, 729	65, 296	50.00
	05100 RECOVERY ROOM	20, 023		213, 909	2, 727	03, 270	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0		3, 199	0	0	52.00
	05300 ANESTHESI OLOGY	0	U U	0	949	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 300		1, 980	1,008	0	54.00
	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 05404 ULTRA SOUND	1, 237 1, 237		0	6, 711 19	0	54.01 54.02
	05405 MAMMOGRAPHY	1, 650		686	43	0	54.02
	05500 RADI OLOGY-THERAPEUTI C	1, 650		0	5	0	55.00
	05700 CT SCAN	2, 475		0	3, 898	0	57.00
		825		0	589	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 918 15, 674		2, 286	2, 084	4, 370 0	59.00 60.00
	06001 LABORATORY-PATHOLOGI CAL	1, 031		0	2	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	206		0	0	0	62.00
	06500 RESPI RATORY THERAPY	5, 362		42	236	8, 461	65.00
	06600 PHYSI CAL THERAPY	1, 031		9, 107	65	0	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	206		0	0	0	67.00 68.00
	06900 ELECTROCARDI OLOGY	1, 650		0	2, 258	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 856		0	0	15, 281	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0 E44 4E0	0	72.00 73.00
	07300 RENAL DIALYSIS			0	544, 659 286	0	73.00
	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	412	2, 034	0	1	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
	09000 CLINIC	4, 537	13, 475	744	66	5,038	
90.01	09001 DI ABETES CENTER	0	0	0	0	0	90.01
	09002 NEUROPSYCH	206		0	0	0	90.02
	09003 WOUND CENTER 09004 HYPERBARI C OXYGEN THERAPY	1, 444		8, 684	221	0	90.03 90.04
	09004 HYPERBARIC OXYGEN THERAPY 09005 VIMCARE CLINIC	2,062		48	59	0	90.04 90.05
	09006 MEDICATION MGMT CLINIC	412		40	0	0	90.05
91.00	09100 EMERGENCY	15, 261		792	220	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	10, 724	43, 905	0	574	0	95.00
	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/24/2022 10:	pared: 23 am
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
SPECIAL PURPOSE COST CENTERS	1	1	r			
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	190, 970	549, 444	250, 68	4 567, 709	127, 950	118.00
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	206	0		0 0		190.00
194. 00 07950 WELLNESS COMMUNITY	619	0		0 0		194.00
194. 01 07951 BUI LDI NG RENTALS	0	0		0 0		194.01
194. 02 07952 HOSPI CE	0	0		0 37		194.02
194. 03 07953 OUTREACH CLINICS	0	0		0 0		194.03
194. 04 07954 SPEECH - HEARING AIDS	0	0		0 0		194.04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0 0		194.05
194. 06 07956 CRH FOUNDATION	206	0		0 0		194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0		0 0		194.07
194. 08 07958 CRHP	6, 806	0		0 0		194.08
194. 09 07959 NEUROPSYCH PART B	619	0		0 0		194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	100 100	U 540 444				201.00
202.00 TOTAL (sum lines 118 through 201)	199, 426	549, 444	250, 68	4 567, 746	127, 950	202.00

From 01/02/12/02 Part II (22/22/02) Part III (22/22/02) Part III (22/22/02)		Financial Systems	COLUMBUS REGIO		CN. 1E 0112		u of Form CMS-2	2552-10
Cost Center Description SERVICE SERVICE SERVICE PMANUE PEGAN PMANUE PEGAN PMANUE SERVICE SERVICE SERVICE SERVICE	ALLUCA	TION OF CAPITAL RELATED COSTS		Provider C	F	rom 01/01/2021	Date/Time Pre	
BRUEAL STRUCT ON CONTRACT 17.00 23.00 23.01 23.02 24.00 1.00 00000 CAP REL COSTS -WALE EXAT 1.00 2.00		Cost Center Description				RESI DENCY		23 am
1.000 DOTOD GAV REL 0033-BLUC & FIXI 1.00 4.000 DOTOD GAV REL 0033-BLUC & FIXI 2.00 0.000 DOTOD GAV REL 0033-BLUC & FIXI 7.00 0.000 DOTOD GAV REL 0033-BLUC & FIXI 7.00 0.0000 DOTOD GAV REL 0033-BLUC & FIXI 7.00 1.000 DITOD GAV REL 0033-BLUC & FIXI 7.00 1.000 DITOD GAV REL 0033-BLUC & FIXI 0 1.00 1.000 DITOD GAV REL 0033-BLUC & FIXI 0 2.00 2.00 0.0000 DITOD GAV REL 0034-BLUC & FIXI 0 2.00 2			17.00	23.00	23.01		24.00	
2.00 DOCOOL GAR PELL DOTS -WARE F EQUIP 4.00 5.00 DOCOOL GAR PELL DOTS -WARE F EQUIP 4.00 5.00 DOCOOL GAR IN STRAIN THE A RUMARL 5.00 5.00 DOCOOL GAR IN STRAIN THE A RUMARL 6.00 5.00 DOCOOL GAR IN STRAIN THE A RUMARL 6.00 5.00 DOCOOL GAR IN STRAIN THE A RUMARL 6.00 5.00 DOCOOL GAR IN STRAIN THE A RUMARL 6.00 5.00 DOCOOL GAR INSTRAIN THE A RUMARL 6.00 5.00 DOCOOL AND SEVERET HING 7.00 5.00 DOCOOL AND SEVERET HING 7.00 5.00 DOCOOL AND SEVERET HING 7.00 5.00 DOCOOL AND S	1 00			-	1			
4.00 Doctod EMELOREE ENERTITS DEPARTMENT 4.00 7.00 DOCTOD OFERATION FINATURE A DELEMAL 5.00 7.00 DOCTOD OFERATION FINATURE A DELEMAL 9.00 7.00 DOCTOD OFERATION FINATURE A DELEMAL 9.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 9.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 9.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 11.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 17.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 0 23.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 0 33.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 0 34.00 7.00 DOTOD OFERATION FINATURE A DELEMAL 0 0 34.00 7.00 DOTOD OFERATION FINATURE A DELEMAL								1
5.00 DODDO JARIH NI SHIN TY & & CENERAL 5.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 6.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & E & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & E & CENERAL 7.00 7.00 DODDO JARIH NI SHIN TY & E & CENE UNI T 0 7.00 7.00 DODDO JARIH NI SHIN TY & CARE UNI T 0 7.00 7.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
0.00 00000 LANNEY & LINER SERVICE 8.00 00000 LINERAL PLANCE 8.00 10.00 DITADO LITERALY 8.00 00000 PLANCE 9.00 11.00 DITADO LITERALY 11.00								5.00
9.00 00000 HOUSEKEEP ING 9.00 0000	7.00	00700 OPERATION OF PLANT						7.00
10. 00 DIONDO DIFTARY 0								
11.00 01100 CAFETERIA 11.00								
14.00 01400 CNNRAL SERVICES & SUPPLY 14.00 14.00 15.00 10.00 01400 MECONINS & LIBRARY 15.00								11.00
10. 00 01500 PHARMARY 15.00								1
10. 00 00 10000 MEDICAL DECORDS & LIBBARY 16. 00 17. 00 23. 00 02300 PARAMED D PRG 0 0 23. 00 02300 PARAMED D PRG 0 0 10. 0200 MARANE FULCATION 0 0 53. 97.0 13. 00 02300 PARAMEV PRG 0 0 53. 97.0 13. 00 02300 PARAMEV PRG 0 0 30.00 14. 000 INTENS VE CARE UNIT 0 0 32.00 32.00 10. 00 30100 INTENS VE CARE UNIT 0 0 32.00 32.00 32.00 10. 00 4000 SUBROVICE R - IFF 0 0 0 0.00 0.00 32.00 10. 00 4000 SUBROVICE R - IFF 0 0 0.00 0.00 0.00 0.00 10. 00 4000 SUBROVICE R - IFF 0 0 0.00 0.00 0.00 0.00 10. 00 4000 SUBROVICE R - IFF 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
17 00 00 1700 SOLIAL SERVICE 0 17.00 23.00								
23.01 D2301 RAY EDUCATION 23.01			0					17.00
23.02 Q 2302 PHAMMACY RESIDENCY PROG 0 39, 439 23, 02 IMPATTER NUTTINE SERVICE COST CENTERS 0	23.00		0	0				23.00
IDEATE NOT ROUTINE SERVICE COST CENTERS					53, 976			
30. 00 03000 ADULTS & PEDIATRICS 0 3, 465, 506 30. 00 3, 665, 506 30. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 33. 00	23.02		0	L		39, 439	<u> </u>	23.02
32.00 03200 CORONARY CARE UNIT 0 32.00 03.00	30.00		0				3, 865, 808	30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 034.00 04.0			-					
34.00 0400 SURG LAL INTENSIVE CARE UNIT 0 34.00 0400 34.00 0400.00 40.00 40.00 41.00 DATOD SUBPROVIDER - IPF 0 40.00			0				-	
40.00 4000 SUBPROVIDER - 1PF 0 40.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>			0				-	
42.00 04200 SUBPROVIDER 0 10 42.00 44.00 04400 NURSEEY 0 111.844 43.00 44.00 05000 OPERATI NG RACLLITY 0 04400 3.816.226 50.00 50.00 05000 OPERATI NG ROM 0 137.764 51.00 52.00 05200 DELIVERY ROM & LABOR ROOM 0 137.764 51.00 50.00 05200 DELIVERY ROM & LABOR ROOM 0 144.05 52.00 137.764 51.00 51.00 05400 RADI LOGY 0 104.266 348.45 54.00 54.00 05400 RADI LOGY 104.00571 C 0 112.266 54.02 54.00 05400 RADI LOGY 104.00571 C 0 112.266 54.02 55.00 05500 RADI LOGY 112.276 54.02 356.26 54.02 55.00 05500 RADI LOGY 112.37.84 54.02 36.88 58.00 6500 RADI LOGY 140.04 36.88 58.00 10.55.78 50.00 6500 RADI LOGY 0 13.83.			0					
43. 00 04300 NURSERY 0 111. 864 43. 00 44. 00 04400 OPENATING FACILITY 0 44. 00 MOLLARY SERVICE COST CENTERS			0				405, 526	41.00
44.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 13.816.226 50.00 13.816.226 50.00 13.816.226 50.00 13.816.226 50.00 13.816.226 50.00 13.816.226 50.00 13.817.764 51.00 13.816.226 52.00 13.816.226 52.00 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.220 13.818.250 13.81			-				-	
NACLLARY SERVICE COST CENTERS 0.00 GOOD OPERATING ROOM 0 51.00 05100 DEFLATING ROOM 0 52.00 05200 DELVICER ROOM 0 53.00 05300 DELVICER NOM & LABOR ROOM 0 53.00 05300 ANESTHESIOLOGY 0 54.01 05400 ANESTHESIOLOGY 0 54.01 05400 ANESTHESIOLOGY 0 54.01 05400 ANESTHESIOLOGY 0 54.01 05402 MUCLEAR MEDICINE-DIAGNOSTI C 0 54.03 05400 MUTRA SOUND 0 112, 246 54.02 55.00 05500 CT SCOM CANDACY-HERAPEUTI C 0 133, 343 55.00 57.00 05700 CT SCOM MAMOGRAPHY 0 1, 33, 343 55.00 59.00 05900 CARDIAL CATHETER ZATI ON 0 1, 33, 343 55.00 60.00 06000 MRI 0 1, 35, 764 60.00 60.00 06000 LABORATORY - PATHEDICCI CAL 0 1, 38, 688 62.00 60.00 06000 LABORATORY - PATHETER ZATI ON 0 1, 36, 646.00 60.00 060000 CUPAT TONAL A THETERY 0								
51.00 06100 RECOVERY ROM & LABOR ROM 0 137,744 51.00 52.00 05200 DELVICERY ROM & LABOR ROM 0 174,405 52.00 53.00 05300 ANESTHESI OLOGY 0 40.0638 54.00 64.00 06400 AULOLASY-IN AGNOSTI C 0 438.445 54.00 74.00 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0 318.445 54.00 74.00 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0 318.445 54.00 74.00 05402 NUCLEAR MEDI CINE-DI AGNOSTI C 0 318.445 54.00 75.00 05500 OKADI OLOGY-THERAPEUTI C 0 1.313.343 55.00 75.00 05500 CT SCAN 0 1.75.829 57.00 76.00 05500 CARDI AL CATHETER IZATI ON 0 1.03.57.04 60.00 76.00 05900 CARDI AL CATHETER IZATI ON 0 1.03.57.04 60.00 60.00 76.00 05900 CARDI AL CATHETER IZATI ON 0 1.03.57.04 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00	11.00						Ŭ	11.00
52.00 05200 DELIVERY ROOM 0 174,405 52.00 53.00 55.00 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td>1</td></td<>			-					1
53.00 05300 ANESTHESI OLOGY 0 10,366 53.00 54.00 D5400 PADI OLOGY-DI ARMOSTI C 0 318,445 54.01 54.00 D5400 UTRA SOUND 0 318,445 54.01 54.00 D5400 UTRA SOUND 0 318,445 54.01 54.00 D5400 UTRA SOUND 0 112,246 54.02 55.00 D5500 D5500 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></t<>								1
54.00 OS400 RADIOLAGY-DI AGNOSTIC 0 420.638 54.00 54.01 OS402 NUCLEAR MEDI CIN F-DI AGNOSTI C 0 318.445 54.01 54.02 OS404 ULTA SOUND 0 317.226 54.03 55.00 OS500 RADIOLOGY-THERAPEUTI C 0 112.246 54.03 55.00 OS500 RADIOLOGY-THERAPEUTI C 0 175.829 57.00 56.00 OS500 RADIOLACOSTACA 0 175.829 57.00 59.00 OS500 LABORATORY 0 1.035.704 60.00 60.00 LABORATORY 0 1.035.704 60.00 61.00 CACINO & PACKER BED BLOOD CELL 0 33.83 60.01 62.00 OSC00 NEADER PERATORY 0 431.330 65.00 65.00 OSC00 RESTRATORY THERAPY 0 436.85.00 67.00 66.00 OSC00 CECTROENCERPHALOGRAPHY 0 209.466 70.00 70.00 CTOTO NELCAL SUBGRAPHY 0 229.463 70.00 736.85.00 70.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
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54.03 05406 MAMMOGRAPHY 0 376, 226 54.03 55.00 05500 RADI 0LOGY-HERAPEUTI C 0 1,313, 343 55.00 57.00 05700 CT SCAN 0 175, 829 57.00 58.00 DS800 MRI 0 433, 343 55.00 59.00 DS900 CARDI AC CATHETERI ZATI ON 0 490, 442 59.00 60.00 06000 LABORATORY - PATHOLOGI CAL 0 93, 833 60.01 38, 60.01 62.00 06200 RESPIR ATORY THERAPY 0 431, 330 65.00 65.00 06500 RESPIR ATORY THERAPY 0 431, 330 65.00 66.00 06600 PHYSI CAL THERAPY 0 108, 188 68.00 67.00 05700 CLEATROCARDI OLOGY 0 108, 188 68.00 69.00 66000 PHYSI CAL THERAPY 0 229, 964 77.00 71.00 DELCTROCARDI OLOGY 0 108, 188 68.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
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99. 10 09910 CORF 0 99. 10		OTHER REIMBURSABLE COST CENTERS	1			1		1
			-					
			0					

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/24/2022 10:23 am
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
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUI SI TI ON	0				0 109.00
110.00 11000 INTESTINAL ACQUISITION	0				0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0				0 111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	20, 120, 661 118.00
NONREI MBURSABLE COST CENTERS					<u> </u>
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0				53, 795 190.00
194. 00 07950 WELLNESS COMMUNITY	0				79, 073 194. 00
194. 01 07951 BUI LDI NG RENTALS	0				69, 456 194. 01
194. 02 07952 HOSPI CE	0				4, 187 194.02
194. 03 07953 OUTREACH CLINICS	0				0 194.03
194. 04 07954 SPEECH - HEARING AIDS	0				7, 772 194.04
194. 05 07955 NONALLOWABLE MARKETING	0				21, 350 194. 05
194.06 07956 CRH FOUNDATION	0				42, 396 194.06
194. 07 07957 HEALTHY COMMUNI TI ES	0				0 194.07
194. 08 07958 CRHP	0				2, 146, 709 194. 08
194.09 07959 NEUROPSYCH PART B	0	0	50.0		11, 685 194. 09
200.00 Cross Foot Adjustments		0	53, 9	76 39, 439	93, 415 200. 00
201.00 Negative Cost Centers	0	0	F		0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	53, 9	76 39, 439	22, 650, 499 202. 00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COLUMBUS REGION	AL HOSPITAL Provider CCN: 1	15-0112	Peri od:	u of Form CMS- Worksheet B	2552-10
				From 01/01/2021 To 12/31/2021		
Cost Center Description	Intern &	Total		<u> </u>	5/24/2022 10:	23 am
	Residents					
	Cost & Post Stepdown					
	Adjustments					
	25.00	26.00				
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MUBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00
15. 00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 01700 SOCI AL SERVI CE 23. 00 02300 PARAMED ED PRGM						17.00
23. 01 02300 PARAMED ED PRGM 23. 01 02301 XRAY EDUCATION						23.00
23. 02 02302 PHARMACY RESIDENCY PROG						23.02
INPATIENT ROUTINE SERVICE COST CENTERS	1 -1					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	3, 865, 808 687, 145				30.00
32. 00 03200 CORONARY CARE UNIT	0	007, 145				32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	О				33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	0 405, 526				40.00
42. 00 04200 SUBPROVI DER	0	0				42.00
43. 00 04300 NURSERY	0	111, 864				43.00
44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0				44.00
50. 00 05000 OPERATING ROOM	0	3, 816, 226				50.00
51.00 05100 RECOVERY ROOM	0	137, 764				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	174, 405				52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 366 420, 638				53.00 54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	318, 445				54.01
54.02 05404 ULTRA SOUND	0	112, 246				54.02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	376, 226 1, 313, 343				54.03 55.00
57. 00 05700 CT SCAN	0	175, 829				57.00
58.00 05800 MRI	0	53, 888				58.00
59.00 05900 CARDIAC CATHETERIZATION	0	490, 442				59.00
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL	0	1, 035, 704 93, 833				60.00 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	38, 028				62.00
65. 00 06500 RESPI RATORY THERAPY	0	431, 330				65.00
66. 00 06600 PHYSI CAL THERAPY	0	610, 156				66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	209, 966 108, 183				67.00 68.00
69.00 06900 ELECTROCARDI OLOGY	0	348, 570				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	229, 843				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	265, 778 279, 845				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 503, 640				73.00
74. 00 07400 RENAL DI ALYSI S	0	31, 651				74.00
76.00 03020 ACUPUNCTURE	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	49, 861				76.97
88. 00 08800 RURAL HEALTH CLINIC	0	0				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC 90. 01 09001 DIABETES CENTER	0	284, 444				90.00
90. 01 09001 DTABETES CENTER 90. 02 09002 NEUROPSYCH	0	7, 456				90.01
90.03 09003 WOUND CENTER	0	242, 904				90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	54, 020				90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	0	143, 181 40, 330				90.05 90.06
91. 00 09100 EMERGENCY	0	1,016,403				90.08
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		(DE 074				
95. 00 09500 AMBULANCE SERVICES	0	625, 374				95.00

Health Financial Systems	COLUMBUS REGIONAL	- HOSPI TAL		In Lieu	」of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0112	Peri od:	Worksheet B
				From 01/01/2021	Part II
				To 12/31/2021	Date/Time Prepared: 5/24/2022 10:23 am
Cost Center Description	Intern &	Total		· · · · · · · · · · · · · · · · · · ·	372472022 10.23 am
	Residents				
	Cost & Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
99. 10 09910 CORF	0	0			99.10
101.0010100 HOME HEALTH AGENCY	0	0			101.00
SPECIAL PURPOSE COST CENTERS	· · · ·				
109.00 10900 PANCREAS ACQUI SI TI ON	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	20, 120, 661			118.00
NONREI MBURSABLE COST CENTERS		50 705			
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	53, 795			190.00
194. 00 07950 WELLNESS COMMUNITY	0	79, 073			194.00
194. 01 07951 BUI LDI NG RENTALS	0	69, 456			194.01
194. 02 07952 HOSPI CE	0	4, 187			194.02
194. 03 07953 OUTREACH CLINICS	0	0			194.03
194. 04 07954 SPEECH - HEARING AIDS	0	7,772			194.04
194. 05 07955 NONALLOWABLE MARKETING	0	21, 350			194.05
194.06 07956 CRH FOUNDATION	0	42, 396			194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0			194.07
	0	2, 146, 709			194.08
194.0907959 NEUROPSYCH PART B	0	11, 685			194.09
200.00 Cross Foot Adjustments	0	93, 415			200.00 201.00
201.00 Negative Cost Centers	0	0			
202.00 TOTAL (sum lines 118 through 201)	0	22, 650, 499			202.00

ST A	n Financial Systems ALLOCATION - STATISTICAL BASIS	002011200 112010	NAL HOSPITAL Provider C		Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/24/2022 10:	
		CAPI TAL REL	ATED COSTS			372472022 10.	
	Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUI P (DEPR)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5.00	
	GENERAL SERVICE COST CENTERS					L	
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	728, 501	12 400 251				1.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 128	13, 498, 251 5, 965	86, 521, 406			4.
00	00500 ADMI NI STRATI VE & GENERAL	64, 006	7, 183, 595	16, 549, 738		221, 416, 505	5.
00	00700 OPERATION OF PLANT	350, 531	309, 051	3, 048, 200			7.
00	00800 LAUNDRY & LINEN SERVICE	792	0	41, 301		872, 418	
00	00900 HOUSEKEEPI NG	5, 194	134, 190	2, 120, 652		3, 551, 025	
00 00	01000 DI ETARY 01100 CAFETERI A	7, 864 6, 181	8, 978 12, 825	907, 196 1, 295, 804		1, 703, 015 1, 699, 357	
00	01300 NURSI NG ADMI NI STRATI ON	10, 046	30, 695	5, 184, 552		7, 954, 733	
00	01400 CENTRAL SERVICES & SUPPLY	7, 597	50, 130	28, 269		1, 066, 514	
00	01500 PHARMACY	4, 800	185, 913	3, 341, 061	0	6, 630, 537	15
	01600 MEDICAL RECORDS & LIBRARY	3, 653	1, 278	735, 742		1, 317, 766	
00	01700 SOCIAL SERVICE	0	0	(-	0	17
00	02300 PARAMED ED PRGM 02301 XRAY EDUCATION	0	0 14, 333	472, 997	0 0	0 638, 217	23
02		376	8, 079	377, 553			
	INPATIENT ROUTINE SERVICE COST CENTERS						
00		78, 439	177, 233				
00		11, 208	63, 693	2, 344, 625			31
00 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32
00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				34
00	04000 SUBPROVIDER - IPF	0	0	(0 0	0	40
00	04100 SUBPROVI DER – I RF	10, 331	9, 450	1, 511, 898	3 0	2, 522, 311	41
00	04200 SUBPROVI DER	0	0	(0 0	0	42
00	04300 NURSERY	583	18, 324 0	1, 155, 193 (
. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		<u> </u>	0	44
. 00	05000 OPERATI NG ROOM	39, 827	1,005,403	1, 325, 534	0	18, 957, 304	50
00	05100 RECOVERY ROOM	3, 185	3, 191	55, 436	0	1, 457, 904	51
00	05200 DELIVERY ROOM & LABOR ROOM	3, 822	19, 461	(-	1, 984, 446	
00 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	119 8, 497	3, 001 148, 721	1, 324, 852		112, 762 2, 502, 179	
. 00	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 361	123, 631	506, 993		2, 302, 179	
02	05404 ULTRA SOUND	1, 504	46, 675	526, 697		935, 976	
03	05405 MAMMOGRAPHY	101	167, 638			1, 331, 848	54
		7, 825	1,035,965	730, 787			
	05700 CT SCAN	1, 798	62, 731	799, 196		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	900 8, 904	9, 903 124, 020	353, 196 1, 736, 922		658, 630 3, 191, 131	
00		10, 868	247, 742	4, 277, 620		14, 048, 072	
01	06001 LABORATORY-PATHOLOGI CAL	1, 212	13, 416	389, 034		1, 452, 678	
00		428	1, 885	83, 111		725, 291	
00		7, 901	78, 601	2,084,101		3, 470, 004	
00 00		616	18, 270 3, 451	294, 322 63, 155		5, 565, 537 2, 080, 351	
00		0	19, 092	219, 791		975, 120	
		1, 398	266, 376			1, 404, 190	
00		0	7,445	703, 348	3 0	1, 290, 252	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	(, s	6, 970, 123	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			7, 339, 047 25, 149, 633	
		0	n 0			822, 564	
00	03020 ACUPUNCTURE	0	0	(0 0	0	76
97	07697 CARDI AC REHABI LI TATI ON	1, 581	3, 802	211, 306	0	360, 108	76
00	OUTPATIENT SERVICE COST CENTERS			-	2		
00 00		0	0	(0	88
		7, 302	20, 528	1, 513, 541		2, 408, 000	
01	09001 DI ABETES CENTER	0	20, 020	., 515, 54	0	0	90
02	09002 NEUROPSYCH	87	131	93, 680		141, 508	90
03		0	3, 460	591, 240		1, 761, 424	
		0	222	105, 283		283, 435	
05	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	4, 255	6, 463 7, 657	559, 947 234, 199		843, 328 333, 108	
. 00	09000 MEDICATION MGMT CEINIC	18, 055	133, 789			11, 442, 743	

Health Financial Systems	COLUMBUS REGIO				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/24/2022 10:	epared
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQ FEET)	MVBLE EQUI P (DEPR)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	8, 032	227, 387	3, 029, 39		.,	
99. 10 09910 CORF	0	0		0 0		1
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.0
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.0
110. 00 11000 NTESTINAL ACQUISITION	0	0		0 0		1109.0
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.0
113. 00 11300 I NTEREST EXPENSE	J	0				113.0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	715, 545	12, 023, 789	84, 897, 69	-54, 087, 119	215, 115, 398	118.0
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 727	180		0 0		
194.0007950 WELLNESS COMMUNITY	0	3, 484	185, 51			
194. 01 07951 BUILDING RENTALS	0	0		0 0	218, 239	
194. 02 07952 HOSPI CE	0	0		0 0	108, 830	
194. 03 07953 OUTREACH CLINICS 194. 04 07954 SPEECH - HEARING AIDS	0	0		0 0		194.0
194. 05 07955 NONALLOWABLE MARKETING	0	0		0 0	203, 832 559, 921	
194. 06 07956 CRH FOUNDATION	1, 923	0	51, 76	52 0	85, 105	
194. 07 07957 HEALTHY COMMUNI TI ES	1, 725	0	51, 70	0 0		194.0
194. 08 07958 CRHP	7, 770	1, 469, 995	1, 386, 43			
194.0907959 NEUROPSYCH PART B	536	803		0 0	4, 745	194.0
200.00 Cross Foot Adjustments						200.0
201.00 Negative Cost Centers						201.0
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 399, 988	12, 976, 860	30, 215, 83	32	54, 087, 119	202.0
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 412465	0. 961373	0. 34923	30	0. 244278	
204.00 Cost to be allocated (per Wkst. B, Part II)			88, 22	21	8, 442, 809	204.0
205.00 Unit cost multiplier (Wkst. B, Part			0. 00102	20	0. 038131	205.0
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.0
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.0

	Financial Systems	COLUMBUS REGIO			In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	
				To	0 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (TIME SPT)	DI ETARY (MEALS)	CAFETERI A (FTES)	
		(SQ FEET)	(LDRY LBS)		. ,		
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
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 ADMINI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	302, 836 792	2, 011, 968				7.00 8.00
9.00	00900 HOUSEKEEPI NG	5, 194	2,011,900				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	7, 864 6, 181	0	59 84	152, 218 0	967	10.00 11.00
	01300 NURSI NG ADMI NI STRATI ON	10, 046	0		0	57	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	7, 597 4, 800	0	85 50	0	11 30	14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	3, 653	0	5	0	29	16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00 23. 01	02300 PARAMED ED PRGM 02301 XRAY EDUCATI ON	0 100	0 0		0 0	0 7	23.00 23.01
23.02	02302 PHARMACY RESIDENCY PROG	376	0	4	0	4	23.02
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	78, 439	667, 652	2, 398	120, 518	232	30.00
	03100 I NTENSI VE CARE UNI T	11, 208	83, 792		15, 695	28	31.00
	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	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 10, 331	0 75, 990	0 283	0 10, 887	0 19	40.00 41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	583 0	21, 621 0	0	0	12 0	43.00 44.00
	ANCILLARY SERVICE COST CENTERS			-	-	-	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	39, 827 3, 185	435, 297 88, 152	822 71	722 0	100 12	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 822	31, 648	73	0	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	119 8, 497	0 145, 058	0 141	0 187	0 16	53.00 54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 361	0	79	0	6	54.01
54.02 54.03	05404 ULTRA SOUND 05405 MAMMOGRAPHY	1, 504 101	0 9, 903		0	6	54.02 54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 825	26, 697	84	787	8	55.00
57.00 58.00	05700 CT SCAN 05800 MRI	1, 798 900	0	16 10	0	12 4	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	8, 904	117, 915		590	19	59.00
		10, 868	0	132	0	76	
	06001 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 212 428	0	6	0	5 1	60. 01 62. 00
	06500 RESPI RATORY THERAPY	7, 901	0	164	0	26	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	616 221	55, 175 21, 271	0	0	5 1	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	3	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 398 0	0 2, 276	144	0	8 9	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	72.00 73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0 1, 581	0	0	0	0	76.00 76.97
	OUTPATIENT SERVICE COST CENTERS				-		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90.00	09000 CLINIC	7, 302	81, 740	-	2, 407	22	90.00
	09001 DI ABETES CENTER 09002 NEUROPSYCH	0 87	0	0	0	0 1	90.01 90.02
	09003 WOUND CENTER	0	5, 799	0	0	7	90.03
	09004 HYPERBARI C OXYGEN THERAPY	0	370		0	2	90.04
	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	4, 255 917	10, 806 0	209 18	0	10 2	90. 05 90. 06
91.00	09100 EMERGENCY	18, 055	130, 806	538	425	74	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	I					92.00
	09500 AMBULANCE SERVI CES	8, 032	0	0	0	52	95.00 99.10
	09910 CORF 10100 HOME HEALTH AGENCY	0	0 0	-	0 0		99. 10 101. 00
				·			

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-255	2-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepar 5/24/2022 10:23	
Cost Center Description	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LI NEN SERVI CE (LDRY LBS)	HOUSEKEEPING (TIME SPT)	(MEALS)	CAFETERI A (FTES)	
SDECLAL DUDDOSE COST CENTEDS	7.00	8.00	9.00	10.00	11.00	
SPECIAL PURPOSE COST CENTERS	0	0			0 109	0 00
110. 00 11000 INTESTINAL ACQUISITION	0	0		0 0	0 110	
111.00 11100 I SLET ACQUISITION	0	0			0111	
113. 00 11300 I NTEREST EXPENSE	0	0		0 0		3.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	289, 880	2, 011, 968	6, 09	0 152, 218		
NONREI MBURSABLE COST CENTERS	207,000	2,011,900	0,07	0 152, 210	720 110	0.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2,727	0		0 0	1 190	0 00
194. 00 07950 WELLNESS COMMUNITY	0	0		0 0	3 194	
194. 01 07951 BUI LDI NG RENTALS	0	0		0 0	0 194	
194. 02 07952 HOSPI CE	0	0		0 0	0 194	
194. 03 07953 OUTREACH CLINICS	0	0		0 0	0 194	
194. 04 07954 SPEECH - HEARING AIDS	0	0		0 0	0 194	
194.0507955 NONALLOWABLE MARKETING	0	0		0 0	0 194	4.05
194. 06 07956 CRH FOUNDATI ON	1, 923	0	4	7 0	1 194	4.06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0		0 0	0 194	
194. 08 07958 CRHP	7, 770	0		0 0	33 194	4.08
194.0907959 NEUROPSYCH PART B	536	0		1 0	3 194	4.09
200.00 Cross Foot Adjustments						0.00
201.00 Negative Cost Centers					20 ⁻	1.00
202.00 Cost to be allocated (per Wkst. B, Part I)	14, 310, 907	1, 122, 958	4, 663, 91	1 2, 535, 478	2, 470, 391 202	2.00
203.00 Unit cost multiplier (Wkst. B, Part I)	47. 256294	0. 558139	759. 84213	1 16. 656887	2, 554. 695967 203	3.00
204.00 Cost to be allocated (per Wkst. B, Part II)	3, 434, 946	48, 162	369, 06	9 226, 222	199, 426 204	4.00
205.00 Unit cost multiplier (Wkst. B, Part	11. 342595	0. 023938	60. 12854	3 1. 486171	206. 231644 205	5.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					206	6.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207	7.00

Health Financial Systems	COLUMBUS REGIO				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 01/01/2021	Worksheet B-1	
			T	o 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: 23 am
Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY (DRG COST)	MEDI CAL RECORDS &	SOCI AL SERVI CE	
	N	SUPPLY	(DRG COST)	LIBRARY	(TIME SPT)	
	(NURS HRS)	(STER SUP)	15.00	(TIME SPT)	17.00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 356, 010					11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	22, 358	47, 485				14.00
15.00 01500 PHARMACY	61, 780	0	25, 813, 780			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0	4, 597 0	0	16.00 17.00
23.00 02300 PARAMED ED PRGM	0	0	0	0	0	23.00
23. 01 02301 XRAY EDUCATION 23. 02 02302 PHARMACY RESIDENCY PROG	0	0	0	0	0	23.01 23.02
INPATIENT ROUTINE SERVICE COST CENTERS	7,468	<u> </u>	0	0	0	23.02
30. 00 03000 ADULTS & PEDI ATRI CS	482, 929	1, 308	37, 573	1, 039	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	58, 585 0	42 0	8, 158 0	12 0	0	31.00 32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0 38, 470	0	0 667	9	0	40.00 41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	24, 986 0	0	0	0	0	43.00 44.00
ANCI LLARY SERVICE COST CENTERS	U		0	0	0	44.00
50. 00 05000 OPERATING ROOM	208, 698	40, 913	124, 063	2, 346	0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	25, 797 0	0 606	279 0	0	0	51.00 52.00
53.00 05300 ANESTHESI OLOGY	0	0	43, 142	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	375 0	45, 836 305, 111	0	0	54.00 54.01
54. 02 05404 ULTRA SOUND	0	0	869	0	0	54.02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	130 0	1, 957 226	0	0	54.03 55.00
57. 00 05700 CT SCAN	0	0	177, 215	0	0	57.00
58.00 05800 MRI	0	0	26, 792	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	39, 042 0	433 0	94, 766 42	157 0	0	59.00 60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0	88	0	0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY	0 54, 058	0 8	0 10, 717	0 304	0	62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	54, 058	° 1, 725	2, 958	304 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 17, 549	0	0 102, 678	0	0	68.00 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	6	549	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	0	0	24, 764, 104	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	12, 991	0	0	74.00
76. 00 03020 ACUPUNCTURE 76. 97 07697 CARDI AC REHABI LI TATI ON	0 5, 020	0	0 34	0	0	76.00 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90. 00 09000 CLINIC	33, 257	141	3, 016	181	0	90.00
90. 01 09001 DI ABETES CENTER	0	0	0	0	0	90.01
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	0 14, 677	0 1, 645	0 10, 061	0	0	90.02 90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	3, 143	0	0	0	0	90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	20, 206	9	2, 665	0	0	90. 05 90. 06
90.06 09006 MEDICATION MGMT CLINIC 91.00 09100 EMERGENCY	3, 296 126, 334	0 150	0 9, 987	0	0 0	90.06 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	108, 357	0	26, 097	0	0	95.00
99. 10 09910 CORF	0	0	0	0	0	99.10

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared:
					5/24/2022 10:23 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL
	ADMI NI STRATI O	SERVICES &	(DRG COST)	RECORDS &	SERVI CE
	N	SUPPLY		LI BRARY	(TIME SPT)
	(NURS HRS)	(STER SUP)		(TIME SPT)	
	13.00	14.00	15.00	16.00	17.00
101.0010100 HOME HEALTH AGENCY	0	0		0 0	0 101.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0 111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 356, 010	47, 485	25, 812, 09	8 4, 597	0 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0 190.00
194.0007950 WELLNESS COMMUNITY	0	0		0 0	0 194.00
194. 01 07951 BUI LDI NG RENTALS	0	0		0 0	0 194.01
194. 02 07952 H0SPI CE	0	0	1, 68	2 0	0 194. 02
194.0307953 OUTREACH CLINICS	0	0		0 0	0 194.03
194.0407954 SPEECH - HEARING AIDS	0	0		0 0	0 194.04
194.0507955 NONALLOWABLE MARKETING	0	0		0 0	0 194.05
194.0607956 CRH FOUNDATI ON	0	0		0 0	0 194.06
194.0707957 HEALTHY COMMUNITIES	0	0		0 0	0 194.07
194. 08 07958 CRHP	0	0		0 0	0 194.08
194.0907959 NEUROPSYCH PART B	0	0		0 0	0 194.09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	10, 535, 730	1, 952, 449	9, 071, 70	3 1, 890, 179	0 202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	7.769655	41. 117174	0. 35142	9 411.176637	0.000000 203.00
204.00 Cost to be allocated (per Wkst. B,	549, 444	250, 684	567,74	6 127, 950	0 204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 405192	5. 279225	0. 02199	4 27.833370	0.00000 205.00
206.00 NAHE adjustment amount to be allocated					206.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207.00
Parts III and IV)					
· ·					•

0001 /	Financial Systems ALLOCATION - STATISTICAL BASIS	COLUMBUS REGION	Provi der CC	CN: 15-0112	In Lieu of Form Cl Period: Worksheet From 01/01/2021	
					To 12/31/2021 Date/Time 5/24/2022	Prepared:
	Cost Center Description	PARAMED ED PRGM (PERCENT)	XRAY EDUCATI ON (PERCENT)	PHARMACY RESI DENCY PROG (PERCENT)	572472022	
		23.00	23. 01	23.02	—	
1 00	GENERAL SERVICE COST CENTERS					
14.00 15.00 16.00 17.00 23.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSING ADMINI STRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02300 PARAMED ED PRGM 02301 XRAY EDUCATION	0	100			1.00 2.00 4.00 5.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00 23.00 23.01
			100	10	00	23.02
30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00	INPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03200 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
E0.00	ANCI LLARY SERVICE COST CENTERS		0			F0.00
$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 02\\ 54.\ 03\\ 55.\ 00\\ 57.\ 00\\ 55.\ 00\\ 59.\ 00\\ 60.\ 01\\ 62.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 97\\ 88.\ 00\\ \end{array}$	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND 05405 MAMMOGRAPHY 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06000 LABORATORY-PATHOLOGICAL 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03020 ACUPNCTURE 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC			10		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 70.00 71.00 72.00 73.00 74.00 76.97 88.00
89.00 90.00 90.01 90.02 90.03	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 DI ABETES CENTER 09002 NEUROPSYCH 09003 WOUND CENTER 09004 HYPERBARIC OXYGEN THERAPY 09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC				0 0 0 0 0 0 0 0 0 0	88.00 89.00 90.00 90.01 90.02 90.03 90.04 90.05 90.06
90. 05 90. 06 91. 00		0	0		0	
90.05 90.06 91.00 92.00	09100 EMERGENCY	0	0		0	91.00 92.00 95.00

Health Financial Systems COLU COST ALLOCATION - STATISTICAL BASIS Cost Center Description	RAMED ED PRGM	Provi der CC	N: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1	
Cost Contor Description DA		VDAV		To 12/31/2021	Date/Time Prepa 5/24/2022 10:23	
	PERCENT)	XRAY EDUCATI ON (PERCENT)	PHARMACY RESI DENCY PROG (PERCENT)			
	23.00	23. 01	23.02			
101.00 10100 HOME HEALTH AGENCY	0	0		0	10	01.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0	10	09.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	11	10.00
111.00 11100 I SLET ACQUI SI TI ON	О	0		0	11	11.00
113.00 11300 INTEREST EXPENSE	-				11	13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	100	1(00		18.00
NONREI MBURSABLE COST CENTERS	-1					
190.00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN	0	0		0	19	90.00
194.0007950 WELLNESS COMMUNITY	0	0		0	19	94.00
194. 01 07951 BUI LDI NG RENTALS	0	0		0		94.01
194. 02 07952 H0SPI CE	0	0		0		94.02
194. 03 07953 OUTREACH CLINICS	0	0		0		94.03
194. 04 07954 SPEECH - HEARING AIDS	0	0		0		94.04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0		94.05
194. 06/07956 CRH FOUNDATI ON	0	0		0		94.06
194. 07 07957 HEALTHY COMMUNITIES	0	0		0		94.07
194. 08 07958 CRHP	0	0		0		94.08
194. 09 07959 NEUROPSYCH PART B	0	0		0		94.09
200.00 Cross Foot Adjustments	U	0		0		00.00
201.00 Negative Cost Centers						01.00
201.00 Regative cost centers 202.00 Cost to be allocated (per Wkst. B,	0	817, 488	746 2	14)2.00
Part I)	0	817,488	746, 34	14	20	JZ. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	8, 174. 880000	7, 463. 44000		20	03.00
203.00 Cost to be allocated (per Wkst. B,	0.000000	8, 174. 880000 53, 976	39, 43)3.00)4.00
Part II)	0	55, 970	39, 4,	59	20	J4. UU
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	539. 760000	394. 39000	00	20	05.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0		0	20	06.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	0. 00000	00	20	07.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared:
			e XVIII	lloopital	5/24/2022 10: PPS	23 am
				<u>Hospi tal</u> Costs	PP5	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	<u>col. 26)</u> 1.00	2.00	2.00	4.00	E 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	52, 920, 462		52, 920, 462	2 115, 692	53, 036, 154	30.00
31.00 03100 INTENSIVE CARE UNIT	11, 732, 076		11, 732, 070			
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	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 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	4, 416, 826		4, 416, 820		4, 416, 826 0	41.00 42.00
43. 00 04300 NURSERY	2, 457, 239		2, 457, 239		2, 457, 239	
44.00 04400 SKILLED NURSING FACILITY	0		(0	
ANCI LLARY SERVICE COST CENTERS	00.017.000		00.017.00		00.017.000	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	30, 917, 229 2, 298, 887		30, 917, 22 2, 298, 88		30, 917, 229 2, 298, 887	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 298, 887		2, 747, 865		2, 298, 887	1
53. 00 05300 ANESTHESI OLOGY	161, 091		161, 09			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 596, 049		4, 596, 049		4,601,604	
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 54. 02 05404 ULTRA_SOUND	3, 323, 962 1, 272, 596		3, 323, 962 1, 272, 596		3, 323, 962 1, 272, 596	1
54. 03 05405 MAMMOGRAPHY	1, 737, 271		1, 737, 27		1, 747, 579	
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 580, 353		5, 580, 353		5, 586, 921	55.00
57. 00 05700 CT SCAN	2, 563, 879		2, 563, 879		2, 563, 879	1
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	889, 282 5, 007, 555		889, 282 5, 007, 555		889, 282 5, 019, 543	1
60. 00 06000 LABORATORY	18, 287, 759		18, 287, 759		18, 287, 759	
60. 01 06001 LABORATORY-PATHOLOGI CAL	1, 882, 173		1, 882, 173		1, 919, 457	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	928, 284		928, 284		928, 284	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	5, 431, 163 7, 070, 480	0			5, 447, 506 7, 089, 307	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 613, 406	0			2, 613, 406	
68.00 06800 SPEECH PATHOLOGY	1, 220, 984	0	1, 220, 984		1, 220, 984	68.00
69. 00 06900 ELECTROCARDI OLOGY	2,007,659		2,007,659		2,007,659	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 964, 849 8, 672, 771		1, 964, 849 8, 672, 77		1, 964, 849 8, 672, 771	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 131, 815		9, 131, 81		9, 131, 815	
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 742, 297		40, 742, 29		40, 742, 297	1
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 ACUPUNCTURE	1, 028, 063		1, 028, 063	3 O 0 O	1, 028, 063 0	74.00 76.00
76. 97 07697 CARDIAC REHABILITATION	568, 431		568, 43			
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0		1	0	0	1
89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 90. 00 09000 CLI NI C	0 3, 885, 947		3, 885, 94		0 3, 885, 947	89.00 90.00
90. 01 09001 DI ABETES CENTER	0		(0 0	0	
90. 02 09002 NEUROPSYCH	182, 741		182, 74		182, 741	90.02
90. 03 09003 WOUND CENTER	2, 398, 030		2, 398, 030		2, 423, 634 384, 097	1
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 90. 05 09005 VI MCARE CLI NI C	382, 408 1, 599, 096		382, 408		384, 097 1, 599, 096	90.04 90.05
90. 06 09006 MEDICATION MGMT CLINIC	502, 208		502, 208		502, 208	
91.00 09100 EMERGENCY	16, 760, 345		16, 760, 34		16, 760, 345	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	5, 497, 175		5, 497, 17	5	5, 497, 175	92.00
95. 00 09500 AMBULANCE SERVICES	7,025,705		7, 025, 70	5 4, 584	7, 030, 289	95.00
99. 10 09910 CORF	0)	0	
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 ACQUISTITION	0		1			1109.00
111.00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113.00 11300 INTEREST EXPENSE						113.00
200.00Subtotal (see instructions)201.00Less Observation Beds	272, 406, 411 5, 497, 175	0	272, 406, 41 [°] 5, 497, 175		272, 665, 031 5, 497, 175	
202.00 Total (see instructions)	266, 909, 236					

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	COLUMBUS REGIO		CN: 15-0112	In Lie Period:	u of Form CMS- Worksheet C	2552-1
CONFUT	ATTON OF RATTO OF COSTS TO CHARGES		FIOVIDEI C		From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/24/2022 10:	
		1	Title	e XVIII	Hospi tal	PPS	
	Cost Costos Description	Lungt's at	Charges	Tatal (asl (TEEDA	
	Cost Center Description	Inpatient	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient	
					Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	70 504 054		70 50/ 05	-		
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	70, 586, 051		70, 586, 05			30.00
	03200 CORONARY CARE UNIT	18, 247, 140 0		18, 247, 14			31.00
	03300 BURN I NTENSI VE CARE UNI T	0					33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
	04000 SUBPROVI DER – I PF	0			0		40.00
	04100 SUBPROVI DER – I RF	5, 988, 760		5, 988, 76	0		41.00
42.00	04200 SUBPROVI DER	0		0 (10 00	0		42.00
		2, 610, 921 0		2, 610, 92			43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0			0		44.00
50.00	05000 OPERATING ROOM	25, 057, 373	70, 026, 055	95, 083, 42	8 0. 325159	0.00000	50.00
	05100 RECOVERY ROOM	2, 142, 684	5, 663, 731			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	4, 988, 157	32, 179	5, 020, 33	6 0. 547347	0. 000000	
	05300 ANESTHESI OLOGY	4, 744, 024	9, 635, 893			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 482, 297	4, 795, 932			0.00000	
	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	796, 849 1, 456, 739	12, 626, 729 5, 639, 133			0. 000000 0. 000000	
54.02	05405 MAMMOGRAPHY	1, 456, 739	5, 893, 216			0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	277, 350	24, 271, 967			0. 000000	
	05700 CT SCAN	12, 318, 164	29, 789, 713			0.000000	
58.00	05800 MRI	1, 913, 352	6, 131, 486	8, 044, 83	8 0. 110541	0. 000000	58.0
	05900 CARDI AC CATHETERI ZATI ON	18, 339, 397	15, 896, 554			0.00000	
60.00	06000 LABORATORY	25, 399, 080	50, 672, 974			0.00000	
	06001 LABORATORY-PATHOLOGI CAL	847, 660	6, 627, 958			0.00000	
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	2, 050, 205 19, 891, 733	1, 218, 134 4, 902, 299			0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	4, 834, 730	4, 902, 299			0. 000000	
	06700 OCCUPATI ONAL THERAPY	3, 359, 061	2, 495, 813			0.000000	
68.00	06800 SPEECH PATHOLOGY	791, 897	1, 209, 293		0 0. 610129	0. 000000	68.00
	06900 ELECTROCARDI OLOGY	5, 195, 362	8, 304, 853			0.00000	
	07000 ELECTROENCEPHALOGRAPHY	255, 486	7, 962, 106			0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 492, 881	9, 733, 284			0.00000	
	07200 TMPL. DEV. CHARGED TO PATTENTS 07300 DRUGS CHARGED TO PATTENTS	5, 554, 260 40, 895, 952	9, 579, 260 80, 425, 466			0. 000000 0. 000000	
	07400 RENAL DI ALYSI S	3, 439, 642	00, 423, 400			0.000000	
	03020 ACUPUNCTURE	0	C		0. 000000	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 298	908, 792	911, 09	0. 623902	0. 000000	76.9 ⁻
	OUTPATIENT SERVICE COST CENTERS			I			
	08800 RURAL HEALTH CLINIC	0	C		0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 60, 048	7, 616, 305	7, 676, 35	0 3 0. 506223	0.00000	89.00 90.00
	09001 DI ABETES CENTER	00, 048	7, 010, 305 C	1,010,35	0. 000000	0. 000000	
	09002 NEUROPSYCH	3, 576	214, 799	218, 37		0. 000000	
	09003 WOUND CENTER	71, 103	9, 150, 674			0.00000	
	09004 HYPERBARIC OXYGEN THERAPY	6, 924	1, 196, 121			0.00000	
	09005 VI MCARE CLI NI C	5,460	1, 686, 142			0.00000	
	09006 MEDICATION MGMT CLINIC	3, 648	785, 786			0.00000	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	23, 637, 624 0	58, 934, 461 14, 251, 242			0. 000000 0. 000000	
92.00	OTHER REIMBURSABLE COST CENTERS	0	14, 231, 242	. 14, 231, 24	2 0. 303733	0.00000	92.00
95.00	09500 AMBULANCE SERVICES	7, 453	12, 898, 944	12, 906, 39	7 0. 544358	0.00000	95.00
99. 10	09910 CORF	0	C)	0		99.10
101.00	10100 HOME HEALTH AGENCY	0	C		0		101.00
100 0-	SPECIAL PURPOSE COST CENTERS			1			100 0
	10900 PANCREAS ACQUI SI TI ON	0	C		0		109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	C				110.00
	11300 INTEREST EXPENSE	0	Ĺ				113.00
200.00		321, 755, 967	492, 959, 770	814, 715, 73	7		200.00
201.00							201.00
202.00	Total (see instructions)	321, 755, 967	492, 959, 770	814, 715, 73			202.00

Health Financial Systems	COLUMBUS REGIONA	AL HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0112	Period: From 01/01/2021	Worksheet C Part I
			To 12/31/2021	Date/Time Prepared:
		Title XVIII	Hospi tal	5/24/2022 10:23 am PPS
Cost Center Description	PPS Inpatient			
	Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T				31.00 32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVIDER - IPF				40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER				41.00 42.00
43. 00 04300 NURSERY				42.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCI LLARY SERVICE COST CENTERS	0.225150			50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0. 325159 0. 294487			50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 547347			52.00
53. 00 05300 ANESTHESI OLOGY	0. 011493			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 732946			54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C 54. 02 05404 ULTRA SOUND	0. 247621 0. 179343			54. 01 54. 02
54. 03 05405 MAMMOGRAPHY	0. 179343			54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 227579			55.00
57.00 05700 CT SCAN	0. 060888			57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 110541 0. 146616			58.00 59.00
60. 00 06000 LABORATORY	0. 140010			60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 256762			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CE	1			62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 219710			65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0. 426624 0. 446364			66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0. 610129			68.00
69.00 06900 ELECTROCARDI OLOGY	0. 148713			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	0. 239103 NT 0. 357992			70.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 603416			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 335821			73.00
74.00 07400 RENAL DIALYSIS	0. 298887			74.00
76.00 03020 ACUPUNCTURE	0. 000000			76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 623902			76. 97
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLI NI C 90. 01 09001 DI ABETES CENTER	0. 506223 0. 000000			90.00 90.01
90. 01 09001 DTABETES CENTER 90. 02 09002 NEUROPSYCH	0. 836822			90.01
90. 03 09003 WOUND CENTER	0. 262816			90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 319271			90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	0. 945315 0. 636162			90.05 90.06
91. 00 09100 EMERGENCY	0. 202978			90.08
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA				92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES 99. 10 09910 CORF	0. 544714			95.00 99.10
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUI SI TI ON				109.00
110.00 11000 INTESTINAL ACQUISITION				110. 00 111. 00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	pared:
					5/24/2022 10:	23 am
		liti	e XIX	Hospi tal Costs	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Ádj.		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	52, 920, 462		52, 920, 462	2 115, 692	53, 036, 154	30.00
31.00 03100 INTENSIVE CARE UNIT	11, 732, 076		11, 732, 076		11, 732, 076	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0				0	32.00 33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0				0	34.00
40. 00 04000 SUBPROVIDER - IPF	0		(0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	4, 416, 826		4, 416, 826		4, 416, 826	41.00
42. 00 04200 SUBPROVI DER	0		2 457 220		0	42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	2, 457, 239 0		2, 457, 239		2, 457, 239 0	
ANCI LLARY SERVICE COST CENTERS	0				0	
50. 00 05000 OPERATI NG ROOM	30, 917, 229		30, 917, 229		30, 917, 229	50.00
51.00 05100 RECOVERY ROOM	2, 298, 887		2, 298, 887		2, 298, 887	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	2, 747, 865 161, 091		2, 747, 865 161, 091		2, 747, 865 165, 269	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 596, 049		4, 596, 049		4, 601, 604	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 323, 962		3, 323, 962		3, 323, 962	54.01
54.02 05404 ULTRA SOUND	1, 272, 596		1, 272, 596		1, 272, 596	
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 737, 271		1, 737, 27		1, 747, 579	
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	5, 580, 353 2, 563, 879		5, 580, 353 2, 563, 879		5, 586, 921 2, 563, 879	55.00 57.00
58. 00 05800 MRI	889, 282		889, 282		889, 282	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5,007,555		5, 007, 555	5 11, 988	5, 019, 543	59.00
60. 00 06000 LABORATORY	18, 287, 759		18, 287, 759		18, 287, 759	
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 882, 173		1, 882, 173		1, 919, 457	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY	928, 284 5, 431, 163	0	928, 284 5, 431, 163		928, 284 5, 447, 506	62.00 65.00
66.00 06600 PHYSI CAL THERAPY	7, 070, 480	0			7, 089, 307	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 613, 406	0			2, 613, 406	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 220, 984	0	1, 220, 984		1, 220, 984	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 007, 659 1, 964, 849		2, 007, 659 1, 964, 849		2, 007, 659 1, 964, 849	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 672, 771		8, 672, 77		8, 672, 771	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 131, 815		9, 131, 815		9, 131, 815	
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 742, 297		40, 742, 297		40, 742, 297	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 ACUPUNCTURE	1, 028, 063		1, 028, 063		1, 028, 063 0	74.00 76.00
76. 97 07697 CARDIAC REHABILITATION	568, 431		568, 43		568, 431	
OUTPATIENT SERVICE COST CENTERS				·1		
88.00 08800 RURAL HEALTH CLINIC	0		(0	
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C	0 3, 885, 947		3, 885, 947	-	0 3, 885, 947	89.00 90.00
90. 01 09000 DI ABETES CENTER	3, 865, 947		3, 000, 94,		3, 885, 947	90.00
90. 02 09002 NEUROPSYCH	182, 741		182, 74	0	182, 741	90.02
90.03 09003 WOUND CENTER	2, 398, 030		2, 398, 030		2, 423, 634	90.03
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 90. 05 09005 VI MCARE CLINI C	382, 408		382, 408		384,097	90.04
90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC	1, 599, 096 502, 208		1, 599, 096 502, 208		1, 599, 096 502, 208	
91. 00 09100 EMERGENCY	16, 760, 345		16, 760, 345		16, 760, 345	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 497, 175		5, 497, 175	5	5, 497, 175	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF	7,025,705		7, 025, 705	5 4, 584)	7, 030, 289 0	
101.00 10100 HOME HEALTH AGENCY	0					101.00
SPECIAL PURPOSE COST CENTERS			`			
109.00 10900 PANCREAS ACQUISITION	0		(109.00
110.00 11000 INTESTINAL ACQUISITION	0					110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0				0	111.00 113.00
200.00 Subtotal (see instructions)	272, 406, 411	0	272, 406, 41	258, 620	272, 665, 031	
201.00 Less Observation Beds	5, 497, 175		5, 497, 175	5	5, 497, 175	201.00
202.00 Total (see instructions)	266, 909, 236	0	266, 909, 236	258, 620	267, 167, 856	202.00

ealth Financial Syst OMPUTATION OF RATIO	OF COSTS TO CHARGES	COLUMBUS REGIO			Period:	u of Form CMS- Worksheet C	
					From 01/01/2021	Part I	onor
					To 12/31/2021	Date/Time Pre 5/24/2022 10:	epar · 23
			Ti tl	e XIX	Hospi tal	PPS	. 20
			Charges				
Cost Cen	er Description	I npati ent	Outpati ent	Total (col.)	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INE SERVICE COST CENTERS			70 50/ 05	1		1
. 00 03000 ADULTS &		70, 586, 051		70, 586, 05			30
. 00 03100 I NTENSI V		18, 247, 140		18, 247, 14	0		3
. 00 03200 CORONARY		0			0		32
	ENSIVE CARE UNIT	0			0		33
0. 00 03400 SUBPROVI	INTENSIVE CARE UNIT	0			0		34
. 00 04100 SUBPROVI		-		E 000 74	-		40
2. 00 04200 SUBPROVI		5, 988, 760 0		5, 988, 76	0		42
3. 00 04300 NURSERY	JER .	2, 610, 921		2, 610, 92	-		43
	NURSING FACILITY	2,010,921			0		4
	CE COST CENTERS	0			0		
. 00 05000 OPERATI N		25,057,373	70, 026, 055	95, 083, 42	8 0. 325159	0. 000000	50
. 00 05100 RECOVERY		2, 142, 684	5, 663, 731			0. 000000	
	ROOM & LABOR ROOM	4, 988, 157	32, 179			0. 000000	
00 05300 ANESTHES		4, 744, 024	9, 635, 893			0. 000000	
. 00 05400 RADI OLOG		1, 482, 297	4, 795, 932			0. 000000	
	MEDI CI NE-DI AGNOSTI C	796, 849	12, 626, 729			0. 000000	
. 02 05404 ULTRA SO	JND	1, 456, 739	5, 639, 133			0. 000000	
. 03 05405 MAMMOGRA	РНҮ	626	5, 893, 216	5, 893, 84	2 0. 294760	0. 000000) 54
. 00 05500 RADI OLOG	-THERAPEUTI C	277, 350	24, 271, 967	24, 549, 31		0. 000000	55
. 00 05700 CT SCAN		12, 318, 164	29, 789, 713	42, 107, 87	7 0. 060888	0. 000000	5
. 00 05800 MRI		1, 913, 352	6, 131, 486	8, 044, 83	8 0. 110541	0. 000000	58
. 00 05900 CARDI AC	CATHETERI ZATI ON	18, 339, 397	15, 896, 554	34, 235, 95	0. 146266	0. 000000	59
0. 00 06000 LABORATO	RY	25, 399, 080	50, 672, 974	76, 072, 05	4 0. 240400	0. 000000	60
0. 01 06001 LABORATO	RY-PATHOLOGI CAL	847, 660	6, 627, 958	7, 475, 61	8 0. 251775	0. 000000	60
2.00 06200 WHOLE BL	OOD & PACKED RED BLOOD CELL	2,050,205	1, 218, 134	3, 268, 33	9 0. 284023	0. 000000) 62
5. 00 06500 RESPI RAT	DRY THERAPY	19, 891, 733	4, 902, 299	24, 794, 03	2 0. 219051	0. 000000	65
5. 00 06600 PHYSI CAL	THERAPY	4, 834, 730	11, 782, 476	16, 617, 20	6 0. 425492	0. 000000) 66
7. 00 06700 0CCUPATI	NAL THERAPY	3, 359, 061	2, 495, 813	5, 854, 87	4 0. 446364	0. 000000) 67
3.00 06800 SPEECH P	ATHOLOGY	791, 897	1, 209, 293	2,001,19	0 0. 610129	0. 000000	68
0. 00 06900 ELECTROC		5, 195, 362	8, 304, 853	13, 500, 21		0. 000000	
0. 00 07000 ELECTROE		255, 486	7, 962, 106			0. 000000	
	SUPPLIES CHARGED TO PATIENT	14, 492, 881	9, 733, 284			0. 000000	
	 CHARGED TO PATIENTS 	5, 554, 260	9, 579, 260			0. 000000	
	ARGED TO PATIENTS	40, 895, 952	80, 425, 466			0.00000	
. 00 07400 RENAL DI		3, 439, 642	0			0. 000000	
0.00 03020 ACUPUNCT		0	0		0 0.000000	0.00000	
. 97 07697 CARDI AC		2, 298	908, 792	911, 09	0 0. 623902	0.00000	2 76
OUTPATTENT SER	VICE COST CENTERS					0.00000	
. 00 08800 RURAL HE		0	0		0 0.00000		
	QUALIFIED HEALTH CENTER	40 040	U 7 616 305		0 0.000000	0. 000000 0. 000000	
00 09000 CLINIC 01 09001 DIABETES	CENTER	60, 048	7, 616, 305	7, 676, 35	3 0. 506223 0 0. 000000	0.00000	
. 02 09002 NEUROPSY		3, 576	214, 799	218, 37		0. 000000	
0. 02 09002 NEUROPSY 0. 03 09003 WOUND CEI		3, 576	9, 150, 674			0.00000	
	C OXYGEN THERAPY	6, 924	9, 150, 874 1, 196, 121			0. 000000	
0. 05 09005 VI MCARE		6, 924 5, 460	1, 196, 121			0. 000000	
0. 06 09006 MEDI CATI		3, 648	785, 786			0. 000000	
. 00 09100 EMERGENC		23, 637, 624	58, 934, 461			0. 000000	
	ON BEDS (NON-DISTINCT PART	23, 037, 024	14, 251, 242			0. 000000	
	ABLE COST CENTERS	0	11,201,242	1 1,201,24	- 0.000700	0.00000	4 '
. 00 09500 AMBULANC		7, 453	12, 898, 944	12, 906, 39	7 0. 544358	0. 000000	95
. 10 09910 CORF		0	0		0	2.000000	99
1.00 10100 HOME HEA	TH AGENCY	0	0	1	0		10
SPECIAL PURPOS							1
9. 00 10900 PANCREAS		0	0		0		10
0. 00 11000 I NTESTI N		0	0		0		110
1.00 11100 I SLET AC		0	0		0		111
3.00 11300 I NTEREST							113
	(see instructions)	321, 755, 967	492, 959, 770	814, 715, 73	7		200
	ervation Beds						201
2.00 Total (se	e instructions)	321, 755, 967	492, 959, 770	814, 715, 73	7		202

Health Financial Systems	COLUMBUS REGIONA	AL HOSPITAL	In Lieu	」of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0112	Period:	Worksheet C
			From 01/01/2021 To 12/31/2021	Part I Date/Time Prepared:
		Title XIX	Hospi tal	5/24/2022 10:23 am PPS
Cost Center Description	PPS Inpatient		nospitai	110
	Ratio			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT				32.00 33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T				34.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41.00 04100 SUBPROVIDER - IRF				41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY				42.00 43.00
44. 00 04400 SKILLED NURSING FACILITY				43.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 325159			50.00
51.00 05100 RECOVERY ROOM	0. 294487 0. 547347			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 011493			52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 732946			54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 247621			54.01
54. 02 05404 ULTRA SOUND	0. 179343			54.02
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 296509 0. 227579			54.03 55.00
57. 00 05700 CT SCAN	0. 060888			57.00
58. 00 05800 MRI	0. 110541			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 146616			59.00
	0. 240400			60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 256762 0. 284023			60. 01 62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 219710			65.00
66.00 06600 PHYSI CAL THERAPY	0. 426624			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 446364			67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 610129 0. 148713			68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 239103			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1 1			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 603416			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0. 335821 0. 298887			73.00 74.00
76. 00 03020 ACUPUNCTURE	0. 298887			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 623902			76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			88.00 89.00
90. 00 09000 CLINIC	0. 506223			90.00
90. 01 09001 DI ABETES CENTER	0. 000000			90.01
90. 02 09002 NEUROPSYCH	0. 836822			90.02
90. 03 09003 WOUND CENTER	0. 262816			90.03
90. 04 09004 HYPERBARI C 0XYGEN THERAPY 90. 05 09005 VIMCARE CLINI C	0. 319271 0. 945315			90.04 90.05
90. 06 09006 MEDICATION MGMT CLINIC	0. 636162			90.06
91.00 09100 EMERGENCY	0. 202978			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 385733			92.00
95.00 09500 AMBULANCE SERVICES	0. 544714			95.00
99. 10 09910 CORF	0. 544714			99.10
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION				109.00 110.00
111. 00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00 202.00
202.00 Total (see instructions)				JZU2. 00

Health Financial Systems	COLUMBUS REGIO			In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R/ REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pre 5/24/2022 10:	epared:
		Ti +I	e XIX	Hospi tal	PPS	23 811
Cost Center Description	Total Cost (Wkst. B,	Capital Cost (Wkst. B,	Operating Cost Net of	Capi tal	Operating Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 - col. 2)		Amount	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	30, 917, 229	3, 816, 226	27, 101, 00	03 0	0	50.00
51.00 05100 RECOVERY ROOM	2, 298, 887				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 747, 865				0	1
53. 00 05300 ANESTHESI OLOGY	161, 091	10, 366			0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 596, 049	420, 638	4, 175, 41	1 0	0	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	3, 323, 962	318, 445	3, 005, 51	7 0	0	54.01
54.02 05404 ULTRA SOUND	1, 272, 596	112, 246	1, 160, 35	0 0	0	54.02
54.03 05405 MAMMOGRAPHY	1, 737, 271	376, 226	1, 361, 04	5 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 580, 353	1, 313, 343	4, 267, 01	0 0	0	55.00
57.00 05700 CT SCAN	2, 563, 879	175, 829	2, 388, 05	0 0	0	57.00
58. 00 05800 MRI	889, 282	53, 888	835, 39	04 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 007, 555		4, 517, 11		0	59.00
60. 00 06000 LABORATORY	18, 287, 759	1, 035, 704	17, 252, 05	5 0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	1, 882, 173	93, 833	1, 788, 34		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	928, 284	38, 028			0	62.00
65. 00 06500 RESPI RATORY THERAPY	5, 431, 163				0	
66. 00 06600 PHYSI CAL THERAPY	7, 070, 480				0	
67.00 06700 OCCUPATI ONAL THERAPY	2, 613, 406				0	67.00
68.00 06800 SPEECH PATHOLOGY	1, 220, 984				0	68.00
69.00 06900 ELECTROCARDI OLOGY	2,007,659				0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 964, 849				0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	8, 672, 771	265, 778			0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 131, 815				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 742, 297				0	
74.00 07400 RENAL DIALYSIS	1, 028, 063		996, 41		0	
	0	0	F10 F7	0 0	0	
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	568, 431	49, 861	518, 57	0 0	0	76.97
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	1
90. 00 09000 CLINIC	3, 885, 947	284, 444	3, 601, 50		0	
90. 01 09001 DI ABETES CENTER	0,000,747	0	3,001,30	0 0	0	1
90. 02 09002 NEUROPSYCH	182, 741	7, 456	175, 28	-	0	1
90. 03 09003 WOUND CENTER	2, 398, 030				0	90.03
90. 04 09004 HYPERBARIC OXYGEN THERAPY	382, 408			-	0	90.04
90. 05 09005 VI MCARE CLI NI C	1, 599, 096		1, 455, 91		0	90.05
90.06 09006 MEDICATION MGMT CLINIC	502, 208				0	1
91.00 09100 EMERGENCY	16, 760, 345				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 497, 175				0	92.00
OTHER REIMBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				
95. 00 09500 AMBULANCE SERVI CES	7, 025, 705	625, 374	6, 400, 33	1 0	0	95.00
99. 10 09910 CORF	0	0		0 0	0	99.10
101.0010100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	1		1			
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE			105		-	113.00
200.00 Subtotal (sum of lines 50 thru 199)	200, 879, 808					200.00
201.00Less Observation Beds202.00Total (line 200 minus line 201)	5, 497, 175					201.00
202.00 Total (line 200 minus line 201)	195, 382, 633	15, 050, 318	180, 332, 31	J 0	0	202.00

Health Financia	al Systems	COLUMBUS REGIO	NAL HOSPITAL		Inlie	u of Form CMS-	2552-10
	OUTPATIENT SERVICE COST TO CHARGE RA		Provi der C		Peri od:	Worksheet C	2002 10
REDUCTIONS FOR	MEDICALD ONLY				From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/24/2022 10:	23 am
			Ti tl	e XIX	Hospi tal	PPS	25 am
Со	ost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operating	Part I,	Charge Ratic			
		Cost	column 8)	(col. 6 /			
		Reduction		col. 7)			
		6.00	7.00	8.00			
	RY SERVICE COST CENTERS	20 017 220	05 000 400	0.00515	0		50.00
	COVERY ROOM	30, 917, 229	95, 083, 428 7, 806, 415				50.00 51.00
	LIVERY ROOM & LABOR ROOM	2, 298, 887 2, 747, 865					51.00
	IESTHESI OLOGY	2, 747, 805	14, 379, 917				52.00
	ADI OLOGY-DI AGNOSTI C	4, 596, 049					54.00
	ICLEAR MEDI CI NE-DI AGNOSTI C	3, 323, 962					54.00
	TRA SOUND	1, 272, 596					54.02
	MMOGRAPHY	1, 737, 271	5, 893, 842				54.03
	DI OLOGY-THERAPEUTI C	5, 580, 353					55.00
57.00 05700 CT		2, 563, 879					57.00
58.00 05800 MR	81	889, 282	8, 044, 838	0. 11054	1		58.00
59.00 05900 CA	ARDI AC CATHETERI ZATI ON	5, 007, 555	34, 235, 951	0. 14626	6		59.00
60.00 06000 LA	BORATORY	18, 287, 759	76, 072, 054	0. 24040	00		60.00
60.01 06001 LA	BORATORY-PATHOLOGI CAL	1, 882, 173	7, 475, 618	0. 25177	'5		60.01
	IOLE BLOOD & PACKED RED BLOOD CELL	928, 284	3, 268, 339	0. 28402	3		62.00
	SPI RATORY THERAPY	5, 431, 163					65.00
	IYSI CAL THERAPY	7,070,480					66.00
	CUPATIONAL THERAPY	2, 613, 406	5, 854, 874				67.00
	PEECH PATHOLOGY	1, 220, 984	2,001,190				68.00
	ECTROCARDI OLOGY	2,007,659					69.00
	ECTROENCEPHALOGRAPHY	1, 964, 849					70.00
	EDI CAL SUPPLIES CHARGED TO PATIENT	8, 672, 771	24, 226, 165				71.00
	IPL. DEV. CHARGED TO PATIENTS	9, 131, 815					72.00
	RUGS CHARGED TO PATIENTS	40, 742, 297 1, 028, 063	121, 321, 418 3, 439, 642				73.00 74.00
	CUPUNCTURE	1, 028, 003	3, 439, 042				76.00
	ARDI AC REHABI LI TATI ON	568, 431	911,090				76.97
	ENT SERVICE COST CENTERS	0007101	,,,,,,,,,	0102070			
	IRAL HEALTH CLINIC	0	0	0.00000	00		88.00
	DERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00 09000 CL	LI NI C	3, 885, 947	7, 676, 353	0. 50622	3		90.00
90.01 09001 DI	ABETES CENTER	0	0	0.00000	00		90.01
	UROPSYCH	182, 741	218, 375	0. 83682	22		90.02
	DUND CENTER	2, 398, 030	9, 221, 777				90.03
	PERBARIC OXYGEN THERAPY	382, 408					90.04
	MCARE CLINIC	1, 599, 096					90.05
	DICATION MGMT CLINIC	502, 208					90.06
91.00 09100 EM		16, 760, 345					91.00
	BSERVATION BEDS (NON-DISTINCT PART	5, 497, 175	14, 251, 242	0. 38573	3		92.00
	EI MBURSABLE COST CENTERS	7 005 705	10.00/ 207	0 54425	0		
	IBULANCE SERVI CES	7, 025, 705					95.00
99.10 09910 C0		0	0				99.10
	ME HEALTH AGENCY PURPOSE COST CENTERS	0	0	0.00000			101.00
	NCREAS ACQUISITION	0	0	0.00000	10		109.00
	ITESTINAL ACQUISITION	0		0.00000			110.00
	SLET ACQUISITION	0	0 0	0.00000			111.00
113.00 11300 I N		0			-		113.00
	Ibtotal (sum of lines 50 thru 199)	200, 879, 808	717, 282, 865				200.00
	ess Observation Beds	5, 497, 175					201.00
	otal (line 200 minus line 201)	195, 382, 633					202.00
	•						-

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/24/2022 10:	pared: 23 am
		Title	e XVIII	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)	Total Patient Days	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 SUBGICAL 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	3, 865, 808 687, 145 0 0 0 405, 526 0 111, 864 0 5, 070, 343 Inpati ent	C C C Linpati ent	3, 865, 80 687, 14 405, 52 111, 86 5, 070, 34	15 3, 972 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	112. 87 173. 00 0. 00 0. 00 0. 00 143. 24 0. 00 39. 36 0. 00	31.00 32.00 33.00 34.00 40.00 41.00 42.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	Program days	Program Capital Cost (col. 5 x col. 6) 7.00	_			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	10, 868 810 0 0 0 1, 234 0 0 0 12, 912	140, 130 0 0 0 176, 758 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

\PPOR	I FINANCIAL SYSTEMS FIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0112	Peri od:	Worksheet D	2552-1
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/24/2022 10:	epared:
			Title	XVIII	Hospi tal	PPS	23 dili
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	· · · · · · · · · · · · · · · · · · ·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	Č, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)	5	,	
		col. 26)	,	,			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 816, 226	95, 083, 428	0.04013	8, 426, 730	338, 215	50.00
51.00	05100 RECOVERY ROOM	137, 764	7, 806, 415	0. 01764	8 750, 837	13, 251	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	174, 405	5, 020, 336	0. 03474	0 23, 355	811	52.00
53.00	05300 ANESTHESI OLOGY	10, 366	14, 379, 917	0.00072	1, 708, 594	1, 232	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	420, 638	6, 278, 229	0. 06699	621,034	41,609	54.00
54.01	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C	318, 445	13, 423, 578	0. 02372	360, 050	8, 541	54.01
54.02	05404 ULTRA SOUND	112, 246	7,095,872	0. 01581		8, 602	
54.03	05405 MAMMOGRAPHY	376, 226	5, 893, 842	0.06383		0	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 313, 343	24, 549, 317	0.05349		7, 719	
57.00	05700 CT SCAN	175, 829	42, 107, 877	0.00417		20, 080	
58.00	05800 MRI	53, 888	8,044,838	0.00669		4, 742	
59.00	05900 CARDI AC CATHETERI ZATI ON	490, 442	34, 235, 951	0. 01432		90, 240	
50.00	06000 LABORATORY	1, 035, 704	76, 072, 054	0. 01432		121, 817	
	06001 LABORATORY-PATHOLOGI CAL	93, 833		0.01255		3, 190	
50.01			7, 475, 618	0.01255			
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 028	3, 268, 339			8, 536	
55.00	06500 RESPI RATORY THERAPY	431, 330	24, 794, 032	0.01739		115, 521	
56.00	06600 PHYSI CAL THERAPY	610, 156	16, 617, 206	0.03671		52, 238	
57.00	06700 OCCUPATI ONAL THERAPY	209, 966	5, 854, 874	0. 03586		30, 107	
58.00	06800 SPEECH PATHOLOGY	108, 183	2,001,190	0.05405		5, 629	
59.00	06900 ELECTROCARDI OLOGY	348, 570	13, 500, 215	0. 02582		55, 588	
70.00	07000 ELECTROENCEPHALOGRAPHY	229, 843	8, 217, 592	0. 02797		2, 767	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	265, 778	24, 226, 165	0. 01097		57, 279	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	279, 845	15, 133, 520	0. 01849		49, 104	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 503, 640	121, 321, 418	0. 01239	13, 430, 674	166, 460	
74.00	07400 RENAL DI ALYSI S	31, 651	3, 439, 642	0.00920)2 1, 442, 219	13, 271	74.0
76.00	03020 ACUPUNCTURE	0	0	0.00000	0 0	0	76.0
76.97	07697 CARDI AC REHABI LI TATI ON	49, 861	911, 090	0.05472	27 660	36	76.9
	OUTPATIENT SERVICE COST CENTERS						
38.00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88.00
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89.0
90.00	09000 CLI NI C	284, 444	7, 676, 353	0.03705	55 35, 489	1, 315	90.0
90.01	09001 DI ABETES CENTER	0	0	0.00000	0 0	0	90.0
90. 02	09002 NEUROPSYCH	7, 456	218, 375	0. 03414	13 0	0	90.0
90.03	09003 WOUND CENTER	242, 904	9, 221, 777	0. 02634	29, 682	782	90.0
90.04	09004 HYPERBARI C OXYGEN THERAPY	54, 020	1, 203, 045	0.04490	6, 924	311	90.04
90.05	09005 VI MCARE CLINIC	143, 181	1, 691, 602	0. 08464		107	
90.06	09006 MEDICATION MGMT CLINIC	40, 330	789, 434	0.05108		81	90.0
91.00	09100 EMERGENCY	1, 016, 403	82, 572, 085	0. 01230		111, 440	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	400, 689	14, 251, 242	0. 02811		0	
00	OTHER REIMBURSABLE COST CENTERS	100,007		5. 02011	-1 0	0	1
95.00	09500 AMBULANCE SERVICES						95.00

Health Financial Systems	COLUMBUS REGION	IAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021		epared: 23 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		0 0	l o	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0		
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	-	
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	-	
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	-	
42. 00 04200 SUBPROVI DER	0	0		0 0	-	
43. 00 04300 NURSERY	0	0		0 0		
	0	0		0 0	-	
44.00 04400 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	0	U	Talal Dallas	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		Inpatient	
	-	(sum of cols.	Days	(col. 5 ÷	Program Days	
		1 through 3,		col. 6)		
	instructions) m					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0				
31.00 03100 INTENSIVE CARE UNIT		0				
32.00 03200 CORONARY CARE UNIT		0		0 0.00		•
33.00 03300 BURN INTENSIVE CARE UNIT		0		0 0.00	0	33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		0 0.00	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0.00	0	40.00
41. 00 04100 SUBPROVIDER – IRF	0	0	2,83	0.00	1, 234	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0.00	0	42.00
43. 00 04300 NURSERY		0	2,84	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0 0.00	l o	44.00
200.00 Total (lines 30 through 199)		0	43, 89	95	12, 912	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T	0					33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
40. 00 04000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	0					
						41.00
42. 00 04200 SUBPROVI DER	0					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)	0					200.00

ADDODT	Financial Systems		NAL HOSPITAL		D I			2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PAS	S Provider C	IN: 15-0112		/01/2021 /31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 10:	
			Title	XVIII	Hosp	i tal	PPS	20 411
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied	Heal th	Allied Health	
		Anestheti st	Program	Program	Post-S	Stepdown		
		Cost	Post-Stepdown		Adj us	stments		
			Adjustments					
		1.00	2A	2.00		3A	3.00	
F0 00	ANCI LLARY SERVICE COST CENTERS					0	0	1 50 00
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-		0	0	-	52.00
53.00 54.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	-	817, 488	54.00 54.01
	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	0	0		0	0	0	
54.02	05405 MAMMOGRAPHY	0	0		0	0	-	54.02
54.03		0	0		0	0	0	54.03 55.00
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	0		0	0	0	
57.00	05800 MRI	0	0		0	0	0	57.00
58.00 59.00		0	0		0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0	0	0	•
60.00 60.01	06001 LABORATORY - PATHOLOGI CAL	0	0		0	0		60.00 60.01
62.00		0	0		0	0	0	62.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	746, 344	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	0	76.97
10. 77	OUTPATIENT SERVICE COST CENTERS	0	0			0	0	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90.00	09000 CLINIC	0	0		0	0	0	90.00
90.01	09001 DI ABETES CENTER	0	0		0	0	0	90.01
90.02	09002 NEUROPSYCH	0	0		0	0	0	90.02
90.03	09003 WOUND CENTER	0	0		0	0	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	90.04
90.05	09005 VI MCARE CLINIC	0	0		0	0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0	0		0	0	0	90.06
91.00	09100 EMERGENCY	0	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, i i i i i i i i i i i i i i i i i i i		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS				- 1			1
	09500 AMBULANCE SERVICES							95.00
95.00	O'SOO ANDOLANCE SERVICES							70.00

Health Financial Systems		NAL HOSPITAL	CN. 1E 0110		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE UTHER PAS	S Provider C	UN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	norodi
				10 12/31/2021	5/24/2022 10:	23 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 95, 083, 428	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0			0 7, 806, 415	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 5, 020, 336	0,000000	
53. 00 05300 ANESTHESI OLOGY	0	-		0 14, 379, 917	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-	817, 48		0. 130210	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 13, 423, 578	0.000000	
54. 02 05404 ULTRA SOUND	0	0		0 7,095,872	0.000000	
54. 03 05405 MAMMOGRAPHY	0	0		0 5, 893, 842	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 549, 317	0.000000	55.00
57.00 05700 CT SCAN	0	0		0 42, 107, 877	0.000000	57.00
58. 00 05800 MRI	0	0	1	0 8, 044, 838	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 34, 235, 951	0.00000	59.00
60. 00 06000 LABORATORY	0	0		0 76, 072, 054	0.00000	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0		0 7, 475, 618	0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 3, 268, 339	0.00000	•
65. 00 06500 RESPI RATORY THERAPY	0	0		0 24, 794, 032	0.00000	
66.00 06600 PHYSI CAL THERAPY	0	0		0 16, 617, 206	0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 854, 874	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 2,001,190	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 13, 500, 215	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 8, 217, 592	0.000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 24, 226, 165 0 15, 133, 520	0.000000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0		746, 34		0.000000	
74. 00 07400 RENAL DI ALYSI S	0			0 3, 439, 642	0.000000	
76. 00 03020 ACUPUNCTURE	0	-		0 3, 437, 042	0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 911,090	0.000000	
OUTPATIENT SERVICE COST CENTERS				,,,,,,,,,	01000000	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90. 00 09000 CLINIC	0	0		0 7, 676, 353	0.000000	90.00
90. 01 09001 DI ABETES CENTER	0	0		0 0	0.000000	90.01
90. 02 09002 NEUROPSYCH	0	0		0 218, 375	0.00000	90.02
90. 03 09003 WOUND CENTER	0	0		0 9, 221, 777	0.000000	•
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0		0 1, 203, 045	0.000000	
90. 05 09005 VI MCARE CLI NI C	0			0 1, 691, 602	0.000000	
90.06 09006 MEDICATION MGMT CLINIC	0			0 789, 434	0.000000	•
91.00 09100 EMERGENCY	0			0 82, 572, 085	0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 14, 251, 242	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)	0	1, 563, 832	1, 563, 83	32 704, 376, 468		95.00 200.00

	<u> </u>	COLUMBUS REGIONA	Provi der C	CN: 15-0112	Peri od:	u of Form CMS-2 Worksheet D	2002 10
	COSTS	NICE OTHER PASS	FIOVIDEI C		From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/24/2022 10:	epared: 23 am
			Title	e XVIII	Hospi tal	PPS	20 011
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	8, 426, 730		0 15, 250, 038	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	750, 837		0 994, 414	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	23, 355		0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	1, 708, 594		0 2, 124, 856	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 130210	621, 034	80, 86	5 1, 275, 645	166, 102	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	360, 050		0 4, 694, 697	0	54.01
54.02	05404 ULTRA SOUND	0. 000000	543, 784		0 1, 028, 659	0	54.02
54.03	05405 MAMMOGRAPHY	0. 000000	0		0 463, 367	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	144, 280		0 7, 962, 209	0	55.00
57.00	05700 CT SCAN	0. 000000	4, 808, 437		0 6, 651, 578	0	57.00
58.00	05800 MRI	0. 000000	707, 908		0 1, 640, 426	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	6, 299, 462		0 4, 978, 693	0	59.00
60.00	06000 LABORATORY	0. 000000	8, 947, 237		0 4, 232, 339	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 000000	254, 157		0 1, 427, 241	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	733, 675		0 284, 087	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	6, 640, 293		0 1, 268, 844	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 422, 693		0 44, 259	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	839, 515		0 11, 336	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	104, 122		0 139, 573	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	2, 152, 909		0 2, 411, 054	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	98, 944		0 1, 467, 940	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 220, 942		0 2, 097, 841	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 655, 409		0 2, 951, 277	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.006152	13, 430, 674	82, 62	29, 763, 256	183, 104	73.00
74.00	07400 RENAL DI ALYSI S	0. 000000	1, 442, 219		0 0	0	74.00
76.00	03020 ACUPUNCTURE	0. 000000	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 000000	660		0 275, 706	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90.00	09000 CLI NI C	0. 000000	35, 489		0 2, 987, 942	0	90.00
90.01	09001 DI ABETES CENTER	0. 000000	0		0 0	0	90.01
90.02	09002 NEUROPSYCH	0. 000000	0		0 4, 615	0	90.02
90.03	09003 WOUND CENTER	0. 000000	29, 682		0 3, 311, 325	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	6, 924		0 282, 730	0	90.04
90.05	09005 VIMCARE CLINIC	0. 000000	1, 266		0 150, 627	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	1, 583		0 390, 542	0	90.06
91.00	09100 EMERGENCY	0. 000000	9, 053, 531		0 9, 000, 301	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 2, 691, 478	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00		1	77, 466, 395	163, 49	1 112, 258, 895	349, 206	000 00

	<u>cial Systems</u> IT OF MEDICAL, OTHER HEALTH SERVICES AND		NAL HOSPITAL Provider C	CN: 15 0112	Peri od:	u of Form CMS-2 Worksheet D	2552-10
APPORTIONMEN	II OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN. 15-0112	From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	
			Title	× XVIII	Hospi tal	5/24/2022 10: PPS	<u>23 am</u>
				Charges	10301 tu	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	•	Charge Ratio	Reimbursed	Reimbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCLLI	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	OPERATING ROOM	0. 325159	15, 250, 038		0 130	4, 958, 687	50.00
	RECOVERY ROOM	0. 294487			0 0	292, 842	51.00
	DELIVERY ROOM & LABOR ROOM	0. 547347			0 0	0	52.00
53.00 05300	ANESTHESI OLOGY	0. 011202	2, 124, 856		0 0	23, 803	53.00
	RADI OLOGY-DI AGNOSTI C	0. 732061	1, 275, 645		0 0	933, 850	54.00
	NUCLEAR MEDICINE-DIAGNOSTIC	0. 247621	4, 694, 697		0 0	1, 162, 506	
1 1	ULTRA SOUND	0. 179343			0 0	184, 483	
	MAMMOGRAPHY	0. 294760			0 0	136, 582	•
	RADI OLOGY-THERAPEUTI C	0. 227312			0 0	1,809,906	•
	CT SCAN	0. 060888			0 0	405,001	57.00
	CARDI AC CATHETERI ZATI ON	0. 110541 0. 146266	1, 640, 426 4, 978, 693		0 0 0 0	181, 334 728, 214	58.00 59.00
	LABORATORY	0. 240400			0 0	1, 017, 454	•
1 1	LABORATORY-PATHOLOGI CAL	0. 251775			0 0	359, 344	60.01
1 1	WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284023			0 0	80, 687	62.00
	RESPIRATORY THERAPY	0. 219051	1, 268, 844		0 0	277, 942	65.00
	PHYSI CAL THERAPY	0. 425492			0 0	18, 832	66.00
67.00 06700	OCCUPATI ONAL THERAPY	0. 446364	11, 336		0 0	5,060	67.00
	SPEECH PATHOLOGY	0. 610129	139, 573		0 0	85, 158	68.00
69.00 06900	ELECTROCARDI OLOGY	0. 148713	2, 411, 054		0 0	358, 555	69.00
	ELECTROENCEPHALOGRAPHY	0. 239103			0 0	350, 989	•
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 357992			0 0	751, 010	•
	IMPL. DEV. CHARGED TO PATIENTS	0. 603416			0 0	1, 780, 848	
	DRUGS CHARGED TO PATIENTS	0. 335821	29, 763, 256		0 58, 965	9, 995, 126	•
	RENAL DI ALYSI S	0. 298887	0		0 0	0	74.00
	ACUPUNCTURE CARDI AC REHABI LI TATI ON	0. 000000 0. 623902			0 0	0 172, 014	76.00
	TIENT SERVICE COST CENTERS	0. 023902	275,700		0 0	172,014	/0.9/
	RURAL HEALTH CLINIC						88.00
1 1	FEDERALLY QUALIFIED HEALTH CENTER						89.00
	CLINIC	0. 506223	2, 987, 942		0 0	1, 512, 565	1
	DI ABETES CENTER	0. 000000			0 0	0	90.01
90.02 09002	NEUROPSYCH	0. 836822	4, 615		0 0	3, 862	90.02
90.03 09003	WOUND CENTER	0. 260040	3, 311, 325		0 0	861, 077	90.03
	HYPERBARIC OXYGEN THERAPY	0. 317867	282, 730		0 0	89, 871	90.04
	VIMCARE CLINIC	0. 945315			0 0	142, 390	
	MEDICATION MGMT CLINIC	0. 636162			0 0	248, 448	
	EMERGENCY	0. 202978			0 0	1, 826, 863	
	OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	0. 385733	2, 691, 478	I	0 0	1, 038, 192	92.00
	AMBULANCE SERVICES	0. 544358			0		95.00
	Subtotal (see instructions)	0. 044308	112, 258, 895		0 59,095	31, 793, 495	•
			112,200,090			51, 775, 495	
	Less PBP Clinic Lab Services-Program						1201 00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	42				50.00
51. 00 05100 RECOVERY ROOM	0	42				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				54.01
54.02 05404 ULTRA SOUND	0	0				54.02
54.03 05405 MAMMOGRAPHY	0	0				54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0				60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65.00 06500 RESPIRATORY THERAPY	0	0				65.00
66.00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				71.00 72.00
73. 00 07200 TMPL. DEV. CHARGED TO PATTENTS	0	19, 802				72.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
76. 00 03020 ACUPUNCTURE	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS		ŭ				/0///
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 DI ABETES CENTER	0	0				90.01
90. 02 09002 NEUROPSYCH	0	0				90.02
90.03 09003 WOUND CENTER	0	0				90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0				90.04
90. 05 09005 VI MCARE CLI NI C	0	0				90.05
90.06 09006 MEDICATION MGMT CLINIC	0	0				90.06
91.00 09100 EMERGENCY	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS	-		1			05 06
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	0	19, 844				200.00
5	0				2	201.00
0nly Charges 202.00 Net Charges (line 200 - line 201)	0	19, 844				202.00
	0	1 17,044	I		2	00

ealth Financial Systems	COLUMBUS REGIO				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0112	Period: From 01/01/2021	Worksheet D Part II	
		Component	CCN: 15-T112	To 12/31/2021	Date/Time Pre 5/24/2022 10:	epared:
		Title	e XVIII	Subprovider -	PPS	23 411
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)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1		1			-
50.00 05000 OPERATING ROOM	3, 816, 226				2, 145	
51.00 05100 RECOVERY ROOM	137, 764	7, 806, 415			103	
52.00 05200 DELIVERY ROOM & LABOR ROOM	174, 405				0	
3.00 05300 ANESTHESI OLOGY	10, 366				9	
54.00 05400 RADI OLOGY-DI AGNOSTI C	420, 638				717	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	318, 445				0	
54.02 05404 ULTRA SOUND	112, 246				256	
4. 03 05405 MAMMOGRAPHY	376, 226				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 313, 343				0	
57.00 05700 CT SCAN	175, 829			76 30, 485	127	57.0
i8. 00 05800 MRI	53, 888	8, 044, 838	0. 00669	98 6, 937	46	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	490, 442	34, 235, 951	0. 01432		123	59.0
0. 00 06000 LABORATORY	1, 035, 704	76, 072, 054	0. 01361	15 219, 593	2, 990	60.0
0. 01 06001 LABORATORY-PATHOLOGI CAL	93, 833	7, 475, 618	0. 01255	52 5, 351	67	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 028	3, 268, 339	0. 01163	35 18, 027	210	62.0
5. 00 06500 RESPI RATORY THERAPY	431, 330	24, 794, 032	0. 01739	97 246, 476	4, 288	65.0
6. 00 06600 PHYSI CAL THERAPY	610, 156	16, 617, 206	0. 03671	638, 614	23, 449	66.0
7.00 06700 OCCUPATI ONAL THERAPY	209, 966	5, 854, 874	0. 03586	52 573, 022	20, 550	67.0
8.00 06800 SPEECH PATHOLOGY	108, 183	2,001,190	0. 05405	59 208, 928	11, 294	68.0
9. 00 06900 ELECTROCARDI OLOGY	348, 570	13, 500, 215	0. 02582	20 7, 822	202	69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	229, 843	8, 217, 592	0. 02797	70 1, 594	45	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	265, 778	24, 226, 165	0. 01097	71 81, 611	895	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	279, 845	15, 133, 520	0. 01849	42, 348	783	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 503, 640	121, 321, 418	0. 01239	378, 968	4, 697	73.0
4.00 07400 RENAL DIALYSIS	31, 651	3, 439, 642			593	74.0
6.00 03020 ACUPUNCTURE	0		0. 00000		0	76.0
6. 97 07697 CARDI AC REHABI LI TATI ON	49, 861	911, 090	0.05472	27 0	0	76.9
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 00	0	88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 00	0	89.0
0. 00 09000 CLINIC	284, 444	7, 676, 353	0. 03705	55 168	6	90.0
0. 01 09001 DI ABETES CENTER	0	0	0. 00000	0 00	0	90.0
0. 02 09002 NEUROPSYCH	7, 456	218, 375	0. 03414	13 0	0	90.0
0.03 09003 WOUND CENTER	242, 904	9, 221, 777	0. 02634		734	90.0
0.04 09004 HYPERBARI C OXYGEN THERAPY	54, 020				0	90.0
0. 05 09005 VI MCARE CLI NI C	143, 181	1, 691, 602			0	
0.06 09006 MEDICATION MGMT CLINIC	40, 330				0	
1.00 09100 EMERGENCY	1, 016, 403				165	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
						1
OTHER REIMBURSABLE COST CENTERS						
0THER REI MBURSABLE COST CENTERS 25. 00 09500 AMBULANCE SERVICES						95.0

Heal th	Financial Systems	COLUMBUS REGIO	NAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0112	Peri od:	Worksheet D	
THROUC	GH COSTS		Component (CCN: 15-T112	From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/24/2022 10:	pared:
			Title	XVIII	Subprovider -	PPS	25 am
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS				-	-	
50.00	05000 OPERATING 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 0		54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0	-	54.01
54.02	05404 ULTRA SOUND	0	0		0 0	-	54.02
54.03	05405 MAMMOGRAPHY	0	0		0 0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	-	55.00
57.00	05700 CT SCAN	0	0		0 0	-	57.00
58.00	05800 MRI	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	-	59.00
60.00	06000 LABORATORY	0	0		0 0	-	60.00
60.01	06001 LABORATORY-PATHOLOGI CAL	0	0		0 0	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	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	-	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	-	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 76.00	07400 RENAL DI ALYSI S	0	0		0 0		74.00 76.00
76.00		0	0		0 0		76.00
10.91	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	/0.9/
88.00	08800 RURAL HEALTH CLINIC	0	0	[0 0	0	88.00
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	-	89.00
90.00	09000 CLINIC	0	0		0 0		90.00
90.00 90.01	09001 DI ABETES CENTER	0	0		0 0	0	90.00
90.01 90.02	09001 DTABETES CENTER	0	0		0 0	0	90.01
90.02 90.03	09003 WOUND CENTER	0	0		0 0	-	90.02
90.03 90.04	09004 HYPERBARIC OXYGEN THERAPY	0	0		0 0	0	90.03
90.04 90.05	09005 VIMCARE CLINIC	0	0		0 0	0	90.04
90.03 90.06	09006 MEDICATION MGMT CLINIC	0	0		0 0	-	90.05
90.08 91.00	09100 EMERGENCY	0	0		0 0	-	90.08
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS	0			<u> </u>	0	72.00
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	0		0 0	1, 563, 832	
200.00		۱ V	0	I	-1 0	1 ., 000, 002	1-00.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provider C	CN: 15-0112	Peri od:	Worksheet D	
HROUGH COSTS		Component	CCN: 15-T112	From 01/01/2021 To 12/31/2021	Date/Time Pre	
					5/24/2022 10:	23 am
		litle	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum o	f C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	-
50. 00 05000 OPERATING ROOM	0	0		0 95, 083, 428	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0			0 7, 806, 415		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5,020,336		
33.00 05300 ANESTHESI OLOGY	0	0		0 14, 379, 917		
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	817, 488	817, 4			
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 13, 423, 578		
54. 02 05404 ULTRA SOUND	0	0	1	0 7, 095, 872	0. 000000	54.02
54. 03 05405 MAMMOGRAPHY	0	0		0 5, 893, 842	0. 000000	54.03
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 549, 317	0. 000000	55.00
57.00 05700 CT SCAN	0	0		0 42, 107, 877	0. 000000	57.00
58. 00 05800 MRI	0	0		0 8, 044, 838		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 34, 235, 951		
0. 00 06000 LABORATORY	0	0		0 76, 072, 054		
0. 01 06001 LABORATORY-PATHOLOGI CAL	0	0		0 7, 475, 618		
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 3, 268, 339		
05.00 06500 RESPI RATORY THERAPY	0	0		0 24, 794, 032		
06.00 06600 PHYSICAL THERAPY 07.00 06700 OCCUPATI ONAL THERAPY	0	0		0 16, 617, 206 0 5, 854, 874		
57. 00 06800 SPEECH PATHOLOGY	0	0		0 5, 854, 874 0 2, 001, 190		
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 13, 500, 215		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 8, 217, 592		
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 24, 226, 165		
22.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 133, 520		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	746, 344	746, 34			
4.00 07400 RENAL DIALYSIS	0	0		0 3, 439, 642		
76. 00 03020 ACUPUNCTURE	0	0)	0 0	0. 000000	76.00
6. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 911, 090	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0			0 (
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
20. 00 09000 CLINIC	0	0		0 7, 676, 353		
0. 01 09001 DI ABETES CENTER	0	0		0 (0.000000	
20. 02 09002 NEUROPSYCH	0	0		0 218, 375		
20. 03 09003 WOUND CENTER	0	0		0 9, 221, 777		
20. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0		0 1, 203, 045		
20. 05 09005 VIMCARE CLINIC	0	0		0 1, 691, 602		
20.06 09006 MEDICATION MGMT CLINIC 21.00 09100 EMERGENCY	0	0		0 789, 434 0 82, 572, 085		
21.00 09100 EMERGENCY 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 82, 572, 085 0 14, 251, 242		
OTHER REIMBURSABLE COST CENTERS	0	0	1	0 14,201,242	0.00000	92.00
25. 00 09500 AMBULANCE SERVICES						95.00
			1	1	1	1 /0.00

Health Financial Systems	COLUMBUS REGIONA				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET	RVICE OTHER PASS	Provider C	CN: 15-0112	Period: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T112	To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared:
		Title	e XVIII	Subprovi der –	PPS	<u>23 dili</u>
				I RF		
Cost Center Description	Outpatient	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost to Charges	Program	Program Pass-Throug	Program h Charges	Program Pass-Through	
	(col. 6 ÷	Charges	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
50. 00 05000 OPERATI NG ROOM	0. 000000	53, 452		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	5, 861		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	12, 420		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 130210	10, 708	1, 39	94 0	0	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	0		0 0	0	54.01
54.02 05404 ULTRA SOUND	0. 000000	16, 189		0 0	0	54.02
54.03 05405 MAMMOGRAPHY	0. 000000	0		0 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	30, 485		0 0	0	57.00
58. 00 05800 MRI	0. 000000	6, 937		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	8, 612		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	219, 593		0 0	0	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 000000	5, 351		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	18, 027		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	246, 476		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	638, 614		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	573, 022		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	208, 928		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7,822		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 594		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000	81, 611		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0. 000000 0. 006152	42, 348 378, 968			0	72.00
74. 00 07400 RENAL DI ALYSI S	0. 000152	64, 422		0 0	0	74.00
76. 00 03020 ACUPUNCTURE	0. 000000	04, 422		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	0.000000	0		0	0	/0. //
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 CLINIC	0. 000000	168		0 0	0	90.00
90. 01 09001 DI ABETES CENTER	0. 000000	0		0 0	0	90.01
90. 02 09002 NEUROPSYCH	0. 000000	0		0 0	0	90.02
90. 03 09003 WOUND CENTER	0. 000000	27, 863		0 0	0	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	90.04
90. 05 09005 VI MCARE CLINIC	0. 000000	0		0 0	0	90.05
90.06 09006 MEDICATION MGMT CLINIC	0. 000000	0		0 0	0	90.06
91.00 09100 EMERGENCY	0. 000000	13, 437		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			05.05
95.00 09500 AMBULANCE SERVICES		2 (72 000			2	95.00
200.00 Total (lines 50 through 199)	1 1	2,672,908	3, 7	25 0	0	200.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared.
				10 12/01/2021	5/24/2022 10:	23 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 ADULTS & PEDIATRICS	3, 865, 808	0	0,000,00		112.87	
31.00 INTENSIVE CARE UNIT	687, 145		687, 14	15 3, 972	173.00	
32.00 CORONARY CARE UNIT	0			0 0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	405, 526	0	405, 52	2, 831	143.24	41.00
42.00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	111, 864		111, 86	2, 842	39.36	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	5, 070, 343		5, 070, 34	43, 895		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 ADULTS & PEDIATRICS	936	105, 646				30.00
31.00 INTENSIVE CARE UNIT	115	19, 895				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 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER – IRF	26	3, 724				41.00
42.00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	246	9, 683				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
						200.00

NPPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre	pared.
					5/24/2022 10:	23 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			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)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	3, 816, 226	95,083,428			127, 280	
51.00 05100 RECOVERY ROOM	137, 764	7, 806, 415			4, 749	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	174, 405	5,020,336	0. 03474	1, 819, 602	63, 213	52.00
3. 00 05300 ANESTHESI OLOGY	10, 366	14, 379, 917	0. 00072	21 647, 419	467	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	420, 638	6, 278, 229	0. 06699	99 173, 576	11, 629	54.00
4.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	318, 445	13, 423, 578	0. 02372	23 87, 399	2, 073	54.01
54.02 05404 ULTRA SOUND	112, 246	7,095,872	0. 01581	18 214, 395	3, 391	54.02
54. 03 05405 MAMMOGRAPHY	376, 226	5, 893, 842	0. 06383	34 0	0	54.03
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 313, 343	24, 549, 317			74	55.00
57. 00 05700 CT SCAN	175, 829	42, 107, 877			7, 578	
58. 00 05800 MRI	53, 888	8,044,838			2, 179	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	490, 442	34, 235, 951	0. 01432		24, 276	
50. 00 06000 LABORATORY	1, 035, 704	76, 072, 054			60, 230	
	93, 833				1, 573	
		7, 475, 618				
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 028	3, 268, 339			3, 737	62.00
5.00 06500 RESPIRATORY THERAPY	431, 330	24, 794, 032			47,834	65.00
6.00 06600 PHYSI CAL THERAPY	610, 156	16, 617, 206			13, 055	
57.00 06700 OCCUPATI ONAL THERAPY	209, 966	5, 854, 874			9, 377	67.00
8.00 06800 SPEECH PATHOLOGY	108, 183	2,001,190			2, 017	•
9. 00 06900 ELECTROCARDI OLOGY	348, 570	13, 500, 215			17, 982	•
0.00 07000 ELECTROENCEPHALOGRAPHY	229, 843	8, 217, 592			1, 259	•
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	265, 778	24, 226, 165	0. 01097		16, 179	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	279, 845	15, 133, 520	0. 01849	300, 508	5, 557	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 503, 640	121, 321, 418	0. 01239	6, 217, 427	77, 059	73.00
4.00 07400 RENAL DIALYSIS	31, 651	3, 439, 642	0.00920	02 1, 043, 878	9, 606	74.00
76. 00 03020 ACUPUNCTURE	0	0	0. 00000	0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	49, 861	911, 090	0. 05472	27 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
38. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 00	0	88.00
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
20.00 09000 CLINIC	284, 444	7, 676, 353			4	90.00
0. 01 09001 DI ABETES CENTER	0	0			0	90.01
00. 02 09002 NEUROPSYCH	7,456	218, 375			0	90.02
20. 03 09003 WOUND CENTER	242, 904	9, 221, 777	0. 02634		40	•
0. 04 09004 HYPERBARI C OXYGEN THERAPY	54, 020	1, 203, 045			40	90.03
0. 05 09005 VINCARE CLINIC	143, 181	1, 691, 602			273	
						90.05
	40, 330	789, 434			0	
21.00 09100 EMERGENCY	1, 016, 403	82, 572, 085			52, 768	
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	400, 689	14, 251, 242	0. 02811	16 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					
25.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	14, 825, 633	704, 376, 468	1	32, 562, 645	565, 459	1200.00

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	rs Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021		epared: 23 am
		Ti tl	e XIX	Hospi tal	PPS	20 0
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown	J	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0		
32. 00 03200 CORONARY CARE UNIT	0	0		0 0		
33. 00 03300 BURN I NTENSI VE CARE UNI T	0	0		0 0		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	
40. 00 04000 SUBPROVI DER – I PF	0	0		0 0	0	
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	-	I npati ent	200.00
cost center bescription		(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col. 6)	riogram bays	
				COL 0)		
	instructions)		(00	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0			936	
31.00 03100 INTENSIVE CARE UNIT		0				
32.00 03200 CORONARY CARE UNI T		0		0 0.00	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0 0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0 0.00	0	34.00
40. 00 04000 SUBPROVI DER – I PF	0	0		0 0.00	0	40.00
41.00 04100 SUBPROVI DER – I RF	0	0	2,8		26	41.00
42. 00 04200 SUBPROVI DER	0	0		0 0.00	0	
43. 00 04300 NURSERY	0	0			246	
					240	
44. 00 04400 SKI LLED NURSI NG FACI LI TY		0				
200.00 Total (lines 30 through 199)		0	43, 89	75	1, 323	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 I NTENSI VE CARE UNI T	0					33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40. 00 04000 SUBPROVI DER – I PF	0					40.00
41. 00 04100 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	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

	Financial Systems	COLUMBUS REGIO		01 45 0440	D	In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0112	Period: From 01/0 To 12/3)1/2021 31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 10:	
			Ti tl	e XIX	Hospi -	tal	PPS	20 411
	Cost Center Description	Non Physi ci an	Nursi ng	Nursi ng	Allied	Heal th	Allied Health	
		Anesthetist	Program	Program	Post-St			
		Cost	Post-Stepdown		Adj usti	ments		
		1.00	Adjustments					
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	34	A I	3.00	
50.00	05000 OPERATING ROOM	0	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	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	817, 488	
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	Ő	017,100	54.01
54.02	05404 ULTRA SOUND	0	0		0	0	0	54.02
54.03	05405 MAMMOGRAPHY	0	0		0	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MRI	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0	1	0	0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			0	0	746, 344 0	73.00
74.00	03020 ACUPUNCTURE	0	-		0	0	0	76.00
76.00 76.97	07697 CARDI AC REHABI LI TATI ON	0			0	0	0	76.00
70. 77	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	/0.9/
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	Ő	0	89.00
90.00	09000 CLINIC	0	0		0	0	0	90.00
90.01	09001 DI ABETES CENTER	0	0		0	0	0	90.01
90.02	09002 NEUROPSYCH	0	0		0	0	0	90.02
90.03	09003 WOUND CENTER	0	0	1	0	0	0	90.03
90.04	09004 HYPERBARIC OXYGEN THERAPY	0	0		0	0	0	90.04
90.05	09005 VIMCARE CLINIC	0	0		0	0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0	0		0	0	0	90.06
91.00	09100 EMERGENCY	0			0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
05 05	OTHER REIMBURSABLE COST CENTERS	1		1				05.05
95.00	09500 AMBULANCE SERVICES					~	1 540 000	95.00
200.00	Total (lines 50 through 199)	0	0	I	0	0	1, 563, 832	1200.00

Health Financial Systems	COLUMBUS REGIO			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PAS	SS Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 10:	pared:
		Ti tl	e XIX	Hospi tal	PPS	20 011
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	F C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		, i	and 4)	,	(see	
			· ·		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0 95, 083, 428	0.000000	
51.00 05100 RECOVERY ROOM	0	0		0 7, 806, 415	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 020, 336	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 14, 379, 917	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	817, 488	817, 48	38 6, 278, 229	0. 130210	54.00
54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 13, 423, 578	0.00000	54.01
54.02 05404 ULTRA SOUND	0	0		0 7, 095, 872	0.00000	54.02
54.03 05405 MAMMOGRAPHY	0	0		0 5, 893, 842	0.00000	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 549, 317	0.00000	55.00
57.00 05700 CT SCAN	0	0		0 42, 107, 877	0.000000	57.00
58.00 05800 MRI	0	0		0 8, 044, 838	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 34, 235, 951	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 76, 072, 054	0. 000000	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	0	0		0 7, 475, 618	0. 000000	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 3, 268, 339	0. 000000	62.00
65.00 06500 RESPI RATORY THERAPY	0	0)	0 24, 794, 032	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0)	0 16, 617, 206	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0 5, 854, 874	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0)	0 2,001,190	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 13, 500, 215	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 8, 217, 592	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 24, 226, 165	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 133, 520	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	746, 344	746, 34	121, 321, 418	0.006152	73.00
74.00 07400 RENAL DIALYSIS	0	0	1	0 3, 439, 642	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		0 911, 090	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.00000	89.00
90. 00 09000 CLINIC	0	0		0 7, 676, 353	0.00000	90.00
90. 01 09001 DI ABETES CENTER	0	0		0 0	0.00000	90.01
90. 02 09002 NEUROPSYCH	0	0		0 218, 375	0.00000	90.02
90.03 09003 WOUND CENTER	0	0		0 9, 221, 777	0.000000	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0	0		0 1, 203, 045	0. 000000	90.04
90. 05 09005 VIMCARE CLINIC	0	0		0 1, 691, 602	0.000000	
90.06 09006 MEDICATION MGMT CLINIC	0	0		0 789, 434	0. 000000	90.06
91. 00 09100 EMERGENCY	0	0		0 82, 572, 085	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 14, 251, 242	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, 563, 832	1, 563, 83	32 704, 376, 468		200.00

	Financial Systems	COLUMBUS REGIONA		ON 15 0110		u of Form CMS-2	2002-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	RVICE UTHER PASS	Provi der U	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/24/2022 10:	pared: 23 am
			Ti tl	e XIX	Hospi tal	PPS	20 4
	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		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	
50.00	ANCI LLARY SERVICE COST CENTERS	0.000000	0 474 004	1		-	
50.00	05000 OPERATING ROOM	0. 000000	3, 171, 221		0 0	0	
51.00	05100 RECOVERY ROOM	0. 000000	269, 110		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1, 819, 602		0 0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0.000000	647, 419			0	53.00 54.00
			173, 576		0 0	-	
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	87, 399			0	54.01
54.02 54.03	05404 ULTRA SOUND 05405 MAMMOGRAPHY	0. 000000	214, 395	1		0	54.02
54.03	05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	54.03
57.00	05700 CT SCAN	0. 000000	1, 390		0 0	0	55.00
57.00	05800 MRI		1, 814, 606 325, 341		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000 0. 000000	325, 341 1, 694, 640		0 0	0	58.00 59.00
60.00	06000 LABORATORY	0. 000000	4, 423, 797		0 0	0	60.00
60.00		0. 000000			0 0	0	
	06001 LABORATORY-PATHOLOGI CAL		125, 337		0 0	-	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0. 000000	321, 177		0 0	0	62.00
65.00 66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 749, 533 355, 545		0 0	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	261, 467		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	37, 317		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	696, 421		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	45, 022		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 474, 750		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	300, 508		0 0	0	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 006152	6, 217, 427	38, 25		0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	1, 043, 878		0 0	0	
76.00	03020 ACUPUNCTURE	0. 000000	1, 043, 070		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	
/0. //	OUTPATIENT SERVICE COST CENTERS	0.000000					/0. //
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	108		0 0	0	90.00
90.01	09001 DI ABETES CENTER	0. 000000	0		0 0	0	90.01
90.02	09002 NEUROPSYCH	0. 000000	0		0 0	0	90.02
90.03	09003 WOUND CENTER	0. 000000	1, 520		0 0	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	90.04
90.05	09005 VI MCARE CLINIC	0. 000000	3, 228		0 0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 000000	0		0 0	0	90.06
91.00	09100 EMERGENCY	0. 000000	4, 286, 911		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		32, 562, 645	60, 85	51 0	0	200.00

Health Financial Systems	COLUMBUS REGIO				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/24/2022 10:	
		Ti tl	e XIX	Hospi tal	PPS	20 011
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C, Part I, col.	inst.)	Subject To Ded. & Coins	Subject To . Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 325159	0	9, 970, 25	5 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 294487	0	1, 016, 75	5 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 547347	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 011202	0	1, 637, 32		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 732061	0			0	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 247621	0	.,		0	
54. 02 05404 ULTRA SOUND	0. 179343				0	
54. 03 05405 MAMMOGRAPHY 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 294760 0. 227312				0	
57. 00 05700 CT SCAN	0. 227312					57.00
58. 00 05800 MRI	0. 110541		-,, -,	-	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 146266			-	0	
60. 00 06000 LABORATORY	0. 240400				0	
60. 01 06001 LABORATORY-PATHOLOGI CAL	0. 251775				0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284023	0			0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 219051	0		i0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 425492				0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 446364		, .		0	1
68.00 06800 SPEECH PATHOLOGY	0. 610129				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 148713				0	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 239103 0. 357992				0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 603416		.,,.		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 335821				0	
74. 00 07400 RENAL DI ALYSI S	0. 298887		-,,	0 0	0	
76.00 03020 ACUPUNCTURE	0.00000	0		0 0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 623902	0	18, 76	02 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		1			
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		_			_	89.00
90. 00 09000 CLINIC	0. 506223				0	
90. 01 09001 DI ABETES CENTER 90. 02 09002 NEUROPSYCH	0.00000			0 0	0	
90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER	0. 836822 0. 260040				0	
90. 04 09004 HYPERBARI C OXYGEN THERAPY	0. 317867					90.03
90. 05 09005 VI MCARE CLI NI C	0. 945315	-			0	1
90. 06 09006 MEDICATION MGMT CLINIC	0. 636162					1
91.00 09100 EMERGENCY	0. 202978				0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 385733	0	3, 485, 92	24 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0. 544358	0				95.00
200.00 Subtotal (see instructions)		0	86, 268, 83			200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nly Charges 202.00 Net Charges (line 200 - line 201)	-	0	86, 268, 83	37 0	_	202.00
	I	1 0	1 00, 200, 03	,, U	0	1202.00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C	CN: 15-0112	Period: From 01/01/2021	u of Form CMS-2 Worksheet D Part V	
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	epared: 23 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos		-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			
0. 00 05000 OPERATING ROOM	3, 241, 918	0				50.00
1.00 05100 RECOVERY ROOM	299, 421	0				51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
3. 00 05300 ANESTHESI OLOGY	18, 341	0				53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	729, 525	0				54.00
4. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	307, 169	0				54.0
4.02 05404 ULTRA SOUND	233, 899	0				54.0
4. 03 05405 MAMMOGRAPHY	149, 042	0				54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	612, 570	0				55.0
7.00 05700 CT SCAN	405, 917	0				57.0
8. 00 05800 MRI	111, 296	0				58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	274, 951	0				59.0
0. 00 06000 LABORATORY	2, 458, 751	0				60.0
0. 01 06001 LABORATORY-PATHOLOGI CAL	224, 525	0				60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	51, 540	0				62.0
5. 00 06500 RESPI RATORY THERAPY	186, 029	0	•			65.0
6. 00 06600 PHYSI CAL THERAPY	746, 796	0				66.0
7.00 06700 OCCUPATIONAL THERAPY	10, 721	0	1			67.0
8.00 06800 SPEECH PATHOLOGY	288, 658	0				68.0
9.00 06900 ELECTROCARDI OLOGY	149, 164	0	1			69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	399, 895	0				70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	445, 363	0				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	502, 550	0	•			72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DIALYSIS	2, 815, 112	0	1			73.0
4. 00 07400 RENAL DI ALYSI S 6. 00 03020 ACUPUNCTURE	0	0	1			74.0
6. 97 07697 CARDI AC REHABI LI TATI ON	11, 706	0				76.9
OUTPATIENT SERVICE COST CENTERS	11,700	0				/0.9
8. 00 08800 RURAL HEALTH CLINIC						88. 0
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.0
0. 00 09000 CLINIC	431, 365	0				90.0
0. 01 09001 DI ABETES CENTER	0	0				90.0
0. 02 09002 NEUROPSYCH	77, 551	0	•			90.0
0.03 09003 WOUND CENTER	393, 708	0				90.0
0. 04 09004 HYPERBARI C OXYGEN THERAPY	37, 415	0				90.0
0. 05 09005 VI MCARE CLINIC	967, 274	0				90.0
0.06 09006 MEDICATION MGMT CLINIC	20, 850	0				90.0
1.00 09100 EMERGENCY	4, 010, 488					91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 344, 636	0				92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES	1, 587, 573					95.0
00.00 Subtotal (see instructions)	23, 545, 719	0				200.00
01.00 Less PBP Clinic Lab. Services-Program	ט ו					201.0
Only Charges						
02.00 Net Charges (line 200 - line 201)	23, 545, 719	0				202.0

	Financial Systems COLUMBUS REGIONA ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0112	Period: From 01/01/2021	u of Form CMS-2 Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Cost Caster Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		34, 250	1 1.
00	Inpatient days (including private room days, excluding swing	-bed and newborn days)		34, 250	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation)	bed days)		30, 700	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private n	oom davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)			Ũ	
00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			Ũ	
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	10, 868	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instru-	ctions)		_	
00	Swing-bed SNF type inpatient days applicable to title XVIII pecember 31 of the cost reporting period (if calendar year,		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
00	through December 31 of the cost reporting period			0	
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
00	reporting period	20)		53, 036, 154	21
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		tina period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24
00	7 x line 19)	21 of the east reportin	a paried (line 0	0	25
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 OF the cost reportin	g period (inne 8	0	25
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		53, 036, 154	27
. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		-	0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0.00	34
00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	53, 036, 154	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			4 5 40 55	
	Adjusted general inpatient routine service cost per diem (ser Program general inpatient routine service cost (line 9 x line			1, 548. 50 16, 829, 098	
. UU					
. 00	Medically necessary private room cost applicable to the Prog		1	0	1 40

	Financial Systems ATION OF INPATIENT OPERATING COST	COLUMBUS REGIO		CN: 15-0112 P	In Lie eriod:	u of Form CMS- Worksheet D-1	
					rom 01/01/2021		epared:
			Title	e XVIII	Hospi tal	PPS	25 am
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	C	0.00	0	C	42.00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	11 722 074	2.072		010	2 202 400	1 42 00
	CORONARY CARE UNIT	11, 732, 076 0	3, 972 C				
	BURN I NTENSI VE CARE UNI T	0	C				
	SURGI CAL I NTENSI VE CARE UNI T	0	C				
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk		2 Lino 200)			1.00 20,516,414	48.00
	Total Program inpatient costs (sum of lines			ons)		39, 738, 001	
	PASS THROUGH COST ADJUSTMENTS	ri till ough 10/ (0,,,00,00,	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 366, 801	50.00
	111)						
	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, su	um of Parts II	1, 494, 112	2 51.00
	and IV) Total Program excludable cost (sum of lines :	50 and 51)				2, 860, 913	52.00
	Total Program inpatient operating cost exclu		elated, non-ph	vsician anesthe	etist. and	36, 877, 088	
	medical education costs (line 49 minus line 🗉	5 1	·····	J			
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					C	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ng cost and ta	arget amount (line 56 minus l	ine 53)		
	Bonus payment (see instructions)				1110 00)	C C	
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and cor	npounded by the	-	
	market basket	•	-				
	Lesser of lines 53/54 or 55 from prior year					0.00	
	If line 53/54 is less than the lower of line					C	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		LS (TITHES 54 X	60), OF 1% OF	the target		
	Relief payment (see instructions)	hotr dotrono)				C	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			C	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reportin	ng period (See	C	64.00
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	C	65.00
	instructions)(title XVIII only)			cost reporting	period (See		
	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVIII	only). For	C	66.00
1	CAH (see instructions)					_	
	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31	of the cost rep	porting period	C	67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 31 of	the cost repo	ting period	C	68.00
	(line 13 x line 20)				ting period		
69.00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	e 68)		C	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
	Skilled nursing facility/other nursing facil	2		• •			70.00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line 1		ine /u ÷ line	∠)			71.00
	Medically necessary private room cost application		n (line 14 x l	ine 35)			73.00
	Total Program general inpatient routine serv	0	•				74.00
	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, Pa	art II, column		75.00
	26, line 45) Des dies eesitel veleted eeste (line 75 – lie						7/ 00
1	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00
	Inpatient routine service cost (line 74 minu:						78.00
	Aggregate charges to beneficiaries for excess		provi der recor	ds)			79.00
	Total Program routine service costs for comp		cost limitatio	n (line 78 minu	us line 79)		80.00
1	Inpatient routine service cost per diem limi						81.00
	Inpatient routine service cost limitation (I		· .				82.00
	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:		13)				83.00
	Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions)		line 2)			3,550	
88.00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (se	•				1, 548. 50 5, 497, 175	
89 00 1							

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: 23 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	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	3, 865, 808	53, 036, 154	0. 07289	0 5, 497, 175	400, 689	90.00
91.00 Nursing Program cost	0	53, 036, 154	0.00000	0 5, 497, 175	0	91.00
92.00 Allied health cost	0	53, 036, 154	0.00000	0 5, 497, 175	0	92.00
93.00 All other Medical Education	0	53, 036, 154	0.00000	0 5, 497, 175	0	93.00

OMPUT	Financial Systems COLUMBUS REGIONAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T112	From 01/01/2021 To 12/31/2021	Date/Time Pre	pare
		Title XVIII	Subprovider -	5/24/2022 10: PPS	<u>23</u> a
	Cost Center Description		IRF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		2, 831	1 1.
00	Inpatient days (including private room days, excluding swing-			2, 831	2
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only p	rivate room days,	0	3
	do not complete this line.		-		
00	Semi-private room days (excluding swing-bed and observation b	5,		2, 831	4
00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decemb	er 31 of the cost	0	5
00	reporting period	am dave) often December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	on days) after becenber	31 OF the COST	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
50	reporting period	in days) thi bagit becembe		0	'
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	1, 234	9
00	newborn days) (see instructions)			-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room dave) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		Toom days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12
	through December 31 of the cost reporting period	5 (5)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	1 17
. 00	reporting period			0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19
	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s arter December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	c)		4, 416, 826	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
	5 x line 17)		ting portou (init	0	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
00	7 x line 19)	21 . C. I.L		0	0
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 416, 826	
. 00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT			1, 110, 020	1 - 1
00	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 22)(soo instru	ctions)	0. 00 0. 00	
00	Average per diem private room cost differential (line 34 x li		5 ti 0113 j	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
-	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1, 560. 16	
	Program general inpatient routine service cost (line 9 x line	-		1, 925, 237	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	. ,		0 1, 925, 237	
(n)				1,720,237	1 4 1

OMPUTATION OF INPATIENT OPERATING COST		NAL HOSPITAL Provider C	CN: 15-0112	Peri od:	u of Form CMS- Worksheet D-	
		Component	CCN: 15-T112	From 01/01/2021 To 12/31/2021	Date/Time Pre	
		Title	e XVIII	Subprovider -	5/24/2022 10: PPS	: 23 ar
				I RF		
Cost Center Description	Total I npati ent Cost	Total I npati ent Days	Average Per Diem (col. ÷ col. 2)	0 3	Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00 0.	4.00	5.00) 42.
Intensive Care Type Inpatient Hospital Un	-	(0.	00 0	<u> </u>	J 42.
3.00 INTENSIVE CARE UNIT	0	C				43.
4. 00 CORONARY CARE UNIT 5. 00 BURN INTENSIVE CARE UNIT	0	C				
6.00 SURGICAL INTENSIVE CARE UNIT	0	C				
7.00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	3, line 200)			1, 015, 988	3 48.
9.00 Total Program inpatient costs (sum of lin			ons)		2, 941, 225	5 49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program	innatient routine	services (fro	m Wkst D si	m of Parts L and	176, 758	3 50.
		301 11 003 (110	m m(3t. D, 3t		1/0,/30	5 50.
1.00 Pass through costs applicable to Program	inpatient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	78, 219	9 51.
and IV) 2.00 Total Program excludable cost (sum of lin	es 50 and 51)				254, 977	7 52
3.00 Total Program inpatient operating cost ex		elated, non-ph	ysi ci an anest	hetist, and	2, 686, 248	
medical education costs (line 49 minus li	ne 52)					_
TARGET AMOUNT AND LIMIT COMPUTATION 4.00 Program discharges					0	54.
5.00 Target amount per discharge					0.00	
b. 00 Target amount (line 54 x line 55)					0	
 7.00 Difference between adjusted inpatient ope 8.00 Bonus payment (see instructions) 	rating cost and ta	arget amount (Tine 56 minus	s Tine 53)		
0.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and d	compounded by the		
market basket				_	0.00	
0.00 Lesser of lines 53/54 or 55 from prior ye 1.00 If line 53/54 is less than the lower of l					0.00	
which operating costs (line 53) are less						
amount (line 56), otherwise enter zero (s	ee instructions)					
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive p	avment (see instru	uctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
4.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Dece	ember 31 of th	e cost report	ing period (See	C	64.
5.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	per 31 of the	cost reportir	ng period (See	0	65.
instructions)(title XVIII only)						
6.00 Total Medicare swing-bed SNF inpatient ro CAH (see instructions)	utine costs (line	64 plus line	65)(title XVI	II only). For	C	66.
7.00 Title V or XIX swing-bed NF inpatient rou	tine costs through	n December 31	of the cost r	eporting period	c c	67.
(line 12 x line 19)	+:)				
8.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	tine costs arter t	Jecember 31 of	the cost rep	borting period	C	68.
9.00 Total title V or XIX swing-bed NF inpatie					C	69.
PART III - SKILLED NURSING FACILITY, OTHE D. 00 Skilled nursing facility/other nursing fa				7)		70.
1.00 Adjusted general inpatient routine servic						71.
2.00 Program routine service cost (line 9 x li						72.
3.00 Medically necessary private room cost app	5	•	· ·			73.
4.00 Total Program general inpatient routine s 5.00 Capital-related cost allocated to inpatie				Part II. column		74.
26, line 45)				, , , , , , , , , , , , , , , , , , , ,		
6.00 Per diem capital-related costs (line 75 ÷ 7.00 Program capital-related costs (line 9 x l	,					76.
3.00 Inpatient routine service cost (line 74 m						78.
9.00 Aggregate charges to beneficiaries for ex						79.
0.00 Total Program routine service costs for c 1.00 Inpatient routine service cost per diem I	•	cost limitatio	n (line 78 mi	nus line 79)		80.
 I.00 Inpatient routine service cost per diem 2.00 Inpatient routine service cost limitation)				81.
3. 00 Reasonable inpatient routine service cost	•					83.
4.00 Program inpatient ancillary services (see						84.
5.00 Utilization review – physician compensati 6.00 Total Program inpatient operating costs (85. 86.
PART IV - COMPUTATION OF OBSERVATION BED					I	
7.00 Total observation bed days (see instructi					0	
8.00 Adjusted general inpatient routine cost p 9.00 Observation bed cost (line 87 x line 88)					0.00) 88.) 89.
	(noti doti 000)				, C	- 07.

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component (CCN: 15-T112	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: 23 am
		Title	XVIII	Subprovider -	PPS	
				I RF	1	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ŕ		(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	405, 526	4, 416, 826	0. 0918	14 0	0	90.00
91.00 Nursing Program cost	0	4, 416, 826	0.0000	0 00	0	91.00
92.00 Allied health cost	0	4, 416, 826	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	4, 416, 826			0	93.00

OMPUT	Financial Systems COLUMBUS REGIONAL HOSP CATION OF INPATIENT OPERATING COST Prov	ider CCN: 15-0112	Period: From 01/01/2021	of Form CMS-2 Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, ex-	cluding newborn)		34, 250	1 1.
00 00	Inpatient days (including private room days, excluding swing-bed and Private room days (excluding swing-bed and observation bed days).	nd newborn days)	rivate room days,	34, 250 0	2.
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed day Total swing-bed SNF type inpatient days (including private room day		er 31 of the cost	30, 700 0	
00	reporting period Total swing-bed SNF type inpatient days (including private room day	,, 3		0	
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room day		0		
00	reporting period Total swing-bed NF type inpatient days (including private room days	, 0		0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the			936	
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (0		0	
00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only ()	3 /	0	
	December 31 of the cost reporting period (if calendar year, enter () Swing-bed NF type inpatient days applicable to titles V or XIX on ()	0 on this line)	3 /	0	
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX on	5 (51	3 /	0	
	after December 31 of the cost reporting period (if calendar year, Medically necessary private room days applicable to the Program (e:	enter O on this li	ne)	0	
00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	nor adring enring bed		2, 842 246	15
	Medicare rate for swing-bed SNF services applicable to services th	nough December 21	of the cost		
	reporting period	0		0.00	
	Medicare rate for swing-bed SNF services applicable to services af reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to services through the period	C C		0.00	
	Medicaid rate for swing-bed NF services applicable to services after reporting period	er December 31 of	the cost	0.00	
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 5 x line 17)	of the cost repor	ting period (line	53, 036, 154 0	21
00	Swing-bed cost applicable to SNF type services after December 31 or x line 18)	f the cost reporti	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December 31 (7 x line 19)	of the cost report	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 31 of x line 20)	the cost reporting	g period (line 8	0	25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		0 53, 036, 154	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed c	narges)	0	28
. 00	Private room charges (excluding swing-bed charges)		5	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus l		ctions)	0.00	
00	Average per diem private room cost differential (line 34 x line 31))		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and p	rivate room cost d	fferential (line	0 53, 036, 154	36 37
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN				
	Adjusted general inpatient routine service cost per diem (see inst	ructions)		1, 548. 50	
	Program general inpatient routine service cost (line 9 x line 38)			1, 449, 396	39
	Medically necessary private room cost applicable to the Program (1)	100 14 v 11 05		0	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	COLUMBUS REGIO		CN: 15-0112 P	In Lie eriod:	u of Form CMS- Worksheet D-1	
				rom 01/01/2021		epared:
		Ti tl	e XIX	Hospi tal	PPS	25 am
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	2, 457, 239	2, 842	864.62	246	212, 697	42.00
A 1 Intensive Care Type Inpatient Hospital Un 43.00 INTENSIVE CARE UNIT	its 11, 732, 076	2 072	2, 953. 69	115	339, 674	43.00
44.00 CORONARY CARE UNIT	11, 732, 076	3, 972 C				
45. 00 BURN INTENSIVE CARE UNIT	0	C				
46.00 SURGICAL INTENSIVE CARE UNIT	0	C	0.00	0	C	46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	3. line 200)			8, 875, 695	48.00
49.00 Total Program inpatient costs (sum of lir	•		ons)		10, 877, 462	
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D, sum	of Parts I and	135, 224	50.00
51.00 Pass through costs applicable to Program	innationt ancillar	ny services (f	rom Wkst D si	um of Parts II	626, 310	51 00
and IV)		y services (i	TOIL WKSt. D, St		020, 510	1 31.00
52.00 Total Program excludable cost (sum of lir	nes 50 and 51)				761, 534	52.00
53.00 Total Program inpatient operating cost ex		elated, non-ph	ysician anesthe	etist, and	10, 115, 928	53.00
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					-
54.00 Program di scharges					0	54.00
55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0	56.0
57.00 Difference between adjusted inpatient ope	erating cost and ta	arget amount (line 56 minus I	ine 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost	- reporting pariod	anding 100(undeted and ear	nounded by the	0	
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996,	upuated and com	ipounded by the	0.00	59.0
60.00 Lesser of lines 53/54 or 55 from prior ye	ear cost report, up	odated by the	market basket		0.00	60.0
61.00 If line 53/54 is less than the lower of I					0	61.00
which operating costs (line 53) are less		ts (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (s 62.00 Relief payment (see instructions)	see instructions)				C	62.00
63.00 Allowable Inpatient cost plus incentive p	ayment (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine	costs through Dece	ember 31 of th	e cost reportin	ng period (See	0	64.00
instructions)(title XVIII only)65.00 Medicare swing-bed SNF inpatient routine	costs after Decem	per 31 of the	cost reporting	neriod (See	o	65.00
instructions)(title XVIII only)			cost reporting			
66.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line	64 plus line	65)(title XVIII	only). For	0	66.00
CAH (see instructions)	ting gooto through	December 21	of the east rea	osting poriod	0	47.00
67.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)	itine costs through	1 December 31	of the cost rep	borting period	C	67.00
68.00 Title V or XIX swing-bed NF inpatient rou	itine costs after [December 31 of	the cost repo	ting period	C	68.00
(line 13 x line 20)						
69.00 Total title V or XIX swing-bed NF inpatie		`	,		0	69.00
70.00 Skilled nursing facility/other nursing facility/						70.00
71.00 Adjusted general inpatient routine service	2		• •			71.0
72.00 Program routine service cost (line 9 x li	ne 71)					72.00
73.00 Medically necessary private room cost app	, e	•				73.00
74.00 Total Program general inpatient routine s 75.00 Capital-related cost allocated to inpatie				art II column		74.00
26, line 45)	ant routine service	e costs (110m	worksheet b, ra			/ 5.00
76.00 Per diem capital-related costs (line 75 +	line 2)					76.00
77.00 Program capital-related costs (line 9 x l						77.0
78.00 Inpatient routine service cost (line 74 m 79.00 Aggregate charges to beneficiaries for ex		novi dor rocar	de)			78.0
80.00 Total Program routine service costs for c				us line 79)		80.0
81.00 Inpatient routine service cost per diem I	•		(81.0
82.00 Inpatient routine service cost limitation	n (line 9 x line 8					82.0
83.00 Reasonable inpatient routine service cost		ıs)				83.0
84.00 Program inpatient ancillary services (see		anc)				84.0
85.00 Utilization review - physician compensati 86.00 Total Program inpatient operating costs (85.0 86.0
PART IV - COMPUTATION OF OBSERVATION BED						
87.00 Total observation bed days (see instructi	ons)				3, 550	
88.00 Adjusted general inpatient routine cost p89.00 Observation bed cost (line 87 x line 88)	•				1, 548. 50 5, 497, 175	
					ь <u>л</u> и/ 175	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	pared: 23 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	3, 865, 808	53, 036, 154	0. 07289	0 5, 497, 175	400, 689	90.00
91.00 Nursing Program cost	0	53, 036, 154	0.00000	0 5, 497, 175	0	91.00
92.00 Allied health cost	0	53, 036, 154	0. 00000	0 5, 497, 175	0	92.00
93.00 All other Medical Education	0	53, 036, 154	0. 00000	0 5, 497, 175	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0112 Component CCN: 15-T112	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared:
		Title XIX	Subprovider -	5/24/2022 10:	<u>23 dili</u>
	Cost Center Description	• •		1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		2, 831	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line.		rivate room days,	2, 831 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	2, 831 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through Decembe	r 31 of the cost	100	7.00
8.00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excludin	g swing-bed and	26	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 2, 842	14.0 15.0
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20. 0
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ting period (line	4, 416, 826 0	21.0 22.0
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line é	0	23.0
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost report	ing period (line	0	24.0
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 4, 416, 826	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		nai goo)	0	29.0
30.00	Semi-private room charges (excluding swing-bed charges)	1 : 20)		0	30.0
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
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 instru	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) DADT LL HOSDITAL AND SUDDON/LDEDS ONLY	and private room cost d	inerential (line	4, 416, 826	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see			1, 560. 16	38.00
39.00	Program general inpatient routine service cost (line 9 x line			40, 564	
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0	40.0
44 9-		+ line $4()$		40, 564	1 41 C

MPU	IFINANCIAL SYSTEMS FATION OF INPATIENT OPERATING COST	COLUMBUS REGIO		CN: 15-0112	Period:	u of Form CMS- Worksheet D-	
			Component	CCN: 15-T112	From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Ti tl	e XIX	Subprovider -	5/24/2022 10:	:23 a
	Cost Center Description	Total	Total	Average Pe	IRF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1.00	2.00 C	3.00	<u>4.00</u> 00 0	5.00) 42.
. 00	Intensive Care Type Inpatient Hospital Units			0.	00 0		, 12.
8.00		0	C		00 0		
1.00 5.00		0	C		00 0 00 0		
0.00		0			00 0		
	OTHER SPECIAL CARE (SPECIFY)	0					47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk					276, 886	5 48
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		317, 450	9 49
. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	um of Parts I and	3, 724	1 50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancilla	ry services (f	rom Wkst D	sum of Parts II	0	51
	and IV)		, services (1	ion mist. D _i	Sam of raits II		
2.00	Total Program excludable cost (sum of lines					3, 724	
8. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-ph	ysician anes	Linetist, and	313, 726	5 53
00	TARGET AMOUNT AND LIMIT COMPUTATION					с	54
. 00	Program discharges Target amount per discharge					0.00	
. 00						C	
. 00	, , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (line 56 minus	s line 53)	C	
. 00	Bonus payment (see instructions)		100/			0	
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and o	compounded by the	0.00) 59
. 00		cost report, u	odated by the	market baske [.]	t	0.00	0 60
. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of	f the amount by	C	61
	which operating costs (line 53) are less that		ts (lines 54 x	60), or 1% (of the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)					62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost repor	ting period (See	0	0 64
	instructions)(title XVIII only)	5			51 (
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Deceml	per 31 of the	cost reporti	ng period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	III only). For	C	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost i	reporting period) 67
. 00	(line 12 x line 19)	Ũ					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after l	December 31 of	the cost re	porting period	C	68 (
. 00	Total title V or XIX swing-bed NF inpatient					C	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				7)	1	70
. 00	5 5 5	2		•	/)		71
. 00	Program routine service cost (line 9 x line			_,			72
. 00	5 51 11						73
. 00	Total Program general inpatient routine serv	•		·	Part II column		74
. 00	Capital-related cost allocated to inpatient 26, line 45)	SULTINE SELVICE		NOI KOHEEL D,	rait II, COLUMN		75
. 00							76
. 00 . 00		· · · · ·					77
. 00			provider recor	ds)			79
. 00	55 5 5	• •			nus line 79)		80
	Inpatient routine service cost per diem limi						81
. 00							82
. 00			13)				83
. 00			ons)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					C	87
. 00	Adjusted general inpatient routine cost per	·	÷line 2)			0.00	
		·					1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2021	Worksheet D-1	
		Component	CCN: 15-T112	To 12/31/2021		pared: 23 am
		Ti tl	e XIX	Subprovider -		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	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	0.0000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

Health Financial Systems COLUMBUS REGIO				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0112	Period: From 01/01/2021	Worksheet D-3	3
			To 12/31/2021	Date/Time Pre	
	Title	e XVIII	Hospi tal	5/24/2022 10: PPS	23 am
Cost Center Description	nuc	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			22, 509, 240		30.00
31. 00 03100 I NTENSI VE CARE UNI T			5, 111, 574		31.00
32.00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF			0		34.00 40.00
40. 00 04000 SUBPROVIDER - TPP 41. 00 04100 SUBPROVIDER - TRF			0		40.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			-		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 3251			
51.00 05100 RECOVERY ROOM		0. 2944		221, 112	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.5473			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0114		19, 637 455, 184	
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 24762			
54. 02 05404 ULTRA SOUND		0. 1793		97, 524	
54.03 05405 MAMMOGRAPHY		0. 2965		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2275	79 144, 280	32, 835	55.00
57.00 05700 CT SCAN		0. 0608		292, 776	
58.00 05800 MRI		0. 1105			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1466			
60. 00 06000 LABORATORY 60. 01 06001 LABORATORY-PATHOLOGI CAL		0. 24040		2, 150, 916 65, 258	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 28402			
65. 00 06500 RESPI RATORY THERAPY		0. 2197			
66. 00 06600 PHYSI CAL THERAPY		0. 4266			1
67.00 06700 OCCUPATI ONAL THERAPY		0. 4463	64 839, 515	374, 729	67.00
68.00 06800 SPEECH PATHOLOGY		0. 6101	29 104, 122	63, 528	68.00
69.00 06900 ELECTROCARDI OLOGY		0. 1487			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 23910		23,658	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3579		1, 869, 055	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3358			
74. 00 07400 RENAL DI ALYSI S		0. 2988			
76.00 03020 ACUPUNCTURE		0.0000			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 62390	660	412	76.97
OUTPATIENT SERVICE COST CENTERS			1	-	
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0.0000		0 17, 965	
90. 00 109000 CLINIC 90. 01 109001 DI ABETES CENTER		0. 0000		0	
90. 02 09002 NEUROPSYCH		0. 83682		0	
90. 03 09003 WOUND CENTER		0. 2628		7, 801	
90. 04 09004 HYPERBARI C OXYGEN THERAPY		0. 3192	6, 924	2, 211	
90. 05 09005 VI MCARE CLI NI C		0. 9453			
90. 06 09006 MEDICATION MGMT CLINIC		0.6361			
91.00 09100 EMERGENCY		0. 2029		1, 837, 668	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.3857	33 0	0	92.00
					95.00
					1 /0.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98)			77.466.395	20, 516, 414	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		77, 466, 395 0	20, 516, 414	

IPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	HOSPITAL Provider C	CN: 15-0112	Peri od:	eu of Form CMS- Worksheet D-3	
			From 01/01/202	1	
	Component	CCN: 15-T112	To 12/31/202	I Date/Time Pre 5/24/2022 10:	
	Titl€	e XVIII	Subprovider -	PPS	20 0.
Cost Center Description		Ratio of Co	IRF st Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDI ATRI CS					30.
. 00 03100 I NTENSI VE CARE UNI T					31.
2. 00 03200 CORONARY CARE UNIT					32.
B. OO O3300 BURN INTENSIVE CARE UNIT					33.
. 00 03400 SURGICAL INTENSIVE CARE UNIT					34.
0. 00 04000 SUBPROVIDER - IPF					40.
. 00 04100 SUBPROVIDER - IRF			2, 616, 412	2	41.
					42.
ANCI LLARY SERVICE COST CENTERS		I		I	43.
0. 00 05000 OPERATI NG ROOM		0. 3251	59 53, 452	2 17, 380	50.
. 00 05100 RECOVERY ROOM		0. 2944			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5473			
. 00 05300 ANESTHESI OLOGY		0.0114	93 12, 420	143	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 7329	10, 708	3 7, 848	54.
. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2476		0 0	
. 02 05404 ULTRA SOUND		0. 1793			
		0. 2965			
. 00 05500 RADI OLOGY-THERAPEUTI C . 00 05700 CT_SCAN		0. 2275		-	
. 00 05700 CT SCAN		0.0608			
00 05900 CARDI AC CATHETERI ZATI ON		0. 1466			
00 06000 LABORATORY		0. 2404			
. 01 06001 LABORATORY-PATHOLOGI CAL		0. 2567			
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2840	18, 02	7 5, 120	62.
. 00 06500 RESPI RATORY THERAPY		0. 2197	10 246, 476	5 54, 153	65.
0. 00 06600 PHYSI CAL THERAPY		0. 4266			
. 00 06700 OCCUPATI ONAL THERAPY		0. 4463			
. 00 06800 SPEECH PATHOLOGY		0. 6101			
		0. 1487			
. 00 07000 ELECTROENCEPHALOGRAPHY . 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2391			
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6034			
00 07300 DRUGS CHARGED TO PATIENTS		0. 3358			
. 00 07400 RENAL DI ALYSI S		0. 2988			
00 03020 ACUPUNCTURE		0.0000			
97 07697 CARDI AC REHABI LI TATI ON		0. 6239	02 0	0 0	76.
OUTPATIENT SERVICE COST CENTERS					
00 08800 RURAL HEALTH CLINIC		0.0000		0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
00 09000 CLINIC 01 09001 DIABETES CENTER		0. 5062		3 85 0 0	
02 09002 NEUROPSYCH		0. 8368			
03 09003 WOUND CENTER		0. 2628			
04 09004 HYPERBARI C OXYGEN THERAPY		0. 3192		0 0	
05 09005 VI MCARE CLI NI C		0. 9453		0 0	
. 06 09006 MEDICATION MGMT CLINIC		0. 6361		o o	
00 09100 EMERGENCY		0. 2029			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3857	33 (0 0	92.
OTHER REI MBURSABLE COST CENTERS		1		1	
. 00 09500 AMBULANCE SERVICES			0 170	1	95.
0.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) no (1)		2, 672, 908	1, 015, 988	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)				201.
2.00 Net charges (line 200 minus line 201)		1	2, 672, 908	ין	202.

	Financial Systems COLUMBUS REGIONAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0112	Period:	u of Form CMS-: Worksheet D-3	
INPAIL	ENT ANCILLART SERVICE COST APPORTIONWENT	Provider C	CN. 15-0112	From 01/01/2021	worksneet D-3	1
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	
		Ti tl	e XIX	Hospi tal	PPS	20 411
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	0	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			16, 204, 609		30.00
	03100 I NTENSI VE CARE UNI T			2, 595, 777		31.00
	03200 CORONARY CARE UNIT			0		32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT			0		33.00 34.00
40.00	04000 SUBPROVI DER – I PF			0		40.00
41.00	04100 SUBPROVIDER - IRF			65, 054		41.00
42.00	04200 SUBPROVI DER			0		42.00
43.00	04300 NURSERY			1, 587, 146		43.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATING ROOM		0.3251			
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM		0. 2944 0. 5473			
52.00 53.00	05300 ANESTHESI OLOGY		0. 5473			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 7329			
	05402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 2476			
	05404 ULTRA SOUND		0. 1793			
54.03	05405 MAMMOGRAPHY		0. 2965	09 0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 2275			
	05700 CT SCAN		0.0608			
58.00 59.00			0. 1105			
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		0. 1466 0. 2404			
60.01	06001 LABORATORY-PATHOLOGI CAL		0. 2404			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2840			
65.00	06500 RESPI RATORY THERAPY		0. 2197			
66.00	06600 PHYSI CAL THERAPY		0. 4266	24 355, 545	151, 684	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 4463			
	06800 SPEECH PATHOLOGY		0. 6101			
69.00	06900 ELECTROCARDI OLOGY		0. 1487		103, 567	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2391 0. 3579			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.6034			
	07300 DRUGS CHARGED TO PATIENTS		0. 3358			
	07400 RENAL DI ALYSI S		0. 2988			•
76.00	03020 ACUPUNCTURE		0.0000	00 0	0	76.00
	07697 CARDI AC REHABI LI TATI ON		0. 6239	02 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS		0.0000	20		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
	09000 CLINIC		0. 0000 0. 5062			
	09001 DI ABETES CENTER		0.0002			90.00
90.02	09002 NEUROPSYCH		0. 8368		0	
	09003 WOUND CENTER		0. 2628			
90. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 3192	71 0	0	
90.05	09005 VI MCARE CLI NI C		0. 9453			
90.06	09006 MEDICATION MGMT CLINIC		0. 6361		0	90.06
	09100 EMERGENCY		0.2029		870, 149	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0.3857	33 0	0	92.00
	09500 AMBULANCE SERVICES					95.00
200.00				32, 562, 645	8, 875, 695	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00		,	1	32, 562, 645	1	202.00

Health Financial Systems COLUMBUS REGIONA				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0112	Period: From 01/01/2021	Worksheet D-3	8
	Component	CCN: 15-T112	To 12/31/2021	Date/Time Pre	
		e XIX	Subprovider -	5/24/2022 10:	23 am
			IRF		_
Cost Center Description		Ratio of Co		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x	
			charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-			1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					30.00
32. 00 03200 CORONARY CARE UNI T					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
40. 00 04000 SUBPROVIDER - IPF			(11 101		40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER			641, 101		41.00
43. 00 04300 NURSERY					42.00
ANCI LLARY SERVI CE COST CENTERS		1		1	10100
50. 00 05000 OPERATING ROOM		0. 3251	59 16, 360	5, 320	50.00
51.00 O5100 RECOVERY ROOM		0. 2944			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5473			1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0114			53.00 54.00
54. 01 05402 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 7329		2,761	1
54. 02 05404 ULTRA SOUND		0. 1793			1
54. 03 05405 MAMMOGRAPHY		0. 2965			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2275		66	
57. 00 05700 CT SCAN		0.0608			1
58. 00 05800 MRI		0. 1105			1
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY		0. 1466			1
60. 01 06001 LABORATORY-PATHOLOGI CAL		0. 2404			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2840			1
65. 00 06500 RESPI RATORY THERAPY		0. 2197			
66. 00 06600 PHYSI CAL THERAPY		0. 4266			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4463			
68. 00 06800 SPEECH PATHOLOGY		0. 6101			
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1487			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.3579			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.6034			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3358	21 146, 006	49, 032	73.00
74.00 07400 RENAL DI ALYSI S		0. 2988			1
76.00 03020 ACUPUNCTURE		0.0000			
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 6239	02 0	0 0	76.97
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0 0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 0		
90. 00 09000 CLINIC		0. 5062	23 222		
90. 01 09001 DI ABETES CENTER		0.0000		0	1
90. 02 09002 NEUROPSYCH		0.8368			
90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARI C 0XYGEN THERAPY		0. 2628			1
90. 05 09005 VI MCARE CLINIC		0. 3192			1
90. 06 09006 MEDICATION MGMT CLINIC		0. 6361			
91. 00 09100 EMERGENCY		0. 2029	78 4, 471	908	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3857			92.00
OTHER REIMBURSABLE COST CENTERS		1			05.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98)			744, 376	276, 886	95.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		/44, 3/0	210,880	200.00
202.00 Net charges (line 200 minus line 201)			744, 376		202.00
		1	, ,,,,,,,,	I	

Heal th	Financial Systems COLUMBUS REGIONA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Period: From 01/01/2021	Worksheet E Part A			
			To 12/31/2021	Date/Time Pre			
		Title XVIII	Hospi tal	5/24/2022 10: PPS	23 am		
			noopritai				
				1.00			
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00		
1.01	DRG amounts other than outlier payments for discharges occur	ring prior to October 1	(see	11, 163, 309	1.01		
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see						
1.02	instructions)	The of of aller october	1 (366	20, 450, 325	1.02		
1.03	DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	prior to October	0	1.03		
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	on or after	0	1.04		
	October 1 (see instructions)	ren arbenargee eeearring		Ū			
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.01		
2.01	Outlier payment for discharges for Model 4 BPCI (see instruc	tions)		0	2.01		
2.03	Outlier payments for discharges occurring prior to October 1			237, 838	2.03		
2.04	Outlier payments for discharges occurring on or after Octobe	r 1 (see instructions)		320, 472	2.04		
3.00 4.00	Managed Care Simulated Payments	arting pariod (see instr	uctions)	17, 617, 352	3.00 4.00		
4.00	Bed days available divided by number of days in the cost rep Indirect Medical Education Adjustment	of thig period (see thist)		237.27	4.00		
5.00	FTE count for allopathic and osteopathic programs for the mo	st recent cost reporting	period ending or	0.00	5.00		
6 00	or before 12/31/1996. (see instructions)	the opitarie for an odd	on to the con for	0.00	6 00		
6.00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap for	0.00	6.00		
7.00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f	[•]) (1) (i v) (B) (1)	0.00	7.00		
7.01	ACA § 5503 reduction amount to the IME cap as specified unde	r 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7.01		
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allop	athic and ostoonathic nr	ograms for	0.00	8.00		
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413			0.00	0.00		
	1998), and 67 FR 50069 (August 1, 2002).						
8.01	The amount of increase if the hospital was awarded FTE cap s report straddles July 1, 2011, see instructions.	lots under § 5503 of the	ACA. If the cost	0.00	8.01		
8. 02	The amount of increase if the hospital was awarded FTE cap s	lots from a closed teach	ing hospital	0.00	8.02		
	under § 5506 of ACA. (see instructions)		· · ·				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.00		
10.00	FTE count for allopathic and osteopathic programs in the cur	rent year from your reco	rds	0.00	10.00		
11.00	FTE count for residents in dental and podiatric programs.			0.00			
12.00	Current year allowable FTE (see instructions)			0.00			
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that y	oar onded on or after Se	ntombor 20 1007	0.00			
14.00	otherwise enter zero.		ptember 30, 1997,	0.00	14.00		
15.00	Sum of lines 12 through 14 divided by 3.				15.00		
16.00	Adjustment for residents in initial years of the program				16.00		
17.00 18.00	Adjustment for residents displaced by program or hospital cl Adjusted rolling average FTE count	osure			17.00		
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	Enter the lesser of lines 19 or 20 (see instructions)			0.000000			
22.00	IME payment adjustment (see instructions)			0	22.00		
22.01	IME payment adjustment - Managed Care (see instructions)	22 of the MMA		0	22.01		
23.00	Indirect Medical Education Adjustment for the Add-on for § 4. Number of additional allopathic and osteopathic IME FTE resi		CFR 412, 105	0.00	23.00		
	(f)(1)(iv)(C).						
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00			
25.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or lin	e 24 (see	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			
28.00	IME add-on adjustment amount (see instructions)			0	28.00		
28.01	IME add-on adjustment amount - Managed Care (see instruction	s)		0	28.01		
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.)	01)		0	29.00 29.01		
27.01	Disproportionate Share Adjustment			0	27.01		
30.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	ctions)	4.92			
31.00	Percentage of Medicaid patient days (see instructions)			24.38			
32.00	Sum of lines 30 and 31	c)		29.30			
33.00 34.00	Allowable disproportionate share percentage (see instruction Disproportionate share adjustment (see instructions)	5)		13. 39 1, 058, 267			
000				., 000, 207			

CALCUL	Financial Systems COLUMBUS REGIO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	narod
			10 12/31/2021	5/24/2022 10:	23 an
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		0.000.014.504	7 100 000 710	1 05 0
35.00				7, 192, 008, 710	
35.01 35.02	Factor 3 (see instructions)	nton zono on this line) (o	0. 000246480		
55. UZ	Hospital uncompensated care payment (If line 34 is zero, en instructions)	inter zero on this fine) (se	ee 2, 043, 392	3, 261, 880	35.0
35.03	Pro rata share of the hospital uncompensated care payment a	amount (see instructions)	1, 528, 345	822, 173	35 (
36.00	Total uncompensated care (sum of columns 1 and 2 on line 3	•	2, 350, 518		36.0
	Additional payment for high percentage of ESRD beneficiary				1
10.00	Total Medicare discharges (see instructions)		0		40.0
1.00	Total ESRD Medicare discharges (see instructions)		0		41.0
11.01	Total ESRD Medicare covered and paid discharges (see instru		0		41.0
12.00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42.0
13.00	Total Medicare ESRD inpatient days (see instructions)	ad by line 11 divided by 7	0		43.0
14.00	Ratio of average length of stay to one week (line 43 divide days)	ed by Time 41 divided by 7	0. 000000		44.0
15.00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45.0
16.00	Total additional payment (line 45 times line 44 times line		0		46.0
7.00	Subtotal (see instructions)		35, 580, 729		47.
18.00	Hospital specific payments (to be completed by SCH and MDH,	, small rural hospitals	0		48.0
	only. (see instructions)	-			
				Amount	
0.00	Tatal normant for innationt energing posts (and instruction	222)		1.00	10
i9.00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I)	35, 580, 729 2, 655, 537	
1.00	Exception payment for inpatient program capital (Wkst. L, I			2,000,007	
2.00	Direct graduate medical education payment (from Wkst. E-4,			0	
3.00	Nursing and Allied Health Managed Care payment	,		126, 503	53.
4.00	Special add-on payments for new technologies			9, 001	54.
4. 01	Islet isolation add-on payment			0	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	
6.00	Cost of physicians' services in a teaching hospital (see in			0	56.
7.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57. 58.
58.00 59.00	Ancillary service other pass through costs from Wkst. D, P ⁻ Total (sum of amounts on lines 49 through 58)	L. TV, COL. IT TIME 200)		163, 491 38, 535, 261	
b0.00	Primary payer payments			7, 365	
51.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		38, 527, 896	
2.00	Deductibles billed to program beneficiaries			3, 103, 124	
3.00	Coinsurance billed to program beneficiaries			27, 559	
4.00	Allowable bad debts (see instructions)			372, 740	64.
5.00	Adjusted reimbursable bad debts (see instructions)			242, 281	65.
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		124, 154	
57.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			35, 639, 494	
8.00	Credits received from manufacturers for replaced devices for				
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	6). (FOR SCH see Instruction	ns)	0	
0.00 0.50		nstration) adjustment (see	instructions)	0	
0. 50	Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration			0	
	SCH or MDH volume decrease adjustment (contractor use only)			0	
2.00	Pioneer ACO demonstration payment adjustment amount (see in			0	70.
0.89	HSP bonus payment HVBP adjustment amount (see instructions)	-		0	
	HSP bonus payment HRR adjustment amount (see instructions)	-		0	
0. 90					70.
70. 90 70. 91	Bundled Model 1 discount amount (see instructions)			0	1 /0.
70.89 70.90 70.91 70.92 70.93				62, 520	
70.90 70.91 70.92 70.93 70.94	Bundled Model 1 discount amount (see instructions)			62, 520 -16, 505	70.

	Financial Systems COLUMBUS REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	°N· 15_0112	Peri od:	u of Form CMS-2 Worksheet E	2002-
	ATTOM OF REIMDURSEMENT SETTLEMENT	Provider C	UN. 15-0112	From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	pared
		T 11		11	5/24/2022 10:	23 am
		<u> </u>	XVIII	Hospi tal (yyyy)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column O		0	0	70. 9
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	
0.98	Low Volume Payment-3				0	70.9
0.99	HAC adjustment amount (see instructions)	(0 % 70)			283, 123	
1.00 1.01	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			35, 402, 386 0	71.0
1.01	Demonstration payment adjustment amount after sequestration				0	71.0
1.02	Sequestration adjustment-PARHM pass-throughs				0	71.0
2.00	Interim payments				34, 808, 755	
2.01	Interim payments-PARHM				01,000,700	72.0
3.00	Tentative settlement (for contractor use only)				0	
3.01	Tentative settlement-PARHM (for contractor use only)				-	73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			593, 631	74.(
4.01	Balance due provider/program-PARHM (see instructions)	noo with			1 005 104	74.0 75.0
5.00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ince with			1, 885, 124	/5.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1		
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
2.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.
3.00	Capital outlier reconciliation adjustment amount (see instruc				0	93.
4.00	The rate used to calculate the time value of money (see instr				0.00	94.
5.00	Time value of money for operating expenses (see instructions)		1		0	95.
6.00	Time value of money for capital related expenses (see instruc	tions)			0	96.
				Prior to 10/1 1.00	<u>0n/After 10/1</u> 2.00	
	UCD Denvis Deciment Americat					
	HSP Bonus Payment Amount					
00.00	HSP bonus amount (see instructions)			0		100.
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment				0	
01.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	101.
01.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)			0.000000000	
01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0. 000000000 0. 00000000000000000000000	101. 102.
01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0. 0000000000 0 0. 0000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103.
01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	;)	ustment	0. 0000000000	0. 000000000 0. 000000000 0 0. 0000	101. 102. 103.
01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)) ration) Adju		0. 0000000000 0 0. 0000	0 0. 000000000 0 0. 0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		0. 0000000000 0 0. 0000	0 0. 000000000 0 0. 0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe) ration) Adju		0. 0000000000 0 0. 0000	0 0. 000000000 0 0. 0000 0	101. 102.
01. 00 02. 00 03. 00 04. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin) ration) Adju riod under		0. 0000000000 0 0. 0000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200.
01. 00 02. 00 03. 00 04. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under		0. 0000000000 0 0. 0000	0 0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
01.00 02.00 03.00 04.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under e 49)	the 21st	0. 000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under e 49)	the 21st	0. 000000000000000000000000000000000000	0.000000000 0 0.0000 0 0 0 0	101. 102. 103. 104. 200. 201. 202. 203.
01. 00 02. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount) ration) Adju riod under e 49)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
01. 00 02. 00 04. 00 00. 00 01. 00 02. 00 03. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under e 49)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
01. 00 02. 00 04. 00 00. 00 01. 00 02. 00 03. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under e 49)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	101. 102. 103. 104.
11. 00 22. 00 33. 00 4. 00 00. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under e 49) first year	the 21st	0. 000000000000000000000000000000000000	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 03. 00 04. 00 05. 00 06. 00 07. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst) ration) Adju riod under e 49) first year ructions)	the 21st	0. 000000000000000000000000000000000000	0.0000000000 0 0.0000 0 0	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under e 49) first year ructions)	the 21st	0. 000000000000000000000000000000000000	0.0000000000 0 0.0000 0 0	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under e 49) first year ructions)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
11. 00 12. 00 13. 00 14. 00 11. 00 12. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use) ration) Adju riod under e 49) first year ructions)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
01. 00 02. 00 03. 00 04. 00 01. 00 02. 00 03. 00 05. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 0. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under e 49) first year ructions)	the 21st	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 06. 00 07. 00 08. 00 09. 00 00. 00 01. 00 01. 00 01. 00 01. 00 01. 00 02. 00 03. 00 03. 00 04. 00 05. 00 05. 00 06. 00 05. 00 06. 00 06. 00 07. 00 08. 00 06. 00 06. 00 07. 00 08. 00 06. 00 06. 00 06. 00 07. 00 06. 00 06. 00 06. 00 06. 00 07. 00 06. 00 07. 00 08. 00 09. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	0. 000000000000000000000000000000000000	0.0000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00 11. 00 12. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	0. 000000000000000000000000000000000000	0.000000000000000000000000000000000000	 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212.
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under e 49) first year ructions) line 59) 211)	of the curre	0. 000000000000000000000000000000000000	0 0.000000000 0 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

	Financial Systems COLUMBUS REGIONAL H ATION OF REIMBURSEMENT SETTLEMENT P	IOSPITAL rovider CCN: 15-0112	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	TOVIDEL CCN. 13-0112	From 01/01/2021 To 12/31/2021	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/24/2022 10: PPS	<u>23 am</u>
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			19, 844	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		31, 444, 289	2.00 3.00
3.00 4.00	Outlier payment (see instructions)			27, 639, 185 126, 670	
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		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	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		349, 206	9.00 10.00
11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			19, 844	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			59, 095	12.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		59,095	12.00
14.00	Total reasonable charges (sum of lines 12 and 13))		59, 095	
15 00	Customary charges			0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services .	on a onar gobasi s		10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	59, 095 39, 251	
17.00	instructions)		110 11) (300	57,251	17.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			19, 844	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			28, 115, 061	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	•		5, 185, 081	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of lines 2.	2 and 23] (see	22, 949, 824	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 22, 949, 824	
	Primary payer payments			3, 218	
32.00	Subtotal (line 30 minus line 31)			22, 946, 606	
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. 1-5, line 11)	S)		0	33.00
	Allowable bad debts (see instructions)			452, 520	
35.00	Adjusted reimbursable bad debts (see instructions)			294, 138	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ctions)		224, 544 23, 240, 744	
38.00	MSP-LCC reconciliation amount from PS&R			75	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	,	,	0	39.99
40.00	Subtotal (see instructions)			23, 240, 669	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			23, 389, 490	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-148, 821	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub 15-2	chapter 1.	43, 708	43.01 44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			1 0	94.00

NALYS	I Financial Systems COLUMBUS REGIO SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0112	Period: From 01/01/2021 To 12/31/2021		pared:
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		34, 808, 7	0 0	23, 389, 490 0	1.00 2.00 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					
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02 . 03				0	0	3.02 3.03
. 03 . 04				0	0	3.0
. 05				0	0	3.0
	Provider to Program					
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 51 . 52				0	0	3.5 3.5
. 52				0	0	3.5
. 54				0	0	3.5
. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.9
. 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)		34, 808, 7	55	23, 389, 490	4.0
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. C
	Program to Provider					
. 01	TENTATI VE TO PROVIDER			0	0	5.C
. 02				0	0	5.0
. 03	Provider to Program			U	0	5.C
. 50	TENTATI VE TO PROGRAM			0	0	5.5
. 51				0	0	5.5
. 52				0	0	5.5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER		593, 6	31	0	6.0
. 02	SETTLEMENT TO PROGRAM			0	148, 821	6.0
. 00	Total Medicare program liability (see instructions)		35, 402, 3		23, 240, 669	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	
. 00	Name of Contractor					8

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0112 CCN: 15-T112	Period: From 01/01/202 To 12/31/202		epare
		Title	e XVIII	Subprovider - IRF		
		I npati er	nt Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
00	Total interim payments paid to provider	1.00	2.00	3.00	4.00) 1.
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,005,9	0	C	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	C	
)2				0	0	
)3)4				0		
)4)5				0		
.0	Provider to Program					1
50	ADJUSTMENTS TO PROGRAM			0	0	3 3
1				0	C) 3
52				0	C	
53				0	C	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	C) 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 605, 9	51	C	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1)2	TENTATI VE TO PROVI DER			0		
)2)3				0		
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	5 5
51				0	C	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	C	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		50, 8	00	0	
)2	SETTLEMENT TO PROGRAM		0 / 5 / 7	0	0	
00	Total Medicare program liability (see instructions)		2,656,7	Contractor	NPR Date) 7
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

From 01/01/2021 Pa To 12/31/2021 Da	Worksheet E-1 Part II Date/Time Prepa 5/24/2022 10:23 PPS	
	PPS	
Title XVIII Hospital		
	1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2		3.00
4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost		4.00
reporting periods beginning on or after 10/01/2013, line 32)		4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00 Calculation of the HIT incentive payment (see instructions)		8.00
9.00 Sequestration adjustment amount (see instructions)		9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		
30.00 Initial/interim HIT payment adjustment (see instructions)		30.00
31.00 Other Adjustment (specify)		31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

ALCUL	Financial Systems COLUMBUS REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	L HOSPITAL Provider CCN: 15-0112	Peri od:	Worksheet E-3	2552
		Component CCN: 15-T112	From 01/01/2021 To 12/31/2021	Part III Date/Time Pre 5/24/2022 10:	
		Title XVIII	Subprovi der -	PPS	20 0
			I RF		
				1.00	
00	PART III - MEDICARE PART A SERVICES - IRF PPS			2 127 (70	1
00 00	Net Federal PPS Payment (see instructions) Medicare SSI ratio (IRF PPS only) (see instructions)			2, 127, 678 0. 0492	1
00	Inpatient Rehabilitation LIP Payments (see instructions)			100, 852	23
00	Outlier Payments			432, 096	4
00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior		5
01	Cap increases for the unweighted intern and resident FTE cour program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0.00	7
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth	period of a "new	0.00	8
00	Intern and resident count for IRF PPS medical education adjust	stment (see instructions)	0.00	9
. 00	Average Daily Census (see instructions)			7.756164	
. 00	Teaching Adjustment Factor (see instructions)			0.00000	
. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			2, 660, 626	13
. 00	Nursing and Allied Health Managed Care payments (see instruct Organ acquisition (DO NOT USE THIS LINE)	.ion)		0	14
. 00 . 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15 16
. 00	Subtotal (see instructions)			2, 660, 626	
. 00	Primary payer payments			2,000,020	18
. 00	Subtotal (line 17 less line 18).			2, 660, 626	
. 00	Deducti bl es			4, 452	
. 00	Subtotal (line 19 minus line 20)			2, 656, 174	
. 00	Coinsurance			3, 710	22
. 00	Subtotal (line 21 minus line 22)			2, 652, 464	23
. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		865	24
. 00	Adjusted reimbursable bad debts (see instructions)			562	
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	26
. 00	Subtotal (sum of lines 23 and 25)			2,653,026	27
. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	28
. 00	Other pass through costs (see instructions)			3, 725	
. 00 . 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31
. 98	Recovery of accel erated depreciation.			0	31
. 99	Demonstration payment adjustment amount before sequestration			0	31
. 00	Total amount payable to the provider (see instructions)			2, 656, 751	32
. 01	Sequestration adjustment (see instructions)			0	32
. 02	Demonstration payment adjustment amount after sequestration			0	32
. 00	Interim payments			2, 605, 951	
. 00	Tentative settlement (for contractor use only)			0	34
. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0			50, 800	
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	36
00	TO BE COMPLETED BY CONTRACTOR			400.001	
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			432, 096	
. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	51
2.00 3.00	Time Value of Money (see instructions)			0.00	
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND	BEGINNING BEFORE THE	ND OF THE COVID-1		55
. 00	Teaching Adjustment Factor for the cost reporting period imme			0.000000	99
	Calculated Teaching Adjustment Factor for the current year. (5.	J	0.000000	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od:	Worksheet E-3	
			From 01/01/2021 To 12/31/2021	Part VII Date/Time Pre 5/24/2022 10:	
		Title XIX	Hospi tal	PPS	20 411
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR	XIX SERVICES		
. 00	Inpatient hospital/SNF/NF services		0		1.0
. 00	Medical and other services			23, 545, 719	2.0
. 00	Organ acquisition (certified transplant centers only)		0		3.0
. 00	Subtotal (sum of lines 1, 2 and 3)		0	23, 545, 719	
. 00	Inpatient primary payer payments		0	0	5.0
. 00 . 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	0 23, 545, 719	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			23, 343, 714	/.0
	Reasonable Charges				
. 00	Routi ne servi ce charges		0		8.0
. 00	Ancillary service charges		32, 562, 645	86, 268, 837	9.0
0.00	Organ acquisition charges, net of revenue		0		10.0
1.00 2.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		22 542 445	86, 268, 837	11.0 12.0
2.00	CUSTOMARY CHARGES		32, 562, 645	00, 200, 037	12.0
3.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.0
	basi s	3			
4.00	Amounts that would have been realized from patients liable for		on 0	0	14.0
- 00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0,000000	0,000000	45.0
5.00 6.00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 32, 562, 645	0. 000000 86, 268, 837	
7.00	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	32, 562, 645	62, 723, 118	
	line 4) (see instructions)		02,002,010	02,720,710	
8.00	Excess of reasonable cost over customary charges (complete on	y if line 4 exceeds li	ne 0	0	18.0
	16) (see instructions)			_	
9.00 0.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst		0	0	19.0 20.0
	Cost of covered services (enter the lesser of line 4 or line		0	23, 545, 719	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			20,010,717	21.0
2.00	Other than outlier payments		0	0	22.0
	Outlier payments		0	0	23.0
4.00	Program capital payments		0		24.0
5.00 6.00	Capital exception payments (see instructions)		0 60, 851	0	25. C 26. C
	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		60, 851	0	
8.00	Customary charges (title V or XIX PPS covered services only)		00,001	0	28.0
9.00	Titles V or XIX (sum of lines 21 and 27)		60, 851	23, 545, 719	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0.00	Excess of reasonable cost (from line 18)		0	0	30. C
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	60, 851	23, 545, 719	
2.00 3.00	Deducti bl es Coi nsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	0	35.0
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	60, 851	23, 545, 719	36.0
7.00	TO ZERO OUT MEDICAID		-60, 851	-23, 545, 719	
8.00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39.0
0.00 1.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		0	0	
2.00	1.5		0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2.	0	0	
	chapter 1, §115.2			-	

nd-ty Iy)	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: fom 01/01/2021 o 12/31/2021	Worksheet G Date/Time Pre 5/24/2022 10:	
		General Fund	Speci fi c Purpose Fund 2.00	Endowment Fund 3.00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	68, 213, 477	0	0	0	1.0
00	Temporary investments	205, 344		0	0	
	Notes receivable	0	0	0	0	
	Accounts recei vabl e Other recei vabl e	79, 909, 019		0	0	
	Allowances for uncollectible notes and accounts receivable	1, 575, 476 -33, 357, 316		0	0	5.
	Inventory	5, 580, 683		0	0	7.
	Prepai d expenses	6, 592, 615	-	0	0	
	Other current assets	2, 293, 443		0	0	9.
. 00	Due from other funds	0	0	0	0	10.
	Total current assets (sum of lines 1-10)	131, 012, 741	0	0	0	11.
	FI XED ASSETS	4 070 075		0		1 40
	Land	1, 872, 375 21, 020, 698		0	0	12.
	Land improvements Accumulated depreciation	-13, 329, 255		0	0	14.
	Buildings	210, 976, 511	0	0	0	
	Accumulated depreciation	-153, 471, 888	-	0	0	
	Leasehold improvements	0	0	0	0	17
. 00	Accumulated depreciation	0	0	0	0	18
	Fixed equipment	9, 618, 376		0	0	19
	Accumulated depreciation	-8, 412, 004		0	0	20
	Automobiles and trucks	2, 215, 000		0	0	21
	Accumulated depreciation Major movable equipment	-1, 835, 026 174, 905, 432		0	0	22
	Accumul ated depreciation	-122, 593, 666		0	0	23
	Mi nor equipment depreciable	000 - 122, 373, 000	0	0	0	
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	0	0	0	0	29
	Total fixed assets (sum of lines 12-29)	120, 966, 553	0	0	0	30
	OTHER ASSETS	198, 901, 991	0	0	0	31
	Deposits on Leases	0	0	0	0	
	Due from owners/officers	0	0	0	0	33
. 00	Other assets	11, 014, 043		0	0	34
	Total other assets (sum of lines 31-34)	209, 916, 034		0	0	35
	Total assets (sum of lines 11, 30, and 35)	461, 895, 328	0	0	0	36
	CURRENT LIABILITIES Accounts payable	16, 784, 391	0	0	0	37
	Salaries, wages, and fees payable	13, 715, 123		0	0	
	Payroll taxes payable	3, 195, 771		0	0	
	Notes and Loans payable (short term)	1, 220, 000	0	0	0	40
	Deferred income	0	0	0	0	
	Accel erated payments	20, 772, 097				42
	Due to other funds		0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	11, 229, 375 66, 916, 757		0	0	
. 00	LONG TERM LI ABI LI TI ES	00, 710, 737		9	0	1 73
. 00	Mortgage payable	34, 265, 000	0	0	0	46
	Notes payable	0	0	0	0	
	Unsecured Loans	71, 832		0	0	
	Other long term liabilities	0	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	34, 336, 832 101, 253, 589		0	0	50 51
	CAPITAL ACCOUNTS	101, 255, 569	0	U	0	1 51
	General fund balance	360, 641, 739				52
	Specific purpose fund		0			53
-	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	-	56
	Plant fund balance - invested in plant				0	
00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
~~	Total fund balances (sum of lines 52 thru 58)	360, 641, 739	0	0	0	59
00						1 37

	Financial Systems ENT OF CHANGES IN FUND BALANCES	COLUMBUS REGION	Provi der CC	CN: 15-0112	Period: From 01/01/2021	u of Form CMS- Worksheet G-1	
					To 12/31/2021	Date/Time Pre 5/24/2022 10:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NURSING HOME CONTRIBUTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) EQUITY TRANSFERS WHOLLY OWNED SUBS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	7, 908, 707 0 0 0 0 0 0 0 0 35, 697, 412 0 0 0 0 0	2.00 329, 894, 705 58, 535, 735 388, 430, 440 7, 908, 707 396, 339, 147 35, 697, 412 360, 641, 735	3. 00	4.00 0 0 0 0 0 0 0 0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NURSING HOME CONTRIBUTIONS	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) EQUITY TRANSFERS WHOLLY OWNED SUBS	0 0	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18.00 19.00

TATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0112	Period: From 01/01/2021	Worksheet G-2	
				To 12/31/2021	Date/Time Pre 5/24/2022 10:	
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
00	General Inpatient Routine Services		70 701 0	05	70 704 005	
. 00	Hospi tal		78, 701, 9	35	78, 701, 935	1.
. 00	SUBPROVIDER - IPF		F 00/ F	0	0	2.
. 00	SUBPROVIDER - IRF		5, 996, 5		5, 996, 567	3.
. 00	SUBPROVIDER			0	0	
. 00	Swing bed - SNF			0	0	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY			0	0	
. 00	NURSING FACILITY					8.
. 00	OTHER LONG TERM CARE		04 (00 5	00	04 (00 500	9.
0.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		84, 698, 5	02	84, 698, 502	10.
1.00	INTENSIVE CARE UNIT		18, 558, 0	07	18, 558, 097	1 1 1
2.00	CORONARY CARE UNIT		18, 558, 0			
				0	0	
	BURN INTENSIVE CARE UNIT			0	0	
	SURGI CAL I NTENSI VE CARE UNI T			0	0	
	OTHER SPECIAL CARE (SPECIFY)	n of Linco	10 550 0	70	10 550 007	15.
6.00	Total intensive care type inpatient hospital services (sur 11-15)		18, 558, 0	97	18, 558, 097	16.
7.00	Total inpatient routine care services (sum of lines 10 and	d 16)	103, 256, 5	99	103, 256, 599	17.
	Ancillary services		194, 058, 3		615, 186, 080	
	Outpatient services		23, 657, 6		82, 649, 711	19.
	RURAL HEALTH CLINIC			0 0	0	
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	HOME HEALTH AGENCY			0	0	
	AMBULANCE SERVI CES		7,4	53 12, 868, 561	12, 876, 014	
	СМНС			-	_	24.
	CORF			0 0	0	
	AMBULATORY SURGICAL CENTER (D. P.)					25.
6.00	HOSPI CE					26.
	LEVEL II NURSERY		2,607,1		2, 607, 147	27.
8.00	Total patient revenues (sum of lines 17-27)(transfer colur	mn 3 to Wkst.	323, 587, 1	67 492, 988, 384	816, 575, 551	28.
	G-3, line 1)					
9.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)		1	212 024 000		29.
	PROVISION FOR BAD DEBT		E 274 4	312, 934, 998		30.
	PROVISION FOR DAD DEDI		5, 274, 4	0		
1.00				0		31.
2.00				0		32. 33.
3.00				0		33.
4.00 5.00				0		34.
	Tatal additions (our of Lines 20.25)			-		
6.00	Total additions (sum of lines 30-35)			5, 274, 420		36.
7.00	DEDUCT (SPECIFY)			0		37.
8.00				0		38.
9.00				0		39.
0.00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)			0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus lin	ne 42)(transfer	1	318, 209, 418		43.

Heal th	Financial Systems COLUMBUS REG	I ONAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0112	Peri od:	Worksheet G-3	
			From 01/01/2021		
			To 12/31/2021		
	· · · · · · · · · · · · · · · · · · ·			5/24/2022 10:	23 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 28)		816, 575, 551	1.00
2.00	Less contractual allowances and discounts on patients' ad			469, 261, 254	
3.00	Net patient revenues (line 1 minus line 2)			347, 314, 297	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		318, 209, 418	4.00
5.00	Net income from service to patients (line 3 minus line 4)			29, 104, 879	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			601, 686	6.00
7.00	Income from investments			2, 111, 771	7.00
8.00	Revenues from telephone and other miscellaneous communication	ation services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			47, 876	10.00
11.00	Rebates and refunds of expenses			114, 483	
	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 guests			626, 344	
	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to oth	ner than patients		0	16.00
	Revenue from sale of drugs to other than patients			29, 531	
18.00	Revenue from sale of medical records and abstracts			2, 813	
	Tuition (fees, sale of textbooks, uniforms, etc.)			32,060	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00 21. 00
21.00 22.00	Rental of vending machines Rental of hospital space			-	
22.00	Governmental appropriations			116, 206 236, 490	
23.00	UNREALIZED INVESTMENT INCOME			11, 695, 192	23.00
24.00	JV I NCOME			86, 671	
24.01	WELLNESS REVENUE			5, 115, 926	
24.02	CRHP REVENUE			4, 466, 198	
24.04	OTHER OPERATING REVENUE			1, 926, 377	
24.50	COVID-19 PHE Funding			2, 876, 060	
24.51	FEMA GRANT FUNDING			373, 127	24.51
	GAIN ON INVESTMENT INCOME			0	24.52
25.00	Total other income (sum of lines 6-24)			30, 458, 811	25.00
26.00	Total (line 5 plus line 25)			59, 563, 690	26.00
27.00	LOSS ON DI SPOSAL			-335, 426	27.00
27.01	OTHER NON-OPERATING EXPENSES			1, 363, 381	27.01
28.00				1, 027, 955	
29.00	Net income (or loss) for the period (line 26 minus line 2	28)		58, 535, 735	29.00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0112	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre	pared
		T I II NO(111		5/24/2022 10:	23 am
		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier		1	2, 402, 390	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			2, 102, 0,0	1.
. 00	Capital DRG outlier payments			106, 361	2.
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.
. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			95.85	
. 00	Number of interns & residents (see instructions)	5 1 2 2		0.00	4.
. 00	Indirect medical education percentage (see instructions)			0.00	5.
. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6.
	1.01) (see instructions)				
. 00	Percentage of SSI recipient patient days to Medicare Part A $\boldsymbol{\mu}$	oatient days (Worksheet	E, part A line	4.92	7.
	30) (see instructions)				
. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		24.38	
. 00	Sum of lines 7 and 8			29.30	
	Allowable disproportionate share percentage (see instructions	5)		6. 11	
	Disproportionate share adjustment (see instructions)			146, 786	
2.00	Total prospective capital payments (see instructions)			2, 655, 537	12.
			-	1.00	
	PART II – PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instructions)			0	1.
. 00	Program inpatient ancillary capital cost (see instructions)			0	2.
. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
			-	1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
. 00	Program inpatient capital costs (see instructions)			0	1 1.
. 00	Program inpatient capital costs for extraordinary circumstance	res (see instructions)		0	2.
. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.
. 00	Applicable exception percentage (see instructions)			0.00	4.
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
. 00	Percentage adjustment for extraordinary circumstances (see ir	nstructions)		0.00	
. 00	Adjustment to capital minimum payment level for extraordinary	-	x line 6)	0	
. 00	Capital minimum payment level (line 5 plus line 7)	· · · ·	-	0	8.
. 00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9.
0.00	Current year comparison of capital minimum payment level to o		less line 9)	0	10.
1.00	Carryover of accumulated capital minimum payment level over of	capital payment (from pr	ior year	0	11.
	Worksheet L, Part III, line 14)				
2.00	Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus li	ne 11)	0	12.
0 00	Current year exception payment (if line 12 is positive enter			-	13

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)
15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions) 0 13.00 0 14.00 0 15.00 0 16.00 0 17.00