This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0112 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2024 7:02 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (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. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLUMBUS REGIONAL HOSPITAL (15-0112) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	358, 147	-51, 990	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	11, 814	0		0	3.00
4.00	SUBPROVI DER (OTHER)						4.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00		o	369, 961	-51, 990	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7:02 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2400 EAST 17TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: COLUMBUS Zip Code: 47201-County: BARTHOLOMEW 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COLUMBUS REGIONAL 150112 18020 07/01/1966 Ν 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF COLUMBUS REGIONAL REHAB 15T112 18020 01/01/1984 N Р Ν 5.00 5 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospital -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 8 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column Ν Ν 22.02 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7:02 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 1. 325 1. 219 6, 385 177 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 62 92 0 0 309 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of

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

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0112 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7: 02 am 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23. 01 60.01 60 01 1 instructions) 60.02 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.02 1 60.02 instructions) Y/N LME Direct GME IME Direct GME 1. 00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61. 01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded 0 00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1. 00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings

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

N

63.00

Health Financial Systems	COL UMBUS	S REGIONAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2023	Worksheet S-2 Part I Date/Time Pre 5/30/2024 7:0	pared:
			Unwei ghted	Unwei ghted	Ratio (col.	z aiii
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	r FTE Residents in N	onprovider Settings				
period that begins on or after J	uly 1, 2009 and befo	re June 30, 2010.				
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	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	0.00	0. 000000	64. 00
or (cordinir r dr vr ded by (cordinir	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
	3	3	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care			0.00	0.00	0. 000000	65. 00
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)			Howei abted	Unwoi ghtod	Patio (cal	
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of	unweighted non-prima ccurring in all nonp	rovider settings.	0.00	0.00	0. 000000	66. 00
FTEs that trained in your hospit						
(column 1 divided by (column 1 +	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3.00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	0.00	0.00		67.00

Health Financial Systems COLUMBUS REGIONA	L HOSPITAL		l r	n Lieu	ı of Form	CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN	I: 15-0112	Period: From 01/01/		Workshee Part I				
			To 12/31/		Date/Tir 5/30/202	me Pre	pared:		
	·				1. 00				
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 8					1.00	J			
68.00 For a cost reporting period beginning prior to October 1, 202 MAC to apply the new DGME formula in accordance with the FY 2 (August 10, 2022)?							68.00		
				1.00	2.00	3. 00			
Inpatient Psychiatric Facility PPS	1	1.05	1		1 2.00	0.00	70.00		
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or Enter "Y" for yes or "N" for no.	does it conta	in an ipe s	subprovi der?	N			70.00		
recent cost report filed on or before November 15, 2004? Ent 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility tra program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ent	71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.								
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF),	or does it co	ntain an IF	?F	Υ			75. 00		
subprovider? Enter "Y" for yes and "N" for no. 76.00 If line 75 is yes: Column 1: Did the facility have an approve	ed GME teachin	g program i	n the most	l N	l N	0	76. 00		
recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	ching program Column 3: If	in accordar column 2 is	ice with 42 ; Y,						
				-	1. 00	າ			
Long Term Care Hospital PPS						<i>y</i>	80.00		
80.00   Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  81.00   Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N  "Y" for yes and "N" for no.  TEFRA Providers									
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.  86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.									
87.00 Is this hospital an extended neoplastic disease care hospital classified under section  N  1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.									
			Approved Permane Adjustm (Y/N)	ent ent	Number Approv Perman Adjustm	ved ent ents			
88.00 Column 1: Is this hospital approved for a permanent adjustmer amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions)			1.00 N		2. 00		88. 00		
Column 2: Enter the number of approved permanent adjustments.		Wkst. A Lir	ne Effecti	Ve	Approv	ved			
		No.	Date		Perman Adjusti Amount Discha	ent ment Per			
89.00   Column 1: If line 88, column 1 is Y, enter the Worksheet A li	ne number	1. 00	2.00		3. 00		89. 00		
on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tar per discharge.  Column 3: Enter the amount of the approved permanent adjustment	based. period get amount	0.				0	07.00		
TEFRA target amount per discharge.			V		VIV	,			
			1. 00		XI X 2. 00				
Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital	services? En	ter "V" for	- N		Y		90.00		
yes or "N" for no in the applicable column.									
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	cable column.		N		Y N		91.00		
instructions) Enter "Y" for yes or "N" for no in the applicate 93.00 Does this facility operate an ICF/IID facility for purposes of	ole column.	, ,	. N		N		93.00		
"Y" for yes or "N" for no in the applicable column.									
<ul> <li>94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.</li> <li>95.00 If line 94 is "Y", enter the reduction percentage in the appl</li> </ul>			0. 00		N O. O	0	94. 00 95. 00		
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	in the	N		N		96. 00		
97.00   If line 96 is "Y", enter the reduction percentage in the appl	icable column		0.00		0. 00	)	97.00		

Health Financial Systems COLUMBUS REGIO	NAI HOSDITAI		In lie	u of Form CMS-	2552_10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eri od:	Worksheet S-2			
			rom 01/01/2023 o 12/31/2023		epared:		
			V	5/30/2024 7:0 XIX	02 am		
			1.00	2. 00			
98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			N	Y	98. 00		
98.01 Does title V or XIX follow Medicare (title XVIII) for the IC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.			N	Y	98. 01		
98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			N	Y	98. 02		
reimbursed 101% of inpatient services cost? Enter "Y" for y							
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.	N	N	98. 04				
98.05 Does title V or XIX follow Medicare (title XVIII) and add I Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.	N	Y	98. 05				
98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colur column 2 for title XIX.			N	Y	98. 06		
Rural Providers  105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	thod of payment	N N		105. 00 106. 00		
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for	rost reimbursen	ment for L&R	N		107. 00		
training programs? Enter "Y" for yes or "N" for no in colur Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instructions)	nn 1. (see ins you train I&F PF and/or IRF	structions) Rs in an			107.00		
107.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for L&R training programs? Enter "Y" for yes instructions)	t eligible for				107. 01		
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108. 00				
	Physi cal 1.00	0ccupati onal 2.00	Speech 3. 00	Respiratory 4.00	-		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00		
				1. 00	-		
110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N N	110.00		
appir casi c.							
111.00 f this facility qualifies as a CAH, did it participate in	the Frontier (	Community	1. 00 N	2. 00	111.00		
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating in	period? Enter enter the n column 2.	·				
		1.00	2.00	3. 00			
112.00 Did this hospital participate in the Pennsylvania Rural Her (PARHM) demonstration for any portion of the current cost is period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital content of participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	reporting column 1 is pating in the	N			112.00		
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			0115.00		
116.00 s this facility classified as a referral center? Enter "Y	for yes or	Y			116.00		
"N" for no. 117.00 s this facility legally-required to carry malpractice insu	ırance? Enter	Υ			117. 00		
"Y" for yes or "N" for no.  118.00 s the malpractice insurance a claims-made or occurrence po		and the second s			1		
if the policy is claim-made. Enter 2 if the policy is occur	,	1			118. 00		

118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.0000 NOT USE THIS LINE 119.0000 NOT USE THIS LINE 120.001s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S121 and applicable amendments? (see instructions) Enter in column 2, "" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S121 and applicable amendments? (see instructions) Enter in column 2, "" for yes or "N" for no.  121.001d this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00Does the cost report contain healthcare related taxes as defined in \$1903(w)(3) of the Act?Enter "Y" for yes or "N" for no.  123.00Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  12 column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  12 column 1 and termination date, if applicable, in column 2.  13 column 1 and termination date, if applicable, in column 2.  14 column 1 and termination date, if applicable, in column 2.  15 column 1 and termination date, if applicable, in column 2.	
Premiums   Losses   Insurance	18. 01 18. 02 19. 00 20. 00
118.01   List amounts of mal practice premiums and paid losses:   862,080   0   011	18. 02 19. 00 20. 00
118.01   List amounts of mal practice premiums and paid losses:   862,080   0   011	18. 02 19. 00 20. 00
118.01   List amounts of mal practice premiums and paid losses:   862,080   0   011	18. 02 19. 00 20. 00
118.02Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00D0 NOT USE THIS LINE  119.00D0 NOT USE THIS LINE  120.00Dis this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S1212 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S1212 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00Dld this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00Does the cost report contain heal theare related taxes as defined in \$1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00Dld the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  12 olobes the cost report the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  125.00Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00If this is a Medicare-certified in the publicable, in column 2.  128.00If this is a Medicare-certified panceas transplant program, enter	19. 00 20. 00 21. 00
118.02Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00D0 NOT USE THIS LINE  119.00D0 NOT USE THIS LINE  120.00Dis this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S1212 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S1212 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00Dld this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00Does the cost report contain heal theare related taxes as defined in \$1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00Dld the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  12 olobes the cost report the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  125.00Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00If this is a Medicare-certified in the publicable, in column 2.  128.00If this is a Medicare-certified panceas transplant program, enter	19. 00 20. 00 21. 00
119.00 DO NOT USE THIS LINE 120.00 LS this a SCM or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thacre related taxes as defined in \$1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. 123.00 Id the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consoluting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 If this	20. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.	
122.00 boes the cost report contain heal thcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 bid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 boes this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 lf this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 lf this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  128.00 lf this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 lf this is a Medicare-certified long transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 lf this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 lf this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.	22. 00
123.00 bid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare-certified papalicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.	
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in column 1 and termination date, if applicable, in column 2.  127.00	24 00
in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date	26. 00
in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date	27. 00 28. 00
130.00 If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date	29. 00
131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.  132.00 If this is a Medicare-certified islet transplant program, enter the certification date	30. 00
	31. 00
	32. 00
	33. 00 34. 00
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	40. 00
1.00 2.00 3.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	
	41. 00 42. 00
	43. 00 43. 00
1.00	
	14.00
1.00 2.00	
	45. 00
	46. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	COLUMBUS REGION		N. 15 0112	Dorsi od.	In Lie	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Fr			/01/2023 /31/2023		epared
				<b>'</b>		1.00	-
47.00Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no.			1. 00 N	147. C
48.00 Was there a change in the order o						N	148. 0
149.00 Was there a change to the simplif	ed cost finding method? E					N	149.0
		Part A	Part B		tle V	Title XIX	_
Does this facility contain a prov	iden that qualified for an	1.00	2.00		3. 00	4.00	
or charges? Enter "Y" for yes or							
55. 00 Hospi tal	N 101 110 101 each comport	N	N	J. (See 42	N 941	N N	155.0
56. 00 Subprovi der – TPF		N	l N		N	N N	156. 0
57.00 Subprovi der - IRF		N	l N		N	N	157. 0
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. 0
60. 00 HOME HEALTH AGENCY		N	N N		N	N	160.0
61. 00 CMHC			N		N	N	161. 0
61. 10 CORF			N N		N	N	161. 1
						1.00	$\dashv$
Multicampus						1.00	
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more camp	uses in dif	ferent CB	SAs?	N	165. 0
	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
66.00  f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	166. C
			,	,		1. 00	
Health Information Technology (HI				ment Act			
67.00 s this provider a meaningful use 68.00 of this provider is a CAH (line 1) reasonable cost incurred for the	05 is "Y") and is a meaning	gful user (lin		"), enter	the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, does	s this provide			shi p		168. (
69.00 If this provider is a meaningful transition factor. (see instructi		is not a CAH	(line 105 i				00169. (
					i nni ng	Endi ng	
70.00 5-1 1 1 2 515				1	1.00	2. 00	170 (
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending (	date for the r	eporting				170. (
				1	1.00	2. 00	-
71.00  f  ine 167 is "Y", does this pro	vider have any days for inc	di vi dual si enco	lledin		N	2.00	0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	I. 6? Enter		•		],,,,,

	Financial Systems COLUMBUS REGIO		ON: 1E 0110		u of Form CMS-			
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023		epared:		
				Y/N	Date	02 4111		
				1. 00	2. 00			
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			ter all dates in	the			
. 00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N S)		1.00		
		,	Y/N	Date	V/I			
. 00	Has the provider terminated participation in the Medicare	Drogrom? If	1.00 N	2. 00	3. 00	2.00		
. 00	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi	ng management offices, drug der or its	Y			3.00		
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)							
			Y/N	Туре	Date			
	Et		1.00	2. 00	3. 00			
5. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.  Are the cost report total expenses and total revenues diff	for Compiled, vailable in	Y	A		4.00		
00	those on the filed financial statements? If yes, submit re					0.00		
	Y/N 1.00							
. 00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N the legal operator of the program?							
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.	ne Y		7. 00 8. 00				
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ons.				9. 00		
0.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00		
1. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.		proved 	N	Y/N	11.00		
					1. 00			
	Bad Debts							
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			cost reporting	Y N	12. 00 13. 00		
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurinstructions.	rance amounts w	aived? If yes	s, see	N	14.00		
5. 00	Bed Complement Did total beds available change from the prior cost report		yes, see ins	structions.	Y t B	15.00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	03/31/2024	Y	03/31/2024	16.00		
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/31/2024	Y	03/31/2024	17.00		
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	N		N		18.00		
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00		

Heal th	Financial Systems COLUMBUS REGI	ONAL HOSPITAL		In Lie	u of Form CMS	-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	From To		Peri od: From 01/01/2023	Worksheet S- Part II	2 epared:		
		Desci	ription	Y/N	Y/N			
		MGD CARE PART	0	1.00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	Y	N	20.00				
		Y/N	Date	Y/N	Date			
		1. 00	2. 00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	PEDT CHILDDENS	HUCDI TVI C)		1. 00			
	Capital Related Cost	CEPT CHILDRENS	HUSPITALS)					
22. 00	Have assets been relifed for Medicare purposes? If yes, se	a instruction	c		N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	N N	23. 00					
23.00		e due to appra	i sai s illaue uu	iring the cost	IN	23.00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	sod into durin	a this cost r	operting period?	Υ	24. 00		
24.00	If yes, see instructions	ed Titto dulting	y tilis cost i	epoi triig perrou?	T	24.00		
25 00		, the east res	on+i na noni od	Olfwan and	N	25. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	j the cost rep	orting period	r II yes, see	IN	25.00		
27 00				16	N.	2/ 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during to	the cost repor	ting period?	rr yes, see	N	26. 00		
27 00	instructions.		ina norioda I	f voc oubmit	N	27.00		
27. 00	Has the provider's capitalization policy changed during the	ie cost report	ing perrou? i	i yes, subiii t	N	27. 00		
	Copy.					_		
20.00	Interest Expense	ntored into d	+ba aaa	t ranartina	Υ	30.00		
28. 00	Were new loans, mortgage agreements or letters of credit e	enterea into a	uring the cos	t reporting	Y	28. 00		
20.00	period? If yes, see instructions.	- hl &l- (1	D-b+ C	D	V	20.00		
29. 00	Did the provider have a funded depreciation account and/or		Debt Service	Reserve Funa)	Υ	29. 00		
20.00	treated as a funded depreciation account? If yes, see inst		1.1.10.16		.,	00.00		
30. 00	Has existing debt been replaced prior to its scheduled mat	turity with ne	w debt? IT ye	s, see	Υ	30.00		
04 00	instructions.		1.1.10.16		.,	04.00		
31. 00	Has debt been recalled before scheduled maturity without i	ssuance or ne	w debt? IT ye	s, see	N	31.00		
	instructions.							
00.00	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care se		nea through c	ontractuai	Υ	32.00		
00.00	arrangements with suppliers of services? If yes, see instr					00.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	opiled pertain	ing to compet	ITIVE blading? IT		33. 00		
	no, see instructions.					_		
	Provi der-Based Physi ci ans					٠		
34. 00	Were services furnished at the provider facility under an	arrangement w	ith provider-	based physicians?	Y	34.00		
05 00	If yes, see instructions.				.,	05.00		
35. 00			ents with the	provi der-based	Y	35. 00		
	physicians during the cost reporting period? If yes, see i	nstructions.		V (A)	5 .			
				Y/N	Date			
	U 0CC' 0 I .			1.00	2. 00			
24 00	Home Office Costs			\/		24 00		
	Were home office costs claimed on the cost report?	amanama di ili	o hom:CC'	Y		36.00		
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the	e nome office	? Y		37. 00		
00.00	If yes, see instructions.	CC:				00.00		
38. 00	If line 36 is yes, was the fiscal year end of the home of			f N		38. 00		
20.00	the provider? If yes, enter in column 2 the fiscal year er			- \		20.00		
39. 00	j , , , , , , , , , , , , , , , , , , ,	iei charn comp	onents? IT ye	s, Y		39. 00		
40.00	see instructions.	homo office	If was as-	NI		40.00		
40.00	0.00    If line 36 is yes, did the provider render services to the home office? If yes, see   N							
	i nstructi ons.							
	1.00							
	Cost Report Preparer Contact Information 2.							
41. 00	Cost Report Preparer Contact Information  On Enter the first page Last page and the title/position							
41.00	· ·	first name, last name and the title/position KERRY BEJARANO						
	held by the cost report preparer in columns 1, 2, and 3,							
42 00	respectively.	FORVI S				42.00		
42. 00	Enter the employer/company name of the cost report	IUKVIS				42. UU		
43. 00	preparer. Enter the telephone number and email address of the cost	317-383-4000		KERRY. BEJARANO	@EUDVIS COM	43.00		
45.00	report preparer in columns 1 and 2, respectively.	317-303-4000		KERKT. DEJAKANU	CI DINVI J. COM	45.00		
	1. Sport property in sorumns rand 2, respectivery.	1		T .		П		

Heal th	Financial Systems	COLUMBUS REGION	NAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der	CCN: 15-0112	Peri From To	n 01/01/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 7:0	pared:
				3. 00				
	Cost Report Preparer Contact Information							
	Enter the first name, last name and the title		OI RECTOR					41.00
	held by the cost report preparer in columns	1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost	report						42.00
	preparer.							
43.00	Enter the telephone number and email address	of the cost						43.00
	report preparer in columns 1 and 2, respecti	vel y.						

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Heal th Fi nancial SystemsCOLUMBUSHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0112

				Т	o 12/31/2023	Date/Time Pre 5/30/2024 7:0	
						I/P Days /	2 4111
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA		401	70.070			
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	196	73, 970	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider						3.00
4. 00	HMO IRF Subprovider						4.00
5. 00	4 · · · · · · · · · · · · · · · · · · ·					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		196	72 070	0.00	_	7.00
7.00	beds) (see instructions)		190	73, 970	0. 00	U	7.00
8. 00	INTENSIVE CARE UNIT	31.00	17	6, 205	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT	32.00	0				9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34.00	0	1			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	34.00	0	1	0.00		12.00
13. 00	NURSERY	43.00		•		0	13.00
14. 00	Total (see instructions)	43.00	213	80, 175	0.00	_	14.00
15. 00	CAH visits		213	00, 173	0.00	Ö	15. 00
15. 10	REH hours and visits				0.00		15. 10
16. 00	SUBPROVI DER - I PF	40. 00	0	0		Ö	16. 00
17. 00	SUBPROVI DER - I RF	41.00	19	1		Ö	17. 00
18. 00	SUBPROVI DER	42.00	Ő			Ö	18.00
19. 00	SKILLED NURSING FACILITY	44.00	0			Ö	19. 00
20.00	NURSING FACILITY	11.00					20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	101.00				0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				Ō	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		232				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	o			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						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

Provider CCN: 15-0112

						5/30/2024 7:0	2 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
		T	T1.11 V1.V				
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		4 00	7.00	Pati ents	& Residents	Payrol I	
	DADT I OTATIOTICAL DATA	6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA				T .		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	10, 283	884	31, 001			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	0.045	7 (0)				0.00
2.00	HMO and other (see instructions)	9, 365	7, 606				2.00
3.00	HMO I PF Subprovi der	010	401				3.00
4. 00	HMO I RF Subprovi der	919	401				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	10 000	0				6.00
7. 00	Total Adults and Peds. (exclude observation	10, 283	884	31, 001			7. 00
0.00	beds) (see instructions)	711	170	2 520			0.00
8. 00	INTENSIVE CARE UNIT	711	179	3, 528			8.00
9.00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0				10.00
11.00	SURGICAL INTENSIVE CARE UNIT	U	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		0.40	0 (07			12.00
13.00	NURSERY	10.004	262			4 0/0 00	13.00
14.00	Total (see instructions)	10, 994	1, 325			1, 369. 02	1
15.00	CAH visits	0	0	0			15.00
15. 10	REH hours and visits	U	0			0.00	15. 10
16.00	SUBPROVIDER - I PF	1 700		_		0.00	1
17.00	SUBPROVIDER - IRF	1, 708	62	3, 584		l	1
18.00	SUBPROVI DER	0	0	0		l	l
19.00	SKILLED NURSING FACILITY	U	0	0	0. 00	0.00	1
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0	0		0.00	0.00	21.00
22. 00	HOME HEALTH AGENCY	U	0	0	0. 00	0.00	1
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC		0		0.00	0.00	25.00
25. 10	CMHC - CORF	0	0	0			
26.00	RURAL HEALTH CLINIC	0	0	0		l e	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	0	0		0.00	1
27. 00	Total (sum of lines 14-26)		4 045		0. 00	1, 392. 02	•
28. 00	Observation Bed Days	0.447	1, 245	4, 921			28. 00
29. 00	Ambul ance Tri ps	3, 467					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		4-7-7	0			31.00
32.00	Labor & delivery days (see instructions)	0	177	335			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0	0	_			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0	l	l	34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0112

				To	12/31/2023	Date/Time Prep 5/30/2024 7:03	
		Full Time		Di sch	arges	373072024 7.0	z aiii
		Equi val ents			. 5		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA			,			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 819	1, 857	9, 065	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			4 005			0.00
2.00	HMO and other (see instructions)			1, 905	0		2.00
3.00	HMO IPF Subprovi der				0		3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				U		4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF						6. 00
7. 00							7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	2, 819	1, 857	9, 065	14.00
15. 00	CAH visits			, -	,	, , , , , , ,	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVI DER - I RF	0.00	0	113	29	243	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						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	0.00					25. 00
25. 10	CMHC - CORF	0. 00 0. 00					25. 10 26. 00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 00
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28.00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00				0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0112 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:02 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 1.00 Total salaries (see 120, 625, 322 -731, 434 119, 893, 888 2, 870, 781. 00 41.76 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 3 00 Non-physician anesthetist Part C 0 00 0 00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0.00 0.00 4.01 2, 917, 980 5.00 Physician and Non 2, 917, 980 12, 872. 00 226. 69 5.00 Physician-Part B 6.00 Non-physician-Part B for 229, 584 229, 584 4, 160. 00 55.19 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 7.00 0 0.00 0.00 0 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44 00 SNF 0.00 0 00 9 00 10.00 Excluded area salaries (see 7, 728, 312 1, 187, 218 8, 915, 530 246, 403. 00 36. 18 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 41, 821, 458 41, 821, 458 480, 502.00 87.04 11.00 Contract Labor: Top Level 23, 982. 00 55.73 12.00 1, 336, 556 1, 336, 556 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 6, 453, 552 0 6, 453, 552 48, 782. 00 132. 29 13.00 A - Administrative 14.00 Home office and/or related 0 0.00 14.00 0 0.00 organization salaries and wage-related costs 58, 882. 00 14.01 Home office salaries 7,077,586 7,077,586 120, 20 14.01 Related organization salaries 14.02 14.02 0.00 0.00 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A O 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 26, 626, 941 26, 626, 941 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 2, 189, 265 2, 189, 265 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 21.00 0 0 22.00 Physician Part A -0 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 23.00 696, 428 696, 428 23 00 24.00 Wage-related costs (RHC/FQHC) 24.00 0 25.00 Interns & residents (in an 25.00 approved program) 25.50 1, 766, 694 Home office wage-related 0 1, 766, 694 25.50

0

0

0

25.51

25.52

(core)

Related organization

Home office: Physician Part A

wage-related (core)

- Administrative wage-related (core)

25.51

25.52

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0112 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:02 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 228, 023 -226, 094 1, 929 115.00 16. 77 26.00 27.00 Administrative & General 5.00 23, 634, 267 -385, 505 23, 248, 762 456, 304. 00 50. 95 27.00 28. 00 7, 071, 970 7, 071, 970 87, 899. 00 80. 46 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 3, 813, 673 80, 759 3, 894, 432 104, 074. 00 37. 42 30.00 32, 728 Laundry & Linen Service 8.00 32, 228 1, 410. 00 23. 21 31.00 31.00 500 32.00 Housekeepi ng 9.00 2, 621, 311 574 2, 621, 885 126, 834. 00 20.67 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 2, 805, 487 34.00 Dietary 10.00 -1, 617, 288 1, 188, 199 51, 703. 00 22. 98 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 1, 634, 797 1, 634, 797 71, 138. 00 22. 98 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 6, 834, 982 159, 051. 00 42. 97 38.00 38.00 13.00 6, 656, 413 178, 569 39.00 Central Services and Supply 14.00 150 150 8.00 18. 75 39.00 4, 031, 731 3, 910, 049 71, 300. 00 40.00 Pharmacy 15.00 -121, 682 54.84 40.00 Medical Records & Medical Records Library 2, 684, 198 22. 40 41.00 16.00 -1, 050, 328 1, 633, 870 72, 946. 00 41.00

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-01	Worksheet S-3

110311	THE WAGE TRUES THE ORIGINATION			Trovider c		From 01/01/2023 To 12/31/2023	Part III Date/Time Prep 5/30/2024 7:03	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		124, 549, 728	-731, 434	123, 818, 29	2, 941, 648. 00	42. 09	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 728, 312	1, 187, 218	8, 915, 53	246, 403. 00	36. 18	2.00
	instructions)							
3.00	Subtotal salaries (line 1		116, 821, 416	-1, 918, 652	114, 902, 76	2, 695, 245. 00	42. 63	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		56, 689, 152	0	56, 689, 15	612, 148. 00	92. 61	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		28, 393, 635	0	28, 393, 63	0.00	24. 71	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		201, 904, 203					
7. 00	Total overhead cost (see		53, 579, 451	-1, 505, 698	52, 073, 75	1, 202, 782. 00	43. 29	7. 00
	instructions)							

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0112	Period: Worksheet S-3 From 01/01/2023 Part IV	
		To 12/31/2023 Date/Time Prepared:	

	To 12/31/2023	B Date/Time Pre 5/30/2024 7:0	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	4, 430, 842	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	12, 918, 044	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	440, 127	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	51, 357	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 710, 913	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		599, 796	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
		8, 772, 765	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	1, 784	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (se	<b>e</b> 0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23. 00	Tuition Reimbursement	587, 007	23. 00
24. 00		29, 512, 635	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0112	Peri od: Worksheet S-3
		From 01/01/2023   Part V

		То	12/31/2023	Date/Time Prep 5/30/2024 7:03	
	Cost Center Description		Contract	Benefit Cost	
		L	Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		41, 821, 458	29, 512, 635	1.00
2. 00	Hospi tal		41, 821, 458	29, 512, 635	2.00
3. 00	SUBPROVI DER - I PF		0	0	3.00
4. 00	SUBPROVI DER - I RF		0	0	4.00
5. 00	Subprovi der - (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	SKILLED NURSING FACILITY		0	0	8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospi tal -Based HHA		0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospi tal -Based-CMHC				16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17.00	RENAL DIALYSIS I		0	o	17.00
18. 00	0ther		o	0	18.00

Heal th	Financial Systems COLUMBUS REGIONA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 329948	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				35, 709, 728	2.00		
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplem	ontal naumon	to from Modia	nai dO		3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments			ai u r	7, 259, 869	5.00		
6. 00	Medicaid charges	Trom wearca	ıu		174, 188, 557	6.00		
7. 00	Medicaid cost (line 1 times line 6)				57, 473, 166			
8.00	Difference between net revenue and costs for Medicaid progra	m (see instru	uctions)		14, 503, 569			
	Children's Health Insurance Program (CHIP) (see instructions	for each lir	ne)					
9.00	Net revenue from stand-alone CHIP				0			
10.00	Stand-al one CHIP charges				0	10.00		
11.00	, ,	D (			0			
12. 00	Difference between net revenue and costs for stand-alone CHI			.)	0	12. 00		
13. 00	Other state or local government indigent care program (see in Net revenue from state or local indigent care program (Not in				0	13.00		
14. 00	Charges for patients covered under state or local indigent care				0			
11.00	10)	are program	(Not Therade			11.00		
15.00	State or local indigent care program cost (line 1 times line	14)			0	15.00		
16.00	Difference between net revenue and costs for state or local				0	16.00		
	Grants, donations and total unreimbursed cost for Medicaid, (	CHIP and stat	te/Local indi	gent care progra	ms (see			
47.00	instructions for each line)	6 . !! !				47.00		
17. 00 18. 00	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support o				0	17. 00 18. 00		
19. 00				ns (sum of lines	14, 503, 569			
19.00	8, 12 and 16)	cai indigent	care program	is (suil of filles	14, 303, 307	19.00		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1.00	2. 00	3. 00			
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruction	nc)	10, 784, 2	58 3, 974, 832	14, 759, 090	20.00		
21. 00	Cost of patients approved for charity care and uninsured dis-	,	3, 558, 2					
21.00	instructions)	counts (see	3, 330, 2	3, 774, 032	7, 333, 070	21.00		
22.00	Payments received from patients for amounts previously writte	en off as		0 0	0	22. 00		
	charity care							
23.00	Cost of charity care (see instructions)		3, 558, 2	3, 974, 832	7, 533, 076	23.00		
					4 00			
24. 00	Does the amount on line 20 col. 2, include charges for paties	nt days hove	nd a Longth	of ctay limit	1. 00 N	24. 00		
24.00	imposed on patients covered by Medicaid or other indigent ca		id a religiti (	n Stay IIIIII t	IV	24.00		
25.00	If line 24 is yes, enter the charges for patient days beyond		t care progra	m's Lenath of	0	25. 00		
	stay limit	3		3				
25. 01	Charges for insured patients' liability (see instructions)				0			
26.00					10, 508, 771			
27. 00	` ,				463, 537			
27. 01	Medicare allowable bad debts (see instructions)				713, 132			
28. 00 29. 00	Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt	omounts (sss	i netrueti en	.)	9, 795, 639 3, 481, 646			
30.00		amounts (See	THIS LEWCLEONS	•)	11, 014, 722			
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			25, 518, 291			
00	The state of the s	50)						

	Financial Systems COLUMBUS REGIONAL HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CC	N: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/30/2024 7:0	pared:		
					1. 00			
	PART II - HOSPITAL DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio				0. 326576	1. 00		
1. 00	Cost to charge ratio (see instructions)							
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					2.00		
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplementa	al navmont	s from Modi	sai d2		3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fro	1 2		zai u :		5.00		
6. 00	Medicaid charges	m wearear	u			6. 00		
7. 00	Medicaid cost (line 1 times line 6)					7. 00		
8.00	Difference between net revenue and costs for Medicaid program (s	see instru	ictions)			8.00		
	Children's Health Insurance Program (CHIP) (see instructions for	each lin	e)					
9.00	Net revenue from stand-alone CHIP					9.00		
10.00	Stand-alone CHIP charges					10.00		
	Stand-alone CHIP cost (line 1 times line 10)					11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (s			`		12.00		
12 00	Other state or local government indigent care program (see instr					12.00		
13. 00 14. 00	Net revenue from state or local indigent care program (Not inclu Charges for patients covered under state or local indigent care					13. 00 14. 00		
14.00	10)	program (	Not Therade	i ili ililes o oi		14.00		
15. 00	State or local indigent care program cost (line 1 times line 14)	1				15.00		
	Difference between net revenue and costs for state or local indi		program (se	ee instructions)		16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and stat	e/local indi	gent care progra	ms (see			
	instructions for each line)					17.00		
	00 Private grants, donations, or endowment income restricted to funding charity care							
18. 00	Government grants, appropriations or transfers for support of ho					18.00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	i ndi gent	care program	ns (sum of lines		19.00		
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1			
			patients	patients	,			
			patients 1.00	pati ents 2.00	+ col . 2) 3.00			
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	+ col . 2) 3.00			
20. 00	Charity care charges and uninsured discounts (see instructions)		1.00	2. 00 58 3, 958, 480	+ col . 2) 3.00			
20. 00 21. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour	nts (see	1. 00	2. 00 58 3, 958, 480	+ col . 2) 3.00			
21. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions)	,	1.00	2. 00 58 3, 958, 480 3, 958, 480	+ col . 2) 3.00 14,742,738 7,480,360	21.00		
	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written of	,	1.00	2. 00 58 3, 958, 480	+ col . 2) 3.00			
21. 00 22. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care	,	1. 00 10, 784, 2 3, 521, 8	2.00 58 3,958,480 80 3,958,480 0 0	+ col. 2) 3.00 14,742,738 7,480,360	21. 00 22. 00		
21. 00 22. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written of	,	1.00	2.00 58 3,958,480 80 3,958,480 0 0	+ col . 2) 3.00 14,742,738 7,480,360	21. 00 22. 00		
21. 00 22. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care	,	1. 00 10, 784, 2 3, 521, 8	2.00 58 3,958,480 80 3,958,480 0 0	+ col. 2) 3.00 14,742,738 7,480,360	21. 00 22. 00		
21. 00 22. 00 23. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care	off as	1. 00 10, 784, 2 3, 521, 8 3, 521, 8	2.00 58 3,958,480 80 3,958,480 0 0 80 3,958,480	+ col · 2) 3.00 14,742,738 7,480,360 0 7,480,360	21. 00 22. 00		
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care p	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col · 2) 3.00 14,742,738 7,480,360 0 7,480,360	21. 00 22. 00 23. 00 24. 00		
21. 00 22. 00 23. 00 24. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient cimposed on patients covered by Medicaid or other indigent care patient 24 is yes, enter the charges for patient days beyond the	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col · 2) 3.00 14,742,738 7,480,360 0 7,480,360	21. 00 22. 00 23. 00 24. 00		
21. 00 22. 00 23. 00 24. 00 25. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col. 2) 3.00 14,742,738 7,480,360 0 7,480,360 1.00 N	21. 00 22. 00 23. 00 24. 00 25. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Charges for insured patients' liability (see instructions)	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00  N  0	21. 00 22. 00 23. 00 24. 00 25. 00 25. 01		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care patient 24 is yes, enter the charges for patient days beyond the stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00 N 0 10,461,292	21.00 22.00 23.00 24.00 25.00 25.01 26.00		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care patient 24 is yes, enter the charges for patient days beyond the stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00 N  0 10,461,292 453,143	21.00 22.00 23.00 24.00 25.00 25.01 26.00 27.00		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care partially limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	days beyor	1.00 10,784,2 3,521,8 3,521,8	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00 N  0 10,461,292 453,143 697,142	21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care particularly limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	days beyor program? e indigent	1.00 10,784,2 3,521,8 3,521,8 d a Length of	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit am's length of	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00  N  0 10,461,292 453,143 697,142 9,764,150	21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care partially limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	days beyor program? e indigent	1.00 10,784,2 3,521,8 3,521,8 d a Length of	2.00  58 3,958,480 3,958,480 0 0 80 3,958,480 of stay limit am's length of	+ col. 2) 3.00  14,742,738 7,480,360  0 7,480,360  1.00 N  0 10,461,292 453,143 697,142	21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00		

	Financial Systems	COLUMBUS REGIONA				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C		eriod: rom 01/01/2023	Worksheet A	
					o 12/31/2023	Date/Time Pre	pared:
		1			la	5/30/2024 7:0	2 am
	Cost Center Description	Sal ari es	Other		Reclassificat	Reclassified Trial Balance	
				+ col . 2)	i ons (See A-6)	(col. 3 +-	
					,, 0)	col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT		25, 310, 482				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		0	0	14, 108, 318		2.00
3.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	228, 023	0 25 420 257	25 457 200	2 200 122	0	3.00
4. 00 5. 00	00500 ADMI NI STRATI VE & GENERAL	23, 634, 267	35, 429, 357 57, 946, 126	35, 657, 380 81, 580, 393		32, 449, 258 76, 210, 415	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	3, 813, 673	9, 463, 654			10, 025, 702	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	32, 228	891, 561	923, 789		924, 289	8.00
9. 00	00900 HOUSEKEEPI NG	2, 621, 311	705, 569			3, 327, 454	9.00
10.00	01000 DI ETARY	2, 805, 487	1, 678, 762			1, 894, 790	10.00
11. 00	01100 CAFETERI A	0	0	O	-,,	2, 606, 968	11.00
13.00	01300 NURSING ADMINISTRATION	6, 656, 413	1, 142, 278			7, 988, 111	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	150	1, 000, 584	1, 000, 734		1, 303, 260	14.00
15.00	01500 PHARMACY	4, 031, 731	2, 533, 274			6, 484, 723	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 684, 198	248, 725		-1, 105, 724	1, 827, 199	16.00
17. 00 23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	17. 00 23. 00
23. 00	02301 XRAY EDUCATION	167, 162	4, 599	171, 761	472, 040	643, 801	23.00
23. 02	02302 PHARMACY RESIDENCY PROG	106, 953	6, 172			309, 443	23. 02
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	100, 700	0, 172	110,120	170,010	007, 110	20.02
30.00	03000 ADULTS & PEDIATRICS	28, 196, 234	10, 873, 177	39, 069, 411	-1, 494, 897	37, 574, 514	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 797, 114	2, 850, 689	6, 647, 803	-108, 998	6, 538, 805	31.00
32.00	03200 CORONARY CARE UNIT	0	0	O	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0 104 005	0	0 504 000	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	2, 136, 805	387, 225	2, 524, 030	258, 995	2, 783, 025	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	1, 611, 171	54, 136	1 665 207	20 570	0 1, 636, 729	42. 00 43. 00
44.00	04400 SKILLED NURSING FACILITY	1, 611, 171	04, 130			1, 030, 729	44.00
44.00	ANCI LLARY SERVI CE COST CENTERS	J 0			<u> </u>	0	1 44.00
50.00	05000 OPERATING ROOM	1, 422, 018	37, 014, 037	38, 436, 055	-8, 640, 571	29, 795, 484	50.00
51.00	05100 RECOVERY ROOM	87	1, 665, 818			2, 059, 431	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	2, 128, 538	2, 128, 538	52.00
53.00	05300 ANESTHESI OLOGY	0	65, 401	65, 401		125, 401	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	1, 819, 453	1, 759, 454	3, 578, 907		3, 362, 998	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	603, 737	1, 746, 367			2, 596, 219	54. 01
54. 02 54. 03	05404 ULTRA SOUND	743, 147	107, 219			1, 011, 199	54.02
55.00	05405   MAMMOGRAPHY   05500   RADI OLOGY-THERAPEUTI C	849, 521 704, 350	208, 172 1, 247, 332			1, 310, 251 2, 503, 970	54. 03 55. 00
57. 00	05700 CT SCAN	903, 064	803, 161	1, 706, 225		1, 930, 168	
58. 00	05800 MRI	641, 398	136, 937			1, 406, 689	1
	05900 CARDI AC CATHETERI ZATI ON	2, 100, 370	7, 820, 428				
60.00	06000 LABORATORY	4, 333, 002	7, 747, 496			12, 455, 585	ı
60. 01	06001 LABORATORY-PATHOLOGI CAL	493, 591	964, 943	1, 458, 534		1, 752, 707	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	656, 471	656, 471		744, 425	ı
65.00	06500 RESPI RATORY THERAPY	2, 476, 220	1, 435, 695			3, 824, 671	65.00
66.00	06600 PHYSI CAL THERAPY	286, 647	7, 294, 277	7, 580, 924		7, 214, 843	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	68, 871 219, 196	1, 422, 846			2, 518, 132	67.00
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 059, 531	943, 008 448, 064	1, 162, 204 1, 507, 595		1, 069, 303 1, 517, 344	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	600, 026	676, 721	1, 276, 747		1, 450, 625	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	000,020	0,0,721	0		11, 017, 157	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0			10, 427, 064	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	25, 390, 318	25, 390, 318		25, 390, 318	73.00
74. 00	07400 RENAL DIALYSIS	Ö	824, 501	824, 501		824, 501	74.00
76.00	03020 ACUPUNCTURE	O	0	C	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	315, 907	140, 492	456, 399	3, 164	459, 563	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS	7	^			2	00 00
88. 00 89. 00	08800   RURAL HEALTH CLINIC   08900   FEDERALLY QUALIFIED HEALTH CENTER		0			0	88. 00 89. 00
90.00	09000 CLINIC	3, 049, 128	516, 095	3, 565, 223	-68, 446	3, 496, 777	90.00
90. 01	09001 DI ABETES CENTER	0, 0, 7, 120	0.0,070	0, 000, 220	00, 440	0,470,777	90.01
90. 02	09002 NEUROPSYCH	334, 280	10, 158	344, 438	13, 678	358, 116	90.02
90. 03	09003 WOUND CENTER	864, 381	1, 089, 830			1, 940, 431	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	0	0	0	274, 202	274, 202	90.04
90. 05	09005 VI MCARE CLI NI C	641, 079	66, 987	708, 066		703, 282	90.05
90.06	09006 MEDICATION MGMT CLINIC	310, 317	1, 965	312, 282		293, 987	90.06
91.00	09100 EMERGENCY	7, 945, 689	1, 394, 562	9, 340, 251	2, 225, 860	11, 566, 111	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

Health Financial Systems	COLUMBUS REGION	IAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2023	5 . (7)	
				To 12/31/2023	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col	Reclassi fi cat		z aiii
oost denter beson per on	Sararres	Othor	+ col . 2)	i ons (See	Tri al Balance	
			' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	A-6)	(col. 3 +-	
				,	col . 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 350, 275	426, 598	3, 776, 87	3 97, 572	3, 874, 445	95.00
99. 10 09910 CORF	O	0		0 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	O	0		0 0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	O	0		0 0	0	102.00
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 ACQUISITION	0	0		0	0	111. 00
113.00 11300 INTEREST EXPENSE		2, 578, 661	2, 578, 66	1 -2, 578, 661	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	118, 658, 205	257, 130, 384	375, 788, 58	9 -1, 270, 887	374, 517, 702	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 48, 943	48, 943	190.00
194.00 07950 WELLNESS COMMUNITY	0	0		0 345, 322	345, 322	194.00
194. 01 07951 BUI LDI NG RENTALS	0	909, 413	909, 41	3 -660, 323	249, 090	194. 01
194. 02 07952 HOSPI CE	0	123, 479	123, 47	9 0	123, 479	194. 02
194. 03 07953 OUTREACH CLINICS	0	0		0	0	194.03
194.04 07954 SPEECH - HEARING AIDS	0	0		0 163, 796	163, 796	194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0 821, 990	821, 990	194. 05
194.06 07956 CRH FOUNDATION	59, 407	4, 624	64, 03	1 0	64, 031	194.06
194.07 07957 HEALTHY COMMUNITIES	0	0		0	0	194. 07
194. 08 07958 CRHP	1, 907, 710	906, 210	2, 813, 92	0 551, 159	3, 365, 079	194. 08
194.09 07959 NEUROPSYCH PART B	o	0		0 0	0	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	120, 625, 322	259, 074, 110	379, 699, 43	2 0	379, 699, 432	200. 00

Provi der CCN: 15-0112

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 7: 02 am Cost Center Description Adjustments Net Expenses

		Cost Center Description	Adjustments	Net Expenses		
			(See A-8)	For Allocation		
			6. 00	7. 00		
	GENER	AL SERVICE COST CENTERS				
1.00		CAP REL COSTS-BLDG & FIXT	-4, 579, 275		·	1.00
2. 00 3. 00		CAP REL COSTS-MVBLE EQUIP OTHER CAP REL COSTS	-122, 460 0			2. 00 3. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	-970, 454		l .	4.00
5.00		ADMINISTRATIVE & GENERAL	-27, 392, 412			5. 00
7. 00		OPERATION OF PLANT	-811, 386			7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0 -18, 040			8. 00 9. 00
10.00		DI ETARY	-7, 960			10.00
11. 00		CAFETERI A	-859, 929			11.00
13.00		NURSING ADMINISTRATION	-94, 371			13.00
14. 00 15. 00	1	CENTRAL SERVI CES & SUPPLY   PHARMACY	-55, 122			14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	-61, 953 -2, 553			16.00
17. 00		SOCIAL SERVICE	0			17. 00
23. 00	1	PARAMED ED PRGM	0	0		23. 00
23. 01		XRAY EDUCATION	-28, 190			23. 01 23. 02
23. 02		PHARMACY RESIDENCY PROG LENT ROUTINE SERVICE COST CENTERS	0	309, 443		23.02
30.00		ADULTS & PEDIATRICS	188, 327	37, 762, 841		30.00
31.00	03100	INTENSIVE CARE UNIT	-13, 000			31.00
32.00		CORONARY CARE UNIT	0	1	•	32.00
33. 00 34. 00	1	BURN INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT	0	0	I	33. 00 34. 00
40.00		SUBPROVIDER - IPF	0		·	40.00
41. 00		SUBPROVI DER - I RF	-12, 500		l .	41.00
42.00	1	SUBPROVI DER	0	0		42.00
43.00		NURSERY	0	1, 636, 729		43.00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0		44.00
50.00		OPERATING ROOM	-6, 420, 925	23, 374, 559		50.00
51.00		RECOVERY ROOM	-87, 521	1, 971, 910		51.00
52.00		DELIVERY ROOM & LABOR ROOM	0			52.00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	-2, 428 -1, 117, 482			53. 00 54. 00
54. 01	1	NUCLEAR MEDICINE-DIAGNOSTIC	0			54. 01
54.02		ULTRA SOUND	0	1, 011, 199		54. 02
54. 03	1	MAMMOGRAPHY	-3, 239			54. 03
55. 00 57. 00	1	RADI OLOGY-THERAPEUTI C CT SCAN	-23, 519 -5, 029			55. 00 57. 00
58. 00	05800		-5,029			58.00
59. 00		CARDI AC CATHETERI ZATI ON	-11, 785			59.00
60.00	1	LABORATORY	-18, 756			60.00
60. 01	1	LABORATORY-PATHOLOGICAL	-37, 284			60. 01
62. 00 65. 00		WHOLE BLOOD & PACKED RED BLOOD CELL   RESPIRATORY THERAPY	-16, 029	,		62. 00 65. 00
		PHYSI CAL THERAPY	-24, 071			66.00
	06700	OCCUPATI ONAL THERAPY	0			67.00
68.00		SPEECH PATHOLOGY	-1, 171	1, 068, 132		68.00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	1, 517, 344 1, 450, 625		69. 00 70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11, 017, 157	·	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	10, 427, 064	·	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	25, 390, 318	l .	73. 00
74.00		RENAL DI ALYSI S ACUPUNCTURE	0	824, 501 0		74.00
76. 00 76. 97	1	CARDI AC REHABI LI TATI ON	0	459, 563	l .	76. 00 76. 97
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0	1	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
00 00		TIENT SERVICE COST CENTERS		Ιο		90 00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0		l .	88. 00 89. 00
90.00		CLINIC	-11, 194	1	l .	90.00
90. 01	09001	DI ABETES CENTER	0	0		90. 01
90. 02	1	NEUROPSYCH	-229, 584			90. 02
90. 03 90. 04	1	WOUND CENTER  HYPERBARIC OXYGEN THERAPY	-20, 968 -805			90. 03 90. 04
90.04	1	VIMCARE CLINIC	-603	703, 282		90.04
90.06		MEDICATION MGMT CLINIC	0	293, 987		90.06
91.00		EMERGENCY	-832, 992	10, 733, 119		91.00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1	I		92.00

 
 Health Financial
 Systems
 COLUMBUS REPORTED

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

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			To 12/31/2023 Date/Time F 5/30/2024 7	³repared: 7·02 am
Cost Center Description	Adjustments	Net Expenses	0,00,2021	
	(See A-8)	For		
		Allocation		
	6. 00	7.00		
OTHER REIMBURSABLE COST CENTERS				
95. 00  09500 AMBULANCE SERVICES	-512	3, 873, 933		95.00
99. 10  09910  CORF	0	0		99. 10
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-43, 706, 572	330, 811, 130		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	48, 943		190.00
194. 00 07950 WELLNESS COMMUNITY	23, 868			194. 00
194. 01 07951 BUILDING RENTALS	0	249, 090		194. 01
194. 02 07952 HOSPI CE	0	123, 479		194. 02
194. 03 07953 OUTREACH CLINICS	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	163, 796		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	821, 990		194. 05
194. 06 07956 CRH FOUNDATION	0	64, 031		194. 06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0		194. 07
194. 08 07958 CRHP	-200, 853	3, 164, 226		194. 08
194. 09 07959 NEUROPSYCH PART B	0	0		194. 09
200.00   TOTAL (SUM OF LINES 118 through 199)	-43, 883, 557	335, 815, 875		200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 7:02 am Provider CCN: 15-0112

						5/30/2024 7: 02 am
	01	Increases	6.1	011		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	B - RECLASS INTEREST	3.00	4.00	5.00	 	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 239, 019		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	13 <u>9, 6</u> 33		2. 00
	TOTALS		0	2, 378, 652		
1 00	C - RECLASS INSURANCE	1 00	O	1 450 500		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT LABORATORY	1. 00 60. 00	0	1, 458, 590 5, 470		1.00
3. 00	OCCUPATIONAL THERAPY	67. 00	o	2, 657		3.00
4. 00	AMBULANCE SERVICES	95. 00	ō	63, 252		4.00
	TOTALS		0	1, 529, 969		
	D - RECLASS BILLING COST					
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 085, 750	3, 856		1.00
2. 00	TOTALS	194. 08	00 1, 085, 750	<u>51, 540</u> 55, 396		2.00
	E - RECLASS HYPERBARIC THERAF	PY FXPENSE	1,065,750	33, 390		
1.00	HYPERBARI C OXYGEN THERAPY	90. 04	102, 359	115, 891		1.00
	TOTALS		102, 359	115, 891		
	F - RECLASS CAFETERIA EXPENSE					
1.00	CAFETERI A	1100	<u>1, 624, 6</u> 58	<u>972, 1</u> 71		1.00
	TOTALS		1, 624, 658	972, 171		
1 00	G - RECLASS WELLNESS	104 00	222 400	27 200		1 00
1. 00	WELLNESS COMMUNITY	1 <u>94.</u> 00	22 <u>3, 4</u> 98 223, 498	3 <u>7, 3</u> 88 37, 388		1.00
	H - RECLASS PHYSICIAN FEES		223, 470	37, 300		
1. 00	ADULTS & PEDIATRICS	30.00	0	615, 599		1.00
2. 00	SUBPROVI DER - I RF	41. 00	Ö	212, 378		2. 00
3.00	OPERATING ROOM	50. 00	0	620, 000		3.00
4.00	ANESTHESI OLOGY	53. 00	0	60, 000		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	50, 000		5. 00
6.00	MAMMOGRAPHY	54. 03	0	20, 833		6.00
7.00	RADI OLOGY-THERAPEUTI C	55. 00	0	44, 963		7.00
8.00	CARDI AC CATHETERI ZATI ON	59. 00	0	55, 000		8.00
9. 00 10. 00	LABORATORY-PATHOLOGI CAL RESPI RATORY THERAPY	60. 01 65. 00	0	225, 000 53, 550		9. 00 10. 00
11.00	PHYSI CAL THERAPY	66. 00	0	50, 000		11.00
12. 00	ELECTROCARDI OLOGY	69. 00	0	3, 600		12.00
13. 00	ELECTROENCEPHALOGRAPHY	70. 00	o	16, 900		13.00
14.00	WOUND CENTER	90. 03	0	42, 466		14.00
15.00	HYPERBARIC OXYGEN THERAPY	90. 04	0	2, 534		15.00
16.00	VIMCARE CLINIC	90. 05	0	20, 000		16.00
17. 00	EMERGENCY	91. 00	0	2, 169, 210		17. 00
18. 00	AMBULANCE SERVICES	95.00		17, 500		18.00
	TOTALS  I - ADMINISTRATIVE SALARIES		0	4, 279, 533		
1. 00	CRHP	194. 08	179, 622	0		1.00
2. 00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		179, 622			
	J - RECLASS PHARMACY RES PROC					
1.00	PHARMACY RESIDENCY PROG	23. 02	186, 628	5, 390		1.00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3.00
4.00	TOTALS — — — —		186, 628	<u> 0</u> 5, 390		4. 00
	K - RECLASS RENT EXPENSE		100, 020	3, 3,0		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 200		1.00
2.00	OPERATION OF PLANT	7. 00	O	91, 284		2.00
3.00	MAMMOGRAPHY	54. 03	O	197, 985		3.00
4.00	LABORATORY	60. 00	0	24, 773		4.00
5.00	PHYSI CAL THERAPY	66.00	0	445, 800		5.00
6.00	OCCUPATIONAL THERAPY	67. 00	0	163, 953		6.00
7.00	SPEECH PATHOLOGY ELECTROENCEPHALOGRAPHY	68. 00 70. 00	O	64, 558		7. 00 8. 00
8. 00 9. 00	CLINIC	90.00		129, 394 26, 576		9.00
10.00	WOUND CENTER	90.00	0	97, 004		10.00
11.00	HYPERBARI C OXYGEN THERAPY	90. 04	Ö	53, 418		11.00
12.00	AMBULANCE SERVICES	95. 00	ol	15, 219		12.00
13. 00	WELLNESS COMMUNITY	194. 00	Ö	76, 571		13. 00
14.00	CRHP	194. 08		226, 183		14.00
	TOTALS		0	1, 613, 918		
	L - RECLASS MARKETING EXPENSE					
1. 00	NONALLOWABLE MARKETING	1 <u>94.</u> 05	0	3, 750		1.00
	TOTALS	I	ΟĮ	3, 750		

Provi der CCN: 15-0112

					10 12/31/2023 Date/11/life 5/30/2024	7:02 am
		Increases		0.1.		
	Cost Center 2.00	Li ne # 3.00	Sal ary	Other 5 00		
	M - RECLASS DEPRECIATION EXPE		4. 00	5. 00		
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	13, 968, 685		1.00
	TOTALS			13, 968, 685		
	N - RECLASS MAINTENANCE EXPEN					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	769		1.00
2. 00 3. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	10, 851 62, 948		2. 00 3. 00
4. 00	PHARMACY	15. 00	0	41, 400		4.00
5. 00	ADULTS & PEDIATRICS	30. 00	o	2, 019		5.00
6.00	OPERATING ROOM	50. 00	О	856, 665		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	266, 512		7. 00
8. 00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	0	214, 788		8.00
9. 00 10. 00	MAMMOGRAPHY ULTRA SOUND	54. 03 54. 02	0	127, 406		9. 00 10. 00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	163, 568 511, 780		11.00
12. 00	CT SCAN	57. 00	o	275, 940		12.00
13.00	MRI	58. 00	O	123, 473		13.00
14.00	CARDIAC CATHETERIZATION	59. 00	0	242, 567		14.00
15. 00	LABORATORY	60.00	0	417, 154		15. 00
16.00	LABORATORY - PATHOLOGI CAL	60. 01	0	61, 191		16.00
17. 00 18. 00	RESPI RATORY THERAPY EMERGENCY	65. 00 91. 00	0	3, 960 40, 677		17. 00 18. 00
10.00	TOTALS			3, 423, 668		18.00
	0 - RECLASS DIRECTOR PHARMACY	′	۹	07 1207 0007		
1.00	OCCUPATI ONAL THERAPY	67. 00	3, 226	0		1.00
2.00	SPEECH PATHOLOGY	68. 00	3, 226	0		2. 00
3.00	ELECTROENCEPHALOGRAPHY	70.00	24, 198	0		3.00
4. 00	NEUROPSYCH	<u>90.</u> 02	<u>9, 6</u> 80 40, 330	0		4. 00
	P - GIFT SHOP		40, 330	U <sub>I</sub>		
1.00	GIFT FLOWER COFFEE SHOP &	190. 00	48, 943	0		1.00
	CANTEEN					
	TOTALS		48, 943			
4 00	Q - RECLASS XRAY EDUCATION EX		4/5 4/4	2 424		4 00
1. 00 2. 00	XRAY EDUCATION	23. 01 0. 00	465, 164	3, 436 0		1.00 2.00
3. 00		0.00	0	0		3.00
4. 00		0. 00	Ö	Ö		4.00
5.00		<u> </u>	0_	0		5. 00
	TOTALS		465, 164	3, 436		
1 00	R - OTHER EXPENSE	104 00	ما	27.2/1		1 00
1. 00	CRHP	194. 08		3 <u>7, 3</u> 61 37, 361		1.00
	S - RECLASS NON ALLOW ADVERTI	SING COSTS	U U	37, 301		
1.00	NONALLOWABLE MARKETING	194. 05	0	818, 240		1.00
	TOTALS			818, 240		
	T - EQUIPMENT LEASE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	796, 498		1.00
2. 00 3. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	246, 682 32, 156		2. 00 3. 00
4. 00	SUBPROVI DER – I RF	41. 00	0	32, 136		4.00
5. 00	OPERATING ROOM	50.00	o	1, 054, 458		5.00
6.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	O	29, 009		6. 00
7.00	MRI	58. 00	0	502, 766		7. 00
8. 00	LABORATORY	60.00	0	18, 727		8. 00
9. 00	WOUND CENTER	90. 03	0	5 <u>5, 426</u>		9. 00
	TOTALS  U - RECLASS CHARGEABLE SUPPLY	/ COST	U <sub>1</sub>	2, 768, 388		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	11, 017, 157		1.00
	PATI ENT					
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	10, 427, 064		2.00
3.00	SPEECH - HEARING AIDS	194. 04	0	163, 796		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		0. 00	O	Ō		9. 00
10.00		0. 00	0	0		10.00
11.00		0. 00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
17.00	1	0.00	니.	U <sub>I</sub>		1 14.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0112

					5/30/2024 7: 02 am
		Increases			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00	
15. 00	2.00	0.00	4.00	5.00	15. 00
16. 00		0.00	Ö	0	16.00
17.00		0.00	O	0	17.00
18. 00		0.00	0	0	18.00
	TOTALS	MINATION DD	0	21, 608, 017	
1. 00	V - RECL PTO COST FOR STD ELI EMPLOYEE BENEFITS DEPARTMENT	4. 00	ol	731, 434	1.00
2. 00	EMI ESTEE BENETITIS BETTICTIMENT	0. 00	o	0	2.00
3.00		0.00	О	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5. 00
6. 00 7. 00		0. 00 0. 00	0	0	6. 00 7. 00
8. 00		0.00	0	0	8.00
9. 00		0.00	Ö	0	9. 00
10.00		0. 00	0	0	10.00
11. 00		0.00	0	0	11.00
12.00		0.00	0	0	12. 00 13. 00
13. 00 14. 00		0. 00 0. 00	0	0	14.00
15. 00		0.00	o	ő	15. 00
16. 00		0.00	o	0	16.00
17.00		0. 00	О	0	17.00
18. 00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20. 00 21. 00		0. 00 0. 00	0	0	20. 00 21. 00
22. 00		0.00	0	0	22.00
23. 00		0.00	o	0	23. 00
24.00		0. 00	0	0	24.00
25. 00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27. 00 28. 00		0. 00 0. 00	0	0	27. 00 28. 00
29. 00		0.00	0	0	29.00
30.00		0.00	o	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34. 00	TOTALS — — — — —			000	34.00
	X - RECLASS OT SALARIES AND (	OTHER EXP	<u> </u>	731, 434	
1.00	OCCUPATI ONAL THERAPY	67. 00	0	856, 079	1.00
	TOTALS		0	856, 079	
4 00	Y - LDRP	50.00	1 000 101	100 5/0	4.00
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	<u>1, 990, 424</u> 1, 990, 424	132, 569	1.00
	TOTALS  Z - RECLASS LAB BLOOD SUPERVI	LSUB	1, 990, 424	132, 569	
1. 00	WHOLE BLOOD & PACKED RED	62. 00	87, 954	0	1.00
	BLOOD CELL				
	TOTALS	DENIEL TO	87, 954		
1. 00	WA - RECLASS CONTRACT LABOR E ADMINISTRATIVE & GENERAL	BENEFITS 5.00	O	579, 726	1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	231, 564	2.00
3. 00	OPERATING ROOM	50. 00	o	2, 489, 054	3.00
4.00	RECOVERY ROOM	<u>51.</u> 00	o_	387, <u>6</u> 23	4.00
	TOTALS		0	3, 687, 967	
1 00	WB - RECLASS SALARIES TO HOME		ol.	14 400	1.00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT OPERATION OF PLANT	4. 00 7. 00	0 103, 351	14, 492 0	1.00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	500	0	3.00
4. 00	HOUSEKEEPI NG	9. 00	43, 344	0	4.00
5. 00	DI ETARY	10. 00	26, 903	0	5. 00
6. 00	CAFETERI A	11. 00	37, 014	0	6.00
7. 00	NURSING ADMINISTRATION	13.00	225, 730	0 014	7.00
8. 00 9. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	86, 234	8, 014 0	8. 00 9. 00
9. 00 10. 00	MEDICAL RECORDS & LIBRARY	16. 00	44, 295	0	10.00
11. 00	XRAY EDUCATION	23. 01	3, 440	0	11.00
12.00	PHARMACY RESIDENCY PROG	23. 02	4, 300	0	12.00
13.00	ADULTS & PEDIATRICS	30. 00	149, 658	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	26, 104	0	14.00
15. 00 16. 00	SUBPROVI DER - I RF NURSERY	41. 00 43. 00	24, 072 10, 905	0	15. 00 16. 00
10.00	MONOLINI	43.00	10, 703	U	10.00

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						5/30/2024 7: 02 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
17.00	OPERATING ROOM	50.00	19, 911	89, 216	I	17.00
18.00	RECOVERY ROOM	51.00	0	5, 903	1	18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	18, 797	0		19.00
20.00	RADI OLOGY-DI AGNOSTI C	54.00	50, 725	0		20.00
21.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	4, 625	0	1	21.00
22.00	ULTRA SOUND	54. 02	8, 435	0		22.00
23.00	MAMMOGRAPHY	54. 03	19, 257	0		23.00
24.00	RADI OLOGY-THERAPEUTI C	55. 00	6, 043	0		24.00
25.00	CT SCAN	57.00	6, 491	0		25.00
26.00	MRI	58.00	6, 254	0		26.00
27.00	CARDI AC CATHETERI ZATI ON	59.00	29, 563	0		27.00
28.00	LABORATORY	60.00	80, 250	0		28.00
29.00	LABORATORY-PATHOLOGI CAL	60. 01	7, 982	0	1	29.00
30.00	RESPI RATORY THERAPY	65.00	22, 069	0	1	30.00
31.00	PHYSI CAL THERAPY	66. 00	3, 940	0		31.00
32.00	OCCUPATI ONAL THERAPY	67.00	500	0		32.00
33.00	SPEECH PATHOLOGY	68. 00	4, 336	0		33.00
34.00	ELECTROCARDI OLOGY	69. 00	8, 797	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70. 00	13, 191	0		35.00
36.00	CARDIAC REHABILITATION	76. 97	3, 164	0	1	36.00
37.00	CLINIC	90.00	43, 214	0		37.00
38.00	NEUROPSYCH	90. 02	3, 998	0		38.00
39.00	WOUND CENTER	90. 03	16, 539	0		39.00
40.00	VIMCARE CLINIC	90. 05	9, 921	0		40.00
41.00	MEDICATION MGMT CLINIC	90. 06	1, 000	0		41.00
42.00	EMERGENCY	91.00	95, 985	0		42.00
43.00	AMBULANCE SERVICES	95. 00	32, 543	0		43.00
44.00	WELLNESS COMMUNITY	194. 00	7, 865	0	1	44.00
45. 00	CRHP	194. 08	41, 475	23, 823		45.00
	TOTALS	— ·····	1, 352, 720	141, 448		.5. 55
	WC - RECLASS SEVERANCE PAY		.,, .20	,		
1. 00	NURSI NG ADMINI STRATI ON	13. 00	6, 325	Ο		1.00
	TOTALS		6, 325	— — ă		1.00
500 00	Grand Total: Increases		7, 394, 375	59, 169, 350		500.00
500.00	12. 22 70 (4.1 7.10) 04000	1	., ., ., ., .,	37, 137, 000		1 300. 00

RECLASSI FI CATI ONS

Provider CCN: 15-0112

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 7:02 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 B - RECLASS INTEREST 1.00 INTEREST EXPENSE 113.00 0 2, 378, 652 11 1.00 2.00 2.00 0.00 11 ō TOTALS 2, 378, 652 C - RECLASS INSURANCE ADMINISTRATIVE & GENERAL 1.00 5. 00 0 1, 529, 969 12 1.00 o 2.00 0.00 0 2.00 0 0.00 3.00 0 0 0 3.00 4.00 0.00 0 4.00 TOTALS 0 1, 529, 969 D - RECLASS BILLING COST 1.00 MEDICAL RECORDS & LIBRARY 16.00 1,085,750 55, 396 0 1.00 2.00 2.00 0.00 0 TOTALS 1, 085, 750 55, 396 E - RECLASS HYPERBARIC THERAPY EXPENSE 90. 03 1.00 WOUND CENTER 102, 359 11<u>5, 8</u>91 0 1.00 TOTALS 102, 359 115, 891 - RECLASS CAFETERIA EXPENSI 10. 00 1.00 DI ETARY 1, 624, 658 972, 171 0 1.00 TOTALS 1, 624, 658 972, 171 G - RECLASS WELLNESS 4. 00 1 00 EMPLOYEE BENEFITS DEPARTMENT 223, 498 3<u>7, 3</u>88 O 1.00 TOTALS 223, 498 37, 388 H - RECLASS PHYSICIAN FEES 1.00 ADMINISTRATIVE & GENERAL 5. 00 3, 833, 277 0 1.00 2.00 OPERATING ROOM 50.00 0 446, 256 0 2.00 3.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 4.00 0 0 5.00 0.00 0 5.00 6.00 0.00 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 8.00 0 0.00 0 9.00 0 9.00 10.00 0.00 0 0 10.00 0 11.00 0.00 11.00 o 12.00 0.00 0 12.00 0 0 13.00 0.00 0 13.00 14.00 0.00 0 0 14.00 15.00 0.00 0 0 0 15.00 0 0 16.00 0.00 0 16.00 0 17.00 0.00 0 0 17.00 18.00 0.00 0 18.00 TOTALS ō 4, 279, 533 - ADMINISTRATIVE SALARIES 1.00 RESPIRATORY THERAPY 38, 557 0 65.00 0 1.00 2.00 CLINIC 90.00 128, 934 0 0 2.00 3.00 VIMCARE CLINIC 90.05 12, 131 0 3.00 0 **TOTALS** 179, 622 Λ J - RECLASS PHARMACY RES PROGRAM 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 1, 790 0 1.00 ADMINISTRATIVE & GENERAL 7.659 3,600 2 00 5 00 0 2 00 15.00 159, 674 0 3.00 PHARMACY Ω 3.00 4.00 MEDICATION MGMT CLINIC 90.06 19, 295 0 4.00 **TOTALS** 186, 628 5, 390 K - RECLASS RENT EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 909, 500 9 1.00 2.00 INTEREST EXPENSE 113.00 0 44, 095 0 2.00 3.00 BUILDING RENTALS 194.01 0 660, 323 0 3.00 0 4.00 0 00 0 4 00 5.00 0.00 0 0 5.00 6.00 0.00 o 0 6.00 0 0 0 7.00 0.00 0 7.00 8.00 0.00 0 8.00 0 9.00 0.00 0 0 9.00 0 0 10.00 0.00 10.00 0 0 11.00 0.00 0 11.00 0 0 12.00 0.00 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 14.00 ō TOTALS 1, 613, 918 L - RECLASS MARKETING OPERATING ROOM 3, 750 1.00 50.00 0 1.00 3, 750 TOTALS

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0112

| Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 7:02 am

Cost Control   Line #   Salary   Other   Misc. #A.7 Ref.							5/30/2024 7:	02 am
N			Decreases					
M								
1.00				8. 00	9. 00	10. 00		
COLAS						-		
No.   SECLASS MAINTERNACE EXPENSE	1. 00					9		1.00
1.00   OPERATION OF PLANT				0	13, 968, 685			_
2 00						_1		
3.00   0.		OPERATION OF PLANT	•	1				1
4. 00			•			0		1
5.00			•	•	0	0		1
0.00				-1	0	0		1
7.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00			•		0	0		1
8,00			•	0	0	0		6.00
9.00 11.00 10.00 11.00 10.00 10.00 10.00 11.00 1	7. 00		0. 00	0	0	0		7.00
10. 00	8.00		0.00	0	0	0		8. 00
11.00 12.00 13.00 0.00 0.00 0.00 0.00 0.00 13.00 14.00 16.00 0.00 0.00 0.00 0.00 0.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.0	9.00		0. 00	0	0	0		9. 00
12.00	10.00		0.00	0	0	0		10.00
13.00	11.00		0. 00	0	0	0		11.00
14.00	12.00		0. 00	0	0	O		12.00
15.00	13.00		0.00	o	0	o		13.00
15.00	14.00		0.00	O	0	o		14.00
16. 00				o	0	0		
17.00				o	0	0		
18. 00				o	0	0		1
TOTALS				o	0	0		1
1.00	. 0. 00	TOTALS — — — —	— — <del>- 0.00</del>	- — — <del> </del>	3 423 668			.5.55
1.00			,	<u> </u>	5, 125, 000			1
2 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00			40 330	Ω	n		1 00
3. 00		2.3570110111			-	-		4
4. 00     0   0   0   0   0   0   0   0				-	-	0		1
TOTALS					0	0		1
P - GIFT SNOP	4.00	TOTALS — — — —		40 330	— — <del>Ö</del>	— — — Ч		4.00
1.00   ADMINISTRATIVE & GENERAL   5.00   48,943   0   0   0   0   0   0   0   0   0				40, 330	U			-
TOTALS	1 00		F 00	40.042	0			1 00
0 - RECLASS NRAY EDUCATION EXPENSES   1.00	1.00					4		1.00
1.00			DENCEC	48, 943	U			4
2. 00 ADMINISTRATI VE & GENERAL 5. 00 0 2, 627 0 0 3. 00 ADMINISTRATI VE & GENERAL 5. 00 46.4, 539 0 0 0 0 4. 00 5. 00 MAMMOGRAPHY 5.4, 03 43.47 0 0 0 0 4. 00 5. 00 MAMMOGRAPHY 5.4, 03 43.47 0 0 0 0 0 4. 00 5. 00 MRI 5.00 MRI 5.00 46.5, 16.4 3.436 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 00				000			4
3. 00			•					1
4. 00   MAMMOGRAPHY			•	-		0		1
5.00						0		
TOTALS					0	0		1
R - OTHER EXPENSE	5. 00		58. 00	+	0	0		5.00
1.00				465, 164	3, 436			_
TOTALS								
1.00   ADM INSTRATIVE & GENERAL	1. 00					0		1.00
1.00				0	37, 361			_
TOTALS T - EQUIPMENT LEASE  1. 00 CAP REL COSTS-BLDG & FIXT		S - RECLASS NON ALLOW ADVERTI						
T - EQUI PMENT LEASE	1.00		5. 00		<u>818, 2</u> 40	0		1.00
1.00		TOTALS		0	818, 240			
2. 00 3. 00 4. 00 3. 00 4. 00 5. 00 6. 00 6. 00 7. 00 8. 00 9. 00 10 155, 914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		T - EQUIPMENT LEASE						
3. 00 4. 00 5. 00 6. 00 6. 00 6. 00 7. 00 8. 00 9. 00 0. 00	1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	2, 612, 474	9		1.00
3. 00 4. 00 5. 00 6. 00 6. 00 6. 00 7. 00 8. 00 9. 00 0. 00	2.00	INTEREST EXPENSE	113. 00	O	155, 914	0		2.00
5. 00 6. 00 7. 00 8. 00 9. 00 10 10 10 11 1. 00 12. 00 13. 00 14. 00 11. 00 12. 00 10 10 10 10 10 10 10 10 10 10 10 10 1	3.00		0.00	o				3.00
6. 00 7. 00 8. 00 9. 00 10Tals 1. 00 ADULTS & PEDIATRICS 30. 00 1 0 0 157, 447 3. 00 1 NURSERY 41. 00 1 OPERATI NG ROOM 5. 00 0 OPERATI NG ROOM 5. 00	4.00		0. 00	O	0	o		4.00
7. 00 8. 00 9. 00 1 TOTALS 1	5.00		0.00	O	0	o		5.00
7. 00 8. 00 9. 00 1 TOTALS 1	6.00		0.00	o	0	o		6.00
8.00 9.00  TOTALS  U - RECLASS CHARGEABLE SUPPLY COST  1.00 ADULTS & PEDIATRICS 30.00 3.00 3.00 3.00 3.00 3.00 3.00 3.				o	0	o		
9.00   TOTALS   0   0   0   0   0   0   0   0   0				o	0	0		
TOTALS					0	0		
1.00		TOTALS — — — —		+		— — <del>1</del>		
1. 00       ADULTS & PEDI ATRI CS       30. 00       0       265, 184       0       1. 00         2. 00       I NTENSI VE CARE UNI T       31. 00       0       157, 447       0       2. 00         3. 00       SUBPROVI DER - I RF       41. 00       0       3, 701       0       3. 00         4. 00       NURSERY       43. 00       0       1, 743       0       4. 00         5. 00       OPERATI NG ROOM       50. 00       0       13, 310, 851       0       5. 00         6. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       101, 574       0       6. 00         7. 00       ULTRA SOUND       54. 02       0       2, 596       0       7. 00         8. 00       MAMMOGRAPHY       54. 03       0       103, 681       0       8. 00         9. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       4, 971       0       9. 00         10. 00       CT SCAN       57. 00       0       50, 053       0       10. 00         11. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       7, 244, 889       0       11. 00         12. 00       RESPI RATORY THERAPY       65. 00       0       7, 2			COST		2,700,000			
2. 00 INTENSIVE CARE UNIT 31. 00 0 157, 447 0 3. 00 SUBPROVI DER - I RF 41. 00 0 3., 701 0 3. 00 4. 00 NURSERY 43. 00 0 1, 743 0 4. 00 5. 00 OPERATI NG ROOM 50. 00 0 13, 310, 851 0 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 101, 574 0 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 101, 574 0 6. 00 8. 00 MAMMOGRAPHY 54. 03 0 103, 681 0 9. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 4, 971 0 9. 00 10. 00 CT SCAN 57. 00 0 57. 00 0 50, 053 0 10. 00 11. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 244, 889 0 11. 00 RESPI RATORY THERAPY 65. 00 0 7, 200 0 12. 00 PHYSI CAL THERAPY 66. 00 0 7, 200 0 13. 00 PHYSI CAL THERAPY 66. 00 0 7, 200 0 13. 00 SPEECH PATHOLOGY 68. 00 0 163, 796 0 14. 00 SPEECH PATHOLOGY 68. 00 0 163, 796 0 16. 00 16. 00 16. 00 16. 00 16. 00	1 00			0	265 184	0		1 00
3. 00 SUBPROVI DER - I RF 41. 00 0 3, 701 0 4. 00 NURSERY 43. 00 0 1, 743 0 4. 00 5. 00 OPERATI NG ROOM 50. 00 0 13, 310, 851 0 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 101, 574 0 6. 00 7. 00 ULTRA SOUND 54. 02 0 2, 596 0 7. 00 0 7. 00 NAMMOGRAPHY 54. 03 0 103, 681 0 8. 00 9. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 4, 971 0 9. 00 10. 00 CT SCAN 57. 00 0 50, 053 0 10. 00 11. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 244, 889 0 11. 00 RESPI RATORY THERAPY 65. 00 0 7, 200 12. 00 12. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 163, 796 0 15. 00 16. 00 16. 00 VI MCARE CLI NI C 90. 05 0 16. 853 0 16. 00 16. 00				•				1
4. 00       NURSERY       43. 00       0       1, 743       0       4. 00         5. 00       OPERATI NG ROOM       50. 00       0       13, 310, 851       0       5. 00         6. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       101, 574       0       6. 00         7. 00       ULTRA SOUND       54. 02       0       2, 596       0       7. 00         8. 00       MAMMOGRAPHY       54. 03       0       103, 681       0       9. 00         9. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       4, 971       0       9. 00         10. 00       CT SCAN       57. 00       0       50, 053       0       10. 00         11. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       7, 244, 889       0       11. 00         12. 00       RESPI RATORY THERAPY       65. 00       0       105, 525       0       12. 00         13. 00       PHYSI CAL THERAPY       66. 00       0       7, 200       0       13. 00         14. 00       SPEECH PATHOLOGY       68. 00       0       163, 796       0       14. 00         15. 00       ELECTROENCEPHALOGRAPHY       70. 00       0       4, 31				•				1
5. 00         OPERATI NG ROOM         50. 00         0         13, 310, 851         0         5. 00           6. 00         RADI OLOGY-DI AGNOSTI C         54. 00         0         101, 574         0         6. 00           7. 00         ULTRA SOUND         54. 02         0         2, 596         0         7. 00           8. 00         MAMMOGRAPHY         54. 03         0         103, 681         0         8. 00           9. 00         RADI OLOGY-THERAPEUTI C         55. 00         0         4, 971         0         9. 00           10. 00         CT SCAN         57. 00         0         50, 053         0         10. 00           11. 00         CARDI AC CATHETERI ZATI ON         59. 00         0         7, 244, 889         0         11. 00           12. 00         RESPI RATORY THERAPY         65. 00         0         105, 525         0         0         12. 00           13. 00         PHYSI CAL THERAPY         66. 00         0         7, 200         0         13. 00           14. 00         SPEECH PATHOLOGY         68. 00         0         163, 796         0         14. 00           15. 00         ELECTROENCEPHALOGRAPHY         70. 00         0         4, 314 </td <td></td> <td></td> <td>•</td> <td>1</td> <td></td> <td>- 1</td> <td></td> <td>1</td>			•	1		- 1		1
6. 00 RADI OLOGY - DI AGNOSTI C 54. 00 0 101, 574 0 6. 00 7. 00 ULTRA SOUND 54. 02 0 2, 596 0 7. 00 8. 00 MAMMOGRAPHY 54. 03 0 103, 681 0 9. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 4, 971 0 9. 00 10. 00 CT SCAN 57. 00 0 50, 053 0 10. 00 11. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 244, 889 0 11. 00 RESPI RATORY THERAPY 65. 00 0 105, 525 0 12. 00 14. 00 PHYSI CAL THERAPY 66. 00 0 7, 200 0 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 163, 796 0 14. 00 SPEECH PATHOLOGY 68. 00 0 4, 314 0 15. 00 16. 00 VI MCARE CLINI C 90. 05 0 16, 853 0 16. 00				•		0		
7. 00         ULTRA SOUND         54. 02         0         2, 596         0         7. 00           8. 00         MAMMOGRAPHY         54. 03         0         103, 681         0         8. 00           9. 00         RADI OLOGY-THERAPEUTI C         55. 00         0         4, 971         0         9. 00           10. 00         CT SCAN         57. 00         0         50, 053         0         10. 00           11. 00         CARDI AC CATHETERI ZATI ON         59. 00         0         7, 244, 889         0         11. 00           12. 00         RESPI RATORY THERAPY         65. 00         0         105, 525         0         12. 00           13. 00         PHYSI CAL THERAPY         66. 00         0         7, 200         0         13. 00           14. 00         SPEECH PATHOLOGY         68. 00         0         163, 796         0         14. 00           15. 00         ELECTROENCEPHALOGRAPHY         70. 00         0         4, 314         0         15. 00           16. 00         VI MCARE CLI NI C         90. 05         0         16, 853         0         16. 00			•			0		1
8. 00       MAMMOGRAPHY       54. 03       0       103, 681       0       8. 00         9. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       4, 971       0       9. 00         10. 00       CT SCAN       57. 00       0       50, 053       0       10. 00         11. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       7, 244, 889       0       11. 00         12. 00       RESPI RATORY THERAPY       65. 00       0       105, 525       0       12. 00         13. 00       PHYSI CAL THERAPY       66. 00       0       7, 200       0       13. 00         14. 00       SPEECH PATHOLOGY       68. 00       0       16. 3, 796       0       14. 00         15. 00       ELECTROENCEPHALOGRAPHY       70. 00       0       4, 314       0       15. 00         16. 00       VI MCARE CLI NI C       90. 05       0       16, 853       0       16. 00						0		1
9. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 4, 971 0 9. 00 10. 00 CT SCAN 57. 00 0 50, 053 0 10. 00 11. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 244, 889 0 11. 00 12. 00 RESPI RATORY THERAPY 65. 00 0 105, 525 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 0 7, 200 0 13. 00 14. 00 SPEECH PATHOLOGY 68. 00 0 163, 796 0 14. 00 15. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 4, 314 0 15. 00 16. 00 VI MCARE CLI NI C 90. 05 0 16, 853 0 16. 00				-1		0		1
10. 00     CT SCAN     57. 00     0     50, 053     0     10. 00       11. 00     CARDI AC CATHETERI ZATI ON     59. 00     0     7, 244, 889     0     11. 00       12. 00     RESPI RATORY THERAPY     65. 00     0     105, 525     0     12. 00       13. 00     PHYSI CAL THERAPY     66. 00     0     7, 200     0     13. 00       14. 00     SPEECH PATHOLOGY     68. 00     0     163, 796     0     14. 00       15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLI NI C     90. 05     0     16, 853     0     16. 00				-		0		1
11. 00     CARDI AC CATHETERI ZATI ON     59. 00     0     7, 244, 889     0     11. 00       12. 00     RESPI RATORY THERAPY     65. 00     0     105, 525     0     12. 00       13. 00     PHYSI CAL THERAPY     66. 00     0     7, 200     0     13. 00       14. 00     SPEECH PATHOLOGY     68. 00     0     163, 796     0     14. 00       15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLI NI C     90. 05     0     16, 853     0     16. 00						0		1
12. 00     RESPI RATORY THERAPY     65. 00     0     105, 525     0     12. 00       13. 00     PHYSI CAL THERAPY     66. 00     0     7, 200     0     13. 00       14. 00     SPEECH PATHOLOGY     68. 00     0     163, 796     0     14. 00       15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLINIC     90. 05     0     16, 853     0     16. 00						0		1
13. 00     PHYSI CAL THERAPY     66. 00     0     7, 200     0     13. 00       14. 00     SPEECH PATHOLOGY     68. 00     0     163, 796     0     14. 00       15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLINIC     90. 05     0     16, 853     0     16. 00						0		1
14. 00     SPEECH PATHOLOGY     68. 00     0     163, 796     0     14. 00       15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLINIC     90. 05     0     16, 853     0     16. 00				-1		0		
15. 00     ELECTROENCEPHALOGRAPHY     70. 00     0     4, 314     0     15. 00       16. 00     VI MCARE CLINIC     90. 05     0     16, 853     0     16. 00				-		0		
16. 00 VI MCARE CLINIC 90. 05 0 16, 853 0 16. 00			l .	0		0		1
	15.00	ELECTROENCEPHALOGRAPHY	70. 00	O	4, 314	0		15.00
17. 00   EMERGENCY         91. 00         0         47, 764         0         17. 00	16.00	VIMCARE CLINIC	90. 05	o	16, 853	o		16.00
	17.00	EMERGENCY	91. 00	ol	47, 764	o		17.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0112

					T	o 12/31/2023 Date/Time Pi 5/30/2024 7:	
	Cook Contain	Decreases	C-1	0+1	WI+ A 7 D-6		
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
18. 00	AMBULANCE SERVICES	95.00	0.00	15, 875			18.00
	TOTALS		o	21, 608, 017			
	V - RECL PTO COST FOR STD ELI						
1.00	ADMINISTRATIVE & GENERAL	5. 00	58, 204	0	1		1.00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	22, 592 42, 770	0	0		2.00
4. 00	DI ETARY	10.00	19, 533	0	1		4.00
5. 00	CAFETERI A	11. 00	26, 875	0	O		5.00
6.00	NURSING ADMINISTRATION	13. 00	53, 486	0	O		6.00
7. 00	PHARMACY	15. 00	48, 242	0	0		7. 00
8. 00	MEDICAL RECORDS & LIBRARY	16.00	8, 873	0	0		8.00
9. 00 10. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	120, 678 9, 811	0	0		9.00
11. 00	SUBPROVI DER - I RF	41.00	6, 420	0	0		11.00
12. 00	NURSERY	43. 00	37, 740	0	o		12.00
13.00	OPERATING ROOM	50.00	9, 018	0	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52. 00	13, 252	0	0		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	17, 033	0	0		15.00
16.00	NUCLEAR MEDICINE-DIAGNOSTIC	54. 01	2, 307	0	0		16.00
17.00	ULTRA SOUND	54. 02	8, 574	0	0		17.00
18.00	MAMMOGRAPHY	54. 03	8, 895	0	0		18.00
19. 00 20. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	5, 527 8, 435	0	0		19. 00 20. 00
21. 00	MRI	58. 00	3, 861	0	0		21.00
22. 00	CARDIAC CATHETERIZATION	59.00	43, 510	0			22.00
23. 00	LABORATORY	60.00	43, 003	0	o		23. 00
24.00	RESPI RATORY THERAPY	65. 00	22, 741	0	O		24.00
25.00	PHYSI CAL THERAPY	66. 00	2, 542	0	0		25.00
26.00	SPEECH PATHOLOGY	68. 00	1, 225	0	0		26.00
27. 00	ELECTROCARDI OLOGY	69. 00	2, 648	0	0		27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70. 00	5, 491	0	0		28.00
29. 00	CLINIC	90.00	9, 302	0	0		29.00
30. 00 31. 00	WOUND CENTER VIMCARE CLINIC	90. 03 90. 05	6, 965 5, 721	0	0		30.00
32. 00	EMERGENCY	91.00	32, 248	0	0		32.00
33. 00	AMBULANCE SERVICES	95. 00	15, 067	0	0		33.00
34. 00	CRHP	194. 08	8, 845	0	0		34.00
	TOTALS		731, 434				
	X - RECLASS OT SALARIES AND (						
1. 00	PHYSI CAL THERAPY	66.00	0	85 <u>6, 0</u> 79			1.00
	TOTALS		0	856, 079			
1. 00	Y - LDRP ADULTS & PEDIATRICS	30. 00	1, 990, 424	132, 569	0		1.00
1.00	TOTALS	30.00	1, 990, 424	132, 569			1.00
	Z - RECLASS LAB BLOOD SUPERVI	SOR	1, 770, 121	102,007			
1.00	LABORATORY	60.00	87, 954	0	0		1.00
	TOTALS		87, 954				
	WA - RECLASS CONTRACT LABOR E						
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 687, 967	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
4.00	TOTALS — — — —		— — — ў	3, 687, 967			4.00
	WB - RECLASS SALARIES TO HOME	E DEPT	<u>~</u>	0,007,707	<u></u>		
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 350, 124	141, 448	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 596	0	0		2.00
3.00		0.00	0	0	0		3.00
4. 00		0. 00	0	0	0		4. 00
5. 00		0. 00	0	0	0		5. 00
6. 00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8. 00 9. 00		0. 00 0. 00	٥	0			8. 00 9. 00
10.00		0.00	0	0			10.00
11. 00		0. 00	Ö	0	o		11.00
12.00		0.00	0	0	o		12.00
13.00		0. 00	O	0	0		13.00
14.00		0.00	O	0	0		14.00
15. 00		0. 00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	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	1		20.00
	1	0.00	<u> </u>	U	١		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 7: 02 am Provider CCN: 15-0112

		Decreases			<u>'</u>	6, 66, 262 . 7.	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
21.00		0. 00	0	0	0		21. 00
22.00		0.00	0	0	0		22. 00
23.00		0.00	0	0	0		23. 00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25. 00
26.00		0.00	0	0	0		26. 00
27.00		0.00	0	0	0		27. 00
28.00		0.00	O	0	0		28. 00
29.00		0.00	o	0	0		29. 00
30.00		0.00	O	0	0		30.00
31.00		0.00	O	0	0		31.00
32.00		0.00	O	0	0		32.00
33.00		0.00	O	0	0		33.00
34.00		0.00	O	0	0		34.00
35.00		0.00	O	0	0		35.00
36.00		0.00	O	0	0		36.00
37.00		0.00	O	0	0		37.00
38.00		0.00	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	O	0	0		42.00
43.00		0.00	O	0	0		43.00
44.00		0.00	0	0	0		44.00
45.00		0.00	0	0	0		45.00
	TOTALS	1	1, 352, 720	141, 448			
	WC - RECLASS SEVERANCE PAY	<u> </u>					
1.00	ADMINISTRATIVE & GENERAL	5. 00	6, 325	0	0		1.00
	TOTALS	1	6, 325				
500.00	Grand Total: Decreases		8, 125, 809	58, 437, 916		ĺ	500.00

Provi der CCN: 15-0112

					o 12/31/2023	Date/Time Pre	
				Acqui si ti ons		3/30/2024 /. 0.	z alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	i di chases	Donati on	10141	Retirements	
		1, 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 792, 375	0	C	0	52, 000	1.00
2.00	Land Improvements	21, 019, 398	0	C	0	10, 640	2.00
3.00	Buildings and Fixtures	103, 981, 731	1, 398, 128	C	1, 398, 128	723, 692	3.00
4.00	Building Improvements	107, 806, 004	756, 566		756, 566	361, 147	4.00
5.00	Fi xed Equipment	9, 631, 298	94, 627	C	94, 627	152, 809	5.00
6.00	Movable Equipment	169, 102, 918	6, 124, 448	C	6, 124, 448	3, 025, 849	6.00
7.00	HIT designated Assets	127, 429	0	C	0	127, 429	7.00
8.00	Subtotal (sum of lines 1-7)	413, 461, 153	8, 373, 769	C	8, 373, 769	4, 453, 566	8.00
9.00	Reconciling Items	0	0	(	0	0	9.00
10.00	Total (line 8 minus line 9)	413, 461, 153	8, 373, 769	C	8, 373, 769	4, 453, 566	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1.00	Land	1, 740, 375	0				1.00
2.00	Land Improvements	21, 008, 758	0				2.00
3.00	Buildings and Fixtures	104, 656, 167	0				3.00
4.00	Building Improvements	108, 201, 423	0				4.00
5. 00	Fi xed Equi pment	9, 573, 116	0				5.00
6. 00	Movable Equipment	172, 201, 517	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	417, 381, 356	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	417, 381, 356	0				10. 00

Health Finan	cial Systems	COLUMBUS REGIO	NAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONCI LI ATI	ON OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0112		ri od: om 01/01/2023	Worksheet A-7 Part II	
					То	12/31/2023		pared:
			SI	JMMARY OF CAF	PI TAL	L	37 307 2024 7.0	z aiii
	Cost Center Description	Depreciation	Lease	Interest		Insurance	Taxes (see	
							instructions)	
		9. 00	10.00	11.00	- !	nstructions) 12.00	13. 00	
DAPT I	II - RECONCILIATION OF AMOUNTS FROM WOR					12.00	13.00	
	EL COSTS-BLDG & FLXT	23, 851, 892			0	1, 458, 590	0	1. 00
•	EL COSTS-MVBLE EQUIP	0			0	0	0	2. 00
•	(sum of lines 1-2)	23, 851, 892	d		0	1, 458, 590	0	3.00
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at						
		ed Costs (see	9 through 14)					
		instructions) 14.00	15. 00	_				
PART I	II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
	EL COSTS-BLDG & FIXT	0	25, 310, 482					1. 00
•	EL COSTS-MVBLE EQUIP	0	, , , , , , , , , , , , , , , , , , ,					2.00
3. 00 Total	(sum of lines 1-2)	0	25, 310, 482	2				3. 00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	,	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 7:03	
	COMI	PUTATION OF RA	TI 0S	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	col . 2) 3.00	4.00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	1. 00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FLXT	245, 307, 268		245, 307, 26	8 0. 587729	0	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	172, 074, 088		1		0	2.00
3.00 Total (sum of lines 1-2)	417, 381, 356		417, 381, 35		·	3. 00
,		TION OF OTHER (			F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)	0.00	10.00	
DADT III DECONCILIATION OF CADITAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 PART III - RECONCILIATION OF CAPITAL COSTS	LENTERS 0	0	ı	0 5, 885, 202	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT		-	1	0 14, 102, 112		2.00
3.00 Total (sum of lines 1-2)		-		0 19, 987, 314		3.00
3. 00   10tai (3uiii 01 111ie3 1-2)			JMMARY OF CAPI		0	3.00
		0.				
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions			
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
DART III DECOMOLILATION OF CARLEY COOTS	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		2 017 100			( 020 157	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	-1, 864, 225 -116, 254		1	0 0	6, 938, 157 13, 985, 858	1. 00 2. 00
3.00 Total (sum of lines 1-2)	-1, 980, 479		1	0 0	20, 924, 015	3. 00
3.00   Total (Suil of Titles 1-2)	-1, 900, 479	2, 917, 100	TI .	o <sub>l</sub> 0	20, 924, 015	3.00

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -2, 207, 783 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В -137, 679 CAP REL COSTS-MVBLE EQUIP 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) -62, 756 ADMI NI STRATI VE & GENERAL 4.00 Trade, quantity, and time В 5.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of -153, 058 ADMINISTRATIVE & GENERAL 5.00 B 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -212, 523 ADMI NI STRATI VE & GENERAL 5 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -14, 310 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 9.00 0.00 10.00 Provi der-based physici an -11, 361, 893 10.00 A - 8 - 2adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization -3, 044, 002 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -859, 929 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and -2, 550 MEDICAL RECORDS & LIBRARY 18.00 В 16.00 18.00 abstracts 19.00 Nursing and allied health -28, 190 XRAY EDUCATION 23. 01 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00 20.00 21.00 Income from imposition of 0 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 \*\*\* Cost Center Deleted \*\*\* 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 0 \*\*\* Cost Center Deleted \*\*\* 28.00 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0112 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Description 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 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 32.00 Depreciation and Interest TELEPHONE SERVICES -300 ADMINISTRATIVE & GENERAL 33.00 В 5.00 33.00 DEPR PAT PHONES NEW EQUIP -3. 014 CAP REL COSTS-MVBLE EQUIP 33.01 2.00 33.01 Α -1,545 CAP REL COSTS-MVBLE EQUIP 33.02 TV DEPR NEW EQUIP Α 2.00 33.02 33.03 OPERATIN ROOM OTHER REV В -51, 800 OPERATING ROOM 50.00 33.03 -2, 000 ADMINISTRATIVE & GENERAL 33.04 LAND RENT MOB В 5.00 33.04 33 05 EMPLOY BENEFITS OTHER REV -110, 668 EMPLOYEE BENEFITS DEPARTMENT В 4 00 33 05 33.06 EMERGENCY ROOM OTHER REV В -42, 811 EMERGENCY 91.00 33.06 33.07 MEDICA STAFF INCOME -900 ADMINISTRATIVE & GENERAL 33.07 В 5.00 -4, 573 RADI OLOGY-DI AGNOSTI C 33.08 RADI OLOGY OTHER REV 54.00 33.08 В 33 09 BREAST FILM COPIES 511 MAMMOGRAPHY 54.03 O 33 09 B 33.10 FACILITIES OTHER REVENUE В -542, 513 OPERATION OF PLANT 7.00 33.10 RADIATION ONCOLOGY OTHER REV -9, 276 RADI OLOGY-THERAPEUTI C 33.11 В 55.00 33.11 33. 12 CRHP OTHER REVENUE ADMIN В -3, 392, 186 ADMINISTRATIVE & GENERAL 5.00 0 33.12 CRHP OTHER REVENUE BUILDING -200, 853 CRHP 33.13 В 194.08 33.13 RENTALS CRHP OTHER REVENUE EMPLOYEE В -394, 351 EMPLOYEE BENEFITS DEPARTMENT 33.14 33.14 4.00 BENEFITS FOOD OTHER REV В -7, 960 DI ETARY 33.15 10.00 33.15 0 -8, 405 OPERATION OF PLANT PROTECTIVE SERV OTHER REV 33.16 В 7.00 0 33.16 33. 17 PHARMACY OTHER REVENUE В -61, 953 PHARMACY 15.00 33.17 33. 18 HUMAN RESOURCES OTHER REVENUE В -15 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.18 LACTATION AND PREPARE OTHER -30, 666 ADULTS & PEDIATRICS 33 19 30.00 33 19 B REVENUE -35, 669 CAP REL COSTS-BLDG & FIXT 33, 20 RENTAL PROPERTIES DEPRECIATION Α 1.00 33.20 UNALLOWABLE PHYS RECRUITMENT -73, 652 ADMINISTRATIVE & GENERAL 33. 21 Α 5.00 33.21 DEPRECIATION RELIFED BUILDING 1,088 CAP REL COSTS-BLDG & FIXT 33, 22 1.00 33, 22 Α 137, 986 CAP REL COSTS-MVBLE EQUIP 33.23 DEPRECIATION RELIFED EQUIPMENT Α 2.00 33.23 33. 24 UNALLOWABLE AHA MEMBERSHIP -23, 564 ADMINISTRATIVE & GENERAL 5.00 33.24 AMBULANCE SERVICES -512 AMBULANCE SERVICES 33 25 B 95.00 33.25 -18, 660, 312 ADMI NI STRATI VE & GENERAL HAF ADJUSTMENT 33. 26 Α 5.00 0 33.26 33.27 AUDI OLOGY - OTHER REVENUE В -1, 171 SPEECH PATHOLOGY 68.00 ol 33 27 ORTHOPEDICS OTHER REVENUE -3,000 ADULTS & PEDIATRICS 30.00 33.28 33.28 В 0 -5, 256 LABORATORY 33. 29 LAB SPECIMENT PROC OTHER 60.00 33. 29 В REVENUE X-RAY CT SCAN OTHER REVENUE 33.30 -5, 029 CT SCAN 33.30 В 57.00 0 33.31 CARDI AC STEPDOWN OTHER REVENUE В -12,500 ADULTS & PEDIATRICS 30.00 0 33.31 LAB CORE OTHER REVENUE 33.32 В -6, 500 LABORATORY 60.00 33.32 33 33 NURSING RESOURCES OTHER -5, 072 NURSING ADMINISTRATION 33 33 B 13 00 REVENUE 33.34 ENVIRONMENTAL SERVICES В -40 HOUSEKEEPI NG 9.00 33.34 RESTROOM VEND 33 35 INTENSIVE CARE OTHER REVENUE В -13,000 INTENSIVE CARE UNIT 31 00 33.35 CENTRAL TELEMETRY OTHER -4, 482 ADULTS & PEDIATRICS 33. 36 В 30.00 33.36 REVENUE 33.37 3T MEDICAL SURGICAL OTHER В -28,000 ADULTS & PEDIATRICS 30.00 33.37 REVENUE 4T MED SURG STEPDOWN OTHER В -37, 999 ADULTS & PEDIATRICS 30.00 33.38 33.38 REVENUE 33.39 6T MEDICAL SURGICAL OTHER В -18, 425 ADULTS & PEDIATRICS 30.00 33.39 REVENUE 33.40 7T INPATIENT REHAB OTHER В -12, 500 SUBPROVI DER - I RF 41.00 33.40 REVENUE 33 41 WOUND CENTER OTHER REVENUE -7. 278 WOUND CENTER 90 03 33 41 B 33.42 BEHAVI ORAL HEALTH-OTHER В -23, 426 ADULTS & PEDIATRICS 30.00 33.42 REVENUE ENDOSCOPY-OTHER REVENUE -9, 931 OPERATING ROOM 33.43 В 50.00 33.43 IV THERAPY VASCULAR ACCESS -9, 900 OPERATING ROOM 33.44 В 50.00 33.44 OTHER REV -12,500 RECOVERY ROOM 33.45 POST ANESTHESIA CARE UNIT В 51.00 33.45

-7, 269 CLI NI C

-7. 000 LABORATORY

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MEDICAL ONCOLOGY OTHER REVENUE

LAB MI CROBI OLOGY OTHER REVENUE

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					0 12/31/2023	5/30/2024 7:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
33. 48	SOUTHERN INDIANA HEART &	В	-2, 639	CLINIC	90. 00	0	33. 48
	VASCULAR OT	_				_	
33. 49	COLUMBUS REGIONAL HEALTH	В	-1, 186	CLI NI C	90. 00	0	33. 49
	GENERAL SUR	_	_	L		_	
33. 50	HEALTH INFO DOCUMENT IMAGING	В	-3	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 50
00 54	OTHER R		40.000	HOUGEKEEDING	0.00		00 54
33. 51	ENVI RONMENTAL SERVI CES OTHER	В	-18,000	HOUSEKEEPI NG	9. 00	0	33. 51
22 52	REVENUE	ь.	2 121	CENTRAL CERVI CEC & CURRI V	14.00	0	22 52
33. 52	STERI LE PROCESSI NG-OTHER	В	-3, 131	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 52
22 52	REVENUE	D .	2 705	EMEDGENCY	01.00	0	22 52
	ED REGISTRATION OTHER REVENUE	B B		EMERGENCY	91.00	0	
33. 54	INFO SERVICES APPLICATIONS OTHER REV	В	- 10, 000	ADMINISTRATIVE & GENERAL	5. 00	Ü	33. 54
22 EE	MEDICAL RESEARCH-OTHER REVENUE	В	2 720	  ADMINISTRATIVE & GENERAL	5. 00	0	33. 55
	NONALLOWABLE INT EXP 2023		·	1		11	33. 55
		A		CAP REL COSTS-BLDG & FIXT	1.00		
	NONALLOWABLE INT EXP 2023	Α	•	CAP REL COSTS-MVBLE EQUIP	2. 00	11	33. 57
50.00	TOTAL (sum of lines 1 thru 49)		-43, 883, 557				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0112 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 7:02 am

				10 12/31/2023	5/30/2024 7:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	/2 dill
	El lie lie.	oost center	Expense i tems	Allowable Cost	7 7 7	
					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 O	RGANIZATIONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00	1	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	7, 209, 446		1.00
2.00	1	ADMINISTRATIVE & GENERAL	TRAVEL & ENTERTAINMENT	12, 141	12, 141	2.00
3. 00		EMPLOYEE BENEFITS DEPARTMENT	•	953, 322	1, 243, 503	3.00
4.00	1	ADMINISTRATIVE & GENERAL	GENERAL ADMINISTRATION - SAL	2, 491, 388	2, 611, 267	4.00
4. 01	7. 00	OPERATION OF PLANT	GENERAL ADMINISTRATION - SAL	1, 223, 428	1, 418, 746	4. 01
4. 02		NURSING ADMINISTRATION	GENERAL ADMINISTRATION - SAL	69, 298	80, 362	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	GENERAL ADMINISTRATION - OTH	5, 534, 616	5, 976, 066	4.03
4.04	5. 00	ADMINISTRATIVE & GENERAL	GENERAL ADMINISTRATION - OTH	8, 263, 847	9, 085, 041	4.04
4.05	7. 00	OPERATION OF PLANT	GENERAL ADMINISTRATION - OTH	318, 452	369, 292	4.05
4.06	13.00	NURSING ADMINISTRATION	GENERAL ADMINISTRATION - OTH	490, 052	568, 288	4.06
4. 07	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES - SALARIES	1, 643, 343	1, 654, 644	4.07
4. 08	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES - BENEFITS	625	0	4.08
4. 09	5. 00	ADMINISTRATIVE & GENERAL	GENERAL ADMINISTRATION - SAL	1, 816, 151	2, 446, 506	4.09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	GENERAL ADMINISTRATION - OTH	11, 566	0	4. 10
4. 11	13. 00	NURSING ADMINISTRATION	NURSING ADMIN - SALARIES	1, 270	1, 269	4. 11
4. 12	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES - SALARIES	713, 789	710, 540	4. 12
4. 13	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES - OTHER	24	0	4. 13
4. 14	30.00	ADULTS & PEDIATRICS	ADULTS & PEDS - SALARIES	66, 311	66, 311	4.14
4. 15	31.00	INTENSIVE CARE UNIT	ICU - SALARIES	4, 373	4, 373	4. 15
4. 16	41.00	SUBPROVI DER - I RF	REHAB - SALARI ES	1, 965	1, 965	4. 16
4. 17	50.00	OPERATING ROOM	OPERATING ROOM - SALARIES	9, 354, 483	9, 159, 405	4. 17
4. 18		OPERATING ROOM	OPERATING ROOM - BENEFITS	872	0	4. 18
4. 19		OPERATING ROOM	OPERATING ROOM - OTHER	127	0	4. 19
4. 20	1	RECOVERY ROOM	RECOVERY ROOM - SALARIES	1, 332, 348	1, 307, 336	4. 20
4. 21	1	MAMMOGRAPHY	MAMMOGRAPHY - SALARIES	215	215	4. 21
4. 22		WOUND CENTER	WOUND CENTER - SALARIES	500	500	4. 22
4. 23		EMERGENCY	EMERGENCY ROOM - SALARIES	5, 337	5, 337	4. 23
4. 24		AMBULANCE SERVICES	AMBULANCE - SALARIES	782	782	4. 24
4. 25	194. 08	1	CRHP - SALARI ES	459	459	4. 25
4. 26		ADULTS & PEDIATRICS	CRHP PHYSICIAN PART A	453, 299	0	4. 26
4. 27			EMPLOYEE BENEFITS (SIMH) - B	476, 115	655, 199	4. 27
4. 28		ADMINISTRATIVE & GENERAL	EMPLOYEE BENEFITS (SIMH) - B	421, 271	579, 726	4. 28
4. 29		CENTRAL SERVICES & SUPPLY	EMPLOYEE BENEFITS (SIMH) - B		231, 564	4. 29
4. 30	I	OPERATI NG ROOM	EMPLOYEE BENEFITS (SIMH) - B	1, 808, 727	2, 489, 054	4. 30
4. 31		RECOVERY ROOM	EMPLOYEE BENEFITS (SIMH) - B		387, 623	4. 31
4. 32	I	EMPLOYEE BENEFITS DEPARTMENT	•	29, 013	14, 492	4. 32
4. 33		ADMINISTRATIVE & GENERAL	BUDGET - SALARI ES	19, 356		4. 33
4. 34	I	CENTRAL SERVICES & SUPPLY	BUDGET - SALARI ES	16, 043	8, 014	4.34
4. 35		OPERATING ROOM	BUDGET - SALARI ES	178, 604	89, 216	4. 35
4. 36	1	RECOVERY ROOM	BUDGET - SALARI ES	11, 818		4. 36
4. 37		WELLNESS COMMUNITY	BUDGET - SALARI ES	47, 690		4. 37
5. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to			45, 432, 412	48, 476, 414	5.00
	Worksheet A-8, column 2,					
	line 12.					
	j	I .	I .	I .		

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

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1.00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	E	J BICKEL	O.OO SI HEALTH MANAGEMENT	0.00	6.00
7. 00	E	D TRAPP	O.OOSI HEALTH MANAGEMENT	0.00	7.00
8. 00	Е	Z ELLISON	O.OOSI HEALTH MANAGMENT	0.00	8.00
9. 00	Е	R SHEDD	O.OOSI HEALTH MANAGEMENT	0.00	9.00
10.00	Е	K SHUMAKER	O.OOSI HEALTH MANAGEMENT	0.00	10.00
10. 01	E	D DOUP	O.OOSI HEALTH MANAGMENT	0.00	10. 01

Health Financial Systems	COLUMBUS REGI	ONAL HOSPITAL		In Lie	u of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (	CCN: 15-0112	Peri od:	Worksheet A-8	3-1
OFFICE COSTS				From 01/01/2023 To 12/31/2023		
			Related Orga	nization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of		Vame	Percentage of	
		Ownershi p			Ownershi p	

3.00

4.00

O. OO SI HEALTH MANAGMENT

5.00

0. 00

10.02

100.00

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

D MI CHAEL

1.00

Ε

non-financial) specify:

100.00 G. Other (financial or

10. 02

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

2.00

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

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

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	1	10.00
10. 01	MANAGEMENT COMPANY	1	10. 01
10.02	MANAGMENT COMPANY	1	10. 02
100.00		10	00.00

Health Financial Systems	COLUMBUS REGIONAL	L HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0112	Peri od: From 01/01/2023	Worksheet A-8-1
OFFICE COSTS				Date/Time Prepared: 5/30/2024 7:02 am
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

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

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Provider CCN: 15-0112

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 7: 02 am

							3/30/2024 /. (	<u>12 alli</u>
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	3, 146, 054	2, 917, 537	228, 517	211, 500	975	1.00
2.00	30.00	ADULTS & PEDIATRICS	615, 599	0	615, 599	211, 500	5, 007	2.00
3.00	41.00	SUBPROVI DER - I RF	212, 378	0	212, 378	211, 500	3, 403	3.00
4.00	50.00	OPERATING ROOM	8, 348, 777	5, 895, 056	2, 453, 721	246, 400	20, 212	4.00
5.00	53.00	ANESTHESI OLOGY	60, 000	0	60, 000	246, 400	486	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 156, 831	1, 106, 831	50, 000	271, 900	336	6.00
7.00	54. 03	MAMMOGRAPHY	20, 833	0	20, 833	211, 500	168	7.00
8.00	55. 00	RADI OLOGY-THERAPEUTI C	44, 963	0	44, 963	271, 900	235	8.00
9.00	59. 00	CARDIAC CATHETERIZATION	55, 000	0	55, 000	211, 500	425	9.00
10.00	60. 01	LABORATORY-PATHOLOGI CAL	225, 000	0	225, 000	260, 300	1, 500	10.00
11.00	65. 00	RESPI RATORY THERAPY	53, 550	0	53, 550	211, 500	369	11.00
12.00	66.00	PHYSI CAL THERAPY	50, 000	0	50, 000	211, 500	255	12.00
13.00	69.00	ELECTROCARDI OLOGY	3, 600	0	3, 600	211, 500	36	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	16, 900	0	16, 900	211, 500	169	14.00
15.00	90.00	CLINIC	100	100	o	211, 500	o	15.00
16.00	90. 02	NEUROPSYCH	229, 584	229, 584	0	211, 500	o	16.00
17.00	90. 03	WOUND CENTER	42, 466	0	42, 466	211, 500	283	17.00
18.00	90.04	HYPERBARIC OXYGEN THERAPY	2, 534	0	2, 534	211, 500	17	18.00
19.00	90.05	VIMCARE CLINIC	20, 000	0	20, 000	211, 500	295	19.00
20.00	91.00	EMERGENCY	2, 619, 210	108, 340	2, 510, 870	211, 500	18, 015	20.00
21.00	95. 00	AMBULANCE SERVICES	17, 500	0	17, 500	211, 500	183	21.00
200.00			16, 940, 879	10, 257, 448	6, 683, 431		52, 369	200.00
	•							

| Peri od: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0112

						10 12/31/2023	5/30/2024 7: 0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	99, 141	4, 957		0	0	1.00
2.00	1	ADULTS & PEDIATRICS	509, 125			0	0	2.00
3.00		SUBPROVI DER - I RF	346, 026			0	0	3.00
4.00		OPERATING ROOM	2, 394, 345			0	0	4. 00
5.00		ANESTHESI OLOGY	57, 572			0	0	5.00
6.00	1	RADI OLOGY-DI AGNOSTI C	43, 922			0	0	6. 00
7.00		MAMMOGRAPHY	17, 083			0	0	7. 00
8.00		RADI OLOGY-THERAPEUTI C	30, 720			0	0	8.00
9.00		CARDIAC CATHETERIZATION	43, 215			0	0	9. 00
10.00		LABORATORY-PATHOLOGI CAL	187, 716			0	0	10.00
11. 00		RESPI RATORY THERAPY	37, 521			0	0	11. 00
12.00	•	PHYSI CAL THERAPY	25, 929			0	0	12.00
13.00	•	ELECTROCARDI OLOGY	3, 661	183		0	0	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	17, 184	859	C	0	0	14.00
15. 00		CLI NI C	0	0	C	0	0	15.00
16. 00	90. 02	NEUROPSYCH	0	0	C	0	0	16.00
17.00	90. 03	WOUND CENTER	28, 776	1, 439	C	0	0	17.00
18.00	90. 04	HYPERBARIC OXYGEN THERAPY	1, 729	86	C	0	0	18.00
19.00	90. 05	VIMCARE CLINIC	29, 996	1, 500	C	0	0	19.00
20.00		EMERGENCY	1, 831, 814	91, 591	C	0	0	20.00
21.00	95. 00	AMBULANCE SERVICES	18, 608	930	C	0	0	21.00
200.00			5, 724, 083	286, 203	C	0	0	200.00

| Peri od: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

						0 12/31/2023	5/30/2024 7:0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	07 007 202 1 71	
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	99, 141	129, 376	3, 046, 913		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	509, 125	106, 474	106, 474		2.00
3.00	41. 00	SUBPROVI DER - I RF	0	346, 026	0	0		3.00
4.00	50.00	OPERATING ROOM	0	2, 394, 345	59, 376	5, 954, 432		4.00
5.00	53. 00	ANESTHESI OLOGY	0	57, 572	2, 428	2, 428		5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	43, 922	6, 078	1, 112, 909		6. 00
7. 00	54. 03	MAMMOGRAPHY	0	17, 083	3, 750	3, 750		7. 00
8.00	55. 00	RADI OLOGY-THERAPEUTI C	0	30, 720	14, 243	14, 243		8. 00
9.00	59. 00	CARDIAC CATHETERIZATION	0	43, 215	11, 785	11, 785		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	37, 521	16, 029	16, 029		11.00
12.00	66. 00	PHYSI CAL THERAPY	0	25, 929	24, 071	24, 071		12.00
13.00	69. 00	ELECTROCARDI OLOGY	0	3, 661	0	0		13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	17, 184	0	0		14.00
15. 00	90.00	CLINIC	0	0	0	100		15.00
16.00		NEUROPSYCH	0	0	0	229, 584		16.00
17. 00	90. 03	WOUND CENTER	0	28, 776	13, 690	13, 690		17.00
18.00	90. 04	HYPERBARIC OXYGEN THERAPY	0	1, 729	805	805		18.00
19.00	90. 05	VIMCARE CLINIC	0	29, 996	0	0		19. 00
20.00	91.00	EMERGENCY	0	1, 831, 814	679, 056	787, 396		20.00
21.00	95. 00	AMBULANCE SERVICES	0	18, 608	0	0		21.00
200.00			0	5, 724, 083	1, 104, 445	11, 361, 893		200.00

| Period: | Worksheet B | From 01/01/2023 | Part | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0112

COST CENTER   DESCRIPTION   Net Expenses   COST CENTER   COST   COST CENTER   COST   COST CENTER					o 12/31/2023			
## CF COST CHATTES ## CF COST CH				CAPITAL RELATED COSTS			5/30/2024 /: 0	2 alli
## CF COST CHATTES ## CF COST CH		Coat Conton Decemintion	Not Evpopos	DIDC 0 FLVT	MANDLE FOLLID	EMDL OVEE	Cubtatal	
		cost center bescription		DLUG & FIXI	WVBLE EQUIP		Subtotal	
Col. 77						DEPARTMENT		
DEBERAL SENVICE COST CENTERS								
1.00   001000 CAP REL COSIST-BLOB & FIXT   6. Y98, 157   12, 985, 884   31, 575, 345   4. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.				1.00	2. 00	4. 00	4A	
2.00	4 00			, , , , , , , , , ,	1			
4.00   0.000   DOSE   DYTE TRAILET IS DEPARTIMIST   31,478, IDA   92,100   4,453   31,575, 509   61,752,470   5.00   0.000   DOSE   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000					1			1
1.00   DOZROJ OPERATION OF PLANT   9,214,310   3,346,863   316,803   1,054,289   7,78   8.00   0.0000   DOZROJ   DOZRO		00400 EMPLOYEE BENEFITS DEPARTMENT						1
8.00   0.0800  _AUMORPY & LINEN SERVICE								1
9.00   0.090								•
11.00   01100   CAFETERI A	9. 00	00900 HOUSEKEEPI NG	3, 309, 414	49, 696	128, 369	709, 789	4, 197, 268	9. 00
13.00   01300   NIRESTING ADMINISTRATION   7,893,740   96,493   49,531   1,850,346   9,890,110   13.00								ł
14. 00 01400 CENTRAL SERVICES & SUPPLY 1. 248, 1318		I I						1
16. 00   01600   MEDICAL RECORDS & LIBRARY   1,824,646   34,952   1,140   442,316   2,303,054   6. 00   0. 00		01400 CENTRAL SERVICES & SUPPLY	1, 248, 138	72, 688	75, 818	41	1, 396, 685	14.00
17.00   01700   PARAMED ED PREM		I I						
23.01   0320  PARBANCY RESIDENCY PROG   6.651   6.651   8.502   172, 113   803, 157   23.01			0		1			
			0	-	1	-		
INPATIL ENT ROUTINE SERVICE COST CENTERS   37, 762, 941   744, 755   163, 521   7, 102, 174   45, 773, 291   30, 00   300, 00   3000   3000   5000   6000   6000   6000   32, 00   320,		I I						•
31.00   03100   INTENSIVE CARE UNIT   6,525,805   105,994   124,022   1,032,354   7,788,176   31.00   32.00   03200   CORROMARY CARE UNIT   0   0   0   0   0   0   32.00   33	23. 02	INPATIENT ROUTINE SERVICE COST CENTERS	307, 443	3, 370	4, 170	00, 041	377,000	25.02
32 00   303200 CORROMARY CARE UNIT								•
33.00			6, 525, 805					•
40. 00   04000   SUPROVI DER - I PIF   0   0   0   0   0   0   0   0   0			0	Ö	-			
11.00   04100   SUBPROVI DER   1   1   1   1   1   1   1   1   1			0	0	1			ł
42 00   04200   SUPROVI DER   0   0   0   0   0   0   0   0   0			2, 770, 525	106, 061	1		-	ł
AH		04200 SUBPROVI DER	0	0	1	0		•
ANCILLARY SERVICE COST CENTERS			1, 636, 729		1			1
1. 0	44.00		0	0		U U	0	44.00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   2, 128, 538   35, 076   17, 193   540, 343   2, 721, 150   52.00								1
53.00   05300   AMESTHESI OLOGY   122, 973   1, 139   1, 302   0   125, 144   53.00								1
54 02   OS402 NUCLEAR MEDI CINE-DI AGNOSTIC   2,596,219   32,158   392,157   164,069   3,184,603   54,0154   0.05405   MANMOGRAPHY   1,307,012   966   191,065   232,691   1,731,734   54,03   55,00   05500 RADIOLOGY-THERAPEUTI C   2,480,451   74,717   478,240   190,819   3,224,227   55,00   05500 CADIOLOGY-THERAPEUTI C   2,480,451   74,717   478,240   190,819   3,224,227   55,00   05500 CT SCAN   1,925,139   17,395   252,713   243,949   2,439,196   57,00   05500 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05900 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   4,000,825   59,00   05000 CADIAC CATHETERI ZATI ON   2,947,744   87,853   400,388   564,830   400,088   564,83		05300 ANESTHESI OLOGY						ł
54. 02   05404   LITRA SOUND								ł
54.03   05405   MAMMOGRAPHY								1
57.00   05700   CT SCAN   1, 925, 139   17, 395   252, 713   243, 949   2, 439, 196   57.00   58.00   05800   MRI   1, 406, 689   8, 611   17, 206   174, 210   1, 606, 716   58.00   58.00   058900   CARDI AC CATHETERI ZATI ON   2, 947, 744   87, 853   400, 398   564, 830   4, 000, 825   59.00   60.00   06000   LABORATORY   12, 436, 829   103, 985   300, 989   1, 148, 372   13, 990, 175   60.00   60.01   CABORATORY - PATHOLOGI CAL   1, 715, 423   11, 596   35, 760   135, 784   1, 898, 563   60.01   60.000   LABORATORY - PATHOLOGI CAL   1, 715, 423   11, 596   35, 760   135, 784   1, 898, 563   60.01   60.000   MHOLE BLOOD & PACKED RED BLOOD CELL   744, 425   4, 095   3, 298   23, 811   775, 629   62.00   66.00   66.00   66.00   MHOLE BLOOD & PACKED RED BLOOD CELL   744, 425   4, 095   3, 298   23, 811   775, 629   62.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   FMYSIC LAT HERAPY   7, 190, 772   5, 894   9, 133   77, 978   7, 283, 777   66.00   67.00   6	54. 03	05405 MAMMOGRAPHY	1, 307, 012		191, 065	232, 691	1, 731, 734	
58.00   05800   MRI   1, 406, 689   8, 611   17, 206   174, 210   1, 606, 716   58.00   59.00   05900   CARDIAC CATHETERIZATION   2, 947, 744   81, 87, 853   400, 398   564, 830   4, 000, 825   59.00   60.01   06000   LABORATORY - PATHOLOGICAL   1, 715, 423   11, 596   35, 760   135, 784   1, 898, 563   60.01   62.00   06200   MEDIE BLOOD & PACKED RED BLOOD CELL   744, 425   4, 095   3, 298   23, 811   775, 629   62.00   65.00   06500   RESPIRATORY THERAPY   3, 808, 642   75, 597   120, 349   659, 734   4, 664, 322   65.00   66.00   06600   PHYSI CAL THERAPY   7, 190, 772   5, 894   9, 133   77, 978   7, 283, 777   66.00   67.00   06700   OCUPATI (MAL THERAPY   2, 518, 132   2, 115   5, 698   19, 653   2, 545, 598   67.00   68.00   06800   SPECH PATHOLOGY   1, 068, 132   0   13, 932   61, 056   1, 143, 120   68.00   69.00   06900   ELECTROCARDIALOGRAPHY   1, 450, 625   06, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70.00   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   0   0   0   0   0   0   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   0   0   0   0   0   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   0   0   0   0   0   0   710.00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0								1
59.00   05900   05900   058000   058000   058000   058000   058000   058000   058000   058000   0580								ı
60.01   06001   LABORATORY-PATHOLOGI CAL   1,715,423   11,596   35,760   135,784   1,898,563   60.01   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   744,425   4,095   3,298   23,811   775,629   62.00   65.00   06500   RESPI RATORY THERAPY   3,808,642   75,597   120,349   659,734   4,664,322   65.00   66.00   06600   PHYSI CAL THERAPY   7,190,772   5,894   9,133   77,978   7,283,777   66.00   67.00   06700   0CCUPATI IONAL THERAPY   2,518,132   2,115   5,698   19,653   2,545,598   67.00   68.00   06800   SPEECH PATHOLOGY   1,068,132   0   13,932   61,056   1,143,120   68.00   69.00   06900   ELECTROCARDI OLOGY   1,517,344   13,376   202,861   288,498   2,022,079   69.00   69.00   07000   ELECTROENCEPHALOGRAPHY   1,450,625   0   6,243   171,073   1,627,941   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATI ENT   11,017,157   0   0   0   0   0   10,427,064   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   10,427,064   0   0   0   0   0   25,390,318   73.00   74.00   07400   RENAL DI ALYSIS   824,501   0   0   0   0   0   25,390,318   77.00   76.00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   0   76.97   07697   CARDI AC REHABI LI TATI ON   459,563   15,127   1,860   86,378   562,928   76.97   77.00   07700   ALDGRAFIC HEALTH CLINIC   0   0   0   0   0   0   0   89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   90.01   09000   CLINIC   0   0   0   0   0   0   0   90.02   09000   NEUROSYCH   128,532   823   254   32,046   161,655   90.02   90.03   09000   NUMARE CLINIC   703,282   40,712   5,688   171,404   921,086   90.05	59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 947, 744	87, 853	400, 398	564, 830	4, 000, 825	59.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   744, 425   4,095   3,298   23,811   775,629   62.00   65.00   06500   RESPIRATORY THERAPY   3,808,642   75,597   120,349   659,734   4,646,322   65.00   66.00   06600   PHYSI CAL THERAPY   7,190,772   5,894   9,133   777,978   7,283,777   66.00   06600   OCCUPATI ONAL THERAPY   2,518,132   2,115   5,698   19,653   2,545,598   67.00   68.00   06800   SPECCH PATHOLOGY   1,068,132   0   13,932   61,056   1,143,120   68.00   69.00   06900   ELECTROCARDIOLOGY   1,517,344   13,376   202,861   288,498   2,022,079   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   1,450,625   0   6,243   171,073   1,627,941   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   11,017,157   0   0   0   0   11,017,157   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   10,427,064   0   0   0   0   0   0,427,064   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   25,390,318   0   0   0   0   0   25,390,318   73.00   74.00   07400   RENAL DI ALYSIS   824,501   0   0   0   0   0   25,390,318   74.00   76.00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   0   76.00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   76.00   07600   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   78.00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   89.00   08900   FEDERALLY QUALIFIED   128,532   823   254   32,046   161,655   90.03   90.01   09000   CLINIC   09000   00000   00000   00000   90.02   09000   CLINIC   09000   00000   00000   90.03   09000   WURNER   194,643   0   3,521   208,884   2,131,868   90.03   90.04   09000   WOND   CENTER   1,949,463   0   3,521   208,884   2,131,868   90.03   90.04   09000   VIMCARE CLINIC   0703,282   40,712   5,688   171,404   921,086   90.05   90.05   09005   VIMCARE CLINIC   0703,282   40,712   5,688   171,404   921,086   90.05   90.05   09005   VIMCARE CLINIC   071,00000000000000000000000000000000000								
66. 00   06600   PHYSI CAL THERAPY   7, 190, 772   5, 894   9, 133   77, 978   7, 283, 777   66. 00   6700   0CCUPATI ONAL THERAPY   2, 518, 132   2, 115   5, 698   19, 653   2, 545, 598   67. 00   6800   SPEECH PATHOLOGY   1, 517, 344   13, 376   202, 861   288, 498   2, 022, 079   69. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 517, 344   13, 376   202, 861   288, 498   2, 022, 079   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 450, 625   0   6, 243   171, 073   1, 627, 941   70. 00   70. 00   0. 00		I I	· · ·					1
67. 00 06700 OCCUPATI ONAL THERAPY 2, 518, 132 2, 115 5, 698 19, 653 2, 545, 598 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 068, 132 0 13, 932 61, 056 1, 143, 120 68. 00 06900 ELECTROCARDI OLOGY 1, 517, 344 13, 376 202, 861 288, 498 2, 022, 079 69. 00 07000 ELECTROENCEPHALOGRAPHY 1, 450, 625 0 6, 243 171, 073 1, 627, 941 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 11, 017, 157 0 0 0 0 111, 017, 157 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 10, 427, 064 0 0 0 0 110, 427, 064 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 25, 390, 318 0 0 0 0 0 25, 390, 318 30 0 07400 RENAL DI ALYSI S 824, 501 0 0 0 0 0 824, 501 74. 00 76. 00 3020 ACUPUNCTURE 0 0 0 0 0 0 824, 501 74. 00 76. 00 3020 ACUPUNCTURE 0 0 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
68. 00 06800 SPEECH PATHOLOGY 1, 068, 132 0 13, 932 61, 056 1, 143, 120 68. 00 69. 00 69. 00 ELECTROCARDI OLOGY 1, 517, 344 13, 376 202, 861 288, 498 2, 022, 079 69. 00 70. 00 70. 00 FLECTROENCEPHALOGRAPHY 1, 450, 625 0 6, 243 171, 073 1, 627, 941 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 11, 017, 157 0 0 0 0 11, 017, 157 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10, 427, 064 0 0 0 0 10, 427, 064 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 25, 390, 318 0 0 0 0 25, 390, 318 73. 00 74. 00 07400 RENAL DI ALYSI S 824, 501 0 0 0 0 25, 390, 318 73. 00 74. 00 07400 RENAL DI ALYSI S 824, 501 0 0 0 0 0 25, 390, 318 73. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 0 76. 00 76. 00 770. 00 7700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 77. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I						1
70. 00         07000         ELECTROENCEPHALOGRAPHY         1, 450, 625         0         6, 243         171, 073         1, 627, 941         70. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         11, 017, 157         0         0         0         11, 017, 157         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATIENTS         10, 427, 064         0         0         0         10, 427, 064         72. 00         0         0         10, 427, 064         72. 00         0         0         0         10, 427, 064         72. 00         0         0         0         25, 390, 318         0         0         0         25, 390, 318         73. 00         0         0         0         25, 390, 318         73. 00         0         0         0         0         25, 390, 318         73. 00         0         0         0         0         0         0         74. 00         0         0         0         0         0         0         74. 00         0         0         0         0         76. 00         0         0         0         0         76. 00         76. 00         0         0         0         0         0         0         0								1
71. 00								•
72. 00				0				•
74. 00 07400 RENAL DI ALYSI S 824, 501 0 0 0 0 824, 501 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				Ö	1	-		1
76. 00				0	1			1
76. 97   07697   CARDI AC REHABI LI TATI ON   459, 563   15, 127   1, 860   86, 378   562, 928   76. 97   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   0   0   0   78. 00   0   0   0   0   0   0   0   0   0			824, 501	0	1	-		•
78. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	459, 563	15, 127	-			76. 97
SECTION   SERVICE COST CENTERS   SECTION   S			0					1
88. 00	10.00		0		· · · · · · · · · · · · · · · · · · ·	ı U	0	70.00
90. 00   09000   CLI NI C   3,485,583   69,062   19,550   799,727   4,373,922   90.00   90.01   09001   DI ABETES CENTER   0 0 0 0 0 0 0 90.01   90.02   09002   NEUROPSYCH   128,532   823   254   32,046   161,655   90.02   90.03   09003   WOUND CENTER   1,919,463   0   3,521   208,884   2,131,868   90.03   90.04   09004   HYPERBARI C OXYGEN THERAPY   273,397   0   210   27,710   301,317   90.04   90.05   09005   VI MCARE CLI NI C   703,282   40,712   5,688   171,404   921,086   90.05		08800 RURAL HEALTH CLINIC	0		l .			1
90. 01   09001   DI ABETES CENTER   0   0   0   0   0   90. 01   90. 02   90. 02   90. 03   90. 03   90. 04   90. 04   90. 05   9			3 405 503	-				1
90. 02   09002   NEUROPSYCH   128, 532   823   254   32, 046   161, 655   90. 02   90. 03   09003   WOUND CENTER   1, 919, 463   0   3, 521   208, 884   2, 131, 868   90. 03   90. 04   09004   HYPERBARI C 0XYGEN THERAPY   273, 397   0   210   27, 710   301, 317   90. 04   90. 05   09005   VI MCARE CLI NI C   703, 282   40, 712   5, 688   171, 404   921, 086   90. 05			0, 400, 303		1			ı
90. 04   09004   HYPERBARI C 0XYGEN THERAPY 273, 397 0 210 27, 710 301, 317 90. 04 90. 05   09005   VI MCARE CLI NI C 703, 282 40, 712 5, 688 171, 404 921, 086 90. 05		09002 NEUROPSYCH			l .			1
90. 05 09005 VI MCARE CLI NI C 703, 282 40, 712 5, 688 171, 404 921, 086 90. 05				-				1
		I I		-				•
	90. 06	09006 MEDICATION MGMT CLINIC	293, 987	8, 774	4, 839	79, 055	386, 655	90.06

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0112	Peri od: From 01/01/2023	

COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	Fi	rom 01/01/2023 b 12/31/2023	Part I Date/Time Pre 5/30/2024 7:0	pared: 2 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	col. 7)					
	0	1. 00	2. 00	4. 00	4A	
91. 00   09100   EMERGENCY	10, 733, 119	172, 750	95, 436	2, 168, 287	13, 169, 592	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS	2 072 022	7/ 050	100, 202	011 707	F 0F0 070	05 00
95. 00   09500   AMBULANCE   SERVI CES 99. 10   09910   CORF	3, 873, 933	76, 850	190, 382	911, 707	5, 052, 872 0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	O O	-	101.00
102.00 10200  OPI OI D TREATMENT PROGRAM	0	0	0	O O		101.00
SPECIAL PURPOSE COST CENTERS	U	U	U	U <sub>I</sub>	U	102.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	٥	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	o o	0	Ö	0		111.00
113. 00 11300   NTEREST EXPENSE	J	Ŭ.	Ĭ	Ĭ	· ·	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	330, 811, 130	6, 784, 887	12, 577, 284	30, 909, 493	328, 583, 410	
NONREI MBURSABLE COST CENTERS		27 . 2 . 7 2 2 . 1	.=,, =	227 1217 112		
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	48, 943	31, 881	236	13, 250	94, 310	190. 00
194. 00 07950 WELLNESS COMMUNITY	369, 190	0	3, 322	62, 634	435, 146	194.00
194. 01 07951 BUI LDI NG RENTALS	249, 090	0	0	0	249, 090	194. 01
194. 02 07952 HOSPI CE	123, 479	8, 946	0	0	132, 425	194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0	194. 03
194. 04 07954 SPEECH - HEARING AIDS	163, 796	0	0	0	163, 796	194.04
194. 05 07955 NONALLOWABLE MARKETING	821, 990	0	0	0	821, 990	194. 05
194. 06 07956 CRH FOUNDATION	64, 031	18, 399	0	16, 082	98, 512	194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0	194. 07
194. 08 07958 CRHP	3, 164, 226	88, 906	1, 403, 417	573, 910	5, 230, 459	
194. 09 07959 NEUROPSYCH PART B	0	5, 138	1, 599	0		194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	335, 815, 875	6, 938, 157	13, 985, 858	31, 575, 369	335, 815, 875	202. 00

Provider CCN: 15-0112

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am

					12/31/2023	5/30/2024 7:0	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	OFNEDAL OFDILLOS COOT OFNEDO	5. 00	7. 00	8. 00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	41 252 470					4. 00 5. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	61, 252, 470	17 050 401				•
7. 00 8. 00	00700 OPERATION OF PLANT	3, 110, 341	17, 052, 431				7. 00 8. 00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	209, 867	44, 061				9.00
		936, 369 512, 075	288, 958		5, 422, 595		•
10.00	01000 DI ETARY	1			43, 216	3, 288, 162	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	505, 553	351, 935		58, 931	0	11.00
14. 00		2, 206, 385	561, 060		18, 661	0	13. 00 14. 00
15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	311, 586	422, 645		66, 788 39, 287	0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 733, 344	267, 039			0	1
17. 00	01700 SOCIAL SERVICE	513, 788	203, 228 0		9, 822	0	16. 00 17. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
23. 00	02300 PARAMED ED PROM 02301 XRAY EDUCATION	179, 176	39, 833	-	6, 875	0	23.00
23. 01	1	88, 759	•	1		0	23.01
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS	88, 739	20, 918	0	2, 947	U	23.02
30. 00	03000 ADULTS & PEDIATRICS	10, 211, 682	4, 330, 368	400, 261	2, 084, 178	2, 619, 438	30.00
31. 00	03100   NTENSIVE CARE UNIT						31.00
		1, 737, 464	616, 303 0		275, 009	294, 664	•
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0		0	0	32.00
34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33. 00 34. 00
40.00	04000 SUBPROVI DER - I PF	0	0		0	0	40.00
		_	414 403	40 772	270 020	- 1	ł
41. 00	04100 SUBPROVI DER - I RF	773, 811	616, 693		278, 938		41.00
42.00	04200 SUBPROVI DER	0	22 424	0	1 0/4	0	42.00
43.00	04300 NURSERY	464, 217	32, 434		1, 964	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
EO 00	ANCILLARY SERVICE COST CENTERS	E 042 074	2 202 (27	) DEE 011	000 430	12 040	EO 00
50.00	05000 OPERATING ROOM	5, 842, 074	2, 203, 627		802, 438		•
51.00	05100 RECOVERY ROOM	447, 259	177, 191			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	607, 061	203, 951				52.00
53.00	05300 ANESTHESI OLOGY	27, 979	6, 620		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	636, 521	471, 045			1, 300	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	710, 453	186, 983		70, 717	0	54.01
54. 02	05404 ULTRA SOUND	282, 595	83, 672		17, 679	0	54.02
54. 03	05405 MAMMOGRAPHY	386, 333	5, 619			0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	719, 293	434, 439		78, 574	8, 124	55.00
57. 00	05700 CT SCAN	544, 160	101, 141		21, 608		57.00
58. 00	05800 MRI	358, 442	50, 070		10, 804	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	892, 544	510, 823			6, 855	1
60.00	06000 LABORATORY	3, 121, 068	604, 620		102, 146		60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	423, 550	67, 427		5, 893	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	173, 035	23, 811		3, 929	0	62.00
65. 00	06500 RESPI RATORY THERAPY	1, 040, 564	439, 557		125, 719	0	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 624, 938	34, 270			0	66. 00
67. 00	1	567, 897	12, 295	13, 456	0	_	67.00
68. 00	06800 SPEECH PATHOLOGY	255, 019		0	0	15	
69. 00	06900 ELECTROCARDI OLOGY	451, 106	77, 775	0	3, 929	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	363, 177	0	1, 133	149, 291	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 457, 818	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 326, 174	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 664, 326	0	0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	183, 938	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	125, 584	87, 956	0	3, 929	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						l
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	975, 778	401, 560	50, 476	76, 610	28, 177	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	36, 064	4, 784	. 0	1, 964	0	90. 02
90. 03	09003 WOUND CENTER	475, 598	0	2, 333		0	90.03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	67, 221	Ö	149	0	Ō	90.04
90. 05	09005 VI MCARE CLI NI C	205, 485	236, 719	1	95, 271	Ö	90.05
90.06	09006 MEDICATION MGMT CLINIC	86, 259	51, 016		13, 750	Ō	90.06
91.00	09100 EMERGENCY	2, 938, 004	1, 004, 455		The state of the s	16, 387	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_, . 30, 001	1, 23., .00			. 5, 55,	92.00
55	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	1, 127, 245	446, 845	0	0	0	95.00
99. 10		0					
	i I	<u>,                                     </u>			<u> </u>		

			T <sub>1</sub>	12/31/2023	Date/Time Pre 5/30/2024 7:0	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	/2 dill
	E & GENERAL		LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
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 ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	59, 638, 979	16, 161, 245	1, 194, 655	5, 379, 379	3, 288, 162	118. 00
NONREI MBURSABLE COST CENTERS			_	_1		ļ
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	21, 040	185, 369	0	0		190.00
194. 00 07950 WELLNESS COMMUNITY	97, 077	0	0	0		194.00
194. 01 07951 BUILDING RENTALS	55, 569	0	0	0		194. 01
194. 02 07952 HOSPI CE	29, 543	52, 017	0	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	36, 541	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	183, 378		0	0		194. 05
194. 06 07956 CRH FOUNDATION	21, 977	106, 982	0	43, 216		194. 06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0	0	0		194. 07
194. 08 07958 CRHP	1, 166, 863	·		0		194. 08
194. 09 07959 NEUROPSYCH PART B	1, 503	29, 875	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)	61, 252, 470	17, 052, 431	1, 194, 655	5, 422, 595	3, 288, 162	202.00

Provider CCN: 15-0112

Peri od: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am

					5/30/2024 7:0	2 am
Cost Center Description	CAFETERI A	NURSING ADMINISTRATIO	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11. 00	N 13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 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 & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00  01000  DI ETARY						10.00
11. 00   01100   CAFETERI A	3, 182, 557					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	218, 022		0 004 540			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	36, 809		2, 234, 513	10 510 0/0		14.00
15. 00   01500   PHARMACY	96, 270	605, 312	0	10, 510, 960	2 120 002	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	99, 101	0	0	0	3, 128, 993	16.00
17. 00   01700   SOCIAL SERVICE 23. 00   02300   PARAMED ED PRGM	0	0	0	0	0	17. 00 23. 00
23. 01   02300   PARAMED ED PROM 23. 01   02301   XRAY EDUCATION	19, 820	0	0	0	0	23. 00
23. 02   02302   PHARMACY RESI DENCY PROG	8, 494	44, 228	0	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 474	44, 220	0	<u> </u>	0	23.02
30. 00 03000 ADULTS & PEDIATRICS	733, 352	4, 526, 162	31, 805	15, 354	312, 611	30.00
31. 00 03100 I NTENSI VE CARE UNI T	93, 438		6, 874	6, 811	52, 000	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	o	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	o	0	0	0	34.00
40. 00   04000   SUBPROVI DER - 1 PF	0	o	0	0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	65, 123	398, 588	0	452	25, 663	41.00
42. 00  04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY	39, 640	236, 898	0	6	6, 528	43.00
44.00 O4400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	319, 955		1, 764, 042	109, 993	384, 560	50.00
51. 00   05100   RECOVERY ROOM	36, 809		0	51	29, 396	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	56, 629	356, 603	13, 542	888	17, 031	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	20 (40	0	120 (12)	20, 356	62, 371	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C	39, 640 16, 989		120, 612	14, 657 82, 839	26, 399	54. 00 54. 01
54. 02 O5404 ULTRA SOUND	19, 820		0	62, 639 1, 046	49, 158 33, 808	54.01
54. 03   05405   MAMMOGRAPHY	33, 977		28, 383	356	24, 537	54. 02
55. 00   05500   RADI OLOGY-THERAPEUTI C	22, 652	137, 564	20, 303	10	75, 608	55. 00
57. 00   05700 CT SCAN	31, 146		0	110, 934	173, 560	57.00
58. 00   05800 MRI	22, 652		0	20, 442	49, 981	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	56, 629		183, 102	25, 134	126, 039	59. 00
60. 00   06000   LABORATORY	206, 696		0	22	282, 864	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	19, 820		0	60	28, 364	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 831	o	0	0	11, 660	62.00
65. 00 06500 RESPIRATORY THERAPY	73, 618	455, 223	0	387	111, 948	65.00
66. 00 06600 PHYSI CAL THERAPY	11, 326		5, 016	759	68, 049	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 831		0	0	24, 669	67.00
68. 00 06800 SPEECH PATHOLOGY	8, 494		0	0	8, 553	68.00
69. 00 06900 ELECTROCARDI OLOGY	33, 977		0	126, 146	59, 740	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	19, 820		0	3	32, 059	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	1	0	0	131, 079	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0 024 000	67, 959	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DI ALYSIS	0	0	0	9, 934, 099 5, 170		73.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03020   ACUPUNCTURE	0	0	0	5, 170	9, 241 0	74. 00 76. 00
76. 97   07697   CARDI AC REHABI LI TATI ON	8, 494	56, 450	0	14	7, 568	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0, 474	30, 430	0	0	7, 300	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	Ö	78.00
OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>	J	Ü	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	O	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90. 00   09000   CLI NI C	124, 584	323, 228	14, 280	6, 231	36, 761	90.00
90. 01   09001 DI ABETES CENTER	0	0	0	0	0	90.01
90. 02 09002 NEUROPSYCH	5, 663	ol	0	0	643	90.02
90. 03 09003 WOUND CENTER	22, 652		46, 026	5, 545	45, 144	90.03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	2, 831	21, 211	0	0	3, 953	90.04
90. 05   09005   VI MCARE   CLI NI C	31, 146		30	6, 891	5, 768	90.05
90.06 09006 MEDICATION MGMT CLINIC	5, 663		0	0	2, 715	90.06
91. 00   09100   EMERGENCY	268, 988	1, 398, 842	5, 252	5, 598	299, 574	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	405 0:5	000 01=		40.05-	45 56-	05.00
95. 00  09500  AMBULANCE SERVI CES	135, 910	832, 818	0	10, 090	45, 585	95. 00

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

			lo	12/31/2023	Date/lime Prepared: 5/30/2024 7:02 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
COST CENTER DESCRIPTION	CALLILITA	ADMI NI STRATI O	SERVICES &	THANWACT	RECORDS &
		N	SUPPLY		LI BRARY
	11. 00	13. 00	14.00	15. 00	16. 00
99. 10   09910   CORF	0	0	0	0	0 99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS					
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 052, 311	12, 894, 238	2, 218, 964	10, 510, 344	3, 128, 993 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 831	0	0	0	0 190.00
194. 00 07950 WELLNESS COMMUNITY	11, 326	0	0	0	0 194.00
194. 01 07951 BUI LDI NG RENTALS	0	0	0	0	0   194. 01
194. 02 07952 HOSPI CE	0	0	0	616	0 194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0	0 194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0	0 194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	0 194. 05
194. 06 07956 CRH FOUNDATION	2, 831	0	0	0	0 194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0	0 194. 07
194. 08 07958 CRHP	107, 595	0	15, 549	0	0 194. 08
194. 09 07959 NEUROPSYCH PART B	5, 663	0	0	0	0 194. 09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	o	0	o	0 201.00
202.00 TOTAL (sum lines 118 through 201)	3, 182, 557	12, 894, 238	2, 234, 513	10, 510, 960	3, 128, 993 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0112 Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

			Τ̈́	o 12/31/2023	Date/Time Pre 5/30/2024 7:0	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY PROG	Subtotal	Z diii
	17. 00	23. 00	23. 01	23. 02	24.00	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FIXT  2. 00 00200 CAP REL COSTS-MVBLE EQUIP  4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT  5. 00 00500 ADMINISTRATIVE & GENERAL  7. 00 00700 OPERATION OF PLANT  8. 00 00800 LAUNDRY & LINEN SERVICE  9. 00 00900 HOUSEKEEPING  10. 00 01000 DIETARY  11. 00 01100 CAFETERIA  13. 00 01300 NURSING ADMINISTRATION  14. 00 01400 CENTRAL SERVICES & SUPPLY  15. 00 01500 PHARMACY  16. 00 01600 MEDICAL RECORDS & LIBRARY  17. 00 01700 SOCIAL SERVICE  23. 00 02300 PARAMED ED PRGM  23. 01 02301 XRAY EDUCATION	0 0 0	0	1, 048, 861			1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 23. 00 23. 01
23. 02 02302 PHARMACY RESIDENCY PROG	0			563, 206		23. 02
INPATI ENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0			71, 038, 502 11, 491, 011 0 0 0 5, 975, 998 0 2, 872, 479	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM  51. 00 05100 RECOVERY ROOM  52. 00 05200 DELIVERY ROOM & LABOR ROOM  53. 00 05300 ANESTHESI OLOGY  54. 00 05400 RADI OLOGY-DI AGNOSTI C  54. 01 05402 NUCLEAR MEDICINE-DI AGNOSTI C  54. 02 05404 ULTRA SOUND  55. 00 05500 RADI OLOGY-THERAPEUTI C  57. 00 05700 CT SCAN  58. 00 05800 MRI  59. 00 05900 CARDI AC CATHETERI ZATI ON  60. 01 06001 LABORATORY  60. 01 06001 LABORATORY  60. 01 06600 RESPIRATORY THERAPY  66. 00 06600 RESPIRATORY THERAPY  66. 00 06600 SPEECH PATHOLOGY  69. 00 06900 SPEECH PATHOLOGY  69. 00 07000 ELECTROENCEPHALOGRAPHY  71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT  72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS  73. 00 07300 DRUGS CHARGED TO PATI ENTS  74. 00 07400 RENAL DI ALYSI S  76. 07 07697 CARDI AC REHABILI TATI ON  07800 CAR T-CELL IMMUNOTHERAPY  OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 048, 861 1, 048, 861 00 00 00 00 00 00 00 00 00 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39, 848, 996 3, 020, 315 4, 075, 189 242, 740 5, 418, 049 4, 301, 742 1, 705, 353 2, 248, 156 4, 715, 045 3, 421, 745 2, 119, 107 6, 320, 489 18, 307, 591 2, 443, 677 990, 895 6, 911, 338 9, 059, 163 3, 166, 746 1, 415, 201 2, 984, 626 2, 193, 424 13, 606, 054 12, 821, 197 41, 947, 796 1, 022, 850 0 852, 923 0	57. 00 58. 00 59. 00 60. 01 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 97 77. 00 78. 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 09001 DIABETES CENTER 90. 02 09002 NEUROPSYCH 90. 03 09003 WOUND CENTER 90. 04 09004 HYPERBARIC OXYGEN THERAPY 90. 05 09005 VIMCARE CLINIC 90. 06 09006 MEDICATION MGMT CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0			0 6, 411, 607 0 210, 773 2, 868, 309 396, 682 1, 508, 876 579, 727 19, 723, 370	88. 00 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	0	C	0	7, 651, 365	95, 00
	<u>,                                    </u>	O <sub>1</sub>		<u>,                                    </u>	7, 001, 000	, , , , , , ,

			To		Date/Time Pre 5/30/2024 7:0	
Cost Center Description	SOCI AL	PARAMED ED	XRAY	PHARMACY	Subtotal	2 aiii
out contain bood in param	SERVI CE	PRGM	EDUCATI ON	RESI DENCY	oub tota.	
				PROG		
	17. 00	23. 00	23. 01	23. 02	24.00	
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
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 ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1, 048, 861	563, 206	325, 889, 106	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	303, 550	
194. 00 07950 WELLNESS COMMUNITY	0	0	0	0	543, 549	
194. 01 07951 BUILDING RENTALS	0	0	0	0	304, 659	
194. 02 07952 HOSPI CE	0	0	0	0	214, 601	
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0	0	0	200, 337	
194. 05 07955 NONALLOWABLE MARKETING	0	0	0	0	1, 005, 368	
194. 06 07956 CRH FOUNDATION	0	0	0	U	273, 518	
194.07 07957 HEALTHY COMMUNITIES 194.08 07958 CRHP	0	U	0	0		194. 07
194. 08 07958 CRHP 194. 09 07959 NEUROPSYCH_PART_B	0	0	0	U O	7, 037, 409 43, 778	
	U	0	0	0		200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	0	o o		200.00
202.00 TOTAL (sum lines 118 through 201)		ol Ol	1, 048, 861	563, 206	335, 815, 875	
202.00   TOTAL (Suil TITIES TTO LITTOUGH 201)	l 이	Ч	1, 040, 001	303, 200	333, 013, 073	1202.00

				To 12/31/2023 Date/lime Pro 5/30/2024 7:0	
	Cost Center Description	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
CI	ENEDAL SEDVICE COST CENTERS	25. 00	26. 00		
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT				1.00
1	0200 CAP REL COSTS-MVBLE EQUIP				2.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT				4.00
	0500 ADMINISTRATIVE & GENERAL				5. 00
	0700 OPERATION OF PLANT				7. 00
1	0800 LAUNDRY & LINEN SERVICE				8. 00
1	0900 HOUSEKEEPI NG				9.00
10. 00 0	1000 DI ETARY				10.00
11. 00 0	1100 CAFETERI A				11.00
13. 00 0°	1300 NURSING ADMINISTRATION				13.00
14. 00 0	1400 CENTRAL SERVICES & SUPPLY				14.00
	1500 PHARMACY				15.00
	1600 MEDICAL RECORDS & LIBRARY				16. 00
	1700 SOCI AL SERVI CE				17.00
1	2300 PARAMED ED PRGM				23. 00
	2301 XRAY EDUCATION				23. 01
	2302 PHARMACY RESIDENCY PROG				23. 02
_	NPATIENT ROUTINE SERVICE COST CENTERS		71 029 502		20.00
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	0	71, 038, 502 11, 491, 011		30.00
	3200 CORONARY CARE UNIT		0		32.00
	3300 BURN INTENSIVE CARE UNIT		o		33.00
	3400 SURGICAL INTENSIVE CARE UNIT		o		34.00
1	4000 SUBPROVI DER – I PF		o		40.00
	4100 SUBPROVI DER - I RF	O	5, 975, 998		41.00
1	4200 SUBPROVI DER	0	0		42.00
	4300 NURSERY	0	2, 872, 479		43.00
44.00 04	4400 SKILLED NURSING FACILITY	0	О		44.00
1A	NCILLARY SERVICE COST CENTERS		·		
	5000 OPERATING ROOM	0	39, 848, 996		50.00
	5100 RECOVERY ROOM	0	3, 020, 315		51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	4, 075, 189		52.00
	5300 ANESTHESI OLOGY	0	242, 740		53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	5, 418, 049		54.00
	5402 NUCLEAR MEDICINE-DIAGNOSTIC	0	4, 301, 742		54. 01
	5404 ULTRA SOUND	0	1, 705, 353		54. 02
	5405 MAMMOGRAPHY 5500 RADI OLOGY-THERAPEUTI C	0	2, 248, 156		54. 03 55. 00
	5700 CT SCAN		4, 715, 045 3, 421, 745		57.00
	5800 MRI		2, 119, 107		58.00
	5900 CARDI AC CATHETERI ZATI ON		6, 320, 489		59.00
1	6000 LABORATORY		18, 307, 591		60.00
	6001 LABORATORY-PATHOLOGI CAL		2, 443, 677		60. 01
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	990, 895		62.00
	6500 RESPI RATORY THERAPY	0	6, 911, 338		65.00
66. 00 0	6600 PHYSI CAL THERAPY	0	9, 059, 163		66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	0	3, 166, 746		67.00
	6800 SPEECH PATHOLOGY	0	1, 415, 201		68. 00
	6900 ELECTROCARDI OLOGY	0	2, 984, 626		69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	2, 193, 424		70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 606, 054		71.00
	7200 DRUCS CHARCED TO PATIENTS	0	12, 821, 197		72.00
	7300 DRUGS CHARGED TO PATIENTS	0	41, 947, 796		73.00
	7400 RENAL DI ALYSI S 3020 ACUPUNCTURE		1, 022, 850 0		74.00
	7697 CARDIAC REHABILITATION		852, 923		76. 00 76. 97
	7700 ALLOGENEIC HSCT ACQUISITION		032, 423		77.00
1	7800 CAR T-CELL IMMUNOTHERAPY		o		78.00
	UTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		1 . 5. 55
	8800 RURAL HEALTH CLINIC	0	0		88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	o	o		89. 00
	9000 CLI NI C	o	6, 411, 607		90.00
	9001 DI ABETES CENTER		0		90. 01
	9002 NEUROPSYCH	0	210, 773		90. 02
	9003 WOUND CENTER	0	2, 868, 309		90. 03
	9004 HYPERBARIC OXYGEN THERAPY	0	396, 682		90. 04
	9005 VIMCARE CLINIC	0	1, 508, 876		90. 05
	9006 MEDICATION MGMT CLINIC	0	579, 727		90.06
	9100 EMERGENCY	0	19, 723, 370		91.00
92.00  09	9200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00

Health Financial Systems	COLUMBUS REGION	IAI HOSPITAI		In lie	ı of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	OCCUMBOS REGION	Provider CCN:	: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/30/2024 7:02 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00			
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0	7, 651, 365			95.00
99. 10   09910   CORF	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0			101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0			102. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	325, 889, 106			118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	303, 550			190. 00
194.00 07950 WELLNESS COMMUNITY	0	543, 549			194. 00
194. 01 07951 BUI LDI NG RENTALS	0	304, 659			194. 01
194. 02 07952 HOSPI CE	0	214, 601			194. 02
194. 03 07953 OUTREACH CLINICS	0	0			194. 03
194.04 07954 SPEECH - HEARING AIDS	0	200, 337			194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	1, 005, 368			194. 05
194.06 07956 CRH FOUNDATION	0	273, 518			194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0			194. 07
194. 08 07958 CRHP	0	7, 037, 409			194. 08
194.09 07959 NEUROPSYCH PART B	0	43, 778			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	335, 815, 875			202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

				Io	12/31/2023	Date/lime Pre   5/30/2024 7:0	
			CAPI TAL REI	LATED COSTS		1070072021 7.0	2 (1111
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DELAKTIMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	02 102	4 462	04 545	0/ 5/5	2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	1, 012, 440	92, 102 566, 627		96, 565 7, 972, 311	96, 565 16, 744	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	161, 194	3, 346, 682		3, 834, 679	3, 225	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	7, 578		7, 578	27	8.00
9.00	00900 HOUSEKEEPI NG	2, 281	49, 696	128, 369	180, 346	2, 171	9. 00
10.00	01000 DI ETARY	5, 166	75, 243		92, 042	984	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	7, 108 19, 644	60, 527 96, 493		83, 640 165, 668	1, 354 5, 659	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 076	72, 688		150, 582	5, 659	14.00
15. 00	01500 PHARMACY	4, 848	45, 926		293, 269	3, 238	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 308	34, 952	1, 140	37, 400	1, 353	16.00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
23. 00	02300 PARAMED ED PRGM	0	0	0 500	0	0	23.00
23. 01 23. 02	O2301   XRAY EDUCATION   O2302   PHARMACY RESIDENCY PROG	0	6, 851 3, 598		15, 433 7, 776	526 247	23. 01 23. 02
20.02	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0,070	1, 170	7,770	217	20.02
30.00	03000 ADULTS & PEDIATRICS	391, 580	744, 755	163, 521	1, 299, 856	21, 710	30.00
31.00	03100 INTENSIVE CARE UNIT	57, 704	105, 994	124, 023	287, 721	3, 158	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	Ö	Ö	Ö	o	0	40.00
41.00	04100 SUBPROVI DER - I RF	58, 654	106, 061	8, 770	173, 485	1, 784	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	455 0	5, 578	9, 639	15, 672	1, 312 0	43. 00 44. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	U	U	U U	<u>U</u>	0	44.00
50. 00	05000 OPERATING ROOM	977, 122	378, 989	2, 045, 611	3, 401, 722	1, 186	50.00
51.00	05100 RECOVERY ROOM	8, 639	30, 474	2, 428	41, 541	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 762	35, 076		63, 031	1, 653	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY	0	1, 139		2, 441	1 150	53.00
54. 00	05400  RADI OLOGY-DI AGNOSTI C   05402  NUCLEAR   MEDI CI NE-DI AGNOSTI C	6, 850 26, 389	81, 012 32, 158		238, 617 450, 704	1, 150 502	54. 00 54. 01
54. 02	05404 ULTRA SOUND	2, 395	14, 390		56, 784	615	•
54.03	05405 MAMMOGRAPHY	165, 430	966	191, 065	357, 461	712	54.03
55. 00	05500 RADI OLOGY-THERAPEUTI C	10, 716	74, 717		563, 673	584	55.00
57.00	05700 CT SCAN	547	17, 395		270, 655	746	57.00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	480, 863 32, 907	8, 611 87, 853	17, 206 400, 398	506, 680 521, 158	533 1, 728	58. 00 59. 00
60.00	06000 LABORATORY	21, 767	103, 985		426, 741	3, 512	1
60. 01	06001 LABORATORY-PATHOLOGI CAL	336	11, 596		47, 692		60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	4, 095		7, 393	73	1
65.00	06500 RESPI RATORY THERAPY	11, 143	75, 597		207, 089	2, 018	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	408, 704 139, 984	5, 894 2, 115		423, 731 147, 797	239 60	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	50, 584	0	13, 932	64, 516	187	68.00
69. 00	06900 ELECTROCARDI OLOGY	2, 031	13, 376		218, 268	882	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	173, 304	0	6, 243	179, 547	523	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	o o	0		Ö	0	74.00
76. 00	03020 ACUPUNCTURE	o	Ö	0	Ö	0	76.00
76. 97	07697 CARDIAC REHABILITATION	0	15, 127	1, 860	16, 987	264	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY  OUTPATIENT SERVICE COST CENTERS	0	0	0	<u></u> 0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	o	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	Ö	0	ő	0	89.00
90.00	09000 CLI NI C	2, 290	69, 062	19, 550	90, 902	2, 446	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02 90. 03	O9002   NEUROPSYCH   O9003   WOUND CENTER	122, 218	823	254 3, 521	1, 077 125, 739	98 639	90. 02 90. 03
90.03	09003 WOUND CENTER 09004 HYPERBARIC OXYGEN THERAPY	101, 979	0	210	102, 189	85	1
90. 05	09005 VI MCARE CLINI C	448	40, 712		46, 848	524	90.05
90.06	09006 MEDICATION MGMT CLINIC	0	8, 774		13, 613	242	90.06
91. 00	09100  EMERGENCY	22, 659	172, 750	95, 436	290, 845	6, 632	91.00

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

From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: 5/30/2024 7:02 am CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Di rectly MVBLE EQUIP Subtotal Assi gned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4. 00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 0 95.00 09500 AMBULANCE SERVICES 26, 825 76, 850 190, 382 294, 057 2, 788 95.00 99. 10 09910 CORF 99. 10 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 0 0 0 111.00 11100 | SLET ACQUISITION 0 C 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 4, 531, 350 6, 784, 887 12, 577, 284 23, 893, 521 94, 528 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 31,881 236 32, 117 41 190.00 194. 00 07950 WELLNESS COMMUNITY 63, 273 3, 322 66, 595 192 194. 00 0 194. 01 194. 01 07951 BUILDING RENTALS 54.003 54, 003 Ω 0 194.02 194. 02 07952 HOSPI CE 0 8, 946 0 8, 946 194. 03 07953 OUTREACH CLINICS 0 0 0 194. 03 194. 04 07954 SPEECH - HEARING AIDS 0 0 194.04 0 0 194. 05 07955 NONALLOWABLE MARKETING 0 0 0 194. 05 194.06 07956 CRH FOUNDATION 49 194. 06 0 18, 399 0 18, 399 194. 07 07957 HEALTHY COMMUNITIES 0 194.07 194. 08 07958 CRHP 1, 755 194. 08 226, 879 88, 906 1, 403, 417 1, 719, 202 194. 09 07959 NEUROPSYCH PART B 0 194. 09 1, 599 5, 138 6,737 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 6, 938, 157 13, 985, 858 25, 799, 520 96, 565 202. 00 4, 875, 505

Provider CCN: 15-0112

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/30/2024 7:02 am

						5/30/2024 7:0	
	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	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	7, 989, 055					5.00
7.00	00700 OPERATION OF PLANT	405, 673	4, 243, 577				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 372	10, 965		l .		8. 00 9. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	122, 128 66, 788	71, 909 108, 874	0	376, 554 3, 001	271, 689	10.00
11. 00	01100 CAFETERI A	65, 938	87, 581	0	4, 092	271,009	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	287, 773	139, 622	-	1, 296	Ö	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	40, 639	105, 177	l o	l ' '	Ö	14.00
15.00	01500 PHARMACY	226, 075	66, 454	0	l ' '	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	67, 012	50, 574	0	682	0	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
23. 01	02301 XRAY EDUCATION	23, 369	9, 913	•	477	0	23. 01
23. 02		11, 577	5, 206	0	205	0	23. 02
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 331, 952	1, 077, 629	15, 393	144, 728	216, 437	30.00
31. 00	03100 I NTENSI VE CARE UNI T	226, 613	153, 370		· · ·	24, 347	31.00
32. 00	03200 CORONARY CARE UNIT	0	133, 370	1, 732	17, 077	24, 347	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	O	0	l o	o	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	O	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	100, 926	153, 467	1, 876	19, 370	24, 734	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	60, 547	8, 071	382	l .	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
F0 00	ANCILLARY SERVICE COST CENTERS	7/4 0/5	F40, 000	0.011	FF 700	1 111	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	761, 965	548, 383		· .	1, 144 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	58, 335 79, 177	44, 095 50, 754	2, 033 722		0	52.00
53. 00	05300 ANESTHESI OLOGY	3, 649	1, 648		3, 323	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	83, 020	117, 222		8, 253	107	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	92, 662	46, 532		4, 911	0	54. 01
54. 02	05404 ULTRA SOUND	36, 858	20, 822	0		0	54.02
54.03	05405 MAMMOGRAPHY	50, 388	1, 398	185	2, 251	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	93, 815	108, 112	560	5, 456	671	55.00
57. 00	05700 CT SCAN	70, 973	25, 169		.,	0	57.00
58. 00	05800 MRI	46, 751	12, 460		750	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	116, 412	127, 121	2, 719		566	59.00
60.00	06000 LABORATORY	407, 072	150, 463		7, 093	0	60.00
60. 01 62. 00	06001   LABORATORY-PATHOLOGI CAL   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	55, 242 22, 568	16, 780 5, 925		409 273	0	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	135, 718	109, 386		8, 730	0	65.00
66. 00	06600 PHYSI CAL THERAPY	211, 936	8, 528			0	66.00
67. 00	1 1	74, 069	3, 060		l .	0	67.00
68.00		33, 261	0	0	0	1	68.00
69. 00	06900 ELECTROCARDI OLOGY	58, 836	19, 355	0	273	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	47, 368	0	44	10, 367	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	320, 566	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	303, 396	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	738, 782	0	0	0	0	73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 ACUPUNCTURE	23, 991 0	0	0	0	0	74. 00 76. 00
76. 00	07697 CARDI AC REHABI LI TATI ON	16, 380	21, 888		273	0	76.00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	10, 300	21,000		2/3	0	77.00
78. 00	1	0	0	0	o	0	78.00
	OUTPATIENT SERVICE COST CENTERS	-1	-	-	-1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	127, 268	99, 930	1, 941	5, 320	2, 328	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	4, 704	1, 191	0	136	0	90. 02
90. 03	09003 WOUND CENTER	62, 031	0	90	0	0	90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	8, 767	50,000	6	0	0	90.04
90. 05 90. 06	09005 VI MCARE CLINI C   09006   MEDICATION   MGMT   CLINI C	26, 801	58, 909 12, 605		6, 616 955	0	90. 05 90. 06
90.06	09100 EMERGENCY	11, 251 383, 196	12, 695 249, 963		37, 376	1, 354	90.06
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	303, 170	247, 703	3,017	37, 370	1, 334	92.00
, 00	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	147, 023	111, 199	0	0	0	95.00
99. 10		0	0		o	0	99. 10

			Te	12/31/2023	Date/Time Pre 5/30/2024 7:0	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 778, 613	4, 021, 800	45, 942	373, 553	271, 689	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 744	46, 130	0	0		190. 00
194. 00 07950 WELLNESS COMMUNITY	12, 661	0	0	0		194. 00
194. 01 07951 BUI LDI NG RENTALS	7, 248		0	0		194. 01
194. 02 07952 HOSPI CE	3, 853	12, 945	0	0		194. 02
194. 03 07953 OUTREACH CLINICS	0	0	0	0		194. 03
194. 04 07954 SPEECH - HEARING ALDS	4, 766	0	0	0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	23, 917		0	0		194. 05
194. 06 07956 CRH FOUNDATION	2, 866	26, 623	0	3, 001		194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0	0	0		194. 07
194. 08 07958 CRHP	152, 191	128, 644	0	0		194. 08
194.09 07959 NEUROPSYCH PART B	196	7, 435	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)	7, 989, 055	4, 243, 577	45, 942	376, 554	271, 689	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0112

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

5/30/2024 7:02 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 11 00 13.00 15 00 16.00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 |OO4OO|EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 242,605 11 00 01300 NURSING ADMINISTRATION 16, 620 13.00 616, 638 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 2.806 303.842 14 00 15.00 01500 PHARMACY 7, 339 28, 948 0 628, 051 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7, 554 0 164, 575 16.00 17.00 01700 SOCIAL SERVICE 0 0 C 0 0 17.00 23.00 02300 PARAMED ED PRGM 0 C 0 0 0 23.00 23 01 1, 511 02301 XRAY EDUCATION 0 0 0 23.01 02302 PHARMACY RESIDENCY PROG 0 23.02 0 23.02 648 2, 115 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 55, 899 917 16, 479 30.00 216, 452 4, 325 30.00 03100 INTENSIVE CARE UNIT 31.00 7, 123 27, 260 935 407 2,741 31.00 03200 CORONARY CARE UNIT 32.00 0 C 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34.00 04000 SUBPROVI DER - I PF 40.00 0 0 O 40.00 04100 SUBPROVI DER - I RF 41 00 4,964 19,062 0 27 1, 353 41.00 42.00 04200 SUBPROVI DER 0 0 0 42.00 04300 NURSERY 43.00 3,022 11, 329 0 0 344 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 24, 390 94,028 239, 870 6,572 20, 272 50.00 05100 RECOVERY ROOM 51.00 2,806 11,031 1,550 51.00 C 05200 DELIVERY ROOM & LABOR ROOM 52 00 4.317 17.054 1.841 53 898 52 00 05300 ANESTHESI OLOGY 53.00  $\cap$ 1, 216 3, 288 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,022 876 1, 392 54.00 C 16, 400 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 1, 295 C 4, 950 2, 591 54.01 0 05404 ULTRA SOUND 1,511 1, 782 54 02 54 02 C 63 54.03 05405 MAMMOGRAPHY 2,590 C 3,859 21 1.293 54.03 3, 986 05500 RADI OLOGY-THERAPEUTI C 1,727 55.00 6,579 55.00 57 00 05700 CT SCAN 2, 374 O 6, 629 9, 149 57 00 r 05800 MRI 58.00 1,727  $\cap$ 1, 221 2,635 58.00 16, 813 24, 898 05900 CARDI AC CATHETERI ZATI ON 4, 317 59.00 59.00 1,502 6,644 60.00 06000 LABORATORY 15, 756 14, 911 60.00 0 06001 LABORATORY-PATHOLOGI CAL 1, 495 0 60 01 60 01 1,511 4 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 216 0 0 615 62.00 65.00 06500 RESPIRATORY THERAPY 5, 612 21,770 0 23 5, 901 65.00 06600 PHYSI CAL THERAPY 66.00 863 682 45 3.587 66,00 06700 OCCUPATI ONAL THERAPY 1, 300 67.00 216 0 0 67 00 68.00 06800 SPEECH PATHOLOGY 648 0 0 451 68.00 06900 ELECTROCARDI OLOGY 69.00 2,590 10,037 0 7, 538 3, 149 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 511 70.00 0 1.690 70.00 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 C 0 0 6.910 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 582 72.00 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 593, 582 20, 499 73.00 07400 RENAL DIALYSIS 309 74.00 0 C 0 487 74.00 0 76.00 03020 ACUPUNCTURE 0 0 Λ 76.00 07697 CARDIAC REHABILITATION 0 399 76.97 76.97 648 2,700 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 0 09000 CLINIC 9, 497 90 00 15, 458 1,942 372 1,938 90 00 90.01 09001 DI ABETES CENTER 0 90.01 0 09002 NEUROPSYCH 90.02 432 0 0 34 90.02 90.03 09003 WOUND CENTER 1,727 2.380 6,654 6, 258 331 90.03 09004 HYPERBARI C OXYGEN THERAPY 90.04 216 1,014 0 208 90.04 0 09005 VIMCARE CLINIC 90.05 2, 374 4 412 304 90.05 90.06 09006 MEDICATION MGMT CLINIC 0 143 90.06 432 1,610 09100 EMERGENCY 91 00 20, 505 66, 896 714 335 15, 792 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 2, 403 10 360 39 828 0 603 95 00

			То	12/31/2023	Date/Time Pre 5/30/2024 7:03	
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	
99. 10   09910   CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPI OID TREATMENT PROGRAM	0	0	0	0	0	102.00
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 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	232, 676	616, 638	301, 728	628, 014	164, 575	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	216		0	0		190.00
194. 00 07950 WELLNESS COMMUNITY	863	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	216	0	0	0		194. 06
194. 07 07957 HEALTHY COMMUNI TI ES	0	0	0	0		194. 07
194. 08 07958 CRHP	8, 202	0	2, 114	0		194. 08
194. 09 07959 NEUROPSYCH PART B	432	0	0	O		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)	242, 605	616, 638	303, 842	628, 051	164, 575	202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0112

			<del> </del>	To 12/31/2023	Date/Time Prep 5/30/2024 7:00	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	XRAY EDUCATI ON	PHARMACY RESI DENCY PROG	Subtotal	Z diii
	17. 00	23. 00	23. 01	23. 02	24.00	
GENERAL SERVICE COST CENTERS  1.00   OO100   CAP REL COSTS-BLDG & FLXT			Ī			1.00
2.00   00200   CAP REL COSTS-MUBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT 5.00   00500   ADMINI STRATI VE & GENERAL 7.00   00700   OPERATION OF PLANT						2. 00 4. 00 5. 00 7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG						8. 00 9. 00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON						10. 00 11. 00 13. 00
14.00   01400   CENTRAL SERVI CES & SUPPLY 15.00   01500   PHARMACY						14. 00 15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	0					16. 00 17. 00
23. 00   02300   PARAMED ED PRGM	0	0				23. 00
23. 01   02301  XRAY EDUCATION 23. 02   02302  PHARMACY RESIDENCY PROG	0		51, 229	27, 774		23. 01 23. 02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   NTENSIVE CARE UNIT	0				4, 401, 777 754, 704	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0				0	32. 00
33.00   03300   BURN INTENSIVE CARE UNIT 34.00   03400   SURGICAL INTENSIVE CARE UNIT	0				0	33. 00 34. 00
40. 00   04000   SUBPROVI DER - 1 PF	0				0	40. 00
41. 00   04100   SUBPROVI DER -   RF 42. 00   04200   SUBPROVI DER	0				501, 048 0	41. 00 42. 00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY	0				100, 815 0	43. 00 44. 00
ANCILLARY SERVICE COST CENTERS			I			
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	0				5, 165, 069 164, 259	50. 00 51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM 53.00   05300   ANESTHESIOLOGY	0				225, 025	52.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0				12, 242 473, 403	53. 00 54. 00
54. 01   05402   NUCLEAR MEDICINE-DIAGNOSTIC 54. 02   05404   ULTRA SOUND	0				604, 147 119, 663	54. 01 54. 02
54. 03   05405   MAMMOGRAPHY	0				420, 158	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	0				785, 164 387, 195	55. 00 57. 00
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	0				572, 757 830, 562	58. 00 59. 00
60. 00   06000   LABORATORY	o				1, 025, 549	60.00
60. 01   06001   LABORATORY-PATHOLOGI CAL 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0				123, 548 37, 063	60. 01 62. 00
65. 00 06500 RESPI RATORY THERAPY	0				496, 247	65. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0				650, 865 227, 019	
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0				99, 064 320, 928	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				241, 050	70. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	0				327, 476 306, 978	71. 00 72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0				1, 352, 863 24, 787	73. 00 74. 00
76. 00 03020 ACUPUNCTURE	0				0	76.00
76.97 O7697 CARDIAC REHABILITATION 77.00 O7700 ALLOGENEIC HSCT ACQUISITION	0				59, 540 0	76. 97 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0				0	78. 00
88. 00 08800 RURAL HEALTH CLINIC	0				0	88.00
89. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER 90. 00   09000   CLI NI C	0				0 359, 342	89. 00 90. 00
90. 01 09001 DI ABETES CENTER	0				0	90. 01
90. 02   09002   NEUROPSYCH 90. 03   09003   WOUND CENTER	0				7, 672 205, 849	90. 02 90. 03
90. 04   09004   HYPERBARI C OXYGEN THERAPY 90. 05   09005   VI MCARE CLINI C	0				112, 485 143, 041	90. 04 90. 05
90.06 09006 MEDICATION MGMT CLINIC	0				40, 941	90.06
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS   (NON-DISTINCT   PART	0				1, 076, 625	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS					/00 0/1	
95. 00  09500  AMBULANCE SERVI CES	0			<u> </u>	608, 261	95. 00

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

Form 01/01/2023 Part II
To 12/31/2023 Part II
Date/Time Prepared: 5/30/2024 7:02 am Cost Center Description SOCI AL PARAMED ED XRAY PHARMACY Subtotal SERVI CE PRGM **EDUCATION RESI DENCY** PROG 17. 00 23. 00 23. 01 24.00 23 02 99. 10 | 09910 | CORF 101. 00 | 10100 | HOME | HEALTH | AGENCY 0 0 99. 10 0 0 101.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 0 109. 00 109. 00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 0 23, 365, 181 118. 00 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 81, 248 190. 00 0 0 0 0 0 0 0 0 194. 00 07950 WELLNESS COMMUNITY 80, 311 194. 00 194. 01 07951 BUI LDI NG RENTALS 61, 251 194. 01 194. 02 07952 HOSPI CE 25, 781 194. 02 194. 03 07953 OUTREACH CLINICS 0 194. 03 194. 04 07954 SPEECH - HEARING AIDS 4, 766 194. 04 194. 05 07955 NONALLOWABLE MARKETING 23, 917 194. 05 194. 06 07956 CRH FOUNDATION 51, 154 194. 06 194. 07 07957 HEALTHY COMMUNITIES 0 194. 07 194. 08 07958 CRHP 2, 012, 108 194. 08 194. 09 07959 NEUROPSYCH PART B 14, 800 194. 09 Cross Foot Adjustments 79, 003 200. 00 200.00 51, 229 27, 774 0 201.00 201.00 Negative Cost Centers 0 202.00 TOTAL (sum lines 118 through 201) 51, 229 27, 774 25, 799, 520 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/30/2024 7:02 am Provider CCN: 15-0112

				5/30/2024 7:0	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	0,00,202	
		Adjustments	27.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		İ		4.00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
					14. 00
					15. 00
	01600 MEDI CAL RECORDS & LI BRARY				16.00
	01700 SOCI AL SERVI CE				17.00
	02300 PARAMED ED PRGM				23.00
23. 01	02301 XRAY EDUCATION				23. 01
23. 02	O2302   PHARMACY RESI DENCY PROG				23. 02
20 00	O3000 ADULTS & PEDIATRICS	O	4, 401, 777		30.00
30.00	03100 I NTENSI VE CARE UNI T		754, 704		31.00
32. 00	1 1		754, 704		32.00
	03300 BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	o	o		34.00
	04000 SUBPROVI DER – I PF	o	ol		40.00
	04100 SUBPROVI DER - I RF	o	501, 048		41.00
42.00	04200 SUBPROVI DER	0	0		42.00
43.00	1 1	O	100, 815		43.00
44.00	04400 SKILLED NURSING FACILITY	0	o		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	5, 165, 069		50.00
	05100 RECOVERY ROOM	0	164, 259		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	225, 025		52. 00
53. 00	l i	0	12, 242		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	473, 403		54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	604, 147		54. 01
	05404 ULTRA SOUND	0	119, 663		54. 02
54. 03 55. 00	05405   MAMMOGRAPHY   05500   RADI OLOGY-THERAPEUTI C	0	420, 158		54. 03 55. 00
57. 00	05700 CT SCAN		785, 164 387, 195		57.00
58. 00			572, 757		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		830, 562		59.00
60.00	06000 LABORATORY		1, 025, 549		60.00
		o o	123, 548		60.01
62. 00	l i	o	37, 063		62.00
	06500 RESPIRATORY THERAPY	0	496, 247		65.00
66.00	06600 PHYSI CAL THERAPY	0	650, 865		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	227, 019		67.00
68.00	06800 SPEECH PATHOLOGY	0	99, 064		68. 00
	06900 ELECTROCARDI OLOGY	0	320, 928		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	241, 050		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	327, 476		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	306, 978		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 352, 863		73.00
	07400 RENAL DI ALYSI S	0	24, 787		74.00
	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	0	0 59, 540		76. 00 76. 97
	07700 ALLOGENEIC HSCT ACQUISITION		0		77.00
	07800 CAR T-CELL I MMUNOTHERAPY		o		78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		89. 00
		O	359, 342		90.00
	09001 DI ABETES CENTER	O	0		90. 01
		0	7, 672		90.02
	09003 WOUND CENTER		205, 849		90.03
90. 04	09004 HYPERBARI C OXYGEN THERAPY	0	112, 485		90.04
		0	143, 041		90.05
		0	40, 941		90.06
91. 00	09100 EMERGENCY	0	1, 076, 625		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	N: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/30/2024 7:02 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00			
OTHER REIMBURSABLE COST CENTERS					
95. 00   09500 AMBULANCE SERVICES	0	608, 261			95.00
99. 10  09910  CORF	0	0			99. 10
101.00 10100 HOME HEALTH AGENCY	0	0			101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0			102. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 ISLET ACQUISITION	0	0			111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	23, 365, 181			118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	81, 248			190. 00
194.00 07950 WELLNESS COMMUNITY	0	80, 311			194. 00
194. 01 07951 BUILDING RENTALS	0	61, 251			194. 01
194. 02 07952 HOSPI CE	0	25, 781			194. 02
194. 03 07953 OUTREACH CLINICS	0	0			194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	4, 766			194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	23, 917			194. 05
194.06 07956 CRH FOUNDATION	0	51, 154			194. 06
194. 07 07957 HEALTHY COMMUNITIES	0	0			194. 07
194. 08 07958 CRHP	0	2, 012, 108			194. 08
194. 09 07959 NEUROPSYCH PART B	0	14, 800			194. 09
200.00 Cross Foot Adjustments	o	79, 003			200.00
201.00 Negative Cost Centers	o	0			201.00
202.00 TOTAL (sum lines 118 through 201)	o	25, 799, 520			202. 00

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description **BENEFLTS** F & GENERAL (SQ FEET) (DEPR) n (ACCUM. COST) DEPARTMENT (GROSS SAL) 1. 00 2.00 5.00 4.00 5A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 725, 141 00200 CAP REL COSTS-MVBLE EQUIP 2.00 13, 967, 749 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 9,626 4, 457 116, 636, 175 4.00 00500 ADMINISTRATIVE & GENERAL 6, 384, 959 274, 563, 405 5.00 59, 221 20, 222, 579 -61, 252, 470 5.00 7.00 00700 OPERATION OF PLANT 349, 778 326, 380 3, 894, 432 13, 942, 090 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 792 32, 727 940, 727 8.00 9.00 00900 HOUSEKEEPI NG 5, 194 128, 203 2, 621, 885 4, 197, 268 9.00 7, 864 01000 DI ETARY 1, 188, 199 0 2, 295, 372 10 00 10.00 11, 618 11.00 01100 CAFETERI A 6,326 15, 984 1, 634, 797 2, 266, 138 11.00 13.00 01300 NURSING ADMINISTRATION 10,085 49, 467 6, 834, 983 9, 890, 110 13.00 0 01400 CENTRAL SERVICES & SUPPLY 7, 597 75, 720 14.00 150 1, 396, 685 14.00 3, 910, 050 7, 769, 708 15.00 01500 PHARMACY 4,800 242, 181 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3,653 1, 139 1, 633, 870 0 2, 303, 054 01700 SOCIAL SERVICE 0 17.00 0 0 0 o 02300 PARAMED ED PRGM 23 00 0 0 23 00 0 02301 XRAY EDUCATION 23.01 716 8, 571 635, 766 0 803, 157 23.01 02302 PHARMACY RESIDENCY PROG 297, 880 397, 860 23.02 23.02 376 4.173 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 77 838 163 309 26, 234, 787 0 45, 773, 291 30 00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 0 31.00 11,078 123, 862 3, 813, 406 7, 788, 176 31.00 03200 CORONARY CARE UNIT 0 32.00 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 C 0 34 00 o 40.00 04000 SUBPROVI DER - I PF 0 0 0 04100 SUBPROVI DER - I RF 0 41.00 11,085 8,759 2, 154, 456 3, 468, 604 41.00 04200 SUBPROVI DER 0 42.00 42.00 0 04300 NURSERY 0 2,080,853 43.00 583 9.627 1, 584, 336 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 2.042.963 0 26, 187, 072 39, 610 1, 432, 911 51.00 05100 RECOVERY ROOM 3, 185 2, 425 0 2,004,836 51.00 87 1, 995, 969 05200 DELIVERY ROOM & LABOR ROOM 17, 171 0 52.00 3,666 2, 721, 150 52.00 0 53.00 05300 ANESTHESI OLOGY 119 1.300 125, 414 53.00  $\cap$ 05400 RADI OLOGY-DI AGNOSTI C 1, 388, 605 2, 853, 202 54.00 8.467 150, 560 54.00 o 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 3, 361 391, 649 606, 054 3, 184, 603 54.01 54 02 05404 ULTRA SOUND 1,504 39, 947 743,008 0 0 1, 266, 733 54.02 05405 MAMMOGRAPHY 1, 731, 734 190.818 859. 535 54.03 101 54.03 05500 RADI OLOGY-THERAPEUTI C 55.00 7 809 477, 621 704,866 3, 224, 227 55.00 2, 439, 196 57.00 05700 CT SCAN 1,818 252, 386 901, 120 0 0 0 57.00 58.00 05800 MRI 900 17, 184 643, 514 1,606,716 2, 086, 422 05900 CARDI AC CATHETERI ZATI ON 4,000,825 59.00 9.182 399, 880 59.00 60.00 06000 LABORATORY 10,868 300, 599 4, 241, 964 13, 990, 175 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 1, 212 35, 714 501, 573 0 1, 898, 563 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 294 87, 954 0 0 775, 629 62.00 428 62.00 06500 RESPIRATORY THERAPY 2, 436, 989 65.00 7.901 120, 193 4,664,322 65 00 66.00 06600 PHYSI CAL THERAPY 616 9, 121 288, 044 7, 283, 777 06700 OCCUPATIONAL THERAPY 67.00 221 5, 691 72, 597 0 0 0 2, 545, 598 67.00 06800 SPEECH PATHOLOGY 68.00 13.914 225, 534 1, 143, 120 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 398 202, 598 1,065,680 2, 022, 079 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 6, 235 631, 925 1,627,941 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 11, 017, 157 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 0 0 10, 427, 064 C 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 25, 390, 318 73.00 07400 RENAL DIALYSIS o 74.00 0 0 824, 501 74.00 o 03020 ACUPUNCTURE 76.00 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 76.97 1, 581 1, 858 319,071 562, 928 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00

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

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description MVBLE EQUIP (SQ FEET) **BENEFITS** E & GENERAL (DEPR) n DEPARTMENT (ACCUM. COST) (GROSS SAL) 1. 00 2.00 4.00 5A 5.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 95.00 09500 AMBULANCE SERVICES 8,032 190, 136 3, 367, 748 0 5, 052, 872 95.00 99. 10 09910 CORF 0 99. 10 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110,00 111.00 11100 I SLET ACQUISITION 0 C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 709, 122 12, 560, 997 114, 176, 499 -61, 252, 470 267, 330, 940 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 3, 332 236 48, 943 0 94, 310 190. 00 194. 00 07950 WELLNESS COMMUNITY 3, 318 o 435, 146 194. 00 231, 363 0 0 249, 090 194, 01 194. 01 07951 BUI LDI NG RENTALS O 0 132, 425 194. 02 194. 02 07952 HOSPI CE 935 C 0 194. 03 07953 OUTREACH CLINICS 0 0 0 0 0 194.03 194. 04 07954 SPEECH - HEARING AIDS 0 163, 796 194. 04 0 0 0 0 194. 05 07955 NONALLOWABLE MARKETING 821, 990 194. 05 0 0 0 194. 06 07956 CRH FOUNDATION 1, 923 C 59, 407 98, 512 194. 06 194. 07 07957 HEALTHY COMMUNITIES 0 0 194.07 0 194. 08 07958 CRHP 9, 292 1, 401, 601 2, 119, 963 5, 230, 459 194. 08 194. 09 07959 NEUROPSYCH PART B 6, 737 194. 09 537 1, 597 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 6, 938, 157 61, 252, 470 202. 00 202.00 Cost to be allocated (per Wkst. B, 13, 985, 858 31, 575, 369 Part I) 203.00 0.270717 0. 223090 203. 00 Unit cost multiplier (Wkst. B, Part I) 9. 568011 1.001296 204.00 Cost to be allocated (per Wkst. B, 7, 989, 055 204. 00 96, 565 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000828 0. 029097 205. 00 II)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)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0112 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				To	12/31/2023	Date/Time Pre 5/30/2024 7:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT (SQ FEET)	(LDRY LBS)	(TIME SPT)	(MEALS)	(FTES)	
		7. 00	8.00	9. 00	10.00	11. 00	
-	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT					ļ	1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	306, 516					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	792	2, 223, 573				8. 00
9.00	00900 HOUSEKEEPI NG	5, 194	0	5, 521	040 504		9.00
10.00	01000 DI ETARY 01100 CAFETERI A	7, 864	0	44	212, 501	1 124	10.00
11. 00 13. 00	01300 NURSING ADMINISTRATION	6, 326 10, 085		60 19	0	1, 124 77	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 597	ĺ		ő	13	14.00
15.00	01500 PHARMACY	4, 800	0	40	0	34	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 653	0	10	0	35	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00 23. 01	O2300   PARAMED ED PRGM   O2301   XRAY EDUCATION	716	0	0 7	0	0 7	23. 00 23. 01
23. 01	02302 PHARMACY RESIDENCY PROG	376		3	o	3	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	77, 838	l .		169, 284	259	30. 00
31.00	03100 I NTENSI VE CARE UNI T	11, 078	93, 529		19, 043	33	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0			0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	Ö	Ö	ō	0	40.00
41.00	04100 SUBPROVI DER - I RF	11, 085	90, 779	284	19, 346	23	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	18, 499 0	1	0	14 0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS	0		<u> </u>	<u> </u>	U	44.00
50. 00	05000 OPERATING ROOM	39, 610	475, 017	817	895	113	50.00
51.00	05100 RECOVERY ROOM	3, 185	98, 396	42	0	13	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 666	34, 950	1	0	20	52.00
53.00	05300 ANESTHESI OLOGY	119	1/1 072	0	0	0	53.00
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05402  NUCLEAR   MEDI CI NE-DI AGNOSTI C	8, 467 3, 361	161, 873		84	14 6	54. 00 54. 01
54. 02	05404 ULTRA SOUND	1, 504	٥		ő	7	54.02
54. 03	05405 MAMMOGRAPHY	101	8, 943	l .	ō	12	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 809	27, 088	80	525	8	55.00
57. 00	05700 CT SCAN	1, 818	0		0	11	57.00
58. 00 59. 00	05800 MRI	900 9, 182	l e	11 98	0	8 20	58. 00 59. 00
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	10, 868	131, 618	104	443	73	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	1, 212	Ö	6	o	7	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	428	0	4	О	1	62.00
65.00	06500 RESPI RATORY THERAPY	7, 901	0	128	0	26	65.00
		616	l .	2 0	0	4	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	221	25, 045		1	1	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 398	Ö	4	ó	12	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 109	152	o	7	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73. 00 74. 00
76. 00	03020 ACUPUNCTURE	0		0	o	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 581	Ö	4	ō	3	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
78. 00		0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0		ol	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	89.00
90.00	09000 CLINIC	7, 218	93, 950	_	1, 821	44	90.00
90. 01	09001 DI ABETES CENTER	0	0	0	0	0	90. 01
90. 02	09002 NEUROPSYCH	86	0	2	0	2	90. 02
90. 03	09003 WOUND CENTER	0	4, 342		0	8	90.03
90. 04 90. 05	09004 HYPERBARI C OXYGEN THERAPY 09005 VI MCARE CLINI C	0 4, 255	277 12, 061	97	0	1 11	90. 04 90. 05
90.05	09006 MEDICATION MGMT CLINIC	4, 255	12,001	14	ol Ol	2	90.05
91. 00	09100 EMERGENCY	18, 055	146, 008		1, 059	95	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
o=	OTHER REIMBURSABLE COST CENTERS				.1		05 5-
95. 00	09500  AMBULANCE SERVI CES	8, 032	0	0	0	48	95.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/30/2024 7:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	JZ alli
cost center bescription	PLANT	LINEN SERVICE	(TIME SPT)	(MEALS)	(FTES)	
	(SQ FEET)	(LDRY LBS)	(TIWE SIT)	(WLALS)	(LILS)	
	7.00	8.00	9.00	10.00	11. 00	
99. 10   09910   CORF	7.00	0.00	7.00	n n	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0				102.00
SPECIAL PURPOSE COST CENTERS			·	0  0		102.00
109. 00 10900 PANCREAS ACQUISITION	0	1		n n	0	109.00
110. 00 11000   NTESTINAL ACQUISITION	0	0				110.00
111. 00 11100   SLET ACQUISITION	0					111.00
113. 00 11300   NTEREST EXPENSE		٥	l '	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	290, 497	2, 223, 573	5, 47	7 212, 501	1 078	118.00
NONREI MBURSABLE COST CENTERS	270, 477	2,223,373	3, 47	7 212, 301	1,070	1110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	3, 332	0		0	1	190. 00
194. 00 07950 WELLNESS COMMUNITY	0,002					194.00
194. 01 07951 BUI LDI NG RENTALS	0	0		0		194. 01
194. 02 07952 HOSPI CE	935	_		0		194. 02
194. 03 07953  OUTREACH CLINICS	0	1		0		194. 03
194. 04 07954 SPEECH - HEARING AIDS	0	0		0		194. 04
194. 05 07955 NONALLOWABLE MARKETING	0	0		0		194. 05
194. 06 07956 CRH FOUNDATION	1, 923	0	4.	4 0		194.06
194. 07 07957 HEALTHY COMMUNITIES	0	0		0		194. 07
194. 08 07958 CRHP	9, 292	0		0		194. 08
194. 09 07959 NEUROPSYCH PART B	537			0		194. 09
200.00 Cross Foot Adjustments		_	İ		_	200.00
201.00 Negative Cost Centers	•					201.00
202.00 Cost to be allocated (per Wkst. B,	17, 052, 431	1, 194, 655	5, 422, 59	5 3, 288, 162	3, 182, 557	202.00
Part I)	, ,	, , , , , , , , , , , , , , , , , , , ,			., . ,	
203.00 Unit cost multiplier (Wkst. B, Part I	) 55. 633086	0. 537268	982. 17623	6 15. 473631	2, 831. 456406	203.00
204.00 Cost to be allocated (per Wkst. B,	4, 243, 577	45, 942	376, 55	4 271, 689		
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	13. 844553	0. 020661	68. 20394	9 1. 278530	215. 840747	205.00
206.00 NAHE adjustment amount to be allocate	d					206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

COST A	ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0112 P	eri od:	Worksheet B-1	
				T	rom 01/01/2023 o 12/31/2023	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/30/2024 7: 0 SOCIAL	2 alli
		ADMI NI STRATI O	SERVICES & SUPPLY	(DRG COST)	RECORDS & LI BRARY	SERVI CE	
		N (NURS HRS)	(STER SUP)		(GROSS	(TIME SPT)	
		, í			CHARGES)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 534, 966	75 70/				13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	72, 058	75, 736 0	26, 421, 426			14. 00 15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	987, 697, 246		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
23. 00 23. 01	O2300   PARAMED ED PRGM   O2301   XRAY EDUCATION	0	0	0	0	0	23. 00 23. 01
	02302 PHARMACY RESIDENCY PROG	5, 265	Ö	0	0	0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	F00 007	4 070	20 50/	00 (77 (40		
30.00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	538, 807 67, 857	1, 078 233	38, 596 17, 121	98, 677, 618 16, 414, 031	0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400  SURGICAL INTENSIVE CARE UNIT   04000  SUBPROVIDER - IPF	0	O	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	47, 449	0	1, 135	8, 100, 724	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	28, 201	0	14 0	2, 060, 566 0	0	43. 00 44. 00
44.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		0	J		1 44.00
50.00	1 1	234, 059	59, 790	276, 490		0	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELI VERY ROOM & LABOR ROOM	27, 458 42, 451	0 459	129 2, 231	9, 279, 014 5, 376, 000	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	51, 170		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 088	36, 844	8, 333, 090	0	54.00
54. 01 54. 02	05402 NUCLEAR MEDICINE-DIAGNOSTIC 05404 ULTRA SOUND	0	0	208, 233 2, 630		0	54. 01 54. 02
	05405 MAMMOGRAPHY	Ö	962	895		0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	16, 376	0	25	23, 866, 217	0	55.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0	278, 855 51, 385	54, 785, 467 15, 776, 974	0	57. 00 58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	41, 852	6, 206		39, 785, 128	0	59.00
	06000 LABORATORY	0	0	56	89, 287, 996	0	60.00
60.01	06001   LABORATORY-PATHOLOGI CAL   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	O	151 0	8, 953, 163 3, 680, 598	0	60. 01 62. 00
65. 00	06500 RESPIRATORY THERAPY	54, 191	0	973	35, 337, 148	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	170	1, 909	21, 480, 128	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	7, 786, 946 2, 699, 931	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	24, 984	0	317, 093		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	8	10, 119, 555	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	41, 375, 845 21, 451, 651	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	0	24, 971, 367	124, 961, 004	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	12, 996	2, 917, 138	0	74.00
76. 00 76. 97	03020 ACUPUNCTURE 07697 CARDI AC REHABI LI TATI ON	6, 720	0	0 36	0 2, 388, 798	0	76. 00 76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	O	0	0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	o	0	0	0	89. 00
90.00	1 1	38, 478	484	15, 662	11, 603, 999	0	90.00
90. 01 90. 02	09001 DI ABETES CENTER 09002 NEUROPSYCH		O	0	0 203, 089	0	90. 01 90. 02
90. 03	09003 WOUND CENTER	16, 564	1, 560	13, 939	The state of the s	0	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	2, 525	0	0	1, 247, 788	0	90.04
90. 05 90. 06	09005 VIMCARE CLINIC 09006 MEDICATION MGMT CLINIC	4, 008	1  O	17, 321 0	1, 820, 601 857, 105	0	90. 05 90. 06
91.00	09100 EMERGENCY	166, 522	178	14, 072		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1					92.00

Health Financ	ial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ON - STATISTICAL BASIS		Provi der CO	CN: 15-0112	Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 7:0	
(	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
		ADMI NI STRATI O	SERVICES &	(DRG COST)	RECORDS &	SERVI CE	
		N (NUDG UDG)	SUPPLY		LI BRARY	(TIME SPT)	
		(NURS HRS)	(STER SUP)		(GROSS		
		13. 00	14. 00	15. 00	CHARGES)	17. 00	
OTHER	REIMBURSABLE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
	AMBULANCE SERVICES	99, 141	0	25, 30	62 14, 389, 282	0	95. 00
99. 10 09910		99, 141	0	20, 30	02 14, 309, 202	0	
	HOME HEALTH AGENCY	0	0			_	101.00
	OPIOID TREATMENT PROGRAM	0	0				102.00
	L PURPOSE COST CENTERS	l o	U		U U	U	1102.00
	PANCREAS ACQUISITION	0	0		0	0	109. 00
	INTESTINAL ACQUISITION	0	0				110, 00
	I SLET ACQUI SI TI ON		0				111.00
	INTEREST EXPENSE		O .			0	113.00
	SUBTOTALS (SUM OF LINES 1 through 117)	1, 534, 966	75, 209	26, 419, 8 <sup>-</sup>	78 987, 697, 246	0	118.00
	MBURSABLE COST CENTERS	1,001,700	, 0, 20,	20/ 117/ 0	.0 ,0,,0,,,2,0		1.10.00
	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	WELLNESS COMMUNITY	0	0		0 0		194.00
194, 01 07951	BUILDING RENTALS	O	0		0 0	0	194. 01
194, 02 07952 1		0	0	1, 5	48 0	0	194. 02
194. 03 07953	OUTREACH CLINICS	o	0	, -	0 0	0	194. 03
194. 04 07954	SPEECH - HEARING AIDS	o	0		0 0	0	194. 04
194. 05 07955 [	NONALLOWABLE MARKETING	o	0		0 0	0	194. 05
194.06 07956	CRH FOUNDATION	o	0		0 0	0	194.06
194. 07 07957 I	HEALTHY COMMUNITIES	O	0		0 0	0	194. 07
194. 08 07958	CRHP	O	527		0 0	0	194. 08
194. 09 07959 [	NEUROPSYCH PART B	O	0		0 0	0	194. 09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
	Cost to be allocated (per Wkst. B,	12, 894, 238	2, 234, 513	10, 510, 9	3, 128, 993	0	202.00
	Part I)						
	Unit cost multiplier (Wkst. B, Part I)		29. 503974				
	Cost to be allocated (per Wkst. B,	616, 638	303, 842	628, 0	51 164, 575	0	204. 00
1 1	Part II)						
205 00 11	Unit cost multiplier (Wkst R Part	0 401727	<i>∆</i> ∩11857	U U537.	71 0 000167	0 000000	1205 00

0. 401727

4. 011857

0.023771

0.000167

0. 000000 205. 00

206. 00

207.00

205.00

206.00

207.00

H)

Unit cost multiplier (Wkst. B, Part

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0112

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 7:02 am Cost Center Description PARAMED ED XRAY **PHARMACY EDUCATION RESI DENCY PRGM** (PERCENT) (PERCENT) PROG (PERCENT) 23. 00 23. 01 23.02 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 02300 PARAMED ED PRGM 23.00 23.00 23.01 02301 XRAY EDUCATION 100 23.01 02302 PHARMACY RESIDENCY PROG 100 23.02 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS О 30.00 03100 INTENSIVE CARE UNIT 0000000 0 31.00 0 31.00 03200 CORONARY CARE UNIT 0 32.00 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40 00 0 40 00 0 41.00 C 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 0 0 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 0 0 51 00 05100 RECOVERY ROOM Ω 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY C 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 100 54.00 0 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54 01 54 01 C 0 54.02 05404 ULTRA SOUND 0 54.02 05405 MAMMOGRAPHY 0 54.03 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 05700 CT SCAN 57 00 0 57 00 58.00 05800 MRI 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 06000 LABORATORY 60.00 0 0 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 0 60.01 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 65 00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 C 67 00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 0 73.00 74.00 07400 RENAL DIALYSIS C 0 74.00 03020 ACUPUNCTURE 0 0 76.00 76.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00000000 C 89 00 90.00 09000 CLI NI C 0 90.00 09001 DI ABETES CENTER 0 90.01 0 90.01 0 90.02 09002 NEUROPSYCH 0 90.02 0 09003 WOUND CENTER 90.03 0 90.03 90.04 09004 HYPERBARIC OXYGEN THERAPY 0 0 90.04 90.05 09005 VIMCARE CLINIC 0 0 90.05 09006 MEDICATION MGMT CLINIC 0 0 90 06 90.06 91.00 09100 EMERGENCY 0 C 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				Т	o 12/31/2023	B Date/Time Prepared: 5/30/2024 7:02 am
	Cost Center Description	PARAMED ED	XRAY	PHARMACY		07 007 2021 7: 02 dill
		PRGM	EDUCATI ON	RESI DENCY		
		(PERCENT)	(PERCENT)	PROG		
		23. 00	23. 01	(PERCENT) 23.02		
OTHER	REIMBURSABLE COST CENTERS	23.00	23.01	25.02		
	AMBULANCE SERVICES	0	0	С	)	95.00
99. 10 09910	CORF	0	0	l o	)	99. 10
101.00 10100	HOME HEALTH AGENCY	0	0	C	)	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	C	)	102.00
SPECI	AL PURPOSE COST CENTERS					
109. 00 10900	PANCREAS ACQUISITION	0	0	C	)	109.00
110. 00 11000	INTESTINAL ACQUISITION	0	0	C	)	110.00
	ISLET ACQUISITION	0	0	0	)	111.00
	INTEREST EXPENSE					113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	100	100	)	118.00
	IMBURSABLE COST CENTERS		_	T		
	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	· ·		190.00
	WELLNESS COMMUNITY	0	0	0	)	194. 00
	BUILDING RENTALS	0	0	0	)	194. 01
194. 02 07952		0	0	0	)	194. 02
	OUTREACH CLINICS	0	0		)	194. 03
	SPEECH - HEARING AIDS	0	0		)	194. 04
	NONALLOWABLE MARKETING	0	0			194. 05 194. 06
	CRH FOUNDATION HEALTHY COMMUNITIES	0	0			194.06
194. 07 07957		0	0			194. 07
	NEUROPSYCH PART B	0	0			194. 08
200. 00	Cross Foot Adjustments	٩	U	·	,	200.00
201. 00	Negative Cost Centers					200.00
202.00	Cost to be allocated (per Wkst. B,	0	1, 048, 861	563, 206		201.00
202.00	Part 1)	o o	1, 040, 001	303, 200	,	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0 000000	10, 488. 610000	5, 632. 060000	)	203.00
204. 00	Cost to be allocated (per Wkst. B,	0. 000000	51, 229			204.00
2011.00	Part II)	٦	0.7227			25 55
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	512. 290000	277. 740000		205.00
	11)					
206. 00	NAHE adjustment amount to be allocated	О	0	0	)	206.00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000	)	207. 00
	Parts III and IV)					

					5/30/2024 7:0	2 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	71, 038, 502		71, 038, 502		71, 144, 976	30.00
31. 00 03100 INTENSIVE CARE UNIT	11, 491, 011		11, 491, 011	0	11, 491, 011	31.00
32. 00   03200   CORONARY CARE UNIT	0		0	0	0	32.00
33. 00   03300   BURN INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT	0		0	0	0	33. 00 34. 00
40. 00   04000   SUBPROVI DER - I PF	0			0	0	40.00
41. 00   04100   SUBPROVI DER -   I RF	5, 975, 998		5, 975, 998		5, 975, 998	41.00
42. 00   04200   SUBPROVI DER	0		0	o	0	42.00
43. 00 04300 NURSERY	2, 872, 479		2, 872, 479	o	2, 872, 479	43.00
44.00 O4400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	39, 848, 996		39, 848, 996		39, 908, 372	50.00
51. 00   05100   RECOVERY ROOM	3, 020, 315		3, 020, 315		3, 020, 315	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	4, 075, 189 242, 740		4, 075, 189 242, 740		4, 075, 189 245, 168	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	5, 418, 049		5, 418, 049		5, 424, 127	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	4, 301, 742		4, 301, 742		4, 301, 742	54. 01
54. 02   05404   ULTRA SOUND	1, 705, 353		1, 705, 353	l	1, 705, 353	54.02
54. 03   05405   MAMMOGRAPHY	2, 248, 156		2, 248, 156	3, 750	2, 251, 906	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 715, 045		4, 715, 045		4, 729, 288	55. 00
57.00 05700 CT SCAN	3, 421, 745		3, 421, 745		3, 421, 745	57.00
58. 00   05800   MRI	2, 119, 107		2, 119, 107		2, 119, 107	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 320, 489		6, 320, 489		6, 332, 274	59.00
60. 00   06000   LABORATORY 60. 01   06001   LABORATORY-PATHOLOGI CAL	18, 307, 591 2, 443, 677		18, 307, 591 2, 443, 677		18, 307, 591 2, 480, 961	60. 00 60. 01
62. 00   06200 WHOLE BLOOD & PACKED RED BLOOD CELL	990, 895		990, 895		990, 895	62.00
65. 00 06500 RESPIRATORY THERAPY	6, 911, 338				6, 927, 367	65.00
66. 00 06600 PHYSI CAL THERAPY	9, 059, 163		9, 059, 163		9, 083, 234	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 166, 746		3, 166, 746		3, 166, 746	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 415, 201	0	1, 415, 201	0	1, 415, 201	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 984, 626		2, 984, 626	l	2, 984, 626	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 193, 424		2, 193, 424	l	2, 193, 424	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	13, 606, 054 12, 821, 197		13, 606, 054 12, 821, 197	0	13, 606, 054 12, 821, 197	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATTENTS	41, 947, 796		41, 947, 796	0	41, 947, 796	73.00
74. 00 07400 RENAL DI ALYSI S	1, 022, 850		1, 022, 850	l .	1, 022, 850	74.00
76. 00   03020   ACUPUNCTURE	0		0	Ö	0	76.00
76. 97 07697 CARDIAC REHABILITATION	852, 923		852, 923	o	852, 923	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS  88. 00   08800   RURAL   HEALTH   CLINIC		I		ol	0	88. 00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	89.00
90. 00   09000   CLI NI C	6, 411, 607		6, 411, 607		6, 411, 607	
90. 01   09001   DI ABETES CENTER	0,, 00,		0,, 00,	o	0	90. 01
90. 02 09002 NEUROPSYCH	210, 773		210, 773	o	210, 773	90. 02
90. 03   09003   WOUND CENTER	2, 868, 309		2, 868, 309	13, 690	2, 881, 999	90. 03
90. 04 09004 HYPERBARI C OXYGEN THERAPY	396, 682		396, 682		397, 487	90. 04
90. 05   09005   VI MCARE CLI NI C	1, 508, 876		1, 508, 876		1, 508, 876	
90. 06 09006 MEDICATION MGMT CLINIC	579, 727		579, 727		579, 727	90.06
91. 00 09100 EMERGENCY	19, 723, 370		19, 723, 370		20, 402, 426	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	9, 746, 237		9, 746, 237		9, 746, 237	92.00
95. 00 09500 AMBULANCE SERVI CES	7, 651, 365		7, 651, 365	ol	7, 651, 365	95. 00
99. 10   09910   CORF	0		0	Ĭ	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0		O		0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	ł .	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	B .	0			110. 00 111. 00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	0		0		0	113.00
200.00 Subtotal (see instructions)	335, 635, 343	0	335, 635, 343	975, 069	336, 610, 412	
201.00 Less Observation Beds	9, 746, 237		9, 746, 237		9, 746, 237	
202.00 Total (see instructions)	325, 889, 106	о	325, 889, 106	975, 069	326, 864, 175	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am Provider CCN: 15-0112

						5/30/2024 7: 0	
				XVIII	Hospi tal	PPS	
			Charges	I <del></del>		TEED.	
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
ΙN	PATIENT ROUTINE SERVICE COST CENTERS	'			· · · · · · · · · · · · · · · · · · ·		
	000 ADULTS & PEDIATRICS	79, 877, 808		79, 877, 808			30.00
	100 INTENSIVE CARE UNIT	16, 414, 031		16, 414, 031			31.00
	200 CORONARY CARE UNIT	0		0			32.00
	300 BURN INTENSIVE CARE UNIT	0		0			33.00
	400 SURGICAL INTENSIVE CARE UNIT 000 SUBPROVIDER - IPF						34.00 40.00
	100 SUBPROVIDER - IRF	8, 100, 724		8, 100, 724			41.00
	200 SUBPROVI DER	0		0,100,721			42.00
	300 NURSERY	2, 060, 566		2, 060, 566			43.00
	400 SKILLED NURSING FACILITY	0		0			44.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	31, 989, 995	89, 399, 026			0. 000000	
	100 RECOVERY ROOM 1200 DELIVERY ROOM & LABOR ROOM	2, 423, 472	6, 855, 542			0.000000	
	300 ANESTHESI OLOGY	5, 286, 424 6, 330, 044	89, 576 13, 357, 766			0. 000000 0. 000000	
	4400 RADI OLOGY-DI AGNOSTI C	1, 760, 649	6, 572, 441			0. 000000	
	402 NUCLEAR MEDICINE-DIAGNOSTIC	879, 826	14, 637, 343			0. 000000	
	404 ULTRA SOUND	1, 723, 469	8, 948, 308			0.000000	
	MAMMOGRAPHY	1, 741	7, 743, 464	7, 745, 205		0. 000000	
	500 RADI OLOGY-THERAPEUTI C	492, 738	23, 373, 479			0. 000000	
	7700 CT SCAN	12, 879, 361	41, 906, 106			0.000000	
	800 MRI 900 CARDIAC CATHETERIZATION	2, 239, 960 20, 770, 473	13, 537, 014 19, 014, 655			0. 000000 0. 000000	
	000 LABORATORY	26, 140, 286	63, 147, 710			0. 000000	
	001 LABORATORY-PATHOLOGI CAL	790, 332	8, 162, 831			0. 000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 109, 899	1, 570, 699			0. 000000	
	500 RESPI RATORY THERAPY	26, 908, 268	8, 428, 880			0. 000000	
	600 PHYSI CAL THERAPY	4, 843, 187	16, 636, 941			0. 000000	
	0700 OCCUPATI ONAL THERAPY	4, 018, 141	3, 768, 805			0. 000000	
	800 SPEECH PATHOLOGY	968, 621	1, 731, 310			0.000000	
	900  ELECTROCARDI OLOGY 000  ELECTROENCEPHALOGRAPHY	6, 002, 396 460, 305	12, 854, 908 9, 659, 250			0. 000000 0. 000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 513, 574	19, 862, 271			0. 000000	
	200 I MPL. DEV. CHARGED TO PATIENTS	9, 081, 240	12, 370, 411			0. 000000	
	300 DRUGS CHARGED TO PATIENTS	36, 392, 945	88, 568, 059			0.000000	
	400 RENAL DIALYSIS	2, 917, 138	0	2, 917, 138		0. 000000	
	020 ACUPUNCTURE	0	0	1		0. 000000	
	CARDI AC REHABI LI TATI ON	4, 033	2, 384, 765			0.000000	
	700 ALLOGENEIC HSCT ACQUISITION 800 CAR T-CELL IMMUNOTHERAPY		0			0. 000000 0. 000000	77. 00 78. 00
	TPATIENT SERVICE COST CENTERS	١			0.000000	0.000000	70.00
	800 RURAL HEALTH CLINIC	0	0	0			88. 00
89. 00 08	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
1	000 CLI NI C	50, 244	11, 553, 755	11, 603, 999		0. 000000	1
1	0001 DI ABETES CENTER	0	0			0. 000000	
	2002 NEUROPSYCH 2003 WOUND CENTER	7, 812 254, 875	195, 277 13, 995, 039	•		0. 000000 0. 000000	
	1003 WOUND CENTER 1004 HYPERBARIC OXYGEN THERAPY	5, 016	1, 242, 772			0. 000000	
	005 VI MCARE CLI NI C	3, 472	1, 817, 129			0. 000000	1
	0006 MEDICATION MGMT CLINIC	2, 103	855, 002			0.000000	
	100 EMERGENCY	24, 726, 270	69, 836, 182		0. 208575	0. 000000	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	18, 799, 810	18, 799, 810	0. 518422	0. 000000	92.00
	HER REIMBURSABLE COST CENTERS	47.470	44 070 400	14 000 000	0 504744	0.000000	05.00
	2500 AMBULANCE SERVICES 2910 CORF	17, 179	14, 372, 103	14, 389, 282	0. 531741	0. 000000	95. 00 99. 10
	1100 HOME HEALTH AGENCY		0	0			101.00
	2200 OPI OI D TREATMENT PROGRAM	o o	0				102.00
	ECIAL PURPOSE COST CENTERS	, -,					
	900 PANCREAS ACQUISITION	0	0				109. 00
	000 INTESTINAL ACQUISITION	0	0				110.00
	100 I SLET ACQUI SI TI ON	0	0	0			111.00
113. 00 11 200. 00	300 INTEREST EXPENSE Subtotal (see instructions)	260 440 417	627 240 420	987, 697, 246			113. 00 200. 00
200.00	Less Observation Beds	360, 448, 617	627, 248, 629	701, 071, 240			200.00
201.00	Total (see instructions)	360, 448, 617	627, 248, 629	987, 697, 246			202.00
	,		,	1	1		,

Heal th Financial Systems

COLUMBUS REGIONAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0112

Period:
From 01/01/2023
Part I

To 12/31/2023
Date/Time Prepared:

5/30/2024 7:02 am Title XVIII Hospi tal PPS Cost Center Description PPS Inpatient Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31 00 31 00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40 00 40 00 41.00 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.328764 50.00 05100 RECOVERY ROOM 0. 325500 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.758034 52.00 53.00 05300 ANESTHESI OLOGY 0.012453 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.650914 54 00 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 0. 277225 54.01 54.01 05404 ULTRA SOUND 0.159800 54 02 54 02 54.03 05405 MAMMOGRAPHY 0. 290748 54.03 05500 RADI OLOGY-THERAPEUTI C 55.00 0. 198158 55.00 05700 CT SCAN 57.00 57.00 0.062457 58.00 05800 MRI 0. 134316 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0. 159162 59.00 06000 LABORATORY 0. 205040 60.00 60.00 06001 LABORATORY-PATHOLOGI CAL 60.01 0.277104 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.269221 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 0. 196036 65.00 66.00 06600 PHYSI CAL THERAPY 0.422867 66,00 06700 OCCUPATI ONAL THERAPY 67.00 0.406674 67.00 06800 SPEECH PATHOLOGY 0. 524162 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 158274 69.00 07000 ELECTROENCEPHALOGRAPHY 0.216751 70.00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 328841 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 597679 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.335687 73.00 07400 RENAL DIALYSIS 74.00 0.350635 74.00 76.00 03020 ACUPUNCTURE 0.000000 76.00 07697 CARDIAC REHABILITATION 76. 97 0. 357051 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 0. 552534 90.00 90.01 09001 DI ABETES CENTER 0.000000 90.01 09002 NEUROPSYCH 1.037836 90. 02 90.02 09003 WOUND CENTER 90.03 0.202247 90.03 90.04 09004 HYPERBARI C OXYGEN THERAPY 0. 318553 90.04 09005 VIMCARE CLINIC 90.05 0.828779 90.05 09006 MEDICATION MGMT CLINIC 90 06 90.06 0.676378 91.00 09100 EMERGENCY 0.215756 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.518422 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.531741 95 00 99. 10 09910 CORF 99.10 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 Total (see instructions) 202.00 202.00

					5/30/2024 7:0	2 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	71, 038, 502	1	71, 038, 502		71, 144, 976	30.00
31. 00   03100   INTENSIVE CARE UNIT	11, 491, 011	l .	11, 491, 011	0	11, 491, 011	31.00
32. 00 03200 CORONARY CARE UNIT	0		0	0	0	32.00
33. 00   03300   BURN INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT			0	0	0	33. 00 34. 00
40. 00   04000 SUBPROVI DER -   PF				0	0	40.00
41. 00   04100   SUBPROVI DER -   RF	5, 975, 998		5, 975, 998	o	5, 975, 998	41.00
42. 00   04200   SUBPROVI DER	0	)	0	0	0	42.00
43. 00  04300   NURSERY	2, 872, 479	·[	2, 872, 479	0	2, 872, 479	43.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS		T				
50. 00 05000 OPERATING ROOM	39, 848, 996		39, 848, 996		39, 908, 372	50.00
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM	3, 020, 315 4, 075, 189		3, 020, 315 4, 075, 189		3, 020, 315 4, 075, 189	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	242, 740	1	242, 740		245, 168	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 418, 049	1	5, 418, 049		5, 424, 127	54.00
54. 01   05402 NUCLEAR MEDICINE-DIAGNOSTIC	4, 301, 742	1	4, 301, 742		4, 301, 742	54.01
54.02   05404   ULTRA SOUND	1, 705, 353		1, 705, 353	0	1, 705, 353	54.02
54. 03   05405   MAMMOGRAPHY	2, 248, 156		2, 248, 156		2, 251, 906	54.03
55. 00   05500   RADI OLOGY-THERAPEUTI C	4, 715, 045		4, 715, 045		4, 729, 288	55.00
57. 00   05700 CT SCAN	3, 421, 745	1	3, 421, 745		3, 421, 745	57.00
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	2, 119, 107 6, 320, 489	1	2, 119, 107 6, 320, 489		2, 119, 107 6, 332, 274	58. 00 59. 00
60. 00   06000   LABORATORY	18, 307, 591		18, 307, 591		18, 307, 591	60.00
60. 01 06001 LABORATORY-PATHOLOGI CAL	2, 443, 677	1	2, 443, 677		2, 480, 961	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	990, 895	1	990, 895		990, 895	62.00
65. 00 06500 RESPIRATORY THERAPY	6, 911, 338	0	6, 911, 338	16, 029	6, 927, 367	65.00
66. 00 06600 PHYSI CAL THERAPY	9, 059, 163	1	.,,		9, 083, 234	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 166, 746	0		0	3, 166, 746	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 415, 201	0	1, 415, 201	0	1, 415, 201	68.00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	2, 984, 626 2, 193, 424	1	2, 984, 626 2, 193, 424		2, 984, 626 2, 193, 424	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 606, 054	1	13, 606, 054		13, 606, 054	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 821, 197		12, 821, 197	o	12, 821, 197	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	41, 947, 796		41, 947, 796	0	41, 947, 796	73.00
74.00 07400 RENAL DIALYSIS	1, 022, 850	)	1, 022, 850	0	1, 022, 850	74.00
76. 00   03020   ACUPUNCTURE	0	)	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	852, 923	l	852, 923	1	852, 923	76. 97
77. 00 O7700 ALLOGENEIC HSCT ACQUISITION 78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	l .	0	0	0	77.00
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS				U	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC	0		T 0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	•	0	0		89.00
90. 00  09000  CLI NI C	6, 411, 607	1	6, 411, 607	0	6, 411, 607	
90. 01   09001   DI ABETES CENTER	0	)	0	0	0	90. 01
90. 02   09002   NEUROPSYCH	210, 773	1	210, 773		210, 773	90. 02
90. 03   09003   WOUND CENTER 90. 04   09004   HYPERBARI C OXYGEN THERAPY	2, 868, 309	1	2, 868, 309		2, 881, 999	90.03
90. 04   09004   HYPERBARI C OXYGEN THERAPY 90. 05   09005   VI MCARE CLI NI C	396, 682 1, 508, 876	1	396, 682 1, 508, 876		397, 487 1, 508, 876	90. 04 90. 05
90. 06 09006 MEDICATION MGMT CLINIC	579, 727	1	579, 727		579, 727	90.06
91. 00   09100   EMERGENCY	19, 723, 370		19, 723, 370		20, 402, 426	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 746, 237	1	9, 746, 237		9, 746, 237	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	7, 651, 365	1	7, 651, 365	0	7, 651, 365	
99. 10   09910   CORF	0	l .	0		0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	1	0			101.00
102. 00 10200 OPI OLD TREATMENT PROGRAM  SPECIAL PURPOSE COST CENTERS		1			0	102. 00
109. 00 10900 PANCREAS ACQUISITION	0		0		0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	ł	Ö			110.00
111.00 11100 ISLET ACQUISITION	0	)	0		0	111. 00
113. 00 11300   I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	335, 635, 343	1			336, 610, 412	
201.00 Less Observation Beds 202.00 Total (see instructions)	9, 746, 237	1	9, 746, 237		9, 746, 237 326, 864, 175	
202.00   Total (See HISTI UCTIONS)	325, 889, 106	'1 0	325, 889, 106	7/0,009	320, 004, 1/3	<sub> </sub> 202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am Provider CCN: 15-0112

							5/30/2024 7:0	2 am
					e XIX	Hospi tal	PPS	
		Overland Bereit all an		Charges	T. I. I. (I. (	0	TEEDA	
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
			6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	LNDAT	IENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30.00		ADULTS & PEDIATRICS	79, 877, 808		79, 877, 808			30.00
31. 00		INTENSIVE CARE UNIT	16, 414, 031		16, 414, 031			31.00
32. 00		CORONARY CARE UNIT	10, 414, 031		0 10, 414, 031			32.00
33. 00		BURN INTENSIVE CARE UNIT			0			33.00
34. 00		SURGICAL INTENSIVE CARE UNIT	o o		0			34.00
40. 00		SUBPROVI DER - I PF	ol		l o			40.00
41.00		SUBPROVI DER - I RF	8, 100, 724		8, 100, 724			41.00
42.00		SUBPROVI DER	0		0			42.00
43.00		NURSERY	2, 060, 566		2, 060, 566			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31, 989, 995	89, 399, 026	121, 389, 021	0. 328275	0.000000	50.00
51.00		RECOVERY ROOM	2, 423, 472	6, 855, 542		0. 325500	0. 000000	
52.00		DELIVERY ROOM & LABOR ROOM	5, 286, 424	89, 576			0. 000000	
53.00		ANESTHESI OLOGY	6, 330, 044	13, 357, 766			0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	1, 760, 649	6, 572, 441			0. 000000	
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	879, 826	14, 637, 343			0. 000000	
54. 02		ULTRA SOUND	1, 723, 469	8, 948, 308		0. 159800	0. 000000	
54. 03	1	MAMMOGRAPHY	1, 741	7, 743, 464			0. 000000	
55. 00		RADI OLOGY-THERAPEUTI C	492, 738	23, 373, 479		0. 197561	0. 000000	
57.00	1	CT SCAN	12, 879, 361	41, 906, 106			0.000000	
58.00	05800		2, 239, 960	13, 537, 014			0.000000	
59.00	1	CARDI AC CATHETERI ZATI ON LABORATORY	20, 770, 473	19, 014, 655			0.000000	
60. 00 60. 01	1	LABORATORY-PATHOLOGI CAL	26, 140, 286 790, 332	63, 147, 710 8, 162, 831			0. 000000 0. 000000	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	2, 109, 899	1, 570, 699			0. 000000	
65. 00		RESPIRATORY THERAPY	26, 908, 268	8, 428, 880	35, 337, 148		0. 000000	
66. 00		PHYSI CAL THERAPY	4, 843, 187	16, 636, 941			0. 000000	
67. 00		OCCUPATI ONAL THERAPY	4, 018, 141	3, 768, 805			0. 000000	
68. 00		SPEECH PATHOLOGY	968, 621	1, 731, 310		0. 524162	0. 000000	
69. 00		ELECTROCARDI OLOGY	6, 002, 396	12, 854, 908		0. 158274	0. 000000	
70.00		ELECTROENCEPHALOGRAPHY	460, 305	9, 659, 250		0. 216751	0. 000000	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	21, 513, 574	19, 862, 271			0.000000	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9, 081, 240	12, 370, 411	21, 451, 651	0. 597679	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36, 392, 945	88, 568, 059	124, 961, 004	0. 335687	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2, 917, 138	0	2, 917, 138	0. 350635	0.000000	74.00
76.00		ACUPUNCTURE	0	0	0	0. 000000	0.000000	76.00
76. 97		CARDIAC REHABILITATION	4, 033	2, 384, 765	2, 388, 798		0. 000000	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0			0. 000000	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0. 000000	0. 000000	78. 00
		TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	0			0. 000000	
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
90.00	1	CLINIC	50, 244	11, 553, 755	11, 603, 999		0. 000000	1
90. 01		DI ABETES CENTER	7 010	105 277	202 000	0.000000	0.000000	
90. 02	1	NEUROPSYCH	7, 812	195, 277			0.000000	
90. 03 90. 04		WOUND CENTER HYPERBARIC OXYGEN THERAPY	254, 875 5, 016	13, 995, 039 1, 242, 772			0. 000000 0. 000000	
90. 05		VIMCARE CLINIC	3, 472	1, 242, 772		0. 317908	0. 000000	
90.06	1	MEDICATION MGMT CLINIC	2, 103	855, 002			0. 000000	
91. 00		EMERGENCY	24, 726, 270	69, 836, 182			0. 000000	
92.00		OBSERVATION BEDS (NON-DISTINCT PART	24, 720, 270	18, 799, 810			0. 000000	
72.00		REIMBURSABLE COST CENTERS	٩	10, 777, 010	10, 777, 010	0.010122	0.00000	72.00
95. 00		AMBULANCE SERVICES	17, 179	14, 372, 103	14, 389, 282	0. 531741	0. 000000	95.00
	09910		0	0				99. 10
101.00	10100	HOME HEALTH AGENCY	o	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	o	0	0			102.00
	SPECI.	AL PURPOSE COST CENTERS						
109.00		PANCREAS ACQUISITION	0	0	0	0. 000000	0. 000000	109. 00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0. 000000	0. 000000	
	1	ISLET ACQUISITION	0	0	0	0. 000000	0. 000000	
	1	INTEREST EXPENSE						113.00
200.00	1	Subtotal (see instructions)	360, 448, 617	627, 248, 629	987, 697, 246			200. 00
201.00	1	Less Observation Beds						201.00
202.00	ון	Total (see instructions)	360, 448, 617	627, 248, 629	987, 697, 246			202. 00

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

Provider CCN: 15-0112 | Period: From 01/01/2023 | Part I To 12/31/2023 | Date/Time Prepared: 5/30/2024 7: 02 am

				5/30/2024 7:02 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
INDATIENT DOUTINE CEDVICE COCT CENTEDO	11. 00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00   03100   NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				34.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
41. 00   04100   SUBPROVI DER - I RF				41.00
42. 00   04200   SUBPROVI DER				42.00
43. 00   04300   NURSERY				43.00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 328764			50.00
51. 00   05100   RECOVERY ROOM	0. 325500			51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 758034			52.00
53. 00   05300   ANESTHESI OLOGY	0. 012453			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 650914			54.00
54. 01   05402   NUCLEAR MEDICINE-DI AGNOSTI C	0. 277225			54. 01
54. 02   05404   ULTRA SOUND	0. 159800			54. 02
54. 03   05405   MAMMOGRAPHY	0. 290748			54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	0. 198158			55.00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	0.062457			57.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 134316 0. 159162			58. 00 59. 00
60. 00   06000   LABORATORY	1			60.00
60. 00   06000   LABORATORY	0. 205040 0. 277104			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 269221			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 196036			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 422867			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 406674			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 524162			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 158274			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 216751			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328841			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 597679			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 335687			73.00
74.00 07400 RENAL DIALYSIS	0. 350635			74.00
76. 00 03020 ACUPUNCTURE	0. 000000			76.00
76. 97 07697 CARDIAC REHABILITATION	0. 357051			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00   09000   CLI NI C	0. 552534			90.00
90. 01   09001 DI ABETES CENTER	0.000000			90. 01
90. 02   09002   NEUROPSYCH	1. 037836			90.02
90. 03   09003   WOUND CENTER	0. 202247			90.03
90. 04   09004   HYPERBARI C OXYGEN THERAPY	0. 318553			90.04
90. 05   09005   VI MCARE CLI NI C	0. 828779			90.05
90. 06 09006 MEDICATION MGMT CLINIC	0. 676378			90.06
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0. 215756			91. 00 92. 00
92. 00   09200  OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 518422			92.00
95. 00 09500 AMBULANCE SERVICES	0. 531741			95.00
99. 10   09910 CORF	0. 331741			99. 10
101.00 10100 HOME HEALTH AGENCY				101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
109. 00 10900 PANCREAS ACQUISITION	0. 000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0. 000000			110.00
111.00 11100 I SLET ACQUI SI TI ON	0. 000000			111.00
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

						5/30/2024 7:0	<u>2 am</u>
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		2.00	0.00	00	0.00	
	05000 OPERATING ROOM	39, 848, 996	5, 165, 069	34, 683, 927	0	0	50.00
	05100 RECOVERY ROOM	3, 020, 315			ő	0	1
	•				0	0	1
	05200 DELIVERY ROOM & LABOR ROOM	4, 075, 189			-	-	52.00
	05300 ANESTHESI OLOGY	242, 740			0	0	
	05400 RADI OLOGY-DI AGNOSTI C	5, 418, 049			0	0	54.00
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	4, 301, 742			0	0	
	05404 ULTRA SOUND	1, 705, 353	119, 663	1, 585, 690	0	0	54.02
54.03	05405 MAMMOGRAPHY	2, 248, 156	420, 158	1, 827, 998	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 715, 045	785, 164	3, 929, 881	0	0	55.00
57.00	05700 CT SCAN	3, 421, 745	387, 195	3, 034, 550	o	0	57.00
58. 00	05800 MRI	2, 119, 107	572, 757	1, 546, 350	o	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	6, 320, 489			0	0	59.00
	06000 LABORATORY	18, 307, 591			0	0	60.00
	06001 LABORATORY-PATHOLOGI CAL	2, 443, 677			o	0	60. 01
					0	-	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	990, 895	1		-	0	62.00
	06500 RESPI RATORY THERAPY	6, 911, 338			0	0	65.00
	06600 PHYSI CAL THERAPY	9, 059, 163			0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	3, 166, 746			0	0	67.00
	06800 SPEECH PATHOLOGY	1, 415, 201	99, 064	1, 316, 137	0	0	68. 00
	06900  ELECTROCARDI OLOGY	2, 984, 626	320, 928	2, 663, 698	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 193, 424	241, 050	1, 952, 374	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 606, 054	327, 476	13, 278, 578	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 821, 197	306, 978	12, 514, 219	O	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	41, 947, 796	1, 352, 863	40, 594, 933	0	0	73.00
	07400 RENAL DIALYSIS	1, 022, 850			o	0	74.00
	03020 ACUPUNCTURE	0	0	0	0	0	76.00
	07697 CARDIAC REHABILITATION	852, 923	59, 540	793, 383	0	0	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0		o o	0	0	1
	OUTPATIENT SERVICE COST CENTERS				-		1
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	•	o o	Ö	0	
	09000 CLINIC	6, 411, 607	1		Ö	0	90.00
	09001 DI ABETES CENTER	0, 111, 007	007, 012	0,002,200	ő	0	90. 01
	09002 NEUROPSYCH	210, 773	7, 672	203, 101	ő	0	90. 02
	09003 WOUND CENTER	2, 868, 309			0	0	90. 02
	09004 HYPERBARIC OXYGEN THERAPY	396, 682			0	0	90.03
	09005 VI MCARE CLINI C				0	0	90.05
		1, 508, 876	1		- 1	_	1
	09006 MEDICATION MGMT CLINIC	579, 727			0	0	90.06
	09100 EMERGENCY	19, 723, 370			0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 746, 237	603, 009	9, 143, 228	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				_1		
	09500 AMBULANCE SERVICES	7, 651, 365	608, 261	7, 043, 104	0		
	09910 CORF	0	0	0	0		99. 10
	10100 HOME HEALTH AGENCY	0			0		101. 00
	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
5	SPECIAL PURPOSE COST CENTERS						
109. 00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111. 00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	244, 257, 353	18, 209, 846	226, 047, 507	0		200. 00
201.00	Less Observation Beds	9, 746, 237			0	0	201.00
202.00	Total (line 200 minus line 201)	234, 511, 116		216, 904, 279	0	0	202. 00
1					-1		

REDUCTIONS FOR MEDICALD ONLY

						5/30/2024 7:0	02 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,				
		Operating	Part I,	Charge Ratio			
		Cost	column 8)	(col . 6 /			
			COT UIIIT 6)				
	•	Reduction	7.00	col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	39, 848, 996	121, 389, 021	0. 32827	5		50.00
51.00	05100 RECOVERY ROOM	3, 020, 315	9, 279, 014	0. 325500	C		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 075, 189	5, 376, 000	0. 75803	4		52.00
53.00	05300 ANESTHESI OLOGY	242, 740	1				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 418, 049		•			54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	4, 301, 742					54. 01
54. 02	05404 ULTRA SOUND	1, 705, 353	l				54. 02
54. 03	05405 MAMMOGRAPHY	2, 248, 156					54. 03
55.00	05500   RADI OLOGY-THERAPEUTI C	4, 715, 045	23, 866, 217	0. 19756 <sup>-</sup>	1		55. 00
57.00	05700  CT SCAN	3, 421, 745	54, 785, 467	0. 06245	7		57.00
58.00	05800 MRI	2, 119, 107	15, 776, 974	0. 13431	5		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 320, 489			6		59.00
60.00	06000 LABORATORY	18, 307, 591	89, 287, 996				60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	2, 443, 677	l				60. 01
	1 1		1				
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	990, 895	1				62.00
65.00	06500 RESPI RATORY THERAPY	6, 911, 338	1				65.00
66.00	06600 PHYSI CAL THERAPY	9, 059, 163	21, 480, 128				66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 166, 746	7, 786, 946	0. 40667	4		67.00
68.00	06800 SPEECH PATHOLOGY	1, 415, 201	2, 699, 931	0. 52416	2		68.00
69.00	06900 ELECTROCARDI OLOGY	2, 984, 626			4		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 193, 424					70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 606, 054					71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1				
	1 1	12, 821, 197	1	•			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	41, 947, 796	1				73.00
74.00	07400 RENAL DI ALYSI S	1, 022, 850	2, 917, 138				74.00
76.00	03020 ACUPUNCTURE	0	0	0. 000000	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	852, 923	2, 388, 798	0. 35705	1		76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	l o				78.00
	OUTPATIENT SERVICE COST CENTERS		-		-		1
88. 00	08800 RURAL HEALTH CLINIC	0	0	0. 000000			88. 00
	1 1	0	1				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000 CLI NI C	6, 411, 607					90.00
90. 01	09001 DI ABETES CENTER	0	0	0. 000000	0		90. 01
90. 02	09002 NEUROPSYCH	210, 773	203, 089	1. 03783	5		90. 02
90. 03	09003 WOUND CENTER	2, 868, 309	14, 249, 914	0. 20128	6		90.03
90.04	09004 HYPERBARI C OXYGEN THERAPY	396, 682			3		90.04
90. 05	09005 VI MCARE CLI NI C	1, 508, 876	1				90.05
90.06	09006 MEDICATION MGMT CLINIC	579, 727	l				90.06
91.00	09100 EMERGENCY	19, 723, 370	1				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 746, 237	18, 799, 810	0. 51842	2		92.00
	OTHER REIMBURSABLE COST CENTERS				_		
95.00	09500 AMBULANCE SERVI CES	7, 651, 365	14, 389, 282	0. 53174	1		95.00
99. 10	09910 CORF	0	0	0. 000000	O		99. 10
101.00	10100 HOME HEALTH AGENCY	0	0				101.00
	10200 OPI OI D TREATMENT PROGRAM	0	l e				102.00
102.00	SPECIAL PURPOSE COST CENTERS			0.00000	٧١		102.00
100.00	10900 PANCREAS ACQUISITION	0		0.00000			100 00
		0	1				109.00
	11000   NTESTI NAL ACQUI SI TI ON	0	1				110.00
	11100 I SLET ACQUI SI TI ON	0	0	0. 000000	ט		111.00
	11300 I NTEREST EXPENSE						113. 00
200.00		244, 257, 353	881, 244, 117				200.00
201.00	Less Observation Beds	9, 746, 237	0				201.00
202.00		234, 511, 116	881, 244, 117				202.00
	1 ( === ===	,,		1	1		1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0112	Peri od:	Worksheet D	
				From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre 5/30/2024 7:0	pared:
		Title	XVIII	Hospi tal	5/30/2024 /: 0 PPS	2 am
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
oust defiter bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	riaj ao emorre	Related Cost		col . 4)	
	B, Part II,		(col . 1 -		33,	
	col . 26)		col . 2)			
	1. 00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
30. 00 ADULTS & PEDIATRICS	4, 401, 777	0	4, 401, 77	77 35, 922	122. 54	30.00
31.00 INTENSIVE CARE UNIT	754, 704		754, 70	3, 528	213. 92	31.00
32.00 CORONARY CARE UNIT	0			o o	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			o o	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			o o	0.00	34.00
40. 00 SUBPROVIDER - IPF	0	0	)	o o	0.00	40.00
41. 00 SUBPROVI DER - I RF	501, 048	0	501, 04	18 3, 584	139. 80	41.00
42. 00 SUBPROVI DER	0	0		o o	0.00	42.00
43. 00 NURSERY	100, 815		100, 81	15 2, 697	37. 38	43.00
44.00 SKILLED NURSING FACILITY	0			o o	0.00	44.00
200.00 Total (lines 30 through 199)	5, 758, 344		5, 758, 34	45, 731		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10, 283					30.00
31.00   INTENSIVE CARE UNIT	711	152, 097				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER - I PF	0	0				40. 00
41. 00 SUBPROVI DER - I RF	1, 708		1			41.00
42. 00 SUBPROVI DER	0	0	1			42.00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0	1			44.00
200.00 Total (lines 30 through 199)	12, 702	1, 650, 954	1			200. 00

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:02 am Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program C, Part I, (from Wkst. (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 0.042550 372 055 50 00 05000 OPERATING ROOM 5, 165, 069 121, 389, 021 8.743.943 05100 RECOVERY ROOM 164, 259 9, 279, 014 0.017702 714,033 51.00 51.00 12, 640 05200 DELIVERY ROOM & LABOR ROOM 52.00 225, 025 5, 376, 000 0.041857 6, 338 265 52.00 05300 ANESTHESI OLOGY 1, 859, 560 19, 687, 810 0.000622 53.00 12, 242 1.157 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 473, 403 8, 333, 090 0.056810 702, 554 39, 912 54.00 366, 002 54.01 05402 NUCLEAR MEDICINE-DIAGNOSTIC 604, 147 15, 517, 169 0.038934 14, 250 54.01 54.02 05404 ULTRA SOUND 119, 663 10, 671, 777 0.011213 609, 472 6, 834 54.02 420, 158 1, 036 54.03 05405 MAMMOGRAPHY 7, 745, 205 0.054247 56 54 03 7, 735 55.00 05500 RADI OLOGY-THERAPEUTI C 785, 164 23, 866, 217 0.032899 235, 119 55.00 57.00 05700 CT SCAN 387, 195 54, 785, 467 0.007067 5, 087, 412 35, 953 57.00 58.00 05800 MRI 572, 757 15, 776, 974 0.036303 879, 920 31, 944 58.00 05900 CARDI AC CATHETERI ZATI ON 39, 785, 128 5, 961, 786 124, 458 59 00 830, 562 0.020876 59 00 60.00 06000 LABORATORY 1,025,549 89, 287, 996 0.011486 8, 547, 426 98, 176 60.00 60.01 06001 LABORATORY-PATHOLOGI CAL 123, 548 8, 953, 163 0.013799 244, 287 3, 371 60.01 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 37,063 3, 680, 598 0.010070 62.00 605.198 6,094 62.00 65.00 06500 RESPIRATORY THERAPY 496, 247 35, 337, 148 0.014043 9, 290, 167 130, 462 65.00 06600 PHYSI CAL THERAPY 21, 480, 128 0.030301 1, 272, 409 66, 00 650, 865 38, 555 66.00 06700 OCCUPATI ONAL THERAPY 227, 019 7, 786, 946 0.029154 893, 740 67.00 26,056 67.00 06800 SPEECH PATHOLOGY 4, 062 68.00 99,064 2, 699, 931 0.036691 110, 705 68.00 69.00 06900 ELECTROCARDI OLOGY 320, 928 18, 857, 304 0.017019 2, 412, 100 41,052 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 241,050 10, 119, 555 0.023820 191, 263 4,556 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 327 476 41, 375, 845 0.007915 6 963 668 55, 117 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 306, 978 21, 451, 651 0.014310 3, 832, 613 54,845 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 352, 863 124, 961, 004 0.010826 11, 384, 115 123, 244 73.00 07400 RENAL DIALYSIS 74.00 24, 787 2, 917, 138 0.008497 1, 113, 768 9, 464 74.00 03020 ACUPUNCTURE 76 00 0.000000 76.00 0 0 07697 CARDIAC REHABILITATION 76.97 59.540 2, 388, 798 0.024925 692 17 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 77.00 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 359, 342 90.00 09000 CLI NI C 11, 603, 999 0.030967 27, 248 844 90.00 09001 DI ABETES CENTER 90.01 90.01 0.000000 0 0 90.02 09002 NEUROPSYCH 7,672 203, 089 0.037777 1,860 70 90.02 90 03 09003 WOUND CENTER 205, 849 14, 249, 914 0.014446 87,017 1, 257 90.03 09004 HYPERBARIC OXYGEN THERAPY 1, 247, 788 112, 485 0.090148 90.04 90.04 0 09005 VIMCARE CLINIC 90.05 143, 041 1,820,601 0.078568 679 53 90.05 09006 MEDICATION MGMT CLINIC 90.06 40, 941 857, 105 0.047767 1, 142 55 90.06 09100 EMERGENCY 1,076,625 94, 562, 452 0.011385 91.00 106, 635 91.00 9, 366, 241 09200 OBSERVATION BEDS (NON-DISTINCT PART 603, 009 92 00 18, 799, 810 0.032075 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199) 17, 601, 585 866, 854, 835 81, 513, 513 1, 351, 244 200. 00

ealth Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COS	TS Provi der (		Period: From 01/01/2023		
					Date/Time Pre 5/30/2024 7:0	epared: 02 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2.00	3.00	

Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	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		
31. 00 03100 I NTENSI VE CARE UNIT	0	0	0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00   03400   SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00  04100   SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00  04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY	0	0	0	0	0	43.00
44.00   04400   SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00 Total (lines 30 through 199)	0	·		0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00   03000   ADULTS & PEDI ATRI CS	0	1	,	0.00		30.00
31.00 03100 INTENSIVE CARE UNIT		0		0. 00	l .	31.00
32. 00 03200 CORONARY CARE UNIT		0		0. 00	l .	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0	_	0. 00	l .	
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT		0		0. 00	l .	34.00
40. 00   04000   SUBPROVI DER - I PF	0	1	_	0. 00		40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0	0,00.	0. 00		
42. 00   04200   SUBPROVI DER	0	1	1	0. 00	l .	
43. 00   04300   NURSERY		0	' -	0. 00		
44.00 04400 SKILLED NURSING FACILITY		0		0. 00	l .	
200.00 Total (lines 30 through 199)		0	45, 731		12, 702	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
INDATIONE CONTINUE CONTINUE CONTINUE	9. 00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00   03100   NTENSI VE CARE UNI T		1				31.00
	0	1				32.00
	0					
33. 00 03300 BURN INTENSIVE CARE UNIT						33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT						34.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	0	1				40. 00 41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	0	1				42.00 43.00

				10 12/31/2023	5/30/2024 7: 0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0		0 0	0	50.00
51. 00   05100   RECOVERY ROOM	0			0 0	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0	1	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	1	0	1, 048, 861	54.00
54. 01   05402   NUCLEAR MEDICINE-DIAGNOSTIC	0	0	1	0 0	0	54. 01
54. 02   05404   ULTRA SOUND	0	0	1	0	0	
54. 03   05405   MAMMOGRAPHY	0	0	1	0 0	0	54.03
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57. 00   05700   CT   SCAN	0	0		0 0	0	57.00
58. 00   05800   MRI	0	0		0 0	0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00   06000   LABORATORY	0	0		0 0	0	60.00
60. 01   06001   LABORATORY-PATHOLOGI CAL	0	0	1	0 0	0	60. 01
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	1	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	1	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	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	563, 206	
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	74.00
76. 00   03020   ACUPUNCTURE	0	0	1	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	1	0 0	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			ı	0		00 00
88. 00   08800 RURAL HEALTH CLINIC 89. 00   08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	1	88.00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC		0			0	89. 00 90. 00
	0	0			0	
90. 01   09001   DI ABETES CENTER 90. 02   09002   NEUROPSYCH	0	0		0 0	0	90.01
90. 02   09002   NEUROPSYCH 90. 03   09003   WOUND CENTER	0	0		0	0	90.02
	0	0			0	
90. 04   09004   HYPERBARI C OXYGEN THERAPY 90. 05   09005   VI MCARE CLI NI C	0	0		0	0	90.04
90. 05   09005 VIMCARE CLINIC 90. 06   09006   MEDICATION MGMT CLINIC		0			0	90.03
91. 00   09100   EMERGENCY					0	90.06
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		١	Ί		0	91.00
OTHER REIMBURSABLE COST CENTERS				O <sub>I</sub>	1 0	72.00
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	1, 612, 067	
200.00   10tal (111103 30 till ough 177)	1	٥	T	51	1,012,007	1200.00

			1	0 12/31/2023	5/30/2024 7:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_	_	_			
50. 00   05000   OPERATI NG ROOM	0	-		, , .	0. 000000	l
51. 00   05100   RECOVERY ROOM	0	1	· -		0. 000000	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	-,,	0. 000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0		0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0		1, 048, 861		0. 125867	54.00
54. 01 05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	, ,	0. 000000	54.01
54. 02   05404   ULTRA SOUND	0	0		, ,	0. 000000	54.02
54. 03 05405 MAMMOGRAPHY	0	0	ľ	,	0. 000000	54.03
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	· -	-, ,	0. 000000	55.00
57. 00   05700   CT   SCAN	0	0	0	, ,	0. 000000	57.00
58. 00   05800   MRI	0	0			0. 000000	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	1	0.,.00,.00	0. 000000	
60. 00   06000   LABORATORY	0	0			0. 000000	60.00
60. 01   06001   LABORATORY-PATHOLOGI CAL	0	0			0. 000000	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	· -		0. 000000	62.00
65. 00   06500   RESPI RATORY THERAPY	0	0			0. 000000	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	·	,,	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		,	0. 000000	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	·	,	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0		0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	,,	0. 000000	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	1			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	563, 206			0. 004507	73.00
74. 00   07400   RENAL DI ALYSI S	0	0	0	_, ,	0. 000000	74.00
76. 00   03020   ACUPUNCTURE	0	0	·	_	0. 000000	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0			,	0. 000000	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0				0. 000000	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS  88. OO 08800 RURAL HEALTH CLINIC	0	0	0	0	0. 000000	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER					0.000000	89.00
90. 00   08900  FEDERALLY QUALIFIED HEALTH CENTER					0.000000	90.00
90. 00   09000   CLINIC 90. 01   09001   DI ABETES CENTER	0			, ,	0.000000	90.00
90. 01   09001   DI ABETES CENTER 90. 02   09002   NEUROPSYCH	0		· -	_		90.01
90. 02   09002   NEUROPSYCH 90. 03   09003   WOUND CENTER	0				0. 000000 0. 000000	
	0					90. 03 90. 04
90. 04   09004   HYPERBARI C OXYGEN THERAPY 90. 05   09005   VI MCARE CLI NI C			1	, , , , , , , , , , , , , , , , , , , ,	0. 000000 0. 000000	90.04
90. 05   09005 VINCARE CLINIC 90. 06   09006   MEDICATION MGMT CLINIC				,	0. 000000	90.05
91. 00   09100   EMERGENCY	0	1	· -	·	0. 000000	90.06
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0				0. 000000	91.00
OTHER REIMBURSABLE COST CENTERS		1 0	ı	10, 177, 610	0.000000	72.00
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	1, 612, 067	1, 612, 067	866, 854, 835		200.00
	'	1 ., 512, 567	.,012,007	000,001,000	l	1-00.00

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

				10	12/31/2023	5/30/2024 7:0	
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	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	
AN	CILLARY SERVICE COST CENTERS						
50.00 05	OOO OPERATING ROOM	0. 000000	8, 743, 943	0	17, 947, 576	0	50.00
51.00 05	5100 RECOVERY ROOM	0. 000000	714, 033	0	1, 150, 542	0	51.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	6, 338	0	0	0	52.00
53.00 05	300 ANESTHESI OLOGY	0. 000000	1, 859, 560	0	2, 784, 768	0	53.00
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 125867	702, 554	88, 428	1, 304, 385	164, 179	54.00
54. 01   05	5402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	366, 002	0	4, 498, 912	0	54. 01
54. 02   05	5404 ULTRA SOUND	0. 000000	609, 472	0	1, 435, 191	0	54. 02
54. 03   05	MAMMOGRAPHY	0. 000000	1, 036	0	757, 742	0	54.03
	5500 RADI OLOGY-THERAPEUTI C	0. 000000	235, 119	0	6, 579, 617	0	55.00
57. 00 05	5700 CT SCAN	0. 000000	5, 087, 412	o	8, 479, 435	0	57.00
	5800 MRI	0. 000000	879, 920		2, 978, 852	0	58.00
59.00 05	5900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 961, 786	o	5, 608, 297	0	59.00
	5000 LABORATORY	0. 000000	8, 547, 426		4, 249, 193	0	60.00
	0001 LABORATORY-PATHOLOGI CAL	0. 000000	244, 287	0	1, 516, 931	0	60. 01
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	605, 198	_	265, 948	0	62.00
	5500 RESPIRATORY THERAPY	0. 000000	9, 290, 167	0	1, 640, 343	0	65.00
	6600 PHYSI CAL THERAPY	0. 000000	1, 272, 409	_	17, 279	-	66.00
	5700 OCCUPATI ONAL THERAPY	0. 000000	893, 740	1	12, 050	0	67.00
	8800 SPEECH PATHOLOGY	0. 000000	110, 705		103, 500	0	68.00
	900 ELECTROCARDI OLOGY	0. 000000	2, 412, 100	1	3, 478, 829	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	0. 000000	191, 263	1	1, 640, 710	0	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 963, 668	1	4, 248, 802	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 832, 613		3, 424, 126	-	72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 004507	11, 384, 115	1	25, 368, 815	l e	73.00
	400 RENAL DIALYSIS	0.000000	1, 113, 768	· ·	25, 300, 013	0	74.00
	3020 ACUPUNCTURE	0. 000000	1, 113, 700	1	0	0	76.00
1	7697 CARDI AC REHABI LI TATI ON	0. 000000	692	1	839, 640	-	76. 97
	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000	092	1	039, 040	l	77.00
	7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	_	0	1	78.00
	ITPATIENT SERVICE COST CENTERS	0.000000	0	ı o	0	0	76.00
	8800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
	1900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89.00
	2000 CLINIC	0. 000000	27, 248	_	3, 085, 702	0	90.00
	2001 DI ABETES CENTER	0. 000000	27, 240		3,003,702	0	90.00
	2002 NEUROPSYCH	0. 000000	1, 860		48, 058	0	90.01
	2003 WOUND CENTER	0. 000000	87, 017	0	·	0	90.02
	2004 HYPERBARIC OXYGEN THERAPY	0. 000000	67,017		5, 254, 218 323, 532	0	90.03
		1	679	_	·	0	
	2005 VIMCARE CLINIC	0. 000000			133, 992	-	90.05
	2006 MEDICATION MGMT CLINIC	0.000000	1, 142	1	396, 277	0	90.06
	2100 EMERGENCY	0.000000	9, 366, 241	0	9, 209, 744	l	91.00
	0200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	2, 137, 407	0	92.00
	HER REIMBURSABLE COST CENTERS DOOD AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		81, 513, 513	139, 736	120, 920, 413	278, 516	
200.00	Trotal (Trines 50 till bugli 199)	1	01, 010, 013	137, /30	120, 920, 413	2/0,010	<sub>1</sub> 200.00

Health Financial Systems COLUMBUS REGION APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 COLUMBUS REGIONAL HOSPITAL Worksheet D Part V Date/Time Prepared: 5/30/2024 7:02 am Provi der CCN: 15-0112 Peri od: From 01/01/2023 To 12/31/2023 Title XVIII Hospi tal Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost

	cost center bescription	COST TO		_ cost	COST	PP3 Sel VICES	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 328275	17, 947, 576	C	504	5, 891, 741	50.00
51.00	05100 RECOVERY ROOM	0. 325500	1, 150, 542	c	0	374, 501	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 758034	0	l c	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 012329	2, 784, 768		0	34, 333	
	05400 RADI OLOGY-DI AGNOSTI C	0. 650185			0	848, 092	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 277225		1		1, 247, 211	
	05404 ULTRA SOUND	0. 159800					
54. 03	05405 MAMMOGRAPHY	0. 290264	757, 742			219, 945	
	05500 RADI OLOGY-THERAPEUTI C	0. 197561	6, 579, 617			1, 299, 876	
57. 00	05700 CT SCAN	0. 062457		1		529, 600	
	05800 MRI	0. 134316				400, 107	58.00
59. 00				1			
	05900 CARDI AC CATHETERI ZATI ON	0. 158866			_	890, 968	
60.00	06000 LABORATORY	0. 205040		1		871, 255	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 272940			_	414, 031	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 269221	265, 948	l .		71, 599	
65. 00	06500 RESPI RATORY THERAPY	0. 195583			_	320, 823	
66. 00	06600 PHYSI CAL THERAPY	0. 421746		l .	_	7, 287	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 406674		l .	_	4, 900	
68. 00	06800 SPEECH PATHOLOGY	0. 524162			_	54, 251	68. 00
	06900 ELECTROCARDI OLOGY	0. 158274		l .	_	550, 608	
	07000 ELECTROENCEPHALOGRAPHY	0. 216751	1, 640, 710	C	0	355, 626	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328841	4, 248, 802	C	0	1, 397, 180	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 597679	3, 424, 126	C	0	2, 046, 528	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 335687	25, 368, 815	C	90, 344	8, 515, 981	73.00
74.00	07400 RENAL DI ALYSI S	0. 350635	0	C	0	0	74.00
	03020 ACUPUNCTURE	0. 000000	0	C	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	0. 357051	839, 640	C	0	299, 794	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	C	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	l c	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	'			•	<u> </u>	
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 552534	3, 085, 702	d c	0	1, 704, 955	
90. 01	09001 DI ABETES CENTER	0. 000000		1	0	0	90. 01
	09002 NEUROPSYCH	1. 037836		d	0	49, 876	
90. 03	09003 WOUND CENTER	0. 201286		1	_		
	09004 HYPERBARI C OXYGEN THERAPY	0. 317908			_	102, 853	
	09005 VI MCARE CLI NI C	0. 828779		1	_	111, 050	
	09006 MEDICATION MGMT CLINIC	0. 676378		1	_		1
91. 00	09100 EMERGENCY	0. 208575			_		
	l I				_		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 518422	2, 137, 407	C	) 0	1, 108, 079	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0 501744	I	1		I	05 00
	09500 AMBULANCE SERVICES	0. 531741		C		22 100 250	95.00
200.00			120, 920, 413	C	90, 848	33, 198, 950	
201.00					0		201.00
000 5-	Only Charges	1	400 000 ::-	_		00 100 0==	000 00
202. 00	Net Charges (line 200 - line 201)	[	120, 920, 413	(	90, 848	33, 198, 950	J202.00

In Lieu of Form CMS-2552-10 Health Financial Systems COLUMBUS REGIONAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0112 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared:

12/31/2023

5/30/2024 7:02 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 165 50.00 05100 RECOVERY ROOM 0 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 00000000000000000000000000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0 54.01 54.02 05404 ULTRA SOUND 0 54.02 54.03 05405 MAMMOGRAPHY 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MRI 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 0 60 00 60 00 60.01 06001 LABORATORY-PATHOLOGI CAL 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 30. 327 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 76.00 03020 ACUPUNCTURE 0 76.00 07697 CARDIAC REHABILITATION 76. 97 0 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 DI ABETES CENTER 0000000 0 90.01 09002 NEUROPSYCH 90.02 0 90.02 09003 WOUND CENTER 0 90.03 90.03 90.04 09004 HYPERBARIC OXYGEN THERAPY 0 90.04 90.05 09005 VIMCARE CLINIC 0 90.05 09006 MEDICATION MGMT CLINIC 0 90.06 90.06 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 0 30, 492 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 0 202.00 202.00 30, 492

## APPORTIOMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS ## Cost Center Description ## Capital Related Cost (From West, 8, Part II)   Component COst, 15-T112   Cost, 15-T12   Co								
Component CN: 15-T112   From 0/101/2023   Part I   In prepared 5/30/2024 7: 00 mm   Prepared 5					ON. 1E 0110			2552-10
Cost Center Description	APPUR	ITONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL CUSIS	Provider C	JN: 15-0112			
Cost Center Description				Component (			Date/Time Pre	
Cost Center Description				T: ±1 -	V/VI I I	C. de a casa di alaca		12 am
Cost Center Description				litte	AVIII		PP3	
Related Cost (From Wist. Col. 1		Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
B. Part II.   Col. 26.0   Col. 2   Col. 8   Col. 2   Co		· ·						
Col. 26    Col. 26			(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
ANCILLARY SERVICE COST CENTERS				col. 8)	col. 2)			
ANCILLARY SERVICE COST CENTERS   S0.00   GROOD OPERATIN ROMOM   S1.00   S1.00   OSTOOD OPERATING ROMOM   S1.00   S1.00   OSTOOD OPERATING ROMOM   S1.00   S1.00   OSTOOD OPERATING ROMOM   S1.00   S1.00   OSTOOD OPERATING ROMOM   S1.00				0.00	2.00	4.00	F 00	
50.00		ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.0   0.5100   DEJOUREY ROOM   1.64   259   9,279,014   0.017702   8,339   1.48   51.00	50.00		5 165 069	121 389 021	0.04255	0 54 207	2 307	50 00
52.00   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   054500   05400   055								
54. 00   05400   RADIO LOGY-DI AGNOSTIC   473, 403   8, 333, 090   0. 056610   26, 083   1, 482   54   00						· ·		
54. 01   05402   NUCLEAR MEDICINE-DI AGNOSTIC   604, 147   15, 517, 169   0. 038934   5, 980   233   54. 01     54. 02   05404   ULTRA SQUIND   119, 663   10, 671, 771   10, 671, 771   11, 502   10.3   54. 02     54. 03   05405   MAMMOGRAPHY   420, 158   7, 745, 205   0. 054247   0   0   54. 03     55. 00   05500   RODIO CORY-THERAPEUTIC   785, 164   22, 866, 217   0. 032899   0   0   55. 00     55. 00   05500   RODIO CORY-THERAPEUTIC   785, 164   23, 866, 217   0. 032899   0   0. 05900     55. 00   05500   RODIO CORY-THERAPEUTIC   785, 164   0. 007067   43, 790   309   57. 00     56. 00   05800   MRID CORY-THERAPEUTIC   830, 562   39, 785, 128   0. 020876   1, 161   24   59, 00     59. 00   05900   CARDIO AC CATHETER ZATION   830, 562   39, 785, 128   0. 020876   1, 161   24   59, 00     60. 01   06001   LABORATORY   1, 225, 549   89, 287, 796   0. 011486   277, 751   3, 190   60. 00     60. 01   06001   LABORATORY-PATHOLOGIC AL   37, 063   3, 680, 598   0. 0130799   1, 223   17, 60. 01     62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   37, 063   3, 680, 598   0. 014043   735, 221   10, 325   65. 00     65. 00   06500   RESPIRATORY THERAPY   496, 247   35, 337, 148   0. 014043   735, 221   10, 325   65. 00     66. 00   06600   PHYSI CAL THERAPY   227, 019   7, 786, 946   0. 029154   856, 407   249, 686   70. 00     69. 00   06900   ELECTROCARDEN LOLOGY   99, 064   2, 699, 931   0. 036691   308, 639   11, 324   68. 00     69. 00   06900   ELECTROCARDEN LOLOGRAPHY   241, 050   10, 119, 555   0. 023820   1, 805   43   70. 00     70. 00   07000   ELECTROCARDEN LOLOGRAPHY   241, 050   10, 119, 555   0. 023820   1, 805   43   70. 00     70. 00   07000   ELECTROCARDEN LOLOGRAPHY   324, 961, 00   0. 000000   0. 0   0. 000000   0. 0   0. 000000     70. 00   07000   ELECTROCARDEN LOLOGRAPHY   327, 476   61, 41, 375, 845   61, 651   0. 014310   10, 869   156   72. 00     70. 00   07000   DELICARD CARRED TO PATIENTS   306, 978   21, 451, 651   0. 014310   10, 869   156   72. 00     70. 00   07000   DELICARD CARR	53.00	05300 ANESTHESI OLOGY	12, 242	19, 687, 810	0. 00062	2 10, 178	6	53.00
S4 02   05404   ILTRA SOUND	54.00	05400 RADI OLOGY-DI AGNOSTI C	473, 403	8, 333, 090	0. 05681	0 26, 083	1, 482	54.00
54. 03   05405   MAMMOGRAPHY   420, 158   7, 745, 205   0, 054247   0   0   54. 03			604, 147		0. 03893	· ·	233	
55. 00   05500   CADIO LOGY-THERAPEUTI C   785, 164   23, 86.6   217   0, 032899   0   0   55. 00   05700   05700   CT SCAN   387, 195   77. 00   05700   CT SCAN   387, 195   77. 15, 776, 974   0, 036303   8, 378   304   58. 00   05900   CARDIA C CATHETERI ZATI ON   830, 562   39, 785, 128   0, 020876   1, 161   24   59. 00   06000   CARDIA C CATHETERI ZATI ON   830, 562   39, 785, 128   0, 020876   1, 161   24   59. 00   06000   LABORATORY   1, 025, 549   89, 287, 996   0, 011486   277, 751   3, 190   60. 00   60. 00   60000   LABORATORY-PATHOLOGI CAL   123, 548   89, 287, 996   0, 0110070   23, 993   242   62, 00   62, 00   62000   WHOLE BLOOD & PACKED RED BLOOD CELL   37, 663   3, 680, 598   0, 0110070   23, 993   242   62, 00   66, 00   6600   PMSYL CAL THERAPY   496, 247   35, 337, 148   0, 014043   735, 221   10, 325   65, 00   66, 00   6600   PMSYL CAL THERAPY   496, 247   35, 337, 148   0, 014043   735, 221   10, 325   65, 00   66, 00   6600   PMSYL CAL THERAPY   227, 019   7, 786, 946   0, 029154   856, 407   24, 968   67, 00   6900   69000   ELECTROCARDIOLOGY   99, 064   2, 699, 931   0, 036091   308, 639   11, 324   68, 00   68, 00   6900   ELECTROCARDIOLOGY   99, 064   2, 699, 931   0, 036691   308, 639   11, 324   68, 00   69, 00   69000   ELECTROCARDIOLOGY   320, 938   18, 857, 304   0, 017019   14, 932   254   69, 00   69000   ELECTROCARDIOLOGY   320, 938   18, 857, 304   0, 017019   14, 932   254   69, 00   69000   ELECTROCARDIOLOGY   306, 678   21, 451, 651   0, 014310   10, 869   156   72, 00   72								
57.00   05700   CT SCAN   387, 195   54, 785, 467   0. 007067   43, 790   309   57. 00   58.00   05800   MRS						-		
S8.00   05800   NR    572, 757   15, 776, 974   0. 036303   8, 378   304   58. 00   05900   CARDIAC CATHETERIZATION   830, 56.2   39, 785, 122   0.020876   1, 161   24   59. 00   60.00   06000   LABORATORY   1, 025, 549   89, 287, 996   0. 011486   277, 751   3, 190   60. 00   60.00   06000   LABORATORY - PATHOLOGI CAL   123, 548   89, 53. 163   0. 013799   1, 223   17   60. 01   60.00							-	
59.00   05900   05900   05900   CARDIAC CATHETERI ZATI ON   830, 562   39, 785, 128   0.020876   1, 161   24   59, 00   06000   06000   LABORATORY   1, 025, 549   89, 287, 996   0.011486   277, 751   3, 190   06.00   06001   LABORATORY - PATHOLOGI CAL   123, 548   8, 983, 163   0.013799   1, 223   17   66.01   06001   06001   LABORATORY - PATHOLOGI CAL   123, 548   8, 983, 163   0.013799   1, 223   17   66.01   06000   06000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000								
60.00   06000   LABORATORY   1, 025, 549   89, 287, 996   0, 011486   277, 751   3, 190   60.00   60.01   06001   LABORATORY-PATHOLOGI CAL   123, 548   8, 953, 163   0, 013799   1, 223   17   60.01   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   37, 063   3, 680, 598   0, 010070   23, 993   242   62.00   65.00   06500   RESPI RATORY THERAPY   496, 247   35, 337, 148   0, 014043   735, 221   10, 325   65.00   66.00   06600   PHYSI CAL THERAPY   650, 665   21, 480, 128   0, 030301   849, 742   25, 748   66.00   66.00   06600   PHYSI CAL THERAPY   227, 019   7, 786, 946   0, 029154   856, 407   24, 968   67.00   67.00   06700   DECETROATHOLOGY   99, 064   2, 699, 931   0, 036691   308, 639   11, 324   68.00   680, 00   680, 00   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0, 017019   14, 932   254   69.00   70.00   07000   ELECTROCREPHALOGRAPHY   241, 050   10, 119, 555   0, 023820   1, 805   43   70.00   71.00   MEDICAL SUPPLIES CHARGED TO PATI ENTS   306, 978   21, 451, 651   0, 014310   10, 869   156   72.00   73.00   O7200   IMPL. DEV. CHARGED TO PATI ENTS   306, 978   21, 451, 651   0, 014310   10, 869   156   72.00   74.00   07400   REVALD ILALYSIS   24, 787   2, 917, 138   0, 08497   204, 536   1, 738   74.00   74.00   07400   REVALD ILALYSIS   24, 787   2, 917, 138   0, 08497   204, 536   1, 738   74.00   74.00   07400   REVALD ILALYSIS   24, 787   2, 917, 138   0, 000000   0   0, 000000   0   0, 76.00   000000   0   0, 76.00   000000   0   0, 76.00   000000   0   0, 76.00   000000   0   0, 76.00   000000   0   0, 000000   0   0, 000000   0								
60.01   06001   LABORATORY-PATHOLOGICAL   123, 548   8,953, 163   0,013799   1,223   17   60.01   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   37,063   3,686,598   0.010070   23,993   242   62.00   65.00   06500   RESPIRATORY THERAPY   496,247   35,337,148   0.014043   735,221   10,325   65.00   66.00   06600   PHYSI CAL THERAPY   650,865   21,480,128   0.030301   849,742   25,748   66.00   67.00   06700   OCCUPATIONAL THERAPY   227,019   7,786,946   0.029154   856,407   24,968   67.00   68.00   06800   SPEECH PATHOLOGY   99,064   2,699,931   0.036691   308,639   11,324   68.00   69.00   06900   ELECTROCARDI OLOGY   320,928   18,857,304   0.017019   14,932   254   69.00   69.00   06900   ELECTROCENCEPHALOGRAPHY   241,050   10,119,555   0.023820   1,805   43   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   327,476   41,375,845   0.007915   66,849   529   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   306,978   21,451,651   0.014310   10,869   156,72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   1,352,863   124,961,004   0.010826   365,020   3,952   73.00   74.00   07400   RENALD I JALYSI S   24,787   2,917,138   0.008497   204,536   1,738   74.00   76.00   07400   RENALD I JALYSI S   24,787   2,917,138   0.000000   0   0   76.90   77.00   07700   ALLOGENEIC HSCT ACQUI SITION   59,540   2,388,798   0.024925   0   0   76.90   78.00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0.000000   0   0   77.00   78.00   07800   RURAL HEALTH CLINIC   0   0   0.000000   0   0   90.00   79.00   09000   000000   0   0   0   0.000000   0								
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   37,063   3,680,598   0.010070   23,993   242   62.00   65.00   06500   RESPIRATORY THERAPY   496,247   35,337,148   0.014043   735,221   10,325   65.00   66.00   06600   PHYSI CAL THERAPY   650,865   21,480,128   0.030301   849,742   25,748   66.00   67.00   06700   OCCUPATI ONAL THERAPY   227,019   7,786,946   0.029154   856,407   24,968   67.00   68.00   06800   SPEECH PATHOLOGY   99,064   2,699,931   0.036691   308,639   11,324   68.00   69.00   06900   ELECTROCARDIOLOGY   320,928   18,857,304   0.017019   14,922   254   69.00   71.00   07000   ELECTROCARDIOLOGY   320,928   18,857,304   0.017019   14,922   254   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   327,476   41,375,845   0.007915   66,849   529   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   37,476   41,375,845   0.007915   66,849   529   71.00   73.00   07300   DRUGS CHARGED TO PATIENTS   366,978   21,451,651   0.014310   10,869   156   72.00   74.00   07400   RENAL DI ALYSI S   24,787   2,917,138   0.008497   204,536   1,738   74.00   76.00   03020   ACUPUNCTURE   0 0 0.000000   0 0 76.00   76.07   07697   CARDIA CREHABI LITATION   59,540   2,388,798   0.024925   0 0 0 76.00   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0 0 0 0.000000   0 0 0 0.000000   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0 0 0 0.000000   0 0 0 0.000000   79.00   07900   IMPL. BEALLY GUAL FIED HEALTH CENTER   0 0 0.000000   0 0 0.000000   79.00   09000   CLI NI C   359,342   11,603,999   0.030967   0 0 90.00   79.01   09000   DIABETES CENTER   0 0 0.000000   0 0 0 0.000000   79.02   09002   NEUROPSYCH   7,672   203,089   0.037777   0 0 90.00   79.03   09003   WOUND CENTER   205,849   14,249,914   0.014446   0 0 90.03   79.04   09004   HYPERBARI C OXYGEN THERAPY   112,485   1,247,788   0.000000   0 0 0 0.00000   79.05   09005   VI MCARE CLI NI C   143,041   1,820,601   0.078568   0 0 0 90.05   79.06   09006   MEDILANCE SERVI CES   143,041   1,820,601   0.000000   0 0 0 0 0 0 0 0 0 0 0 0 0								1
65.00   06500   RESPIRATORY THERAPY   496, 247   35, 337, 148   0.014043   735, 221   10, 325   65.00   66.00   06600   PHYSI CAL THERAPY   650, 865   21, 480, 128   0.030301   849, 742   25, 748   66.00   67.00   06700   OCCUPATI ONAL THERAPY   227, 019   7, 786, 946   0.029154   856, 407   24, 968   67.00   68.00   06800   SPEECH PATHOLOGY   99, 064   2, 699, 931   0.036691   308, 639   11, 324   68.00   69.00   06900   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0.017019   14, 932   254   69.00   70.00   07000   ELECTROENCEPHALIOGRAPHY   241, 050   10, 119, 555   0.023820   1, 805   43   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   327, 476   41, 375, 845   0.007915   66, 849   529   71.00   72.00   07200   IMPLE DEV. CHARGED TO PATI ENTS   366, 978   21, 451, 651   0.014310   10, 869   156   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   1, 352, 863   124, 961, 004   0.010826   365, 020   3, 952   73.00   74.00   07400   RENAL DI ALYSI S   24, 787   2, 917, 138   0.008497   204, 536   1, 738   74.00   76.00   03020   ACUPUNCTURE   0 0 0 0.000000   0 0   76.00   76.97   07697   CARDI AC REHABI ELITATI ON   59, 540   2, 388, 798   0.024925   0 0   76.00   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0 0.000000   0   0   77.00   78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0 0.000000   0   0   0   79.01   09000   DIABETES CENTER   0   0 0.000000   0   0   90.00   79.02   09002   NEUROPSYCH   7, 672   203, 089   0.037777   0   0   90.00   79.01   09000   DIABETES CENTER   200, 0   0.000000   0   0   90.00   79.02   09002   NEUROPSYCH   7, 672   203, 089   0.037777   0   0   90.00   79.03   09005   VIMCARE CLINIC   40, 941   857, 105   0.047767   0   0   90.00   79.04   09004   HYPERBARI C OXYGEN THERAPY   112, 485   14, 249, 914   0.014446   0   0   90.05   79.05   09005   VIMCARE CLINIC   40, 941   857, 105   0.047767   0   0   90.05   79.00   09000   09000   09000   09000   09000   090000   090000   09000   090000   090000   090000   090000   090000   090000   090000   0900								
66.00   06600   PHYSICAL THERAPY   650, 865   21, 480, 128   0. 030301   849, 742   25, 748   66.00   67.00   06700   OCCUPATI ONAL THERAPY   227, 019   7, 786, 946   0. 029154   856, 407   244, 968   67.00   6800   06800   SPEECH PATHOLOGY   99, 064   2, 699, 931   0. 036691   308, 639   11, 324   68.00   69.00   06900   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0. 017019   14, 932   254   69.00   70.00   70.00   CIDETROENCEPHALOGRAPHY   241, 550   10, 119, 555   0. 023820   1, 805   43   70.00   70.00   70.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   241, 550   10, 119, 555   0. 023820   1, 805   43   70.00   70.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   241, 550   10, 119, 555   0. 023820   1, 805   43   70.00   70.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   241, 550   10, 119, 555   0. 023820   1, 805   43   70.00   70.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   241, 550   10, 119, 555   0. 023820   1, 805   43   70.00   70.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   241, 550   14, 375, 845   0. 007915   66, 849   529   71.00   72.00   TOO OLOGO ELECTROENCEPHALOGRAPHY   306, 978   21, 451, 651   0. 014310   10, 869   156   72.00   73.0								1
67. 00   06700   0CCUPATI ONAL THERAPY   227, 019   7, 786, 946   0, 029154   856, 407   24, 968   67. 00   68. 00   06800   SPEECH PATHOLOGY   99, 064   2, 699, 931   0. 036691   308, 639   11, 326   68. 00   06900   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0. 017019   14, 932   254   69. 00   07000   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0. 017019   14, 932   254   69. 00   07000   ELECTROENCEPHALGGRAPHY   241, 050   10, 119, 555   0. 023820   1, 805   43   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   327, 476   41, 375, 845   0. 007915   66, 849   529   71. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   306, 978   21, 451, 651   0. 014310   10, 869   156   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 352, 863   124, 961, 004   0. 010826   365, 020   33, 952   73. 00   74. 00   07400   RENAL DI ALYSI S   24, 787   2, 917, 138   0. 008497   204, 536   1, 738   74. 00   76. 90   76. 90   77. 00   0. 07000   0. 07000   0. 076. 90   77. 00   0. 07000   0. 07000   0. 07000   0. 076. 90   77. 00   0. 07000   0. 07000   0. 07000   0. 076. 90   78. 00   0. 07000   0. 07000   0. 076. 90   0. 07000   0. 076. 90   0. 07000   0. 076. 9						·		1
69.00   66900   ELECTROCARDI OLOGY   320, 928   18, 857, 304   0. 017019   14, 932   254   69.00   70.00   70.00   70.00   ELECTROENCEPHALOGRAPHY   241, 050   10, 119, 555   0. 023820   1, 805   43   70.00   71.00	67.00		227, 019		0. 02915	4 856, 407	24, 968	67.00
70. 00   07000   ELECTROENCEPHALOGRAPHY   241,050   10,119,555   0.023820   1,805   43   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   327,476   41,375,845   0.007915   66,849   529   71.00   72.00   07200   MPL DEV. CHARGED TO PATI ENTS   336,978   21,451,651   0.014310   10,869   156   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   1,352,863   124,961,004   0.010826   365,020   3,952   73.00   74.00   07400   RENAL DI ALYSIS   24,787   2,917,138   0.008497   204,536   1,738   74.00   76.00   3020   ACUPUNCTURE   0 0 0 0.000000   0 0   76.00   76.97   07697   CARDI AC REHABI LI TATI ON   59,540   2,388,798   0.024925   0 0   76.97   077.00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0 0 0.000000   0 0 0 0.000000   0 0   78.00   0000000   0 0   0.000000   0	68.00		99, 064	2, 699, 931	0. 03669	308, 639	11, 324	68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 327, 476 41, 375, 845 0. 007915 66, 849 529 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 306, 978 21, 451, 651 0. 014310 10, 869 156 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 352, 863 124, 961, 004 0. 010826 365, 020 3, 952 73. 00 74. 00 07400 RENAL DI ALYSI S 24, 787 2, 917, 138 0. 008497 204, 536 1, 738 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0.000000 0 0 76. 00 76. 00 76. 97 07697 CARDI AC REHABILI TATI ON 59, 540 2, 388, 798 0. 024925 0 0 76. 97 07697 CARDI AC REHABILI TATI ON 0 0 0.000000 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0 77. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0.000000 0 0 0 78. 00 000000 0 0 0 78. 00 000000 0 0 0 0 000000 0 0 0 0 000000							254	
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   306, 978   21, 451, 651   0.014310   10, 869   156   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   1,352, 863   124, 961, 004   0.010826   365, 020   3, 952   73.00   74.00   0.07400   RENAL DIALYSIS   24, 787   2, 917, 138   0.008497   204, 536   1, 738   74.00   76.00   03020   ACUPUNCTURE   0   0   0.000000   0   0   0.000000   0								
73. 00								
74. 00 07400 RENAL DI ALYSIS 24, 787 2, 917, 138 0. 008497 204, 536 1, 738 74. 00 76. 00 03020 ACUPUNCTURE 0 0 0. 0. 000000 0 0 76. 00 76. 00 76. 00 76. 70 76. 77 07697 CARDI AC REHABILLI TATI ON 59, 540 2, 388, 798 0. 024925 0 0 76. 97 77. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0 0 0. 000000 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0. 000000 0 0 0 78. 00 000000 0 0 0 78. 00 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
76. 00 03020 ACUPUNCTURE 0 0 0.000000 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 59, 540 2, 388, 798 0.024925 0 0 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0.000000 0 0 78. 00  **OUTPATI ENT SERVI CE COST CENTERS**  88. 00 08800 RURAL HEALTH CLINI C 0 0.000000 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0.000000 0 0 88. 00 90. 00 09000 CLI NI C 359, 342 11, 603, 999 0.030967 0 0 90. 00 90. 01 09001 DI ABETES CENTER 0 0 0.000000 0 0 90. 01 90. 02 09002 NEUROPSYCH 7, 672 203, 089 0.037777 0 0 90. 02 90. 03 09003 WOUND CENTER 205, 849 14, 249, 914 0.014446 0 0 90. 02 90. 04 09004 HYPERBARI C OXYGEN THERAPY 112, 485 1, 247, 788 0.090148 0 0 90. 03 90. 05 09005 VI MCARE CLINI C 143, 041 1, 820, 601 0.078568 0 0 90. 05 90. 06 09006 MEDI CATI ON MGMT CLI NI C 40, 941 857, 105 0.047767 0 0 90. 06 91. 00 09100 EMERGENCY 1, 076, 625 94, 562, 452 0.011385 11, 821 135 91. 00 0710 THER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES						· ·	· ·	1
76. 97			1			· ·	· ·	1
77. 00				ŭ				
78. 00			1					
SECTION   SERVICE COST CENTERS   SERVICE COST CENTER   ST CENTER COST CENTE								1
89. 00		OUTPATIENT SERVICE COST CENTERS	1					1
90. 00   09000   CLINIC   359, 342   11, 603, 999   0. 030967   0   0   90. 00   90. 00   90. 01   90. 01   90. 02   90. 02   90. 02   90. 02   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 03   90. 04   90. 04   90. 04   90. 04   90. 04   90. 05   90.			0	0			0	
90. 01   09001   DI ABETES CENTER   0   0   0.000000   0   0   90. 01   90. 02   09002   NEUROPSYCH   7, 672   203, 089   0.037777   0   0   90. 02   90. 03   09003   WOUND CENTER   205, 849   14, 249, 914   0.014446   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   112, 485   1, 247, 788   0.090148   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   143, 041   1, 820, 601   0.078568   0   0   90. 05   90. 06   09006   MEDI CATI ON MGMT CLI NI C   40, 941   857, 105   0.047767   0   0   90. 05   91. 00   09100   EMERGENCY   1, 076, 625   94, 562, 452   0.011385   11, 821   135   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0.000000   0   0   92. 00    OTHER REI MBURSABLE COST CENTERS   95. 00			-1	_				
90. 02   09002   NEUROPSYCH   7, 672   203, 089   0. 037777   0   0   90. 02   90. 03   09003   WOUND CENTER   205, 849   14, 249, 914   0. 014446   0   0   90. 03   90. 04   09004   HYPERBARI C OXYGEN THERAPY   112, 485   1, 247, 788   0. 090148   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   143, 041   1, 820, 601   0. 078568   0   0   90. 05   90. 06   09006   MEDI CATI ON MGMT CLI NI C   40, 941   857, 105   0. 047767   0   0   90. 06   91. 00   09100   EMERGENCY   1, 076, 625   94, 562, 452   0. 011385   11, 821   135   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0. 000000   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00			1	11, 603, 999				
90. 03			-1	0				
90. 04   09004   HYPERBARI C 0XYGEN THERAPY   112, 485   1, 247, 788   0. 090148   0   0   90. 04   90. 05   09005   VI MCARE CLI NI C   143, 041   1, 820, 601   0. 078568   0   0   90. 05   090. 06   09006   MEDI CATI ON MGMT CLI NI C   40, 941   857, 105   0. 047767   0   0   90. 06   09100   EMERGENCY   1, 076, 625   94, 562, 452   0. 011385   11, 821   135   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0. 000000   0   0   92. 00   0716ER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00   09500   09								
90. 05   09005   VI MCARE CLI NI C   143, 041   1, 820, 601   0. 078568   0   0   90. 05   09006   MEDI CATI ON MGMT CLI NI C   40, 941   857, 105   0. 047767   0   0   90. 06   91. 00   09100   EMERGENCY   1, 076, 625   94, 562, 452   0. 011385   11, 821   135   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0. 000000   0   0   92. 00   0716R   REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00   000000   0   0   0   0   0   0								
90. 06   09006   MEDI CATI ON MGMT CLI NI C   40, 941   857, 105   0. 047767   0   0   90. 06   91. 00   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0. 000000   0   0   92. 00   09500   AMBULANCE SERVI CES   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00   000000   0   0   0   0   0   0								
91. 00   09100   EMERGENCY   1,076,625   94,562,452   0.011385   11,821   135   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0   18,799,810   0.000000   0   0   92.00   0THER REIMBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVICES   95.00								
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0   18, 799, 810   0.000000   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00				· ·				
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00								
								]
200.00   Total (lines 50 through 199)   16,998,576  866,854,835    3,901,426  87,597 200.00								
	200.00	)     lotal (lines 50 through 199)	16, 998, 576	866, 854, 835		3, 901, 426	87, 597	200. 00

	Financial Systems	COLUMBUS REGIO		ON 15 0110	D		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE UTHER PAS	S Provider C	CN: 15-0112		riod: om 01/01/2023	Worksheet D Part IV	
ITROUG	on CO313		Component	CCN: 15-T112	То	12/31/2023	Date/Time Pre	
			T: +1 o	xVIII	C.	ubasavi das	5/30/2024 7: 0 PPS	2 am
			IIIIe	: XVIII	50	ubprovider - IRF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anesthetist	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown Adjustments			Adjustments		
		1. 00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00		0,1	0.00	
50.00	05000 OPERATI NG 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	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	1, 048, 861	54.00
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	1	0	0	0	54. 01
54. 02	05404 ULTRA SOUND	0	0		0	0	0	54. 02
54. 03	05405 MAMMOGRAPHY	0	0		0	0	0	54. 03
55. 00 57. 00	O5500   RADI OLOGY-THERAPEUTI C   O5700   CT   SCAN	0	0		0	0	0	55. 00 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	Ö	1	0	0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	Ö		0	0	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	Ö		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	1	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 72. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			0	0	0 563, 206	72. 00 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	Ö		0	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	0	89. 00
90.00	09000 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 90. 04	O9003   WOUND CENTER   O9004   HYPERBARI C OXYGEN THERAPY	0	0	•	0	0	0	90. 03 90. 04
90.04	09005 VI MCARE CLINIC				0	0	0	90.04
90.06	09006 MEDICATION MGMT CLINIC		0		0	0	0	90.05
91.00	09100 EMERGENCY	0	Ö		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	J	0	92.00
	OTHER RELIMBURGARIE COST CENTERS	•						1

95. 00 1, 612, 067 200. 00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co	CN: 15-0112	Peri od:	Worksheet D	
	H COSTS	02 02 7		CCN: 15-T112	From 01/01/2023 To 12/31/2023	Part IV	epared: 02 am
			Title	XVIII	Subprovi der - I RF	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 o		(col. 5 ÷	
		Cost	4)	cols. 2, 3, and 4)	col . 8)	col . 7)	
				anu 4)		(see instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 121, 389, 021	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 9, 279, 014	0.000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 376, 000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 19, 687, 810	0. 000000	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	1, 048, 861	1, 048, 8	8, 333, 090	0. 125867	54.00
54.01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 15, 517, 169	0.000000	54.01
54.02	05404 ULTRA SOUND	0	0		0 10, 671, 777	0. 000000	54.02
54.03	05405 MAMMOGRAPHY	0	0		0 7, 745, 205	0. 000000	54.03
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0		0 23, 866, 217	0. 000000	
57.00	05700 CT SCAN	0	0		0 54, 785, 467	0. 000000	
58.00	05800 MRI	0	0		0 15, 776, 974	0. 000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 39, 785, 128	0. 000000	1
60.00	06000 LABORATORY	0	0		0 89, 287, 996	0. 000000	
60. 01	06001 LABORATORY-PATHOLOGI CAL	0	0		0 8, 953, 163	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 3, 680, 598	0.000000	
65.00	06500 RESPIRATORY THERAPY	0	0		0 35, 337, 148	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 21, 480, 128 0 7 786 946	0.000000	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0	0		7,700,710	0.000000	
69.00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	0	0		=,,	0. 000000 0. 000000	1
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0	0		0 18, 857, 304 0 10, 119, 555	0. 000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0 41, 375, 845	0. 000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0 21, 451, 651	0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		563, 20		0. 004507	
74. 00	07400 RENAL DIALYSIS	0	000, 200	000, 2	0 2, 917, 138	0. 000000	1
76. 00	03020 ACUPUNCTURE	0	0		0 0	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 388, 798	0. 000000	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS						
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. 000000	
90.00	09000  CLI NI C	0	0		0 11, 603, 999	0. 000000	1
90. 01	09001 DI ABETES CENTER	0	0		0	0. 000000	
	09002 NEUROPSYCH	0	0		0 203, 089	0. 000000	1
	09003 WOUND CENTER	0	1		0 14, 249, 914	0. 000000	1
90.04	1	0			0 1, 247, 788	0.000000	
90.05	09005 VI MCARE CLI NI C	0			0 1, 820, 601	0.000000	
90.06	09006 MEDICATION MGMT CLINIC	0			0 857, 105	0.000000	
91.00	09100 EMERGENCY	0			0 94, 562, 452 0 18 799 810	0.000000	1
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	0		0 18, 799, 810	0. 000000	92.00
	IVILLE PLINDURSHOLE COST CENTERS						I
95. 00	09500 AMBULANCE SERVI CES						95.00

Description   Description	of Cost arges 6 ÷ 7) 00 . 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000 . 000000	Title Inpatient Program Charges  10.00  54,207 8,339 0 10,178 26,083 5,980 14,502 0	XVIII  Inpati ent Program Pass-Through Costs (col. 8 x col. 10) 11.00	12.00 0 0 0 0 0 0 0 0 0 0 0	Part IV Date/Time Pre 5/30/2024 7:0 PPS  Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00  0 0 0	50. 00
Ratio of to Cha (col	of Cost arges 6 ÷ 7) 00 . 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000 . 000000	10.00 54,207 8,339 0 10,178 26,083 5,980 14,502	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	IRF Outpatient Program Charges  12.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
Ratio of to Cha (col	of Cost arges 6 ÷ 7) 00 . 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000 . 000000	Program Charges 10.00 54,207 8,339 0 10,178 26,083 5,980 14,502	Program Pass-Through Costs (col. 8 x col. 10) 11.00	Program Charges 12.00	Program Pass-Through Costs (col. 9 x col. 12) 13.00	
To Char (col . col . c	. 000000 . 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000	10. 00 54, 207 8, 339 0 10, 178 26, 083 5, 980 14, 502	Pass-Through Costs (col. 8 x col. 10) 11.00	Charges  12.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pass-Through Costs (col. 9 x col. 12) 13.00	
CCOI . COI	6 ÷ 7) 000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000 . 000000	10. 00 54, 207 8, 339 0 10, 178 26, 083 5, 980 14, 502 0	Costs (col. 8 x col. 10) 11.00	12.00	Costs (col. 9 x col. 12) 13.00	
COI .   P. (COI	7) 000 000000 0000000 0000000 0000000 0000	54, 207 8, 339 0 10, 178 26, 083 5, 980 14, 502	x col . 10) 11.00	12.00 0 0 0 0 0 0 0 0 0 0 0	x col . 12) 13.00	
9.00	. 000000 . 000000 . 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000	54, 207 8, 339 0 10, 178 26, 083 5, 980 14, 502	11.00	) 0 0 0 0 0 0 0 0	13.00	
0.00	. 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000	8, 339 0 10, 178 26, 083 5, 980 14, 502	( ( 3, 28;	0 0 0 0 0 0	0	
Description   Description	. 000000 . 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000	8, 339 0 10, 178 26, 083 5, 980 14, 502	( ( 3, 28;	0 0 0 0 0 0	0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0.   53. 00   05300   ANESTHESI OLOGY   0.   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.   54. 01   05402   NUCLEAR MEDI CI NE-DI AGNOSTI C   0.   54. 02   05404   ULTRA SOUND   0.   555. 00   05500   RADI OLOGY-THERAPEUTI C   0.   57. 00   05700   CT SCAN   0.   58. 00   05800   MRI   0.   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.   60. 00   06000   LABORATORY-PATHOLOGI CAL   0.   0.   0.   0.   0.   0.   0.   0.	. 000000 . 000000 . 125867 . 000000 . 000000 . 000000 . 000000	0 10, 178 26, 083 5, 980 14, 502	3, 28; (	0 0 0 0	0	1 51 00
53. 00   05300   ANESTHESI OLOGY   0.   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.   54. 01   05402   NUCLEAR MEDI CI NE-DI AGNOSTI C   0.   54. 02   05404   ULTRA SOUND   0.   55. 03   05405   MAMMOGRAPHY   0.   55. 00   05500   RADI OLOGY-THERAPEUTI C   0.   57. 00   05700   CT SCAN   0.   58. 00   05800   MRI   0.   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.   60. 00   06000   LABORATORY-PATHOLOGI CAL   0.	. 000000 . 125867 . 000000 . 000000 . 000000 . 000000	10, 178 26, 083 5, 980 14, 502 0	3, 283 (	0 0		
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0.         54. 01       05402       NUCLEAR MEDI CI NE-DI AGNOSTI C       0.         54. 02       05404       ULTRA SOUND       0.         54. 03       05405       MAMMOGRAPHY       0.         55. 00       05500       RADI OLOGY-THERAPEUTI C       0.         57. 00       05700       CT SCAN       0.         58. 00       05800       MRI       0.         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.         60. 00       06000       LABORATORY       0.         60. 01       06001       LABORATORY-PATHOLOGI CAL       0.	. 125867 . 000000 . 000000 . 000000 . 000000	26, 083 5, 980 14, 502 0	3, 283	0	0	
54. 01       05402       NUCLEAR MEDICINE-DIAGNOSTIC       0.         54. 02       05404       ULTRA SOUND       0.         54. 03       05405       MAMMOGRAPHY       0.         55. 00       05500       RADI OLOGY-THERAPEUTIC       0.         57. 00       05700       CT SCAN       0.         58. 00       05800       MRI       0.         59. 00       05900       CARDIAC CATHETERIZATION       0.         60. 00       06000       LABORATORY       0.         60. 01       06001       LABORATORY-PATHOLOGICAL       0.	. 000000 . 000000 . 000000 . 000000	5, 980 14, 502 0	(		0	
54. 02   05404   ULTRA SOUND	. 000000 . 000000 . 000000	14, 502 0		ol ol	0	
54. 03     05405     MAMMOGRAPHY     0.       55. 00     05500     RADI OLOGY-THERAPEUTI C     0.       57. 00     05700     CT SCAN     0.       58. 00     05800     MRI     0.       59. 00     05900     CARDI AC CATHETERI ZATI ON     0.       60. 00     06000     LABORATORY     0.       60. 01     06001     LABORATORY-PATHOLOGI CAL     0.	. 000000 . 000000 . 000000	0	Ι (		0	
55. 00       05500       RADI OLOGY-THERAPEUTI C       0.         57. 00       05700       CT SCAN       0.         58. 00       05800       MRI       0.         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.         60. 00       06000       LABORATORY       0.         60. 01       06001       LABORATORY-PATHOLOGI CAL       0.	. 000000				0	
58. 00   05800   MRI		0	(	o	0	
59. 00       05900       CARDI AC CATHETERI ZATI ON       0.         60. 00       06000       LABORATORY       0.         60. 01       06001       LABORATORY-PATHOLOGI CAL       0.	000000	43, 790	(	o o	0	57.00
60. 00   06000   LABORATORY	. 000000	8, 378	(		0	
60. 01 06001 LABORATORY-PATHOLOGI CAL 0.	. 000000	1, 161		0	0	
	. 000000	277, 751	(		0	
	. 000000	1, 223			0	
	. 000000	23, 993 735, 221		1	0	
	. 000000	849, 742		1 1	0	
	. 000000	856, 407			Ö	
	. 000000	308, 639	(		0	
	. 000000	14, 932	(	o o	0	69.00
	. 000000	1, 805	(		0	
	. 000000	66, 849	(		0	
	. 000000	10, 869	(		0	
	. 004507	365, 020	1, 645		0	
1 1	. 000000	204, 536 0	(		0	
	. 000000	0			0	
	. 000000	0			0	
	. 000000	0	(		0	
OUTPATIENT SERVICE COST CENTERS						
	. 000000	0	(		0	
	. 000000	0	(		0	
	. 000000	0	(		0	
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	. 000000	11, 821	(		0	
· · · · · · · · · · · · · · · · · · ·	. 000000	0	(	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						4
95.00   09500   AMBULANCE SERVICES 200.00   Total (lines 50 through 199)		3, 901, 426	4, 928	3 0		95.00

Health Financial Customs	COLUMBUS REGIO	NAL HOCDITAL		la li o	u of Form CMS-:	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 7:0	epared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)		Per Diem (col. 3 / col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)  Cost Center Description	4,401,777 754,704 0 0 0 0 501,048 0 100,815 0 5,758,344 Inpatient Program days	0	754, 70 501, 04 100, 81	3, 528 0 0 0 0 0 0 0 0 8 3, 584 0 0 5 2, 697 0 0	122. 54 213. 92 0. 00 0. 00 0. 00 0. 00 139. 80 0. 00 37. 38 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	884 179 0 0 0 0 62 0 262 0 1, 387	38, 292 0 0 0 0 8, 668 0 9, 794 0				30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	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	T					
50.00	05000 OPERATING ROOM	5, 165, 069					50.00
51.00	05100 RECOVERY ROOM	164, 259		•			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	225, 025				91, 445	52.00
53.00	05300 ANESTHESI OLOGY	12, 242		1		l .	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	473, 403					54.00
54. 01	05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C	604, 147					
54. 02	05404 ULTRA SOUND	119, 663					54. 02
54.03	05405 MAMMOGRAPHY	420, 158		1		_	54. 03
55.00	05500  RADI OLOGY-THERAPEUTI C	785, 164				1, 073	55.00
57.00	05700 CT SCAN	387, 195		1			57.00
58. 00	05800  MRI	572, 757					58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	830, 562		1			59.00
60.00	06000 LABORATORY	1, 025, 549				50, 836	
60. 01	06001 LABORATORY-PATHOLOGI CAL	123, 548	8, 953, 163			1, 717	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	37, 063	3, 680, 598	0. 01007	0 408, 893	4, 118	62.00
65.00	06500 RESPI RATORY THERAPY	496, 247	35, 337, 148	0. 01404	3, 281, 603	46, 084	65.00
66.00	06600 PHYSI CAL THERAPY	650, 865	21, 480, 128	0. 03030	1 290, 393	8, 799	66.00
67.00	06700 OCCUPATI ONAL THERAPY	227, 019	7, 786, 946	0. 02915	4 258, 589	7, 539	67.00
68.00	06800 SPEECH PATHOLOGY	99, 064	2, 699, 931	0. 03669	1 19, 804	727	68.00
69.00	06900 ELECTROCARDI OLOGY	320, 928	18, 857, 304	0. 01701	9 600, 187	10, 215	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	241, 050	10, 119, 555	0. 02382	57, 760	1, 376	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	327, 476	41, 375, 845	0. 00791	5 2, 617, 623	20, 718	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	306, 978	21, 451, 651	0. 01431	709, 415	10, 152	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 352, 863	124, 961, 004	0. 01082	6, 072, 879	65, 745	73.00
74.00	07400 RENAL DIALYSIS	24, 787	2, 917, 138	0.00849	7 455, 583	3, 871	74.00
76.00	03020 ACUPUNCTURE	0	0	0.00000	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	59, 540	2, 388, 798			0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS				•		
88.00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0	0	89. 00
90.00	09000 CLI NI C	359, 342	11, 603, 999	0. 03096	7 2, 015	62	90.00
90. 01	09001 DI ABETES CENTER	0	0	0.00000	0 0	0	90. 01
90.02	09002 NEUROPSYCH	7, 672	203, 089	0. 03777	7 1, 116	42	90. 02
90.03	09003 WOUND CENTER	205, 849	14, 249, 914	0. 01444	6 3, 627	52	90. 03
90.04	09004 HYPERBARI C OXYGEN THERAPY	112, 485	1, 247, 788	0. 09014	8 0	0	90. 04
90.05	09005 VI MCARE CLI NI C	143, 041	1, 820, 601	0. 07856	8 2, 077	163	90.05
90.06	09006 MEDICATION MGMT CLINIC	40, 941	857, 105			0	90.06
91.00	09100 EMERGENCY	1, 076, 625				44, 599	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	603, 009					92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95.00
200.00	1 1	17, 601, 585	866, 854, 835	;	36, 987, 797	687, 176	
			•	•		•	

Health Financial Systems	COLUMBUS REGION	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	PASS THROUGH COST	S Provider 0		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/30/2024 7:0	
		Ti ti	e XIX	Hospi tal	PPS	
Cost Contor Doscription	Murcina	Nurci pa	Allied Healt	h Allied Health	All Othor	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	BIS Provider C		From 01/01/2023 Fo 12/31/2023		epared: 12 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT 33. 00   03300   BURN INTENSIVE CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF	0 0 0 0 0 0	0 0 0 0		0 0 0 0 0 0 0	0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00
41. 00   04100   SUBPROVI DER -   RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	0 0			0 0 0 0	0 0 0	42. 00 43. 00
44.00   04400   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)	0	0		0		44. 00 200. 00
200.00   Total (lines 30 through 199)  Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,	Total Patient Days	5	Inpatient Program Days	200.00
	instructions)		/ 00	7.00	0.00	
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATI ENT ROUTINE SERVICE COST CENTERS	O O O O O O O O O O O O O O O O O O O	000000000000000000000000000000000000000	3, 52t ( ( ( 3, 58t 2, 69	3 0.00 0 0.00 0 0.00 0 0.00 0 0.00 4 0.00 7 0.00 7 0.00	884 179 0 0 0 0 0 62 0 262 0 1, 387	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00
	x col. 8)					
INPATIENT ROUTINE SERVICE COST CENTERS	9. 00					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY	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   O4400   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)	0 0					44. 00 200. 00

					5/30/2024 7:0	2 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	(	1	0	0	00.00
51.00   05100   RECOVERY ROOM	0	(		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	(	1	0	0	1
53. 00   05300   ANESTHESI OLOGY	0	(	)	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(	)	0	1, 048, 861	54.00
54. 01   05402   NUCLEAR MEDICINE-DIAGNOSTIC	0	(	1	0	0	
54. 02   05404   ULTRA SOUND	0	(	)	0	0	
54. 03   05405   MAMMOGRAPHY	0	(	)	0	0	
55. 00  05500  RADI OLOGY-THERAPEUTI C	0	(	1	0	0	55.00
57. 00  05700 CT SCAN	0	(	)	0	0	57.00
58. 00  05800 MRI	0	(	1	0	0	58. 00
59. 00  05900  CARDI AC CATHETERI ZATI ON	0	(	1	0	0	59.00
60. 00  06000  LABORATORY	0	(	)	0	0	60.00
60. 01  06001 LABORATORY-PATHOLOGICAL	0	(	)	0	0	60. 01
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	(	)	0	0	62.00
65. 00  06500 RESPIRATORY THERAPY	0	(	)	0	0	65.00
66. 00  06600 PHYSI CAL THERAPY	0	(	)	0	0	66.00
67. 00  06700 OCCUPATI ONAL THERAPY	0	(	1	0	0	67.00
68.00   06800   SPEECH PATHOLOGY	0	(	)	0	0	68.00
69. 00  06900  ELECTROCARDI OLOGY	0	(		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		0	0	72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	0	(		0	563, 206	73.00
74. 00   07400   RENAL DI ALYSI S	0	(		0	0	74.00
76. 00   03020   ACUPUNCTURE	0	(		0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0	(		0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	(		0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	(		0 0	0	78. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0		1	0		88. 00
89. 00  08900   FEDERALLY QUALI FI ED HEALTH CENTER	0	(	)	0	0	89. 00
90. 00  09000  CLI NI C	0	(	)	0	0	90.00
90. 01  09001  DI ABETES CENTER	0	(	)	0	0	90. 01
90. 02   09002   NEUROPSYCH	0	(	)	0	0	90. 02
90. 03   09003   WOUND CENTER	0	(	)	0	0	90. 03
90.04 09004 HYPERBARIC OXYGEN THERAPY	0	(	)	0	0	90. 04
90. 05   09005   VI MCARE CLI NI C	0	(	)	0	0	90. 05
90.06 09006 MEDICATION MGMT CLINIC	0	(	)	0	0	90.06
91. 00   09100   EMERGENCY	0	(		0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	(	)	0	1, 612, 067	200.00

12/31/2023

5/30/2024 7:02 am Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ Cost 4) col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 5.00 6.00 4. 00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 121, 389, 021 0.000000 50.00 05100 RECOVERY ROOM 0 0 51.00 9, 279, 014 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 5, 376, 000 0.000000 52.00 C 53.00 05300 ANESTHESI OLOGY 0 19, 687, 810 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000000000000 1,048,861 1,048,861 8, 333, 090 0.125867 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 15, 517, 169 0.000000 54.01 54.01 05404 ULTRA SOUND 0 10, 671, 777 0.000000 54.02 54 02 54.03 05405 MAMMOGRAPHY 0 0 7, 745, 205 0.000000 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 23, 866, 217 0.000000 55.00 57.00 05700 CT SCAN 0 0 54, 785, 467 0.000000 57.00 05800 MRI 0 15, 776, 974 58.00 C 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 39, 785, 128 0.000000 59.00 0 60.00 06000 LABORATORY 89, 287, 996 0.000000 60.00 06001 LABORATORY-PATHOLOGI CAL 0 8, 953, 163 60 01 0 000000 60 01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 680, 598 0.000000 62.00 06500 RESPIRATORY THERAPY 35, 337, 148 0.000000 65.00 65.00 21, 480, 128 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0 7, 786, 946 0 000000 67 00 Ω 67 00 0 68.00 06800 SPEECH PATHOLOGY C 2, 699, 931 0.000000 68.00 06900 ELECTROCARDI OLOGY 18, 857, 304 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 10, 119, 555 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 41, 375, 845 0.000000 71 00 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 21, 451, 651 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 124, 961, 004 0.004507 563, 206 563, 206 73.00 07400 RENAL DIALYSIS 2, 917, 138 74.00 C 0.000000 74.00 03020 ACUPUNCTURE 0 76.00 C 0.000000 76.00 0 76.97 07697 CARDIAC REHABILITATION 0 0 2, 388, 798 0.000000 76.97 77.00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00000000 0 0 0.000000 89.00 0 11, 603, 999 90.00 09000 CLI NI C 0 0.000000 90 00 90.01 09001 DI ABETES CENTER 0.000000 90.01 90 02 09002 NEUROPSYCH 0 0 203, 089 0.000000 90 02 09003 WOUND CENTER 14, 249, 914 0 90.03 0 0.000000 90.03 09004 HYPERBARIC OXYGEN THERAPY 0 90.04 Ω 1, 247, 788 0.000000 90.04 90.05 09005 VIMCARE CLINIC 0 1, 820, 601 0.000000 90.05 90.06 09006 MEDICATION MGMT CLINIC 0 0 857, 105 0.000000 90.06 09100 EMERGENCY 0 0 0.000000 91.00 C 94, 562, 452 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 18, 799, 810 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95.00

0

1, 612, 067

1, 612, 067

866, 854, 835

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	COLUMBUS REGIONAL	_ HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0112	Peri od: From 01/01/2023	Worksheet D Part IV Date/Time Prepared:

				10	J 12/31/2023	5/30/2024 7: 0	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
E E	ANCILLARY SERVICE COST CENTERS	,				T	
	05000 OPERATING ROOM	0. 000000	5, 226, 427	0	0	1	
	05100 RECOVERY ROOM	0. 000000	435, 077	0	0	1	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2, 184, 701	0	0		52. 00
	05300 ANESTHESI OLOGY	0. 000000	1, 072, 133		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 125867	213, 645		0	1	
	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	91, 597	0	0	0	54. 01
	05404 ULTRA SOUND	0. 000000	294, 933		0	1	54. 02
	05405 MAMMOGRAPHY	0. 000000	0	0	0		54.03
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	32, 627	0	0	0	55. 00
	05700 CT SCAN	0. 000000	1, 652, 926	0	0	1	57.00
	05800 MRI	0. 000000	226, 156	0	0	· -	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 308, 354	0	0	1	59. 00
60. 00	06000 LABORATORY	0. 000000	4, 425, 933	0	0	0	60.00
1	06001 LABORATORY-PATHOLOGI CAL	0. 000000	124, 412	0	0	0	60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	408, 893		0	0	62.00
1	06500 RESPI RATORY THERAPY	0. 000000	3, 281, 603	0	0	0	
1	06600 PHYSI CAL THERAPY	0. 000000	290, 393	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	258, 589	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	19, 804	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	600, 187	0	0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	57, 760	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 617, 623	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	709, 415	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 004507	6, 072, 879	27, 370	0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	455, 583	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0. 000000	0	0	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0. 000000	0	-	0	1	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
	09000 CLI NI C	0. 000000	2, 015	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	1, 116	0	0	0	90. 02
90. 03	09003 WOUND CENTER	0. 000000	3, 627	0	0	0	90. 03
90. 04	09004 HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	90. 04
90. 05	09005 VIMCARE CLINIC	0. 000000	2, 077	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	3, 917, 312	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						
4	09500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)		36, 987, 797	54, 261	0	0	200.00

 
 Heal th Financial
 Systems
 COLUMBUS
 REGIO

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE
 COST
 Provi der CCN: 15-0112

						5/30/2024 7:0	2 am
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Servi ces	
	oost center bescription	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From		Servi ces	Servi ces Not	(366 11131.)	
			Services (see				
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 328275	0	14, 452, 142	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 325500	0	1, 455, 177	o	0	51.00
52.00		0. 758034	1		ol	0	52.00
53. 00		0. 012329			o	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 650185	1		0	0	54.00
		1	1	.,, ===	0	-	
54. 01	05402 NUCLEAR MEDICINE-DIAGNOSTIC	0. 277225		1, 101,021	١	0	54. 01
54. 02	05404 ULTRA SOUND	0. 159800			0	0	54. 02
54. 03	05405 MAMMOGRAPHY	0. 290264	ł .		0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 197561	0	2, 466, 971	0	0	55.00
57.00	05700 CT SCAN	0. 062457	0	8, 880, 523	0	0	57.00
58.00	05800 MRI	0. 134316	0	1, 882, 183	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 158866	0		ol	0	59.00
60.00	06000 LABORATORY	0. 205040			0	0	60.00
60. 01	06001 LABORATORY-PATHOLOGI CAL	0. 272940	1		o	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 269221	0		-	0	62.00
						0	65.00
65.00	06500 RESPI RATORY THERAPY	0. 195583	1	.,,		-	
66. 00	06600 PHYSI CAL THERAPY	0. 421746	l .			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 406674				0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 524162				0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 158274	- 0	1, 540, 025	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 216751	0	2, 032, 582	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328841	0	2, 824, 358	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 597679	0	1, 301, 657	ol	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 335687			ol	0	73.00
74.00		0. 350635	<b>1</b>			0	74.00
76. 00	03020 ACUPUNCTURE	0. 000000			_	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 357051	0		-	0	76. 97
77.00			1				1
	I I	0. 000000	1			0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			1	· · · · · · · · · · · · · · · · · · ·		
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00							89. 00
90.00	09000 CLI NI C	0. 552534		1, 338, 724	0	0	90.00
90. 01	09001 DI ABETES CENTER	0. 000000	0	0	0	0	90. 01
90.02	09002 NEUROPSYCH	1. 037836	0	10, 788	0	0	90. 02
90. 03	09003 WOUND CENTER	0. 201286	0		ol	0	90. 03
90. 04	09004 HYPERBARIC OXYGEN THERAPY	0. 317908			0	0	90.04
90. 05	09005 VI MCARE CLI NI C	0. 828779	1	1	0	0	90.05
90.06	09006 MEDICATION MGMT CLINIC	0. 676378			o o	0	90.06
91. 00	09100 EMERGENCY	0. 208575	l t		o o	0	91.00
		1	1		-		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 518422	. 0	4, 825, 870	0	0	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0 5045::	-	0.005.555			05.00
95.00		0. 531741	1				95.00
200.00	,		0			0	200. 00
201.00				0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	114, 944, 408	0	0	202. 00

From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/30/2024 7:02 am Titl<u>e XIX</u> Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 744, 277 50.00 05100 RECOVERY ROOM 51.00 51.00 473,660 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 5, 693 52.00 53.00 05300 ANESTHESI OLOGY 29,004 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 917, 554 0 54.00 05402 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 406, 086 0 54.01 0 54.02 05404 ULTRA SOUND 299, 167 54.02 54.03 05405 MAMMOGRAPHY 209, 070 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 487, 377 55.00 05700 CT SCAN 0 57.00 554, 651 57.00 58. 00 | 05800 MRI 252, 807 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 295, 560 59.00 06000 LABORATORY 0 2.889.533 60 00 60 00 0 60.01 06001 LABORATORY-PATHOLOGI CAL 301, 490 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 76, 701 0 62.00 06500 RESPIRATORY THERAPY 287, 291 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 66.00 1, 127, 643 06700 OCCUPATIONAL THERAPY 67.00 260, 853 67.00 68.00 06800 SPEECH PATHOLOGY 425, 606 68.00 0 69.00 06900 ELECTROCARDI OLOGY 243, 746 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 440, 564 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 928, 765 71.00

7	6. 00	03020 ACUPUNCTURE	0	0	7	76.00
7	6. 97	07697 CARDIAC REHABILITATION	59, 423	0	7	76. 97
7	7.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	7	77.00
7	8. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	7'	78.00
		OUTPATIENT SERVICE COST CENTERS				
8	8. 00	08800 RURAL HEALTH CLINIC			8'	38. 00
8	9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89	39. 00
9	0. 00	09000 CLI NI C	739, 691	0	99	90.00
9	0. 01	09001 DI ABETES CENTER	0	0	99	90. 01
9	0. 02	09002 NEUROPSYCH	11, 196	0	91	90. 02
9	0. 03	09003 WOUND CENTER	297, 578	0	91	90.03
9	0. 04	09004 HYPERBARIC OXYGEN THERAPY	0	0	91	90.04
9		09005 VI MCARE CLI NI C	814, 657	0		90.05
9		09006 MEDICATION MGMT CLINIC	29, 792	0	91	90.06
9	1. 00	09100 EMERGENCY	4, 761, 195	0	9	91.00
9	2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 501, 837	0	9	92.00
		OTHER REIMBURSABLE COST CENTERS				
		09500 AMBULANCE SERVICES	1, 640, 595			95.00
	00. 00	1 1	31, 514, 654	0	l l	00.00
2	01. 00	1 1	0		20	01.00
		Only Charges				
2	02. 00	Net Charges (line 200 - line 201)	31, 514, 654	0	20	02.00

777, 973

4, 223, 619

72.00

73.00

74.00

72.00

07200 IMPL. DEV. CHARGED TO PATIENTS

73. 00 07300 DRUGS CHARGED TO PATIENTS

74.00 07400 RENAL DIALYSIS

Health Financial Systems	COLUMBUS REGIONAL	. HOSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0112	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Prep 5/30/2024 7:02	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room day	s and swing-bed day	s, excluding newborn)		35, 922	1.00
2.00 Inpatient days (including private room day	s, excluding swing-	bed and newborn days)		35, 922	2.00
					0 00

DART I - ALL PROVIDER COMPONENTS		Cost Center Description	113	
Impatriet navis (including private room days and swing-bed days, excluding newborn)   35,922   2.00   Inpatrient days (including private room days, excluding swing-bed and insevern days)   35,922   2.00   Inpatrient days (including private room days, excluding swing-bed and insevernation bed days). If you have only private room days.   35,922   2.00   3.0		DADT I ALL DROW DED COMPONENTS	1. 00	
Input ient days (Including private room days and seing-bed days, excluding needborn)   35,922   1,00				
Private room days (excluding swing-bed and observation bed days)   1. Fyou have only private room days   3.00	1.00		35, 922	1.00
do not complete this line.  4. 00 Senia private room days (excluding swing bed and observation bed days)  5. 00 Total swing-hed SRF type inpatient days (including private room days) after December 31 of the cost  7. 00 Total swing-hed SRF type inpatient days (including private room days) after December 31 of the cost  8. 00 Total swing-hed SRF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total swing-hed SRF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total swing-hed SRF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total inpatient days including private room days after December 31 of the cost  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-hed and newborn days) (see instructions)  10. 00 Swing-hed SRF type inpatient days applicable to title SVIII only (including private room days) after  11. 00 Swing-hed SRF type inpatient days applicable to title SVIII only (including private room days) after  12. 00 Swing-hed SRF type inpatient days applicable to title SVIII only (including private room days) after  13. 00 Swing-hed SRF type inpatient days applicable to title SVIII only (including private room days) after  14. 00 SWING-HEAD				
5.00   Semi-private room days (excluding swing-bed and observation bed days)   3.1,001   4.00	3. 00		01	3. 00
5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if real endar year, enter 0 on this line) 8.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if real endar year, enter 0 on this line) 9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if real endar year, enter 0 on this line) 10.00 Swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if called and year, enter 0 on this line) 11.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to this VIII only (including private room days) after December 31 of the cost reporting period (if called and year, enter 0 on this line) 12.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 13.00 Swing-bed SWF type swing-bed SMF services applicable to services through December 31 of the cost reporting period (including private room days) 14.00	4. 00	· ·	31.001	4.00
6.00 reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost properting period (if calendar year, enter 0 on this line) 8.01 reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Sing-bed NF type inpatient days applicable to it is exit in only including private room days) after 10.00 Sing-bed SNF type inpatient days applicable to the system of the cost reporting period (see instructions) 11.00 Sing-bed SNF type inpatient days applicable to it is exit in only (including private room days) after 11.00 Sing-bed SNF type inpatient days applicable to it is exit in only (including private room days) after 11.00 Sing-bed SNF type inpatient days applicable to it is exit in only (including private room days) 11.00 Sing-bed SNF type inpatient days applicable to it is exit in only (including private room days) 11.00 Sing-bed SNF type inpatient days applicable to it is exit in only (including private room days) 11.00 Sing-bed SNF type inpatient days applicable to it is exit on on this line) 11.00 Sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 Sing-bed SNF type inpatient days applicable to services after December 31 of the cost reporting period 11.00 Sing-bed SNF services applicable to services through December 31 of the cost reporting period 11.00 Sing-bed SNF services applicable to services after December 31 of the cost reporting period (line 12.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line				
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost 9. 00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 10. 00 Total swing-bed Mr (including private room days) after December 31 of the cost 10. 00 Swing-bed SMr type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 11. 00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 12. 00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 13. 00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 14. 00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) 15. 00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 16. 00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 17. 00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 18. 00 Swing-bed SWr type inpatient days applicable to XVIII only (including private room days) 18. 00 Swing-bed SWR type inpatient days applicable to XVIII only (including private room days) 18. 00 Swing-bed SWR type inpatient days applicable to XVIII only (including private room days) 18. 00 Swing-bed SWR type swing-bed SWR services applicable to services through December 31 of the cost 18. 00 Swing-bed Cost applicable to SWR services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SWR services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SWR services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SWR services				,
Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	6.00		0	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	7. 00		0	7. 00
reporting period (if calendar year, enter 0 on this line)  10, 283 9, 00 newborn days) (see instructions)  10, 00 Sin jo-ded SNI type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11, 00 Sin jo-ded SNI type inpatient days applicable to ititle XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  12, 00 Sain jo-ded SNI type inpatient days applicable to ititle XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  13, 00 Sain jo-ded SNI type inpatient days applicable to ititle XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions)  14, 00 Sain jo-ded SNI type inpatient days applicable to titles V or XIX and y (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14, 00 Medically increasary private room days applicable to the Program (excluding swing-bed days) of 15, 00 total nursery days (title V or XIX only)  15, 00 Total nursery days (title V or XIX only)  16, 00 Mursery days (title V or XIX only)  17, 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line days applicable to services after December 31 of the cost or poporting period (line days applicable to SNF type services after December 31 of the cost reporting period (line or poporting period (line days) or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or poporting period (line or po				
10.00   Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   0.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00	8. 00		0	8. 00
newborn days) (see instructions)  10.00 Single ded SNE type inpatient days applicable to Title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Single ded SNE type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Single ded SNE type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Single ded SNE type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Single ded SNE type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 SNE SNE SNE SNE SNE SNE SNE SNE SNE SNE	9. 00		10. 283	9. 00
through December 31 of the cost reporting period (see instructions)  11.00 Sung-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Imply bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Imply bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16.00 Imply bed NF type inpatient days applicable to the Program (excluding swing-bed days)  17.00 Imply bed NF type inpatient days applicable to the Program (excluding swing-bed days)  18.00 Imply bed NF type to XIX only (including private room days)  18.00 Imply bed NF type (including the NF type services applicable to services through December 31 of the cost of the cost of the NF type services applicable to services after December 31 of the cost of the Cost of the NF type services applicable to services after December 31 of the cost of the Cost of the NF type services applicable to services after December 31 of the cost of the Cost of the NF type services applicable to services after December 31 of the cost of the Cost of the NF type services applicable to services after December 31 of the cost of the Cost of the NF type services applicable to Services after December 31 of the cost of the Cost of the NF type services after December 31 of the cost reporting period (line of the NF type services applicable to Services after December 31 of the cost reporting period (line of the NF type services after December 31 of the cost reporting period (line of the NF type services after December 31 of the cost reporting period (line of the NF type services after December 31 of the cost reporting period (line of the NF type services after December 31		newborn days) (see instructions)		
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through December 31 of the cost reporting period 31.00 Many-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Total nursery days (title V or XIX only) 0 16.00 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 23.00 NG mig-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 23.00 NG mig-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 23.00 NG mig-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 3 X line 30) NG mig-bed cost (see instructions) 20.00 Total swing-bed cost (see instructions)	00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	١	
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SWING BED ADJUSTMENT   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost			_	
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18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period of Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period of 10.00 Total general inpatient routine service cost (see instructions) 71, 144, 976 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROMO INFERENTIA LADJUSTMENT 27.00 PRIVATE ROMO INFERENTIA LADJUSTMENT 27.00 PRIVATE ROMO INFERENTIA LADJUSTMENT 27.00 Swing-bed cost applicable to NF type service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 29.00 Private room charges (excluding swing-bed charges) 29.00 2	17. 00		0.00	17. 00
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 2 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service cost net of swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average per diem private room charge (line 29 ÷ line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  36.00 Average per diem private room charge differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23 00			33 00
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x line 20)  26.00 Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26.00  27. 11, 144, 976  27. 00  28. 00  28. 00  29. 00  28. 00  29. 00  29. 00  29. 00  29. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  31. 00  32. 00  32. 00  34. 00  35. 00  36. 00  37. 00 Forgram general inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  27. minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00	25 00	l '		25 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  71, 144, 976  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  9	25.00		·	25.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  29.00  20.00  20.00  20.00  30.00  0.00  32.00  0.00  32.00			-	
28. 00 29. 00 29. 00 Private room charges (excluding swing-bed charges) Semi-private room conduction (line 27 ÷ line 28) Semi-private room per diem charge (line 30 ÷ line 3) Semi-private room per diem charge (line 30 ÷ line 4) Semi-private room conduction (line 30 * line 30) Semi-private room conduction (line 30 * line 31) Semi-private room conduction (line 31 * line 32) Semi-private room conduction (line 32 * line 31) Semi-private room conduction (line 34 * line 31) Semi-private room conductio	27. 00		71, 144, 976	27. 00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71,144,976 and	28. 00		0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  0.00 32.00  31.00 000 32.00  32.00  34.00  35.00 Average per diem private room cost differential (line 7.000  36.00  37.00 20.00  37.00 20.00  38.00 39.00  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 40.00				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 36.00 0.0			0	30. 00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  37.00 35.00  71, 144, 976  71, 144, 976  71, 144, 976  72, 144, 976  73, 00  74, 144, 976  75, 144, 976  76, 144, 976  77, 144, 976  77, 144, 976  78, 100  79, 100  70, 200  70, 36, 893  70, 200  71, 144, 976  71, 144, 976  72, 144, 976  73, 00  74, 144, 976  75, 144, 976  76, 144, 976  77, 144,				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00  71,144,976  71,144,976  71,144,976  72,00				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 71, 144, 976 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 71, 144, 976 71,				
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 144, 976) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 980. 54 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 20, 365, 893 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  20,365,893 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,980.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  20,365,893 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		71,144,770	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 980.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1, 980.54 20, 365, 893 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY		
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  20, 365, 893   39.00   40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
		, , , , , , , , , , , , , , , , , , , ,		
			-	

	Financial Systems ATION OF INPATIENT OPERATING COST	COLUMBUS REGION	NAL HOSPITAL Provider C		In Lie Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1	
					o 12/31/2023	Date/Time Pre 5/30/2024 7:0	
				XVIII	Hospi tal	PPS	
	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)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	11, 491, 011 0	3, 528 0	·		2, 315, 791 0	1
45.00	BURN INTENSIVE CARE UNIT	o	0			0	45.00
	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 21, 259, 746	48. 00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ctions)	·	43, 941, 430	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts I and	1, 412, 176	50. 00
	111)		`	·			
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	1, 490, 980	51.00
52. 00	Total Program excludable cost (sum of lines					2, 903, 156	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	elated, non-ph	ysician anesth	etist, and	41, 038, 274	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges					0	54. 00 55. 00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (	line 56 minus	line 53)	0	57. 00 58. 00
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,		59.00
40.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m prior year	cost roport u	ndatad by the	0.00	60.00
60.00	market basket)	or time 55 fro	om prior year	cost report, u	puared by the	0.00	00.00
61.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operatin	g costs (line	0	61.00
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	rost renorting	neriod (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70.00 71.00
72.00	Program routine service cost (line 9 x line	71)		•			72. 00
73.00	Medically necessary private room cost applic		•	•			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II. column		74. 00 75. 00
	26, line 45)		·	•	·		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79.00
80. 00 81. 00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us line 79)		80. 00 81. 00
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81.00
83.00	Reasonable inpatient routine service costs (	see instruction	•				83.00
	Program inpatient ancillary services (see in		,,,,,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PAS		Jug.i 00)				
	Total observation bed days (see instructions	•	Line 2)			4, 921	
88.00	Adjusted general inpatient routine cost per	aiem (line 27 ÷	· iine 2)			1, 980. 54	88.00

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (	see instructions	)			9, 746, 237	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	H COST					
90.00 Capi tal -related cost	4, 401, 777	71, 144, 976	0. 06187	9, 746, 237	603, 009	90.00
91.00 Nursing Program cost	0	71, 144, 976	0. 00000	9, 746, 237	0	91.00
92.00 Allied health cost	0	71, 144, 976	0. 00000	9, 746, 237	0	92.00
93.00 All other Medical Education	0	71, 144, 976	0. 00000	9, 746, 237	o	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112		Worksheet D-1
	Component CCN: 15-T112	From 01/01/2023 To 12/31/2023	
	Title XVIII	Subprovi der -	PPS
		I RF	

			I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 584	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	3, 584 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	rvate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			3, 584	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Teporiting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)				7 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	a the Dreaman (evaluding	awing had and	1, 708	9. 00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	Swing-bed and	1, 708	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12 00	through December 31 of the cost reporting period	V anly (including privat	a maam daysa)	0	13. 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			U	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	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 t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		5, 975, 998	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a neriod (line A	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ (ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 975, 998	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had sh	argae)	0	28. 00
	Private room charges (excluding swing-bed charges)	d and observation bed cn	ai ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 975, 998	
	27 minus line 36) 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		T	1, 667. 41	38 00
39. 00	Program general inpatient routine service cost per drem (see	•		2, 847, 936	1
	Medically necessary private room cost applicable to the Progr	•		2,047,730	ı
	Total Program general inpatient routine service cost (line 39			2, 847, 936	41.00

COMPUTA	Financial Systems ATION OF INPATIENT OPERATING COST	COLUMBUS REGIO	Provider C	CN: 15-0112	Peri od:	wof Form CMS-2 Worksheet D-1	
			Component	Component CCN: 15-T112 From 01/01/20 To 12/31/20		23   23   Date/Time Prepar 5/30/2024 7:02 a	
			Title XVIII Subprovider		Subprovi der -		
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	dest danter bescription	Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
12.00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00 00 0	5. 00	42.0
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0				
	BURN INTENSIVE CARE UNIT	0	0	ı		-	
	SURGICAL INTENSIVE CARE UNIT	0	0				46.0
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.0
	·					1. 00	
18. 00 18. 01	Program inpatient ancillary service cost (Wk	st. D-3, col. :	3, line 200)	III lino 10	) column 1)	1, 350, 953 0	1
	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						49.0
Ì	PASS THROUGH COST ADJUSTMENTS						
0.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					238, 778	50.0
1. 00	00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II					92, 525	51.0
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)					331, 303	52.0
						3, 867, 586	
	medical education costs (line 49 minus line 52)						
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. (
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	] 3 , 3 ,					0.00	1
	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					Ö	
	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,					0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	m the cost rep	orting period	d ending 1996,	0.00	59.
0. 00						0.00	60.
1. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise					0	61. (
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.
3.00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	63.0
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See					0	64.
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions</pre>					0	66.
7. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period ((line 12 x line 19)					0	67.
8. 00	1'					0	68.
	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					0	69.
	Skilled nursing facility/other nursing facil				7)		70.
- 1	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /U ÷ IIne	۷)			71.
3. 00	Medically necessary private room cost applic	able to Program	•	,			73.
							74. 75.
	Per diem capital-related costs (line 75 ÷ li	,					76.
1							77.
							78. 79.
0. 00	Total Program routine service costs for comp	arison to the			nus line 79)		80.
1	Inpatient routine service cost per diem limi		1)				81.
1	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 83.
	Program inpatient ancillary services (see in		,				84.
35. 00	Utilization review - physician compensation	(see instruction	•				85.
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)				86. (
	Total observation bed days (see instructions					0	87.

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-T112	From 01/01/2023 To 12/31/2023		pared: 2 am
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	ee instructions	)			0	89. 00
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	501, 048	5, 975, 998	0. 08384	13 0	0	90.00
91.00 Nursing Program cost	O	5, 975, 998	0. 00000	00	0	91.00
92.00 Allied health cost	0	5, 975, 998	0. 00000	00	0	92.00
93.00 All other Medical Education	0	5, 975, 998		00	0	93.00
·		•	•	•		•

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od:	Worksheet D-1	
		From 01/01/2023 To 12/31/2023		
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room days	and swing-bed days, excluding newborn)		35, 922	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 35,				

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	35, 922	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	35, 922	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	31, 001	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
	reporting period	  -	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7 00
7. 00	reporting period	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	884	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	U <sub>1</sub>	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2, 697	
16. 00	Nursery days (title V or XIX only)	262	16.00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
17. 00	reporting period	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period	  -	
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	71, 144, 976	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	١	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
0, 00	x line 20)		
26. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 71, 144, 976	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	71, 144, 970	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	-7.00
	Semi-private room charges (excluding swing-bed charges)	0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)	0.000000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	1
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	71, 144, 976	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 980. 54	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 750, 797	•
40.00		1 750 707	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 750, 797	41.00

	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
.0.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ü	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2, 697	
16.00	Nursery days (title V or XIX only)	262	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
00.00	reporting period	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	71, 144, 976	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	71, 144, 970	1
22.00	15 x line 17)	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	In [1] and the cost approached to similarly services after becomes to the cost reporting period (The	O	20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	71, 144, 976	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
	Semi - pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)		33. 00 34. 00
	Average per diem private room coat differential (line 34 x line 31)		35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	_	
37.00	27 minus line 36)	71, 144, 970	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		İ
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 980. 54	38.00
	Program general inpatient routine service cost (line 9 x line 38)	1, 750, 797	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 750, 797	41.00
	· '		

COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0112	Period:	Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	5/30/2024 7: 0 PPS	2 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		I npati ent	I npati ent	Diem (col.	1	(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00 2, 872, 479	2. 00 2, 697	3. 00 1, 065. (	4. 00 262	5. 00 279, 046	42 00
	Intensive Care Type Inpatient Hospital Units	2,012,419	2, 077	1,005.1	00 202	279,040	42.00
	INTENSIVE CARE UNIT	11, 491, 011	3, 528	3, 257. (	09 179	583, 019	43.00
44. 00	CORONARY CARE UNIT	0	0	0. (	00	0	44.00
	BURN INTENSIVE CARE UNIT	0	0			0	
	SURGICAL INTENSIVE CARE UNIT	0	0	0. (	00 0	0	
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
						1. 00	
1	Program inpatient ancillary service cost (Wk					10, 622, 617	
	Program inpatient cellular therapy acquisition				), column 1)	0	
	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.0	))(see instru	ctions)		13, 235, 479	49.00
	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D. su	ım of Parts I and	156, 411	50.00
	III)					122,	
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	741, 437	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				897, 848	52.00
52.00	Total Program inpatient operating cost exclu-	,	elated, non-ph	vsician anest	hetist, and	12, 337, 631	
	medical education costs (line 49 minus line						- 3. 30
	TARGET AMOUNT AND LIMIT COMPUTATION						 
1	Program di scharges						54.00 55.00
	Target amount per discharge Permanent adjustment amount per discharge					l .	55.00
	Adjustment amount per discharge (contractor	use onlv)				l .	55.0
1	Target amount (line 54 x sum of lines 55, 55	J .	)			0	1
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57.00
1	Bonus payment (see instructions)	I			1 ! 4007	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	n the cost rep	orting period	ending 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year (	cost report,	updated by the	0.00	60.00
	market basket)						
61. 00	Continuous improvement bonus payment (if line					0	61.00
	55.01, or line 59, or line 60, enter the less $(53)$ are less than expected costs (lines $(54)$ x						
	enter zero. (see instructions)	,,	J		,,		
	Relief payment (see instructions)					l	62.00
	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportir	ng period (See	0	65.00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	65)(title XVI	II only). for	0	66.00
00.00	CAH, see instructions	55515 (11115	0. p. 40	00) (1. 1. 0 ///	,,,		00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 (	of the cost r	reporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after [	Occombor 21 of	the cost ror	porting ported	0	68.00
00.00	(line 13 x line 20)	e costs arter t	becember 31 or	the cost rep	of tring period	ľ	00.00
	Total title V or XIX swing-bed NF inpatient					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU				<u>'</u>		70.00
1	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•		•			70.00
	Program routine service cost (line 9 x line		THE 70 + TITLE	2)			72.00
	Medically necessary private room cost applications	*	n (line 14 x li	ine 35)			73.00
1	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from )	Worksheet B,	Part II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.0
	Inpatient routine service cost (line 74 minus						78.0
1	Aggregate charges to beneficiaries for excess				nuo line 70)		79.0
1	Total Program routine service costs for companient routine service cost per diem limi		JUST TIMITATIO	ii (iine /8 Mi	nus iinė 79)		80. 0 81. 0
1	Inpatient routine service cost limitation (		1)				82.0
1	Reasonable inpatient routine service costs (		* .				83. 0
84. 00	Program inpatient ancillary services (see in	structions)					84.0
	Utilization review - physician compensation						85.00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougn 85)				86.00
	Total observation bed days (see instructions					4, 921	87.0
	Adjusted general inpatient routine cost per					1, 980. 54	

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	ee instructions	)			9, 746, 237	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 401, 777	71, 144, 976	0. 06187	9, 746, 237	603, 009	90.00
91.00 Nursing Program cost	0	71, 144, 976	0. 00000	9, 746, 237	0	91.00
92.00 Allied health cost	0	71, 144, 976	0.00000	9, 746, 237	0	92.00
93.00 All other Medical Education	0	71, 144, 976	0. 00000	9, 746, 237	o	93.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0112	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T112		Date/Time Prepared: 5/30/2024 7:02 am
	Title XIX	Subprovi der -	
		IRF	

PART 1. ALL REPORTING CONTINUENTS  1.00    PART 1. ALL REPORTING CONTINUENTS   PART 1. ALL REPORTING C			IRF	-	
NeXT 1 = ALL PROVIDER COMPONENTS   NeXT 1 = ALL PROVIDER COMPONENTS   NeXT 1 = ALL PROVIDER COMPONENTS   NeXT 1 = ALL PROVIDER COMPONENTS   NeXT 1 = ALL PROVIDER COMPONENTS   Next 1 = ALL P		Cost Center Description		1.00	
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS		1.00	
Inpatient days (Including private room days, excluding swing-bed and newborn days)   3,584   2,00   3,00   Private room days (Sociuding swing-bed and observation bed days)   17 you have only private room days (Sociuding swing-bed and observation bed days)   17 you have only private room days   3,584   2,00   3,00   4,00   5   5   5   5   5   5   5   5   5					1
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) and private room days) after bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) becomber 31 of the cost reporting period (if calendary year, enter 0 on this line) becomber 31 of the cost reporting period (if calendary year, enter 0 on this line) after becomber 31 of the cost reporting period (if calendary year, enter 0 on this line) after becember 31 of the cost reporting period (if calendary year, enter 0 on this line) after becember 31 of the cost reporting period (if calendary year, enter 0 on this line) after becember 31 of the cost reporting period (if calendary year, enter 0 on this line) after becember 31 of the cost reporting period (illine 3 on after becember 31 of the cost reporting period (illine 3 on after becember 31 of the cost reporting period (illine 3 on after becember 31 of the cost reporting period (illine 4 on after because year year year year year year year yea					
do not complete this line.  4. 00 Sein-private room days (excluding swing-bed and observation bed days)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total sing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and new form days) (see instructions)  10. 00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12. 00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  14. 00 SNR December 31 of the cost reporting period (see instructions)  15. 00 SNR December 31 of the cost reporting period (see instructions)  16. 00 SNR December 31 of the cost reporting period (if calendar year, enter 0 on this line)  17. 00 SNR December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18. 00 SNR December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19. 00 Medicare rate for swing-bed SNR services applicable to services after December 31 of the cost reporting period (including period to the Program (excluding sxing-bed days)  19. 00 Medicare rate for swing-bed SNR services applicable to services after December 31 of the cost reporting period (line 0 x x line 18					
Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost reporting period reporting period days (including private room days) after December 31 of the cost reporting period	3.00		ys). If you have only private room of	uays, 0	3.00
reporting period (if callendar year, enter 0 on this line)  7.00	4.00	·	ed days)	3, 584	4.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11ne)	5. 00		om days) through December 31 of the	cost 0	5. 00
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7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days apticable to the Program (excluding swing-bed and reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and room days) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 7.00 Swing-bed SNF type inpatient days applicable to the Ital XVII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to the Ital XVII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XV or XV only (including private room days) 7.01 Swing-bed NF type inpatient days applicable to titles V or XV only (including private room days) 7.02 Swing-bed NF type inpatient days applicable to title X or XV only (including private room days) 7.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.05 Total nursery days (title V or XIX only) 7.06 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 7.00 Nursery days (title V or XIX only) 7.00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 7.00 Swing-bed Swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 7.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (including private room swing-bed NF services after December 31 of the cost reporting period (including private room swing-bed SNF services after December 31 of the cost reporting period (including swing-bed cost applicable to SNF	0.00		on days) after becember 31 of the co	0	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost period (if cal endar year, enter 0 on this line)	7.00		m days) through December 31 of the	cost 100	7. 00
reporting period (if calendar year, enter 0 on this line) 0.0 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period 12.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) after December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to the Program (excluding swing-bed days) after December 31 of the cost applicable to XIX only) after December 31 of the cost applicable to XIX only) after December 31 of the cost applicable to XIX only applicable to XIX only applicable to XIX only applicable to XIX only applicable to XIX only appear December 31 of the cost applicable to XIX only appear December 31 of the cost applicable to XIX only applicable to XIX only applicable to XIX only applicable to XIX only applicable to XIX only appear December 31 of the cost reporting period (line appeared December 31 of the cost reporting period (line appeared December 31 of the cost reporting period (line appeared December 31 of the cost reporting period (line appeared December 31 of the cost reporting period (line appeared December 31 of the cost reporting period (line appeared Dece	9 00		m days) after December 21 of the co	-+	9 00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and neabtorn days)   0   10.00	0.00		ill days) after beceiliber 31 of the co	51	0.00
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0   10.00	9. 00		o the Program (excluding swing-bed	and 62	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Medical I y necessary private room days applicable to the Program (excluding swing-bed days)  1.00 Nedical I y necessary private room days applicable to the Program (excluding swing-bed days)  1.00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost on 12.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services applicable to services after December 31 of the cost on 19.00 Nedical dar are for swing-bed NF services after December 31 of the cost reporting period (line 19.00 Nedical dar are for swing-bed NF services after December 31 of the cost reporting period (line 19.00 Nedical dar are for swing-bed to SNF type services after December 31 of the cost reporting period (line 19.00 Nedical dar are	10.00				10.00
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12.00   Swing-bed NF type Inpatient days applicable to titles \( \tilde{V} \) or XIX only \( \tilde{V} \) (Including private room days)   0   12.00	11.00			fter 0	11.00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)  20. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  21. 01 Total general inpatient routine service cost services after December 31 of the cost reporting period (line 6 x line 19)  22. 03 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  24. 00 Swing-bed cost applicable to NF type services after				_	
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   16.00   10.00   16.00	12. 00		X only (including private room days	)   0	12.00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   Motically necessary private room days applicable to the Program (excluding swing-bed days)   2,67   15,00   2,607   15,00   16,00	13. 00		X only (including private room days	)   0	13.00
15.00   Total nursery days (title V or XIX only)   2.697   15.00		after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line)		
16.00   Nursery days (title v or XIX only)   262   16.00			am (excluding swing-bed days)		
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period reporting period rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period period rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting r					
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 proporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 proporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Optivate room charges (excluding swing-bed charges)  20.00 Average perivate room per diem charge (line 29 + line 3)  30.00 Average perivate room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00					1 .0.00
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 0	17. 00		es through December 31 of the cost	0.00	17. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period period reporting structions reporting period reporting structions reporting period reporting structions reporting period reporting structions reporting period reporting re	18 00		es after December 31 of the cost	0.00	18 00
19.00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   2	10.00		es after becember 51 of the cost	0.00	10.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  20.00 Average private room per diem charge (line 27 + line 28)  20.00 Average per diem private room charge differential (line 27 + line 28)  20.00 Average per diem private room charge differential (line 30 + line 4)  20.00 Average per diem private room charge differential (line 30 + line 4)  20.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  20.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  20.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  20.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  20.00 Average per diem private room cost differential (line 32 minus line 33)  20.00 Seminus line 36)  20.00 Average per diem private room cost differential (line 32 minus line 33)  20.00 Average per diem private room cost differential (line 32 minus line 33)	19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cost	0.00	19. 00
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5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room charge differential (line 30 + line 31)  34.00 Average per diem private room charge differential (line 30 + line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of Swing-bed cost and private room cost differential (line 5, 975, 998)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					
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x line 20)  26. 00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  29. 00  Private room charges (excluding swing-bed and observation bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  31. 00  General inpatient routine service cost/charge ratio (line 27 ± line 28)  32. 00  Average private room per diem charge (line 29 ± line 3)  33. 00  Average semi-private room per diem charge (line 30 ± line 4)  34. 00  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost per diem (see instructions)  37. 00  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Average per diem private room cost differential (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	25 00	·	31 of the cost reporting period (li	ne 8	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Frivate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998)  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  0 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	20.00		or or the boot roper tring portion (in		20.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average pri vate room per diem charge (line 29 + line 3)  32. 00 Average semi-pri vate room per diem charge (line 30 + line 4)  32. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  103, 379 39. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, ,	(1)		
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average private room per diem charge (line 29 ± line 3)  33.00 Average semi-private room per diem charge (line 30 ± line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Algusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 30.00  20.00 30.00  20.00 30.00  30.00  31.00  32.00	27.00		(Tine 21 minus Tine 26)	5, 975, 998	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 31.00 0.00 32.00 32.00 34.00 35.00 0.00 35.00 0.00 36.00 37.00 0.00 0.00 0.00 0.00 0.00 0.00	28. 00		d and observation bed charges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)	<b>G</b> ,	•	29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 32.00			Line 20)		
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 33.00  37.00 35.00  37.00 35.00  37.00 36.00  37.00 36.00  37.00 36.00  37.00 37.00  38.00 36.00  39.00 Average per diem private room cost differential (line 5, 975, 998)  37.00 37.00  38.00 36.00  39.00 Average per diem private room cost differential (line 5, 975, 998)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  3		, , , , , , , , , , , , , , , , , , , ,	÷ 11ne 28)	l l	
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 975, 998 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 667. 41 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				l l	
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5,975,998 and 100 per line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.				l l	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 975, 998 27.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00			ne 31)	1	1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,667.41 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  103,379 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	and private room cost differential		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,667.41 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  103,379 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	200	27 minus line 36)		, , , , , , , , , , , , , , , , , , , ,	]
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,667.41 38.00  Program general inpatient routine service cost (line 9 x line 38)  103,379 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			UCTMENTS		1
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 103,379 39.00 40.00	38 00			1 667 41	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					1
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   103,379   41.00	40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)	0	40.00
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)	103, 379	41.00

	Financial Systems TION OF INPATIENT OPERATING COST	COLUMBUS REGION		CN: 15-0112	In Lie	u of Form CMS-: Worksheet D-1	
				CCN: 15-T112	From 01/01/2023 To 12/31/2023		
			· ·	e XIX	Subprovi der -	5/30/2024 7:0	
		T. 1.1			. I RF		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Pe Diem (col. ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
2. 00 N	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00 00 0	5.00	42.0
1	ntensive Care Type Inpatient Hospital Unit	S					
4	NTENSIVE CARE UNIT CORONARY CARE UNIT	0	(		00 0		
	BURN INTENSIVE CARE UNIT	0	C		00 0		
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.	00 0	0	46. 47.
. 00	Cost Center Description						47.
. 00 F	Program inpatient ancillary service cost (W	kst D_3 col 3	line 200)			1. 00 306, 650	48.
	Program inpatient cellular therapy acquisit			III, line 1	O, column 1)	0	
	Fotal Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instru	ctions)		410, 029	49.
	Pass through costs applicable to Program in	patient routine	servi ces (fro	m Wkst. D, s	um of Parts I and	8, 668	50.
1	II) Pass through costs applicable to Program in	nationt ancillar	v sorvicos (f	rom Wkst D	cum of Darte II	0	51.
a	and IV)		, JOI VI CES (I	I OIII WKST. D,	Sam Of Farts II		
	Fotal Program excludable cost (sum of lines Fotal Program inpatient operating cost excl		lated non ch	vsician anco	thetist and	8, 668 401, 361	
n	<u>nedical education costs (line 49 minus line</u>		ιατου, ποπ-μπ	ysiciali alles	metrot, and	401, 301	] 55.
	ARGET AMOUNT AND LIMIT COMPUTATION  Program discharges					Ι ο	]   54.
	Farget amount per discharge					0.00	
	Permanent adjustment amount per discharge	una anlu)				0.00	
	Adjustment amount per discharge (contractor Farget amount (line 54 x sum of lines 55, 5					0.00	1
00 [	Difference between adjusted inpatient opera		rget amount (	line 56 minu	s line 53)	0	
	Bonus payment (see instructions) Frended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	ortina perio	d endina 1996	0.00	
lι	updated and compounded by the market basket	)		<b>.</b>			
	Expected costs (lesser of line 53 ÷ line 54 market basket)	, or line 55 fro	m prior year	cost report,	updated by the	0.00	60.
5	Continuous improvement bonus payment (ifli 55.01, orline 59, orline 60, enter the le 53) are less than expected costs (lines 54	sser of 50% of t	he amount by	which operat	ing costs (line	0	61.
	enter zero. (see instructions) Relief payment (see instructions)					0	62.
	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63.
.00 1	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of th	e cost repor	ting period (See	0	64.
	nstructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reporti	ng period (See	0	65.
- 1	nstructions)(title XVIII only)	ino costo (lino	44 plug lipa	(E) (+: +1 o V)/	III only). for		
	Fotal Medicare swing-bed SNF inpatient rout CAH, see instructions	The Costs (Title	64 prus rine	05)(11116 XV	iii oniy); ioi	0	66.
	<pre>Fitle V or XIX swing-bed NF inpatient routi (line 12 x line 19)</pre>	ne costs through	December 31	of the cost	reporting period	0	67.
. 00   1	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost re	porting period	0	68.
. 00 🛮	(line 13 x line 20) Fotal title V or XIX swing-bed NF inpatient					0	69.
	<u>PART III – SKILLED NURSING FACILITY, OTHER</u> Skilled nursing facility/other nursing faci				7)		70.
00 A	Adjusted general inpatient routine service	cost per diem (I			,		71.
	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x l	ine 35)			72. 73.
00 1	Total Program general inpatient routine ser	vice costs (line	72 + line 73	)			74.
	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.
00 F	Per diem capital-related costs (line 75 ÷ l	,					76.
	Program capital-related costs (line 9 x lin npatient routine service cost (line 74 min	,					77. 78.
00	Aggregate charges to beneficiaries for exce	ss costs (from p					79.
- 1	Fotal Program routine service costs for com npatient routine service cost per diem lim	•	ost limitatio	n (line 78 m	nus line 79)		80.
	npatient routine service cost per drem rim		)				82.
	Reasonable inpatient routine service costs		s)				83.
	Program inpatient ancillary services (see i Jtilization review - physician compensation		ns)				84. 85.
. 00 🛮	Total Program inpatient operating costs (su	m of lines 83 th					86.
	'ART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					1

Health Financial Systems	COLUMBUS REGIO	NAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0112	Peri od:	Worksheet D-1	
		Component	CCN: 15-T112	From 01/01/2023 To 12/31/2023		pared: 2 am
		Ti tl	e XIX	Subprovi der -		
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	: line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		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	0	0	0. 00000	00	0	90.00
91.00 Nursing Program cost	0	0	0. 00000	00	0	91.00
92.00 Allied health cost	o	0	0. 00000	00	0	92.00
93.00 All other Medical Education	O	0	0. 00000		0	93.00
	1			1		

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Prep 5/30/2024 7:03	pared: 2 am
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	

		litle	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
			To Charges	Program	Program Costs	
			Ü	Charges	(col. 1 x	
				5	col . 2)	
			1.00	2. 00	3. 00	
	INDATIENT DOUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS		1	04 004 454		00 00
30. 00	03000 ADULTS & PEDI ATRI CS			24, 084, 151		30.00
31. 00	03100 I NTENSI VE CARE UNI T			4, 473, 599		31. 00
32.00	O3200 CORONARY CARE UNIT			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42. 00	1 1			0		42.00
	04200 SUBPROVI DER			U		
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000  OPERATI NG ROOM		0. 328764	8, 743, 943	2, 874, 694	50.00
51.00	05100 RECOVERY ROOM		0. 325500	714, 033	232, 418	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 758034	6, 338	4, 804	52.00
53.00	05300 ANESTHESI OLOGY		0. 012453	1, 859, 560	23, 157	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 650914	702, 554	457, 302	54.00
	1		1			
54. 01	05402  NUCLEAR   MEDI CI NE-DI AGNOSTI C		0. 277225	366, 002	101, 465	54. 01
54. 02	05404 ULTRA SOUND		0. 159800	609, 472	97, 394	54. 02
	05405 MAMMOGRAPHY		0. 290748	1, 036	301	54. 03
55. 00	05500  RADI OLOGY-THERAPEUTI C		0. 198158	235, 119	46, 591	55.00
57.00	05700 CT SCAN		0. 062457	5, 087, 412	317, 744	57.00
58.00	05800 MRI		0. 134316	879, 920	118, 187	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 159162	5, 961, 786	948, 890	59.00
60. 00	06000 LABORATORY		0. 205040		1, 752, 564	60.00
				8, 547, 426		
60. 01	06001 LABORATORY-PATHOLOGI CAL		0. 277104	244, 287	67, 693	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 269221	605, 198	162, 932	62.00
65. 00	06500 RESPI RATORY THERAPY		0. 196036	9, 290, 167	1, 821, 207	65.00
66.00	06600 PHYSI CAL THERAPY		0. 422867	1, 272, 409	538, 060	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 406674	893, 740	363, 461	67.00
68. 00	06800 SPEECH PATHOLOGY		0. 524162	110, 705	58, 027	68.00
	06900 ELECTROCARDI OLOGY		0. 158274	2, 412, 100	381, 773	69.00
			1			1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 216751	191, 263	41, 456	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 328841	6, 963, 668	2, 289, 940	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 597679	3, 832, 613	2, 290, 672	72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS		0. 335687	11, 384, 115	3, 821, 499	73.00
74.00	07400 RENAL DI ALYSI S		0. 350635	1, 113, 768	390, 526	74.00
76.00	03020 ACUPUNCTURE		0.000000	0	0	76.00
	07697 CARDI AC REHABI LI TATI ON		0. 357051	692	247	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0. 000000	0	0	77.00
78. 00	1		0.000000	0	0	78.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0.000000	0	U	78.00
	OUTPATIENT SERVICE COST CENTERS		T			
88. 00	08800 RURAL HEALTH CLINIC		0.000000		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		0	89. 00
90.00	09000  CLI NI C		0. 552534	27, 248	15, 055	90.00
90. 01	09001 DI ABETES CENTER		0.000000	0	0	90. 01
90. 02	09002 NEUROPSYCH		1. 037836	1, 860	1, 930	
	09003 WOUND CENTER		0. 202247	87, 017	17, 599	90.03
90. 04	09004 HYPERBARI C OXYGEN THERAPY		0. 318553	0	0	90.04
90. 05	09005 VI MCARE CLI NI C		0. 828779	679	563	
90.06	09006 MEDICATION MGMT CLINIC		0. 676378	1, 142	772	90. 06
91.00	09100 EMERGENCY		0. 215756	9, 366, 241	2, 020, 823	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 518422	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95 00	09500 AMBULANCE SERVICES					95. 00
200.00				81, 513, 513	21, 259, 746	
		(line (1)		01, 010, 010		
201.00		(TITIE 61)		01 510 510		201.00
202.00	Net charges (line 200 minus line 201)			81, 513, 513		202. 00

	ANCILLARY SERVICE COST APPORTIONMENT	Provi der 0	CCN: 15-0112 CCN: 15-T112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3  Date/Time Pre	3
					5/30/2024 7:0	22 am
		Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
LUDA	TUENT POUTLUE OFFICE COOK OF COOK		1.00	2. 00	3.00	
	TIENT ROUTINE SERVICE COST CENTERS O ADULTS & PEDIATRICS				I	30.00
	O I NTENSI VE CARE UNI T					31.00
	O CORONARY CARE UNIT					32.00
	IO BURN INTENSIVE CARE UNIT IO SURGICAL INTENSIVE CARE UNIT					33.00
	O SUBPROVI DER - I PF					40.00
	O SUBPROVI DER - I RF			3, 863, 291		41.00
	O SUBPROVI DER					42.00
	O NURSERY LLARY SERVICE COST CENTERS					43.00
	O OPERATING ROOM		0. 3287	64 54, 207	17, 821	50.00
51.00 0510	RECOVERY ROOM		0. 3255	00 8, 339	2, 714	51.00
	O DELIVERY ROOM & LABOR ROOM		0. 7580			•
	IO  ANESTHESI OLOGY IO  RADI OLOGY-DI AGNOSTI C		0. 0124 0. 6509			
	2 NUCLEAR MEDICINE-DIAGNOSTIC		0. 2772			
	4 ULTRA SOUND		0. 1598		2, 317	
1	MAMMOGRAPHY		0. 2907			
	IO RADI OLOGY-THERAPEUTI C IO CT SCAN		0. 1981 0. 0624		1	
	O MRI		0. 1343		•	
	O CARDI AC CATHETERI ZATI ON		0. 1591			
1	O LABORATORY		0. 2050			
	11 LABORATORY-PATHOLOGICAL 10 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2771 0. 2692			
1	O RESPIRATORY THERAPY		0. 1960		1	1
	O PHYSI CAL THERAPY		0. 4228	67 849, 742	359, 328	
	O OCCUPATIONAL THERAPY		0. 4066		1	•
	IO SPEECH PATHOLOGY IO ELECTROCARDI OLOGY		0. 5241 0. 1582		•	1
	O ELECTROENCEPHALOGRAPHY		0. 2167		1	1
1	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3288			1
	O IMPL. DEV. CHARGED TO PATIENTS		0. 5976		•	1
1	O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS		0. 3356 0. 3506			1
	O ACUPUNCTURE		0.0000		1	1
	7 CARDI AC REHABI LI TATI ON		0. 3570		1	
	O ALLOGENEIC HSCT ACQUISITION		0.0000		1	
	OCAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS		0.0000	00  0	η <u></u> υ	78.00
	RURAL HEALTH CLINIC		0.0000	00	0	88. 00
	O FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	•
	IO CLINIC  1 DIABETES CENTER		0. 5525 0. 0000			1
	12 NEUROPSYCH		1. 0378		1	1
90. 03 0900	WOUND CENTER		0. 2022	47 C	0	90.03
	HYPERBARIC OXYGEN THERAPY		0. 3185		0	
	15 VIMCARE CLINIC 16 MEDICATION MGMT CLINIC		0. 8287 0. 6763		_	
	O EMERGENCY		0. 0763		1	
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART		0. 5184		0	1
	R REIMBURSABLE COST CENTERS					05.00
95. 00   0950 200. 00	O AMBULANCE SERVICES Total (sum of lines 50 through 94 and 96 through 98)			3, 901, 426	1, 350, 953	95.00
200.00	Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		3, 701, 420	1, 350, 753	201.00
202.00	Net charges (line 200 minus line 201)	/	1	3, 901, 426	1	202.00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2023	Worksheet D-3
		To 12/31/2023	Date/Time Prepared: 5/30/2024 7:02 am

		From 01/01/2023 To 12/31/2023	Date/Time Pre	
	Title XIX	Hospi tal	5/30/2024 7: 0 PPS	2 am
Cost Center Description	Ratio of Cos To Charges		Inpatient Program Costs (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		17, 372, 584		30.00
31.00 03100 INTENSIVE CARE UNIT		2, 429, 848		31.00
32. 00   03200   CORONARY CARE UNIT		0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0		33.00
34. 00   03400  SURGI CAL I NTENSI VE CARE UNI T		0		34.00
40. 00   04000  SUBPROVI DER - I PF 41. 00   04100  SUBPROVI DER - I RF		118		40. 00 41. 00
42. 00   04200  SUBPROVI DER		0		42.00
43. 00   04300   NURSERY		1, 256, 467		43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 3287		1, 718, 261	50.00
51. 00   05100   RECOVERY ROOM	0. 3255		141, 618	1
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 7580		1, 656, 078	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 0124 0. 6509		13, 351 139, 065	53. 00 54. 00
54. 01   05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C	0. 0307		25, 393	1
54. 02   05404   ULTRA SOUND	0. 1598		47, 130	1
54. 03   05405   MAMMOGRAPHY	0. 2907		0	54. 03
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 1981	32, 627	6, 465	55.00
57. 00   05700   CT   SCAN	0. 0624		103, 237	57.00
58. 00   05800   MRI	0. 1343		30, 376	1
59. 00 O5900 CARDI AC CATHETERI ZATI ON	0. 1591		367, 402	59.00
60. 00  06000 LABORATORY 60. 01  06001 LABORATORY-PATHOLOGI CAL	0. 2050		907, 493	1
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0. 2771 0. 2692		34, 475 110, 083	60. 01 62. 00
65. 00   06500   RESPI RATORY THERAPY	0. 2072		643, 312	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 4228		122, 798	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 4066		105, 161	67.00
68. 00   06800   SPEECH PATHOLOGY	0. 5241	19, 804	10, 381	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 1582		94, 994	69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 2167		12, 520	70.00
71.00  07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00  07200 IMPL. DEV. CHARGED TO PATIENTS	0. 3288		860, 782	71.00
72.00  07200 IMPL. DEV. CHARGED TO PATIENTS 73.00  07300 DRUGS CHARGED TO PATIENTS	0. 5976 0. 3356		424, 002 2, 038, 587	72. 00 73. 00
74. 00   07400   RENAL DI ALYSI S	0. 3506		159, 743	74.00
76. 00   03020   ACUPUNCTURE	0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 3570	51 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.0000		0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0.0000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	0.0000	0	0	00 00
88. 00  08800 RURAL HEALTH CLINIC 89. 00  08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 0000 0. 0000		_	
90. 00   09000  CLINIC	0. 5525			
90. 01   09001 DI ABETES CENTER	0.0000			
90. 02   09002   NEUROPSYCH	1. 0378		1, 158	1
90. 03   09003   WOUND CENTER	0. 2022		734	•
90. 04   09004   HYPERBARI C OXYGEN THERAPY	0. 3185		0	90.04
90. 05   09005   VI MCARE CLI NI C	0. 8287		1, 721	1
90. 06  09006 MEDICATION MGMT CLINIC 91. 00  09100 EMERGENCY	0. 6763 0. 2157		0 845, 184	90. 06 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0. 2137		045, 164	1
OTHER REIMBURSABLE COST CENTERS		0	0	, ,2.00
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		36, 987, 797	10, 622, 617	1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)	1	36, 987, 797		202. 00

	REGIONAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0112 CCN: 15-T112	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre	
	'	e XIX	Subprovi der -	5/30/2024 7:0	
Cost Center Description		Ratio of Cos	IRF	I npati ent	
cost center bescription		To Charges	•	Program Costs (col. 1 x	
		1.00	2. 00	col. 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT					30.00
32.00 O3200 CORONARY CARE UNIT					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT					33.00
34. 00   03400  SURGI CAL INTENSI VE CARE UNIT 40. 00   04000  SUBPROVI DER - I PF					34. 00 40. 00
41. 00   04100   SUBPROVI DER - I RF			950, 095		41.00
42. 00   04200   SUBPROVI DER					42.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 3287		0	
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 3255 0. 7580		0	
53. 00   05300   ANESTHESI OLOGY		0.7380		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 6509		1, 879	
54. 01   05402   NUCLEAR   MEDI CI NE-DI AGNOSTI C 54. 02   05404   ULTRA   SOUND		0. 2772 0. 1598		0 221	54. 01 54. 02
54. 03 05405 MAMMOGRAPHY		0. 1378		0	1
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 1981		0	
57. 00   05700   CT   SCAN 58. 00   05800   MRI		0. 0624 0. 1343		105 0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1591		0	
60. 00   06000   LABORATORY		0. 2050		10, 965	1
60. 01   06001   LABORATORY-PATHOLOGI CAL 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2771 0. 2692		0	
65. 00   06500   RESPI RATORY THERAPY		0. 1960		30, 986	
66. 00   06600   PHYSI CAL THERAPY		0. 4228		87, 011	1
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY		0. 4066 0. 5241		83, 337 47, 877	1
69. 00 06900 ELECTROCARDI OLOGY		0. 1582		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2167		0	
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS		0. 3288 0. 5976		2, 894 0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3356		36, 841	
74. 00   07400   RENAL DI ALYSI S 76. 00   03020   ACUPUNCTURE		0. 3506		4, 534	1
76. 00   03020  ACUPUNCTURE 76. 97   07697  CARDI AC REHABI LI TATI ON		0. 0000 0. 3570		0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77. 00
78. 00 O780O CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00   09000   CLI NI C 90. 01   09001   DI ABETES CENTER		0. 5525 0. 0000		0	
90. 02   09002   NEUROPSYCH		1. 0378		0	1
90. 03		0. 2022		0	90.03
90. 04   09004   HYPERBARI C OXYGEN THERAPY 90. 05   09005   VI MCARE CLINI C		0. 3185 0. 8287		0	90.04
90.06 09006 MEDICATION MGMT CLINIC		0. 6763		0	90.06
91. 00 09100 EMERGENCY		0. 2157		0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0. 5184	22 0	0	92.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through			851, 000	306, 650	
201.00 Less PBP Clinic Laboratory Services-Program only	charges (Tine 61)	I	0		201. 00 202. 00

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lieu of	f Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	From 01/01/2023 Pa To 12/31/2023 Da	rksheet E rt A te/Time Prepared: 30/2024 7:02 am

Instructions)  1. DRG instructions products other than outilier payments for discharges occurring on or after October 1 (see 1.7.340, 772   1.02   1.03 DRG for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see Instructions) 1 (see Instructions) 2 (see Instructions) 2 (see Instructions) 3 (see Instructions) 2 (see Instructions) 3 (see Instructions) 4 (see Instructions) 4 (see Instructions) 4 (see Instructions) 4 (see Instructions) 4 (see Instructions) 4 (see Instructions) 5 (see Instructions) 5 (see Instructions) 5 (see Instructions) 5 (see Instructions) 6 (see Instructions) 6 (see Instructions) 6 (see Instructions) 7 (see Instructions) 7 (see Instructions) 7 (see Instructions) 7 (see Instructions) 8 (see Instructions) 8 (see Instructions) 8 (see Instructions) 8 (see Instructions) 8 (see Instructions) 8 (see Instructions) 9 (see		Title XVIII	Hospi tal	5/30/2024 7: 0 PPS	2 am
BART A. HARTIFM HOSPITAL STRUCTS. HORFE LIPPS.				1 00	
1.01   NOR anounts other than outlier payments for discharges occurring on or after October 1 (see   21,745,100   1.01				1. 00	
1.02   Dist anounts other than out   separents for discharges occurring on or after October   Geolege   1.380,772   1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	:	-	1. 00 1. 01
1 (see Instructions)   1.04   806 for federal specific operating payment for Wodel 4 BPCI for discharges occurring on or after   0   1.04   2.05	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (	see	7, 360, 772	1. 02
October 1 (see instructions)   2.00   Coultier payments for discharges, (see instructions)   2.00   Coultier payments for discharges, (see instructions)   3.01   600   3.01	1. 03	1 (see instructions)			1.03
2.01   Outsiles reconcilitation amount   0   2.02		October 1 (see instructions)	or after	0	1.04
2.03         Dutiliter payments for id scharges occurring prior to October 1 (see Instructions)         361,960         2.03           2.04         Date payments for id scharges occurring on or after October 1 (see Instructions)         114,960         2.04           3.00         Managed Care Simulated Payments         200,181         4.00           4.00         Bed days available divided by number of days in the cost reporting period (see Instructions)         200,181         4.00           5.00         File Count for all logatific and osteopathic programs for the most recent cost reporting period ending of the CAA 2021 (see Instructions)         5.00         6.00           6.00         File Cap adjustment for quali Fing hospitals under \$131 of the CAA 2021 (see Instructions)         0.00         6.00           6.00         File Cap adjustment for quali Fing hospitals under \$131 of the CAA 2021 (see Instructions)         0.00         6.00           6.00         File Cap adjustment for quali Fing hospitals under \$131 of the CAA 2021 (see Instructions)         0.00         6.06           6.00         File Cap adjustment for quali Fing hospitals under \$131 of the CAA 2021 (see Instructions)         0.00         6.06           7.00         All School (see Instructions)         1.00         0.00         6.06           8.01         File Cap adjustment for quali Fing hospitals that the cap as specified under \$2 CRR \$412.105(f)(f)(i)(i)(8)(2) if the cap as p	2. 01	Outlier reconciliation amount			2. 01
Managed Care is must aled Payments   22,207,947   3.00	2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		361, 969	2. 03
Indirect Medical Education Adjustment	3.00	Managed Care Simulated Payments	ons)	22, 207, 947	3.00
or before 12/3/17/96. (see Instructions) 0.00 5.01 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for 0.00 6.00 new programs in accordance with 42 CFR 43.79(e) 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0		Indirect Medical Education Adjustment			
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7.00 May Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1)  7.01 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the CAA 2011 (see instructions)  7.01 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the CAA 2011 (see instructions)  7.02 MAJ Section 427 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the CAA 2011 (see instructions)  8.03 MAJ Sustement (increase or decrease) to the FTE count for allopathic and osteopathic programs for artificiated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 3000 (August 11, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions)  8.03 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.04 IN Section of the CAA 2021 (see instructions)  8.05 IN Section of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.06 IN Section of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.07 IN Section of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.08 IN Section of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.09 IN Section of increase if the hospital program in the current year from your records  8.00 IN Section of increase if the hospital program in the current year from your records  8.01 IN S		or before 12/31/1996. (see instructions)			
the CAA 2021 (see Instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.01 ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 7.02 Adjustment (increase or decrease) to the hospital 's rural track programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affili aced programs in accordance with 42.6FR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2	6. 00		o the cap for	0.00	6. 00
7.01         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)(i)		the CAA 2021 (see instructions)			6. 26
Adjustment (increase or decrease) to the hospital's rural track programs FIE limitation(s) for rural track for Medicare (ME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(			7. 00 7. 01
Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s track programs with a rural track for Medicare GME affiliated programs in accordance wit	, I	0.00	7. 02
report straddles July 1, 2011, see instructions   0.00   8.02	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic program affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (		0. 00	8. 00
under \$ 5506 of ACA. (see instructions)		report straddles July 1, 2011, see instructions.			8. 01
Instructions   Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   9.00   10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   11.00   12.00   Current year all owable FTE (see instructions)   0.00   12.00   12.00   Current year all owable FTE count for the prior year.   0.00   13.00   13.00   Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997,   0.00   13.00   13.00   Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997,   0.00   14.00   15.00   15.00   16.		under § 5506 of ACA. (see instructions)			
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   FTE count for allopathic and osteopathic programs in the current year from your records   10.00   Total allowable FTE (see instructions)   0.00   11.00     12.00   Current year allowable FTE (see instructions)   0.00   12.00     13.00   Total allowable FTE count for the prior year.   0.00   12.00     14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or one of the wise enter zero.   0.00   14.00     15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00     16.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00     18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00     18.00   Adjustment rerised to bed ratio (line 18 divided by line 4).   0.000000     19.00   Current year resident to bed ratio (see instructions)   0.00   18.00     19.00   Outrent year resident to bed ratio (see instructions)   0.00   19.00     10.00   Prior year resident to bed ratio (see instructions)   0.00   19.00     10.00   Enter the lesser of lines 19 or 20 (see instructions)   0.22.00     10.01   IME payment adjustment (see instructions)   0.22.00     10.01   IME payment adjustment - Managed Care (see instructions)   0.22.01     10.01   IME payment adjustment - Managed Care (see instructions)   0.22.01     10.01   IME FTE Resident Count Over Cap (see instructions)   0.00000     10.00   0.00000   0.00000   0.000000   0.000000     10.00   0.000000   0.000000   0.0000000   0.00000000		instructions)			
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   10.00   12.00   10.00   10.00   12.00   10.00   1		minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	or, prus or		
13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00   15.00   16.00	11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
Otherwi se enter zero.   Otherwi se enter ze	13.00	Total allowable FTE count for the prior year.	her 30 1997	0. 00	13.00
16.00       Adj ustment for residents in initial years of the program (see instructions)       0.00       16.00         17.00       Adj ustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adj usted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adj ustment (see instructions)       0       22.00         1 IME payment adj ustment - Managed Care (see instructions)       0       22.01         1 IME payment adj ustment Andj ustment for the Add-on for § 422 of the MMA       22.01         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(C)       0.00       24.00       19.00       24.00       19.00       24.00       25.00       19.00       24.00       25.00       25.00       25.00       26.00       26.00       26.00       26.00       26.00       26.00       26.00       27.00       26.00       27.00       <		otherwise enter zero.	501 00, 1777,		
18. 00	16. 00	Adjustment for residents in initial years of the program (see instructions)		0. 00	16.00
20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   22.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   22.00   IME payment adjustment (see instructions)   0.22.00   IME payment adjustment - Managed Care (see instructions)   0.22.01   IME payment adjustment - Managed Care (see instructions)   0.22.01   IME payment adjustment for the Add-on for § 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(C).   (f)(1)(iv)(		Adjusted rolling average FTE count		0.00	18.00
22.00   IME payment adjustment (see instructions)   0   22.00   IME payment adjustment - Managed Care (see instructions)   0   22.01   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	20.00	Prior year resident to bed ratio (see instructions)		0. 000000	20.00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 (1) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 (1) Imes add-on to be ratio (divide line 25 by line 4) 0.000000 (1) Imes payments adjustment factor. (see instructions) 0.000000 (27.00) (1) Imes add-on adjustment amount (see instructions) 0.000000 (27.00) (1) Imes add-on adjustment amount - Managed Care (see instructions) 0.000000 (28.01) (1) Imes add-on adjustment amount - Managed Care (see instructions) 0.00000 (29.00) (1) Imes payment (sum of lines 22 and 28) 0.00 (1) Imes payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 (29.00)		·			22.00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	22. 01			0	22. 01
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  24.25 31.00  32.00 Sum of lines 30 and 31	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR	412. 105	0. 00	23. 00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0       28.01         29.01       Total IME payment (sum of lines 22 and 28)       0       29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0       29.01         Disproportionate Share Adjustment       9.00         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       4.09       30.00         31.00       Percentage of Medicaid patient days (see instructions)       24.25       31.00         32.00       Sum of lines 30 and 31       28.34       32.00		If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24	(see		1
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  28.34 32.00		Resident to bed ratio (divide line 25 by line 4)			
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.09 30.00  31.00 Percentage of Medicaid patient days (see instructions) 24.25 31.00  32.00 Sum of lines 30 and 31 28.34 32.00	28. 00	IME add-on adjustment amount (see instructions)		0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  29. 01  29. 01  4. 09  30. 00  24. 25  31. 00  28. 34  32. 00					•
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.09 30.00 31.00 Percentage of Medicaid patient days (see instructions) 24.25 31.00 32.00 Sum of lines 30 and 31 28.34 32.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		-	•
32.00 Sum of lines 30 and 31 28.34 32.00		Percentage of SSI recipient patient days to Medicare Part A patient days (see instruction	ns)		•
33.00   Allowable disproportionate share percentage (see instructions)   12.60   33.00					•
	33. 00	Allowable disproportionate share percentage (see instructions)		12. 60	33.00

<u>Heal</u> th	Financial Systems COLUMBUS REGION	NAL_HOSPITAL	In_Lie	u of Form CMS-2	<u>2552-1</u> 0
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 7:0	
		Title XVIII	Hospi tal	PPS	2 (111)
				1. 00	
34.00	Disproportionate share adjustment (see instructions)			916, 833	34.00
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35.00
35. 01	Factor 3 (see instructions)		0. 000450068	0.000415673	•
35. 02 35. 03	Hospital UCP, including supplemental UCP (see instructions) Pro rata share of the hospital UCP, including supplemental		3, 093, 946 2, 314, 101	2, 468, 272 620, 440	1
36. 00	1		2, 934, 541	020, 440	36.00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 thro			
40.00	Total Medicare discharges (see instructions)		0		40.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instru	ictions)	0		41. 00 41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ons)	0. 00		45.00
46.00	Total additional payment (line 45 times line 44 times line	•	0		46. 00
47.00	Subtotal (see instructions)		33, 434, 153		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
	only. (See That detrons)			Amount	
49. 00	Total payment for inpatient operating costs (see instruction	one)		1. 00 33, 434, 153	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		)	2, 375, 962	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	1
52.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions)		0	
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			128, 657 11, 175	1
54. 00	Islet isolation add-on payment			0	1
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55.00
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see in	•	through 2E)	0	56. 00 57. 00
58.00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt		tili ougii 35).	139, 736	1
59. 00	Total (sum of amounts on lines 49 through 58)	,		36, 089, 683	•
60.00	Primary payer payments			17, 169	•
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	nus line 60)		36, 072, 514 3, 283, 480	
63.00	Coinsurance billed to program beneficiaries			50, 800	1
	Allowable bad debts (see instructions)			239, 855	
	Adjusted reimbursable bad debts (see instructions)			155, 906	ł
66.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructi ons)		89, 968	•
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	or applicable to MS-DRGs (	see instructions)	32, 894, 140 0	67. 00 68. 00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96	• •		0	1
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		ŕ	0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demon		instructions)	0	70.50
70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestratio			0	70. 75 70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in	nstructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	•
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
70. 92 70. 93	,			9, 382	70. 92
	D. 93 HVBP payment adjustment amount (see instructions) D. 94 HRR adjustment amount (see instructions)			-32, 387	70. 94
70. 94	Thick day as the cit alloant (see This tractions)			02,007	, 0. , 1

ncar tri	Financial Systems COLUMBUS REGIONAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
			FF\	(yyyy)	Amount	
70.01				0	1. 00	70.01
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
70. 98	the corresponding federal year for the period ending on or af Low Volume Payment-3	ter 10/1)		0	0	70. 98
70. 96	HAC adjustment amount (see instructions)			U	0	1
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			32, 871, 135	
71. 00	Sequestration adjustment (see instructions)	07 & 70)			657, 423	1
71. 02	Demonstration payment adjustment amount after sequestration				0	1
71. 03	Seguestration adjustment-PARHM pass-throughs				_	71. 03
	Interim payments				31, 855, 565	1
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0   73)	2, 72, and			358, 147	74.00
74.01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			755, 856	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					]
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				_	
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
91. 00	plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	1
94. 00	The rate used to calculate the time value of money (see instructions)				0.00	
95.00	Time value of money for operating expenses (see instructions)	40110110)			0	1
	Time value of money for capital related expenses (see instruc	tions)			0	1
			1	Prior to 10/1	On/After 10/1	
				1.00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
404.00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	۵)		0. 0000000000	0. 0000000000	1
102.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	S)		0	U	102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0. 0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions	)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonst		ustment	<u> </u>	U	104.00
200.00	Is this the first year of the current 5-year demonstration pe					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					1
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
	Medicare discharges (see instructions)					202. 00
	Case-mix adjustment factor (see instructions)					203. 00
		first year	of the curr	ent 5-year demons	trati on	
	Computation of Demonstration Target Amount Limitation (N/A in	TTTSt year				
203.00	peri od)					
203.00	period) Medicare target amount					204.00
203. 00 204. 00 205. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					205. 00
203. 00 204. 00 205. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	Trist year				1
203. 00 204. 00 205. 00 206. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					205. 00

208.00

209.00

210.00

211. 00

212.00

213. 00 218. 00

210.00 Reserved for future use

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

Health Financial Systems	COLUMBUS REGIONAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 7:02 am

		Title XVIII	Hospi tal	5/30/2024 /: 0 PPS	z alli
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	`		30, 492	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	ons)		32, 920, 434 27, 980, 462	2. 00 3. 00
4. 00	Outlier payment (see instructions)			27, 960, 462	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	5. 00
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs including REH direct	graduate medical education	ation costs from		9. 00
	Wkst. D, Pt. IV, col. 13, line 200			_	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 30, 492	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			30, 472	11.00
	Reasonable charges				
12.00	Ancillary service charges	(0)		90, 848	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	÷ 69)		90, 848	13. 00 14. 00
14.00	Customary charges		l	70, 040	14.00
15. 00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for p	payment for services of	n a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			90, 848	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	ne 11) (see	60, 356	19. 00
20.00	instructions)	: £   : 11   :	10) (	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	II Tine II exceeds III	ne 18) (See	0	20.00
21. 00	Lesser of cost or charges (see instructions)			30, 492	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0 28, 537, 771	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			20, 337, 771	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 2			4, 979, 606	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pluinstructions)	is the sum of lines 22	and 23] (see	23, 588, 657	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)	,			28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			23, 588, 657 2, 638	
32. 00	Subtotal (line 30 minus line 31)			23, 586, 019	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 457, 207	33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			457, 287 297, 237	
36. 00	1 3	ctions)		288, 619	
37. 00	Subtotal (see instructions)			23, 883, 256	37.00
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R			-95	
39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	39. 98 39. 99
40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			23, 883, 351	40.00
40. 01	Sequestration adjustment (see instructions)			477, 667	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			22 457 774	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM			23, 457, 674	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-51, 990	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15.2	chanter 1	34, 672	43. 01 44. 00
74.00	§115. 2	, w. tii owo rub. 10-2, (	Shapter I,		74.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
	Time Value of Money (see instructions)				93.00
			<u>'</u>	<u>'</u>	

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0112	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023		pared:
				5/30/2024 7:0	12 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 7:02 am Provider CCN: 15-0112

				12, 01, 2020	5/30/2024 7: 02	2 am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		31, 855, 56		23, 457, 674	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				О	0	3.05
	Provider to Program		•	<u>'</u>		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				o	l ol	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		31, 855, 56	5	23, 457, 674	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			_		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		358, 14		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	51, 990	6. 02
7. 00	Total Medicare program liability (see instructions)		32, 213, 71		23, 405, 684	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.55			)	1.00	2. 00	
8. 00	Name of Contractor				1 1	8.00

Health Financial Systems	COLUMBUS REGIONAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provider CCN:		Peri od: From 01/01/2023	Worksheet E-1 Part I
		Component CCN	N: 15-T112		Date/Time Prepared: 5/30/2024 7:02 am
		Ti tla Y	\/I I I	Subprovi der -	DDC

		Title	e XVIII	Subprovi der -	5/30/2024 /: 0 PPS	<u> 2 am</u>
		I npati er	nt Part A		t B	
		(11)		(11)		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim nayments naid to provider	1.00	3, 356, 099		4.00	1.00
2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		3, 356, 099		0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					l
3. 01	ADJUSTMENTS TO PROVIDER				0	3.01
3. 02			C	)	0	
3.03			0	)	0	3.03
3.04			0		0	3.04
3. 05			0		0	3.05
	Provi der to Program	Ι	1			
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	3. 50 3. 51
3. 51					0	
3. 53					0	3.53
3. 54					Ö	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0	)	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 356, 099		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02 5. 03			0		0	5. 02 5. 03
5.03	Provider to Program			1	0	3.00
5. 50	TENTATI VE TO PROGRAM			1	0	5.50
5. 51					Ö	5. 51
5. 52			0	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		11, 814		0	6.0
6. 02	SETTLEMENT TO PROGRAM		0		Ō	
7. 00	Total Medicare program liability (see instructions)		3, 367, 913		0	7.00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8.00
8.00	Iname of Contractor	l			I	l 8

Health Financial Systems	COLUMBUS REGIONA	AL HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR	нгт	Provi der CCN: 15-0112	Peri od:	Worksheet E-1	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/30/2024 7:0	
		Title XVIII	Hospi tal	PPS	2 4111
				1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NON	STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA CO	LECTION AND CALCULATION	N			
1.00 Total hospital discharges as defined	in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00 Medicare days (see instructions)					2.00
3.00   Medicare HMO days from Wkst. S-3, Pt.					3.00
4.00 Total inpatient days (see instruction					4.00
5.00 Total hospital charges from Wkst C, I					5.00
6.00 Total hospital charity care charges					6.00
7.00 CAH only - The reasonable cost incur	ed for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
line 168					
8.00 Calculation of the HIT incentive payr					8. 00
9.00 Sequestration adjustment amount (see					9. 00
10.00 Calculation of the HIT incentive payr		(see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE					
30.00 Initial/interim HIT payment adjustment	t (see instructions)				30.00
31.00 Other Adjustment (specify)			,		31.00
32.00 Balance due provider (line 8 (or line	10) minus line 30 and	line 31) (see instructio	ns)		32.00

	Financial Systems COLUMBUS REGION ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0112	Peri od:	wof Form CMS-2 Worksheet E-3	
CALCUL	ATTON OF RETWIDORSEMENT SETTLEMENT		From 01/01/2023	Part III	
		Component CCN: 15-T112	To 12/31/2023	Date/Time Pre 5/30/2024 7:0	
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2, 878, 443	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0135	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			124, 637	3.00
4.00	Outlier Payments			447, 044	ı
5. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE co			0.00	5. 01
	program or hospital closure, that would not be counted with	out a temporary cap adjus	tment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	/ 00
6. 00 7. 00	New Teaching program adjustment. (see instructions)	n the new program growth	norted of a "now	0.00	6. 00 7. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	in the new program growth	perrou or a new	0. 00	7.00
8. 00	Current year's unweighted L&R FTE count for residents within	n the new program growth	neriod of a "new	0.00	8.00
0.00	teaching program" (see instructions)	in the new program growth	perrou or a new	0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adju	0.00	9.00		
10.00	0.00 Average Daily Census (see instructions)				10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0	12.00
	Total PPS Payment (see instructions)			3, 450, 124	
	Nursing and Allied Health Managed Care payments (see instru	cti on)		0	
	Organ acquisition (DO NOT USE THIS LINE)				15.00
	Cost of physicians' services in a teaching hospital (see in	structions)		0	
	Subtotal (see instructions)			3, 450, 124	1
18.00	Primary payer payments Subtotal (line 17 less line 18).			0 2 450 124	
	Deductibles			3, 450, 124 16, 000	•
	Subtotal (line 19 minus line 20)			3, 434, 124	•
	Coi nsurance			12, 800	
	Subtotal (line 21 minus line 22)			3, 421, 324	•
	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		15, 990	
	Adjusted reimbursable bad debts (see instructions)	555) (555 :51: 451: 51.5)		10, 394	
	Allowable bad debts for dual eligible beneficiaries (see in	structions)		14, 434	1
	Subtotal (sum of lines 23 and 25)	•		3, 431, 718	27. 00
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28. 00
	Other pass through costs (see instructions)			4, 928	
	Outlier payments reconciliation			0	
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	
31. 98	Recovery of accelerated depreciation.			0	0 , 0
31. 99	Demonstration payment adjustment amount before sequestration	n		0	
32.00	Total amount payable to the provider (see instructions)			3, 436, 646	ł
32. 01	Sequestration adjustment (see instructions)			68, 733	32. 01

3.00	Inpatient Rehabilitation LIP Payments (see instructions)	124, 637	3.00
4.00	Outlier Payments	447, 044	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
0.0.	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	0.0.
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
0.00	teaching program" (see instructions)	0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9. 819178	
11.00	Teaching Adjustment Factor (see instructions)	0.000000	
12. 00 13. 00	Teaching Adjustment (see instructions)	0 2 4EO 124	12. 00 13. 00
	Total PPS Payment (see instructions)	3, 450, 124	14.00
14. 00 15. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	15. 00
16. 00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
		-	
17. 00 18. 00	Subtotal (see instructions)	3, 450, 124	17. 00 18. 00
	Primary payer payments	0	
19.00	Subtotal (line 17 less line 18).	3, 450, 124	
20.00	Deductibles Subtate (Line 10 minus Line 20)	16, 000	
21. 00	Subtotal (line 19 minus line 20)	3, 434, 124	
22. 00	Coinsurance	12, 800	
23. 00	Subtotal (line 21 minus line 22)	3, 421, 324	
24. 00		15, 990	
25. 00	Adjusted reimbursable bad debts (see instructions)	10, 394	
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14, 434	
27. 00		3, 431, 718	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	4 020	
29. 00 30. 00	Other pass through costs (see instructions)	4, 928	29. 00 30. 00
	Outlier payments reconciliation	0	
31. 00 31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00 31. 50
	Prioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 98 31. 99	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)		
		3, 436, 646	
32. 01 32. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration	68, 733 0	32. 01 32. 02
33. 00	' ' '	3, 356, 099	
34. 00	Interim payments Tentative settlement (for contractor use only)	3, 350, 099	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-	35. 00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	11, 814 0	36.00
30.00		U	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	447, 044	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	
53. 00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (TH		
	COVI D-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99. 01
		'	-

Health Financial Systems	COLUMBUS REGIONAL HOSPI	TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-0112		Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 7:02 am
		Ti +Lo VIV	Hospi tal	DDC

		1	0 12/31/2023	Date/lime Pre 5/30/2024 7:0	
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	KVI OES TOK TITLES V OK XIT	COLITION		
1. 00	Inpatient hospital/SNF/NF services		O		1.00
2. 00	Medical and other services		ŏ	31, 514, 654	2.00
3. 00	Organ acquisition (certified transplant programs only)		0	31, 314, 034	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		0	31, 514, 654	4.00
5. 00	Inpatient primary payer payments		0	31, 314, 034	5.00
6. 00	Outpatient primary payer payments		o o	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	_	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>	31, 314, 034	7.00
	Reasonable Charges				
8. 00	Routine service charges		٥		8. 00
9. 00	Ancillary service charges		36, 987, 797	114, 944, 408	9. 00
10. 00	Organ acquisition charges, net of revenue		0	114, 744, 400	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		36, 987, 797	114, 944, 408	12.00
12.00	CUSTOMARY CHARGES		30, 701, 171	114, 744, 400	12.00
13. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
13.00	basis	i services on a enarge	ŏ	O	13.00
14.00	Amounts that would have been realized from patients liable fo	r navment for services on	0	0	14.00
00	a charge basis had such payment been made in accordance with		Š	, and the second	00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 01 10 (0)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		36, 987, 797	114, 944, 408	16, 00
17. 00	Excess of customary charges over reasonable cost (complete on	lv if line 16 exceeds	36, 987, 797	83, 429, 754	17. 00
	line 4) (see instructions)	,			
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	О	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		0	31, 514, 654	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	_	22. 00
23. 00	Outlier payments		0	0	23.00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		54, 261	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		54, 261	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		54, 261	31, 514, 654	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		_1	_	
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	)	54, 261	31, 514, 654	
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review	1.00	0	04 544 /54	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 minus sum of lines 32 minus sum of lines 32	a 33)	54, 261	31, 514, 654	36.00
37. 00	TO ZERO OUT MEDICALD		-54, 261	-31, 514, 654	
38. 00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40. 00 41. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00 41. 00
41.00	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	41.00
42.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Dub 15 2	0	0	42.00
43.00	chapter 1, §115.2	nee with ows rub 19-2,	١		45.00
	Jonaptor 1, 3110.2		ı		I

Health Financial Systems COLUMBUS REGIONAL HOSPITAL In Lieu					u of Form CMS-2	552-10
					Worksheet E-5	
				From 01/01/2023 To 12/31/2023		
					5/30/2024 7: 02	2 am
			Title XVIII		PPS	
	·					
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt.	A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment	amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment a	mount (see instruc	tions)		0	4.00
5.00	The rate used to calculate the time value o	of money (see instr	uctions)		0. 00	5.00
6.00	Time value of money for operating expenses	(see instructions)			0	6.00
7.00	Time value of money for capital related exp	enses (see instruc	tions)		0	7.00

Health Financial Systems

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

Provi der CCN: 15-0112

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 7:02 am

		Conoral Fund	Specific	Endoumon+	5/30/2024 7:0	2 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	11, 213, 245	1	0	0	1.00
2. 00	Temporary investments	205, 344	1	0	0	2.00
3.00	Notes recei vable	0 405 103	0	0	0	3.00
4. 00 5. 00	Accounts receivable Other receivable	80, 485, 182 543, 261	0	0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	1	0	0	0	6.00
7. 00	Inventory	6, 124, 994	Ö	Ö	0	7. 00
8.00	Prepai d expenses	13, 472, 281	0	О	0	8. 00
9. 00	Other current assets	19, 941, 848	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	96, 710, 514	0	0	0	11.00
12. 00	FIXED ASSETS Land	1, 740, 375	0	ol	0	12.00
13. 00	Land improvements	21, 008, 758		Ö	0	13.00
14. 00	Accumulated depreciation	-14, 375, 020	1	Ö	0	14.00
15.00	Bui I di ngs	212, 748, 318	0	O	0	15. 00
16. 00	Accumulated depreciation	-166, 496, 969	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0 570 11/	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	9, 573, 116 -8, 768, 616		0	0	19. 00 20. 00
21. 00	Automobiles and trucks	2, 418, 476		0	0	21.00
22. 00	Accumulated depreciation	-1, 665, 983		o	0	22.00
23. 00	Maj or movable equipment	169, 892, 313		O	0	23.00
24.00	Accumulated depreciation	-125, 130, 906	0	O	0	24.00
25. 00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0	0	ol Ol	0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	100, 943, 862		0	0	30.00
30.00	OTHER ASSETS	100, 743, 002	0	<u> </u>		30.00
31.00	Investments	159, 081, 445	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8, 482, 336	1	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	167, 563, 781 365, 218, 157	0	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	303, 210, 137	0	<u> </u>		30.00
37.00	Accounts payable	15, 594, 381	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	13, 657, 031	0	0	0	38. 00
39. 00	Payroll taxes payable	2, 842, 479	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	O	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	8, 596, 013	0	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	40, 689, 904		ō		45.00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	70, 501, 112	1	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	0	48.00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	70, 501, 112	0	0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	111, 191, 016		ol ol	0	51.00
31.00	CAPITAL ACCOUNTS	111, 171, 010	0	<u> </u>		31.00
52.00	General fund balance	254, 027, 141				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted	ļ		0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			O	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
50.00	replacement, and expansion				O	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	254, 027, 141	0	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	365, 218, 157	1	o	0	60.00
	[59]	l				

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0112

Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 7:02 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 3.00 4.00 2.00 1.00 Fund balances at beginning of period 288, 105, 611 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 29, 683, 975 2.00 2.00 317, 789, 586 3.00 Total (sum of line 1 and line 2) ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 317, 789, 586 0 11.00 11.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 12.00 63, 762, 445 0 12.00 13.00 0 0 13.00 14.00 0 0 0 14.00 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 63, 762, 445 18.00 0 Fund balance at end of period per balance 19.00 254, 027, 141 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 EQUITY TRANSFERS WHOLLY OWNED SUBS 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 C Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 Health Financial Systems CCC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0112

			То	12/31/2023	Date/Time Pre 5/30/2024 7:0	
	Cost Center Description	I npati en	-	Outpati ent	Total	2 (1111
	0031 001101 203011 pt 1 011	1, 00		2.00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	88, 697,	233		88, 697, 233	1.00
2. 00	SUBPROVIDER - I PF	,,	0		0	2.00
3. 00	SUBPROVI DER - I RF	8, 111,	562		8, 111, 562	3.00
4. 00	SUBPROVI DER	3,,	0		0, , 552	4.00
5. 00	Swing bed - SNF		0		0	5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		0		0	7. 00
8. 00	NURSI NG FACILITY		Ŭ		· ·	8.00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	96, 808,	795		96, 808, 795	10.00
	Intensive Care Type Inpatient Hospital Services	7575557			70,000,170	
11. 00	INTENSIVE CARE UNIT	16, 640,	313		16, 640, 313	11. 00
12. 00	CORONARY CARE UNIT	13,313,	0		0	12.00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT		0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)		Ŭ		· ·	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes 16, 640,	313		16, 640, 313	16. 00
	11-15)		0.0		10/010/010	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	113, 449,	108		113, 449, 108	17. 00
18. 00	Ancillary services	223, 014,		541, 918, 358	764, 932, 637	18.00
19. 00	Outpatient services	24, 875,		69, 916, 343	94, 792, 069	19. 00
20.00	RURAL HEALTH CLINIC	2.,070,	0	0,7,7,0,0,0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY		Ŭ	0	0	22. 00
23. 00	AMBULANCE SERVI CES	19,	512	14, 348, 470	14, 367, 982	23. 00
24. 00	CMHC	177	312	14, 540, 470	14, 307, 702	24. 00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		J		O	25. 00
26. 00	HOSPI CE					26. 00
27. 00	LEVEL 11 NURSERY	2, 079,	844	0	2, 079, 844	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t			626, 183, 171	989, 621, 640	28. 00
20.00	G-3, line 1)	0 WK31. 303, 430,	407	020, 103, 171	707, 021, 040	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			379, 699, 432		29. 00
30.00	PROVISION FOR BAD DEBT	9, 770,	562	0.,,0,,,102		30.00
31. 00		,,,,,,	0			31.00
32. 00			O			32.00
33. 00			0			33.00
34. 00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)		Ŭ	9, 770, 562		36.00
37. 00	DEDUCT (SPECIFY)		Ο	7, 7, 0, 002		37.00
38. 00	223001 (0.2011)		0			38.00
39. 00			0			39. 00
40. 00			0			40.00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		Ĭ	n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		389, 469, 994		43.00
. 3. 00	to Wkst. G-3, line 4)	`		, ,,,,,,		
		'		'	'	

	Financial Systems	COLUMBUS REGIONAL HOSPITAL		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0112	Peri od: From 01/01/2023	Worksheet G-3	5
			To 12/31/2023		
	T			1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Pa			989, 621, 640	
2.00	Less contractual allowances and discounts			595, 540, 699	
3.00	Net patient revenues (line 1 minus line 2)			394, 080, 941	
4.00	Less total operating expenses (from Wkst.			389, 469, 994	1
5. 00	Net income from service to patients (line	3 minus line 4)		4, 610, 947	5.00
	OTHER I NCOME			500.057	
6.00	Contributions, donations, bequests, etc			598, 057	
7.00	Income from investments			4, 694, 190	
8.00	Revenues from telephone and other miscella	ineous communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase discounts			62, 756	
11.00	Rebates and refunds of expenses			153, 058	
12. 00 13. 00	Parking lot receipts			0	
14. 00	Revenue from laundry and linen service	w.ooto		0 995, 229	
15. 00	Revenue from meals sold to employees and o	juests			1
16. 00	Revenue from rental of living quarters Revenue from sale of medical and surgical	cumpling to other than nationts		0	1
17. 00	Revenue from sale of drugs to other than p				17.00
18.00	Revenue from sale of medical records and a			2, 550	
19.00	Tuition (fees, sale of textbooks, uniforms			28, 190	
20.00	Revenue from gifts, flowers, coffee shops,			28, 190	1
21.00	Rental of vending machines	and Carreen		40	1
22. 00	Rental of hospital space			76, 908	1
23. 00	Governmental appropriations			-18, 880	
24. 00	UNREALIZED INVESTMENT INCOME			10, 321, 331	
24. 00	JV I NCOME			-2, 381, 833	
24. 02	WELLNESS REVENUE			170, 751	
24. 03	CRHP REVENUE			4, 211, 658	
24. 04	OTHER OPERATING INCOME			7, 565, 011	1
24. 50	COVI D-19 PHE Funding			7, 303, 011	
24. 51	FEMA GRANT FUNDING			717, 697	
25. 00	Total other income (sum of lines 6-24)			27, 233, 901	1
26. 00	Total (line 5 plus line 25)			31, 844, 848	
27. 00				195, 317	
	OTHER NON-OPERATING EXPENSES			1. 965. 556	

1, 965, 556 27. 01 2, 160, 873 28. 00 29, 683, 975 29. 00

27. 01 OTHER NON-OPERATING EXPENSES
28. 00 Total other expenses (sum of line 27 and subscripts)
29. 00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems COLUMBUS	REGI ONAL HOSPI TAL	Inlie	u of Form CMS-2	2552_10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0112	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III	pared:	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
4 00	CAPITAL FEDERAL AMOUNT			0.000.704	4 00	
1.00	Capital DRG other than outlier			2, 208, 784	•	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01 2. 00	
2. 00 2. 01	Capital DRG outlier payments  Model 4 BPCI Capital DRG outlier payments			36, 639 0		
3. 00	Total inpatient days divided by number of days in the	and reporting period (see in	otrustians)	95. 52		
4. 00	Number of interns & residents (see instructions)	cost reporting period (see in	istructions)	0.00		
5. 00	Indirect medical education percentage (see instruction	ne)		0.00		
6. 00	Indirect medical education percentage (see instruction line)		01 columns 1 and	0.00		
0.00	1.01) (see instructions)	by the sum of filles I and I.	OI, COI UIIIIIS I AIIU	0	0.00	
7. 00	Percentage of SSI recipient patient days to Medicare I 30) (see instructions)	Part A patient days (Worksheet	E, part A line	4. 09	7. 00	
8. 00	Percentage of Medicaid patient days to total days (see	a instructions)		24. 25	8.00	
9. 00	Sum of lines 7 and 8	e mstructions)		28. 34		
10.00	Allowable disproportionate share percentage (see insti	ructions)		5. 91		
11. 00	Disproportionate share adjustment (see instructions)	deti ons)		130, 539		
	Total prospective capital payments (see instructions)	2, 375, 962				
12.00	Total prospective capital payments (see mistractions)			2,373,702	12.00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST			11.00		
1.00	Program inpatient routine capital cost (see instruction	ons)		0	1.00	
2.00	Program inpatient ancillary capital cost (see instruc-			0	2.00	
3.00	Total inpatient program capital cost (line 1 plus line			0	3.00	
4.00	Capital cost payment factor (see instructions)			0	4.00	
5.00	Total inpatient program capital cost (line 3 x line 4)	)		0	5.00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00		
1. 00	Program inpatient capital costs (see instructions)			0	1.00	
2. 00	Program inpatient capital costs (see instructions)	cumetances (see instructions)		0		
3. 00	Net program inpatient capital costs (line 1 minus line			0		
4. 00	Applicable exception percentage (see instructions)	5 2)		0.00		
5. 00	Capital cost for comparison to payments (line 3 x line	2 4)		0.00		
6. 00	Percentage adjustment for extraordinary circumstances	,		0.00		
7. 00	Adjustment to capital minimum payment level for extraor	,	v line 6)	0.00		
8. 00	Capital minimum payment level (line 5 plus line 7)	or arriary or realistances (Trine 2	. x 11110 0)	ő		
9. 00	Current year capital payments (from Part I, line 12, a	as annlicable)		ő	ł	
10.00	Current year comparison of capital minimum payment lev		8 Less line 9)	ő	•	
11. 00	Carryover of accumulated capital minimum payment level			0		
	Worksheet L, Part III, line 14)		,			
12.00	Net comparison of capital minimum payment level to cap			0		
13.00	Current year exception payment (if line 12 is positive			-		
14. 00	Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line		e rorrowing period	0	14. 00	
15. 00	Current year allowable operating and capital payment			0	15. 00	
16.00		•				
17.00	00   Current year exception offset amount (see instructions)   0   17.0					