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: 14-0110 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/20/2024 3:40 pm] Manually prepared cost report use only Ilf 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
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

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

MISREPRESENTATION 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 OTTAWA REGIONAL HOSPITAL & HEALTHCAR (14-0110) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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 ADM	MI NI STRATOR CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1		2	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	54, 842	-52, 976	0	0	1. 00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2. 00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3. 00
5. 00 SWING BED - SNF	0	0	0		0	5. 00
6.00 SWING BED - NF	0				0	6. 00
10.00 RURAL HEALTH CLINIC (RHC) I	0		12, 066		0	10. 00
10.01 RURAL HEALTH CLINIC (RHC) II	0		251, 244		0	10. 01
10.02 RURAL HEALTH CLINIC (RHC) III	0		21, 129		0	10. 02
200. 00 TOTAL	0	54, 842	231, 463	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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0110 Peri od: Worksheet S-2 From 10/01/2022 To 09/30/2023 Part I Date/Time Prepared: 2/20/2024 3:40 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1100 EAST NORRIS DRIVE 1.00 PO Box: 1.00 State: IL County: LA SALLE 2.00 City: OTTAWA Zip Code: 61350 2.00 Payment System (P, Component Name CCN CBSA Provi der Date T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 OTTAWA REGIONAL 140110 99914 07/01/1966 N 0 3.00 HOSPITAL & HEALTHCAR Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 13.00 Separately Certified ASC Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC OTTAWA REGIONAL 99914 03/07/2023 0 15.00 148649 N 0 15.00 HOSP-MARSEILLES 15. 01 Hospital-Based Health Clinic - RHC OTTAWA REGIONAL 148655 99914 03/08/2023 0 N 15.01 HOSP-OTTAWA Hospital-Based Health Clinic - RHC OTTAWA REGIONAL 148652 99914 03/02/2023 Ν 15.02 Ν 0 15.02 HOSP-SOUTH 1111 Hospital -Based Health Clinic - FQHC 16.00 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 1 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22 01 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 22. 02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 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 Which method is used to determine Medicaid days on lines 24 and/or 25 3 N 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.

	Financial Systems OTTAWA REGION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	N: 14-0110		1/2022 0/2023	u of For Workshe Part I Date/Ti 2/20/20	eet S-2 me Pre 024 3:4	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther li cai d lays	
24. 00 I	If this provider is an IPPS hospital, enter the	1, 00	2. 00 978		4.00		401	51	24. 00
25. 00 I	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, but-of-state Medicaid paid days in column 3, but-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 column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, but-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.	0	0		0	3,	0	31	25. 00
					Urban/R		Date of	Geogr	
04 65 -		\			1. (00	2. (00	0/ 0=
27. 00 E r 35. 00 I	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	rural. age) status r"2" for r cation in	at the end ural. If ap column 2.	of the cos	it	2 2 0			26. 00 27. 00 35. 00
	<u> </u>				Begi nı	ni ng:	Endi	ng:	
24 00 5	Fatar and inchin basins and and an data of COU at	C		2/ 6	1. (00	2.0	00	27, 00
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 For numi	er				36. 00
	If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	ıs	0			37. 00
37. 01 I	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37. 01
38. 00 I	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
					Υ/		Υ/		
39. 00 D	Does this facility qualify for the inpatient hospital	navment a	diustment f	for Low volu	ıme Y		2. (Y		39. 00
h 1 a c	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage i)? Enter	(iii)? Ent requiremen in column 2	er in colum its in !"Y" for ye	nn es				
	Is this hospital subject to the HAC program reductior "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y	,			N		40. 00
						V	XVIII	XI X	
le le	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
	Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00 I	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1	•		,		N	N	N	46. 00
1	Pt. III.	2001 + 21 2 F	ator "V f:	. voc or "N"	for me	N		N.I	47. 00
	Is this a new hospital under 42 CFR §412.300(b) PPS o Is the facility electing full federal capital payment					N N	N N	N N	48.00
T	Teachi ng Hospi tal s								
p c t i a	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter "cost reporting periods beginning on or after December the instructions. For column 2, if the response to columous involved in training residents in approved GME programmad are you are impacted by CR 11642 (or applicable ("Y" for yes; otherwise, enter "N" for no in column 2.	YY for yes 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if orior year	no in colu FR 413.78(b this hospit or penultin	umn 1. For b)(2), see al was nate year,	N			56.00
57. 00 F i a	For cost reporting periods beginning prior to Decembers this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no incressidents start training in the first month of this complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i	in approved If column ing period? E-4. If co . For cost)(1)(iv) an f the respo	I GME progra 1 is "Y", o 2 Enter "Y" Dlumn 2 is " reporting p d (v), rega anse to line	ms trained lid for yes on N", periods ardless of e 56 is "Y"	N -			57. 00
f	for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb					N			58.00

61. 20	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 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 00	0. 00	61. 20
					1. 00	
	ACA Provisions Affecting the Health Resources and Ser					
62.00	Enter the number of FTE residents that your hospital		reporting peri	od for which	0.00	62. 00
	your hospital received HRSA PCRE funding (see instruc					
62. 01	Enter the number of FTE residents that rotated from a	Teaching Health Cent	er (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog	ram. (see instruction	ıs)			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se	ttings during this co	st reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	te lines 64 through 6	7. (see instru	ictions)		

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI	OTTAWA REGION LEX IDENTIFICATION DA		FAL & HEALTH Provider CC	CN: 14-0110	Peri od: From 10/01/2022 To 09/30/2023		pared:
					Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	C+:	- FTF D!-		- C-++!	1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J	uly 1, 2009 and befor	re June 30	0, 2010.	inis base yea	r is your cost i	eportring	
	64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0. 000000	64.00
		Program Name	3	ram Code	Unwei ghted FTEs Nonprovi der Si te	· ·	Ratio (col. 3/ (col. 3 + col. 4))	
4F 00	Entor in column 1 15 line (2)	1.00		2. 00	3. 00	4.00	5.00	45.00
	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				Unwei ghted	Unwei ghted	0.000000	
					FTĔs	FTEs in	(col. 1 + col.	
					Nonprovi der Si te	Hospi tal	2))	
					1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovi	der Setting	sEffective	for cost reporti	ng periods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider sery care re the rati	ettings. esident o of s)	0. (
		Program Name	Prog	ram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00	Enter to action 1 the grant	1. 00	:	2. 00	3. 00	4.00	5.00	17.00
	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)				0.0	0.00	0. 000000	, 67. 00

				2/20/20	124 3:4	0 pm	
				1. (00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August				-		
8. 00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permis MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 (August 10, 2022)?					68. 0	
			1.00	2. 00	3.00		
0. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF s	ubprovi der?	N			70. C	
1 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program i	n the most	N	N	0	 71. (
1.00	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. (see instructions) Inpatient Rehabilitation Facility PPS						
5. 00	D Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N						
6. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program i	n the most			0	76. C	
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordan CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instruction	ce with 42 Y,					
			-	1. (00		
	Long Term Care Hospital PPS			1. 0	,0		
0. 00 1. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporti "Y" for yes and "N" for no. TEFRA Providers	ng period?	Enter	N N		80. C	
6. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						
7. 00 ——	Is this hospital an extended neoplastic disease care hospital classified under section [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		1.6	N		87.	
		Approve Perma Adjust (Y/	nent ment N)	Numbe Appro Perma Adjust 2.0	oved nent ments		
3. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and li 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N		2. 0		88. (
	Wkst. A Li	ne Effectiv	e Date	Appro			
	No.			Perma Adjust Amount Disch	ment Per arge		
0. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0	. 00	00	3. 0		89.	
. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	. 33				07.	
	Column 3: Enter the amount of the approved permanent adjustment to the						
	TEFRA target amount per discharge.	V		ΧI	Y		
	TEFRA target amount per discharge.	V 1. (XI 2. 0			
00	TEFRA target amount per discharge. Title V and XIX Services	1. (00	2. 0	00	90 (
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	1. C	00	2. (Y	00		
. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	1. (00	2. 0	00	91.	
. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	1. C	00	2. (Y N	00	91. 92.	
. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	1. C	00	2. C Y N	00	91. 92. 93.	
2. 00 2. 00 3. 00 4. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	1. C	00	2. (Y N N	00	90. (91. (92. (93. (94. (95. (96. (

OTTAWA REGIONAL HOSPITAL & HEALTHCAR	In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	ovider CC		Peri od:	Worksheet S	5-2
				from 10/01/2022 o 09/30/2023	Part I Date/Time P 2/20/2024 3	
				V	XI X	7. 10 pin
0.00	Dece title V on VIV follow Medicana (title VVIII) for the interne	and real	donto noot	1. 00 N	2. 00 N	00
	Does title V or XIX follow Medicare (title XVIII) for the interns stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes column 1 for title V, and in column 2 for title XIX.	s or "N"	for no in	IN.	IN IN	98.
8. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, title XIX.			N	Y	98. (
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.		N	Y	98. (
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical a reimbursed 101% of inpatient services cost? Enter "Y" for yes or 'for title V, and in column 2 for title XIX.			N	N	98. (
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimboutpatient services cost? Enter "Y" for yes or "N" for no in columin column 2 for title XIX.			N	N	98.
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98.
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbu Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.			N	N	98.
05 00	Rural Providers Does this hospital qualify as a CAH?			N	I	105.
	If this facility qualifies as a CAH, has it elected the all-incluse for outpatient services? (see instructions)	sive meth	od of payment	1		106.
07. 00	Column 1: If line 105 is Y, is this facility eligible for cost reitraining programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you to approved medical education program in the CAH's excluded IPF and.	(see inst rain I&Rs	ructions) in an			107.
08. 00	Enter "Y" for yes or "N" for no in column 2. (see instructions) Is this a rural hospital qualifying for an exception to the CRNA 1 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee sched	lul e? See 42	N		108.
		/si cal	Occupati onal	Speech	Respi rator	У
09. 00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N N	2. 00 N	3. 00 N	4. 00 N	109.
	for yes or "N" for no for each therapy					
	for yes or "N" for no for each therapy.					
10.00		anctrati a	n project (\$4	104	1.00	110
10. 00	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Workshee applicable.	r yes or	"N" for no. I	f yes,	1.00 N	110.
	Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Workshee applicable.	r yes or t E-2, li	"N" for no. I nes 200 throu	f yes,		110.
	Did this hospital participate in the Rural Community Hospital Demo Demonstration)for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Workshee	r yes or t E-2, li ontier Co porting p 1 is Y, e ating in	"N" for no. I nes 200 throu	f yes, gh 215, as	N	110.
	Did this hospital participate in the Rural Community Hospital Dem Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost representation for the property of the FCHIP demoints and the property of the FCHIP demoints of the participate in the property of the FCHIP demoints of the participate in the property of the FCHIP demoints of the participate in the property of the FCHIP demoints of the participate in the property of the pro	r yes or t E-2, li ontier Co porting p 1 is Y, e ating in	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	
11. 00	Did this hospital participate in the Rural Community Hospital Demmonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the Frequency Health Integration Project (FCHIP) demonstration for this cost requivalent or yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is participate in the the provided in the participate in the Pennsylvania Rural Health Mospital that apply: "A" for Ambulance services; "B" for additional for the current cost reporting this hospital participate in the Pennsylvania Rural Health Mospital CHARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating	ontier Coporting plain yet at in a line with the coporting plain yet at ing in a line with the coporting in	"N" for no. I nes 200 throu	f yes, gh 215, as	N	111.
11. 00	Did this hospital participate in the Rural Community Hospital Dem Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the Free Health Integration Project (FCHIP) demonstration for this cost repertion of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition for tele-health services. Did this hospital participate in the Pennsylvania Rural Health Mod (PARHM) demonstration for any portion of the current cost reportion period? Enter "Y" for yes or "N" for no in column 1. If column 1.	ontier Coporting plain yet at in a line with the coporting plain yet at ing in a line with the coporting in	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	
11. 00	Did this hospital participate in the Rural Community Hospital Demmonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the Frequency Health Integration Project (FCHIP) demonstration for this cost requivalent to the proof of the FCHIP demonstration for this cost requivalent to the proof of the FCHIP demoniant that apply: "A" for Ambulance services; "B" for addition for tele-health services. Did this hospital participate in the Pennsylvania Rural Health Mod (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or leading to the current cost reporting in column 1. If column 1 is yes, enter the method used (A, B, or leading to the current cost reporting in column 1.	r yes or t E-2, li contier Co porting p 1 is Y, e ating in nal beds; del ng 1 is in the	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	111.
11. 00	Did this hospital participate in the Rural Community Hospital Demmonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost reperation prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition for tele-health services. Did this hospital participate in the Pennsylvania Rural Health Mode (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" per for short term hospital or "98" percent for long term care (inclus psychiatric, rehabilitation and long term hospitals providers) based.	ontier Coporting plis Y, eating in nal beds; del ng lis in the	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	111.
12. 00	Did this hospital participate in the Rural Community Hospital Demmonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Worksheet applicable. If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost reperiod in the property of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition for tele-health services. Did this hospital participate in the Pennsylvania Rural Health Mode (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or lin column 2. If column 2 is "E", enter in column 3 either "93" per for short term hospital or "98" percent for long term care (include psychiatric, rehabilitation and long term hospitals providers) base the definition in CMS Pub. 15-1, chapter 22, §2208. 1. Is this facility classified as a referral center? Enter "Y" for years.	ontier Coporting plais Y, earling in hall beds; deling lis in the for no E only) reent des sed on	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	111.
11. 000 12. 000 15. 000 16. 000 17. 000	Did this hospital participate in the Rural Community Hospital Dem Demonstration) for the current cost reporting period? Enter "Y" for complete Worksheet E, Part A, lines 200 through 218, and Workshee applicable. If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost reperiod with the properties of the FCHIP demonstration for this cost reperiod with the properties of the FCHIP demonstration for addition for tele-health services. Did this hospital participate in the Pennsylvania Rural Health Mode (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" perfor short term hospital or "98" percent for long term care (incluse psychiatric, rehabilitation and long term hospitals providers) best the definition in CMS Pub. 15-1, chapter 22, §2208.1.	ontier Coporting place in the conting properties of the conting properties of the conting properties of the conting properties of the continuous continuou	"N" for no. I nes 200 throu ommunity period? Enter the column 2. and/or "C"	f yes, gh 215, as	N 2.00	1112.

128.00 If this is a Medicare-certified liver transplant program, enter the certification date	1		1
			128. 00
in column 1 and termination date, if applicable, in column 2.			
129.00 f this is a Medicare-certified lung transplant program, enter the certification date			129. 00
in column 1 and termination date, if applicable, in column 2.			
130.00 f this is a Medicare-certified pancreas transplant program, enter the certification			130. 00
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			131. 00
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			132. 00
in column 1 and termination date, if applicable, in column 2.			
133.00 Removed and reserved			133. 00
134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number			134. 00
in column 1 and termination date, if applicable, in column 2.			
All Providers			
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,	Υ	HB1728	140. 00
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)			
1.00 2.00	3. 00		
If this facility is part of a chain organization, enter on lines 141 through 143 the n	ame and address	of the	
home office and enter the home office contractor name and contractor number.			
141.00 Name: OSF HEALTHCARE SYSTEM Contractor's Name: WPS Contractor	r's Number: 0013	1	141. 00
142.00 Street: 124 SW ADAMS PO Box:			142. 00
143.00 City: PEORIA State: IL Zip Code:	6160	2	143. 00
		1.00	
144.00 Are provider based physicians' costs included in Worksheet A?		Y	144. 00
144.00 Are provider based physicians' costs included in Worksheet A?			144. 00
144.00 Are provider based physicians' costs included in Worksheet A?	1, 00	Υ	144. 00
	1.00		
145.00 f costs for renal services are claimed on Wkst. A, line 74, are the costs for	1.00	Υ	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is	1.00	Υ	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting	1.00	Υ	144. 00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		Υ	145. 00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report?	1. 00 N	Υ	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		Υ	145. 00

Health Financial Systems	OTTAWA REGIONAL	_ HOSPIT	AL & HEALTHO	CAR		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CCN: 14-0110 Peri od: From 10/01/2022 To 09/30/2023			epared:		
							1.00	\dashv
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	or "N" for	no.			N N	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y	" for ye	es or "N" fo	r no.			N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	d? Ente					N	149. 00
			Part A	Part		Title V	Title XIX	
Does this facility contain a provi	dor that qualifies fo	or an ov	1.00	2. 00		3.00	4.00	
or charges? Enter "Y" for yes or "								
155. 00 Hospi tal	10 10 10 6001 60	Jiliporterre	N	N	В. (3	N N	N N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157.00 Subprovider - IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
160. 00 HOME HEALTH AGENCY			N	N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1. 00	_
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	s one o	r more campu	ses in di	ffere	nt CBSAs?	N	165. 00
	Name	(County	State	Zip (FTE/Campus	
1// 2015 11 1/5 1	0		1. 00	2. 00	3.0	00 4.00	5. 00	20111
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. 0	00 166. 00
							1.00	-
Health Information Technology (HIT) incentive in the Am	neri can	Recovery and	Reinvest	tment	Act		
167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10	5 is "Y") and is a me	eani ngful				enter the	Y	167. 00 168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is n	ot a meaningful user,	does tl				hardshi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful utransition factor. (see instruction	ser (line 167 is "Y")					"), enter the	9. 9	99169. 00
transition ractor. (see matractic	113)					Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR because period respectively (mm/dd/yyyy)	eginning date and end	ding date	e for the re	porting				170. 00
					-	1. 00	2.00	+
171.00 If line 167 is "Y", does this province section 1876 Medicare cost plans refer to yes and "N" for no in column 1876 Medicare days in column 2. (s	eported on Wkst. S-3, mn 1. If column 1 is	Pt. I,	line 2, col	. 6? Ente		N		0 171. 00

Heal th	Financial Systems OTTAWA REGIONAL HOS	SPITAL & HFALTH	ICAR	In lie	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-0110 F	Peri od:	Worksheet S-2	
				From 10/01/2022 To 09/30/2023	Date/Time Pre	
				Y/N	2/20/2024 3: 4 Date	10 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N			all dates in	the	+
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions) Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2. 00
	voluntary or "I" for involuntary.	III 3, V 101				
3. 00	Is the provider involved in business transactions, including		Υ			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of	of the board				
	of directors through ownership, control, or family and other lationships? (see instructions)	er similar				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert		Y	A		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date avaculumn 3. (see instructions) If no, see instructions.	arrabre in				
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
4 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If you is	the provider	N		6. 00
6. 00	the legal operator of the program?	2: IT yes, Is	s the provider	IN		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7. 00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renew	ved during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.			14		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
	Teaching Program on worksheet A? IT yes, see Instructions.				Y/N	
	T				1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	tions		Υ	12. 00
13. 00				st reporting	Y	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	anco amounte wa	aivod2 lf vos	500	N	14. 00
14.00	instructions.	ance amounts wa	arveu: 11 yes,	366	14] 14.00
15 00	Bed Complement	na noniod2 lf	voo ooo imotr	uati ana	T N	15 00
15.00	Did total beds available change from the prior cost reporti		<u>yes, see mstr</u> ^t A		│ N rt B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
16. 00		N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Y	12/13/2023	Υ	12/13/2023	17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)				1	
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		Υ		18. 00
	but are not included on the PS&R Report used to file this					
10.00	cost report? If yes, see instructions.	N.		NI		10.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00
	information? If yes, see instructions.				I	

If yes, see instructions 25.00 Have changes or new agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Bid the provider have a funded depreciation account? If yes, see instructions or less existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 29.01 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 29.02 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 29.01 Hine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 29.02 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 29.03 If I ine 34 is yes, were the requirements or amended existing agreements with the provider-based physicians? If yes, see instructions. 29.00 Were home office costs 29.00 Were home office costs claimed on the cost report? 29.00 Were home office costs claimed on the cost report? 29.00 If I ine 36 is yes, was a home office cost statement been prepared by the home office? 29.00 If yes, see instructions. 29.01 I ine 36 is yes, was the fiscal year end of the home office? If yes, see instructions. 29.02 I instructions. 29.03 I instructions. 29.04 I instructions. 29.05 I instructions. 29.06 I instructions. 29.07 I ins 36 is yes, was the fiscal year end of the home office? If yes, see instructions. 29.01 I in a see in yes, was the fiscal year end of the	Heal th	Financial Systems OTTAWA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-	2552-10	
Description Y/N Y/N	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	From		From 10/01/2022	Part II Date/Time Pre	epared:	
Provided Section 17 Its year, were adjustments ander to PSAM Report data for Other? Describe the other adjustments: Y/N Date			Descri	Description		Y/N	, , , , , , , , , , , , , , , , , , ,	
Report data for Other? Describe the other adjustments: Y/N Date	00.00	16.11 47 47 1	()			00.00	
21.00 Was the cost report prepared only using the provider's 1.00 2.00 3.00 4.00 21.00 records? If yes, see instructions. 1.00 2.00 3.00 4.00 21.00	20.00				N	N	20.00	
21.00 Was the cost report prepared only using the provider's N N 21.00 records? If yes, see instructions. 22.00 Completes by Cost relibbuses DAND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 23.00 Have changes occurred in the Medicare purposes? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Have there been new capital ized leases entered into during the cost reporting period? If yes, see instructions. 26.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 26.00 Were new leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capital ized leases entered into during the cost reporting period? If yes, see instructions. 28.00 Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 Were new leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions are seen and yet of the period of the provider have a funded depreciation account? If yes, see instructions. 28.00 Has desired and yet of the period of the peri		Those Cade To Central Book Book Book To Central Cad as timento.	Y/N	Date	Y/N	Date		
records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Have changes occurred in the ledicare purposes? If yes, see instructions 23.00 Have changes occurred in the ledicare purposes? If yes, see instructions 23.00 Have changes occurred in the ledicare depreciation expense due to appraisals made during the cost 23.00 Have changes occurred in the ledicare depreciation expense due to appraisals made during the cost 24.00 Were new I cases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 25.00 Have there been new capitalization explains in a during the cost reporting period? If yes, see 25.01 Have there been new capitalization policy changed during the cost reporting period? If yes, see 26.00 Were new I cause, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit 27.01 Has the provider are included depreciation account and/or bond funds (Debt Service Reserve Fund) 28.00 Were new I cause, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 bid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.01 Has existing debt been replaced prior to Its Scheduled maturity with new debt? If yes, see 31.01 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.01 Fine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00 If fine 32 is yes, were the requirements or amended existing agreements with the provider-based physicians? 34.00 If yes, see instructions. 35.00 If fine 36 is yes, has a home office cost statement been prepared by the home office? 36.00 If it in a 36				2. 00		4. 00		
Complete Related Cost Capital	21. 00		N		N		21.00	
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Heal th	Financial Systems	OTTAWA REGIONAL	H0SPI	TAL & HEALTHCAI	₹		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE		Provi der CCN:	14-0110	Peri		Worksheet S-	2
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| Peri od: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 OTTAWA
 REGION

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 14-0110

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						I/P Days / 0/P) piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.		Avai I abl e			
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	PART I - STATISTICAL DATA						
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	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3. 00	HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					o	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		84	30, 660	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	5	1, 825	0.00	0	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	43. 00	00	22 405	0.00	0	13.00
14. 00 15. 00	Total (see instructions) CAH visits		89	32, 485	0.00	0	14. 00 15. 00
15. 00	REH hours and visits					١	15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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
26. 00	RURAL HEALTH CLINIC (RHC)	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC (RHC)	88. 01				0	26. 01
26. 02 26. 25	RURAL HEALTH CLINIC (RHC) FEDERALLY QUALIFIED HEALTH CENTER	88. 02 89. 00				0	26. 02 26. 25
27. 00	Total (sum of lines 14-26)	07.00	89				27. 00
28. 00	Observation Bed Days		07			0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		0	C			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	C)	0	34. 00

 Heal th Financial
 Systems
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 REGIONAL HOSPITAL
 & HEALTHCAR

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 1

Provider CCN: 14-0110

		. 100	(0 (5) (1)	, , , ,		2/20/2024 3: 4) pm
		I/P Days	/ O/P Visits	/ Irips	Full lime I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On	
		6. 00	7. 00	8.00	9. 00	Payrol I 10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 081	929	13, 631			1. 00
1.00	8 exclude Swing Bed, Observation Bed and	1, 001	,2,	10,001			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 674	4, 379				2. 00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	C)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C)		6. 00
7.00	Total Adults and Peds. (exclude observation	4, 081	929	13, 631			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	553	83	1, 205			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		59				13. 00
14.00	Total (see instructions)	4, 634	1, 071	15, 696	0.00	561. 08	14.00
15. 00	CAH visits	O	O				15. 00
15. 10	REH hours and visits						15. 10
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF						16. 00 17. 00
18. 00	SUBPROVI DER - TRF						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			l)		24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC (RHC)	600	354	2, 373	0.00	3. 51	26. 00
26. 01	RURAL HEALTH CLINIC (RHC)	3, 914	3, 881	17, 986	0.00	29. 88	26. 01
26. 02	RURAL HEALTH CLINIC (RHC)	1, 904	2, 888	13, 983	0.00	15. 13	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	609. 60	27. 00
28. 00	Observation Bed Days		726	3, 028	1		28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31. 00	Employee discount days - IRF			C			31. 00
32. 00	Labor & delivery days (see instructions)	0	51	104			32. 00
32. 01	Total ancillary labor & delivery room			l c	1		32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0 0					33. 00 33. 01
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34. 00
34.00	Transportary Expansion Covid-17 The Acute Care	١	O	1	1		34.00

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 REGIONAL HOSPITAL
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 1
 Provider CCN: 14-0110

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3		
From 10/01/2022	Part		
To 09/30/2023	Date/Time Prepared:	2/20/2024	3:40 pm

						2/20/2024 3: 40) pm
		Full Time		Di sch	arges		·
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	12.00	14.00	Pati ents	
	PART I - STATISTICAL DATA	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 231	136	3, 828	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		Ü	1,201	100	0,020	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			615	986		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation 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	1, 231	136	3, 828	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0.00					26.00
26. 01	RURAL HEALTH CLINIC (RHC)	0.00					26. 01
26. 02	RURAL HEALTH CLINIC (RHC)	0.00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)						31. 00 32. 00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. UI	outpatient days (see instructions)						JZ. U I
33. 00	LTCH non-covered days			o			33. 00
33. 01	LTCH site neutral days and discharges			Ö			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00
	, .			. '	'		

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 10/01/2022 Part II

To 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm

1.00 i 2.00 M	PART II - WAGE DATA SALARIES Total salaries (see instructions) Non-physician anesthetist Part	Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
1.00 i 2.00 M	SALARIES Total salaries (see instructions)	1.00	2. 00	A-6)	3)			
1.00 i 2.00 M	SALARIES Total salaries (see instructions)	1.00	2.00			col . 4		
1.00 i 2.00 M	SALARIES Total salaries (see instructions)			3. 00	4. 00	5. 00	6. 00	
2.00 i	instructions)							
2.00		200. 00	53, 374, 563	698, 110	54, 072, 673	1, 268, 036. 00	42. 64	1.00
1.	A		0	0	0	0.00	0. 00	2. 00
l F	Non-physician anesthetist Part B		1, 311, 454	0	1, 311, 454	8, 606. 00	152. 39	3. 00
	Physician-Part A - Administrative		129, 002	0	129, 002	603.00	213. 93	4. 00
5.00 F	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 3, 754, 894	0		0. 00 24, 845. 00	0. 00 151. 13	1
6.00 h	Non-physician-Part B for hospital-based RHC and FQHC services		5, 142, 742	-1, 141, 710	4, 001, 032	71, 047. 00	56. 32	6. 00
7. 00 I	Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	residents (in an approved programs)		0	0	0	0.00	0. 00	7. 01
8. 00 H	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9.00	SNF Excluded area salaries (see	44. 00	0 73, 046	0 1, 238, 285	0 1, 311, 331	0. 00 30, 944. 00		
	instructions) DTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		203, 902	0	203, 902	2, 134. 00	95. 55	11. 00
12. 00 (r	Contract Labor: Top Level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13.00	services Contract Labor: Physician-Part A - Administrative		158, 865	0	158, 865	1, 361. 00	116. 73	13. 00
14.00 H	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
	wage-related costs Home office salaries		11, 094, 534	0	11, 094, 534	272, 287. 00	40. 75	14. 01
14. 02 F	Related organization salaries		0	0	0	0.00	0. 00	14. 02
	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16.00 H	Home office and Contract		0	0	О	0. 00	0. 00	16. 00
16. 01 H	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
16. 02 H	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
W	WAGE-RELATED COSTS Wage-related costs (core) (see		11, 783, 810	0	11, 783, 810			17. 00
ļi	instructions) Wage-related costs (core) (see		11, 703, 610		11, 703, 610			18. 00
	(see instructions) Excluded areas		335, 471	0	335, 471			19. 00
1	Non-physician anesthetist Part A		0	0	0			20. 00
E	Non-physician anesthetist Part B		147, 743		,			21. 00
l l	Physician Part A - Administrative		10, 470	0	10, 470			22. 00
1	Physician Part A - Teaching Physician Part B		0 425, 353	0	0 425, 353			22. 01 23. 00
24. 00 V 25. 00 I	Wage-related costs (RHC/FQHC) Interns & residents (in an		863, 394 0	0	863, 394 0			24. 00 25. 00
25. 50 H	approved program) Home office wage-related (core)		4, 572, 874	0	4, 572, 874			25. 50
25. 51 F	Related organization wage-related (core)		0	0	0			25. 51
25. 52 H	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

0.00

0.00

1, 812. 00

93, 263

0.00

51. 47 42. 00

0.00 43.00

41.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0110 Peri od: Worksheet S-3 From 10/01/2022 Part II 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 1.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 626, 396 2 00 26.00 Employee Benefits Department -626, 372 12.00 24 27.00 Administrative & General 5.00 1, 805, 669 2, 469 1, 808, 138 38, 022. 00 47.56 27.00 28.00 Administrative & General under 0 4, 351.00 0.00 28.00 0 contract (see inst.) Maintenance & Repairs 29.00 0.00 0.00 29.00 6.00 Operation of Plant 1, 384, 716 1, 416, 859 48, 242. 00 29. 37 30.00 7.00 32, 143 30.00 31.00 Laundry & Linen Service 8.00 43, 339 1,006 44, 345 2, 341.00 18.94 31.00 32.00 Housekeepi ng 9.00 1, 307, 656 30, 811 1, 338, 467 64, 745. 00 20. 67 32.00 33.00 Housekeeping under contract 0 0.00 0.00 33.00 (see instructions) Di etary 34.00 10.00 926, 541 -563, 957 362, 584 16, 117. 00 22. 50 34.00 Dietary under contract (see instructions) 0.00 35.00 0.00 35.00 27, 295. 00 36, 00 Cafeteri a 11.00 0 582, 553 582, 553 21. 34 36.00 Maintenance of Personnel 0. 00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 1, 403, 320 39, 983 1, 443, 303 30, 450. 00 47.40 38.00 23. 42 39.00 Central Services and Supply 14.00 478, 453 489, 559 20, 899. 00 39.00 11. 106 23, 496. 00 40.00 Pharmacy 15.00 1, 021, 095 24, 467 1, 045, 562 44.50 40.00

91, 147

2, 116

16.00

17.00

18.00

41.00

42.00

Medical Records & Medical

Records Library Social Service

43.00 Other General Service

Total overhead cost (see

instructions)

7.00

31.05

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 14-0110 Worksheet S-3 Peri od: From 10/01/2022 To 09/30/2023 Part III Date/Time Prepared: 2/20/2024 3:40 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 43, 165, 473 1, 839, 820 45, 005, 293 1, 167, 889. 00 1.00 38. 54 instructions) 2.00 73, 046 1, 238, 285 30, 944. 00 42. 38 2.00 Excluded area salaries (see 1, 311, 331 instructions) 3.00 Subtotal salaries (line 1 43, 092, 427 601, 535 43, 693, 962 1, 136, 945. 00 38. 43 3.00 minus line 2) 4.00 Subtotal other wages & related 11, 457, 301 11, 457, 301 275, 782. 00 41.54 4.00 costs (see inst.) Subtotal wage-related costs 5.00 16, 367, 154 Ω 16, 367, 154 0.00 37. 46 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 70, 916, 882 601, 535 71, 518, 417 1, 412, 727. 00 50. 62

9, 088, 332

-463, 675

8, 624, 657

277, 772. 00

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu of Form CMS-2552-10

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0110
Period: Worksheet S-3
From 10/01/2022 To 09/30/2023 Part IV
Date/Time Prepared: 2/20/2024 3: 40 pm

	10 077 307 2023	2/20/2024 3: 40	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 962, 823	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)	6, 963, 407	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	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)	70, 836	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	531, 258	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	3, 766, 172	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	11	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	271, 634	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	13, 566, 141	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	OTTAWA REGIONAL HOSPITAL & HEALTHCAR	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0110	Peri od:	Worksheet S-3		

		Fr	om 10/01/2022		
		To	09/30/2023	Date/Time Pre	
		Щ,		2/20/2024 3: 4	O pm
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		203, 902	13, 566, 141	1.00
2.00	Hospi tal		203, 902	13, 566, 141	2. 00
3.00	SUBPROVI DER - I PF				3. 00
4.00	SUBPROVI DER - I RF				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				8. 00
9.00	NURSING FACILITY				9. 00
10.00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				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		o	0	14.00
14. 01	Hospital-Based Health Clinic RHC 1		o	0	14. 01
14. 02	Hospi tal -Based Heal th Clinic RHC 2		o	0	14. 02
15. 00	Hospi tal -Based Heal th Clinic FQHC				15. 00
	Hospi tal -Based-CMHC				16. 00
17. 00	RENAL DIALYSIS I				17. 00
18. 00			0	0	

	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0110	Peri od:	Worksheet S-8	
			Component	CCN: 14-8649	From 10/01/2022 To 09/30/2023	Date/Time P 2/20/2024 3	
					RHC I	Cost	
			<u> </u>				
					1.	00	_
00	Clinic Address and Identification Street				102 11TH ST		7
00	311 66 1		C	ty	State	ZIP Code	
				00	2. 00	3. 00	
00	City, State, ZIP Code, County		MARSEI LLES		IL	61341-1048	
						1. 00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	l or "U" for i	ırhan		1.00	0
-	Theory was proced trained one of Book great on Ent.				nt Award	Date	
					1.00	2. 00	
	Source of Federal Funds			T			
00 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						
00	Health Services for the Homeless (Section 34)						
00	Appal achi an Regi onal Commissi on	s(u) / 1110 /101)					
00	Look-Al i kes						
00	OTHER (SPECIFY)						\perp
					1. 00	2. 00	+
00	Does this facility operate as other than a ho	ospi tal -based R	HC or FQHC? E	nter "Y" for	N N	2.00	0 1
	yes or "N" for no in column 1. If yes, indica						
	2. (Enter in subscripts of line 11 the type of	f other operati	on(s) and the	operati ng			
	hours.)	Sund	day		londay	Tuesday	
		from	to	from	to	from	+
		1.00	2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)						
00	CLINIC			08: 00	17: 00	08: 00	1
					1. 00	2. 00	
. 00	Have you received an approval for an exception	on to the produ	ctivity standa	ard?	N N	2.00	1
	Is this a consolidated cost report as defined	d in CMS Pub. 1	00-04, chapte	9, section	N		0 1
. 00		4 1 6	enter in colu	nn 2 the			
	30.8? Enter "Y" for yes or "N" for no in colu						- 1
	number of providers included in this report.			ders and			
					ider name	CCN	+
00	number of providers included in this report. numbers below.			Prov	ider name 1.00	CCN 2. 00	
00	number of providers included in this report.	List the names	of all provi	Prov	1. 00	2. 00	1
00	number of providers included in this report. numbers below.	List the names	of all provid	Prov	1. 00 XI X	2.00 Total Visits	
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN	List the names	of all provi	Prov	1. 00	2. 00	5
. 00	number of providers included in this report. numbers below.	Y/N 1.00	of all provid	Prov	1. 00 XI X	2.00 Total Visits	
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	Y/N 1.00	of all provid	Prov	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	of all provid	Prov	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	Y/N 1.00	of all provid	Prov	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	of all provid	Prov	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	5
00	number of providers included in this report. Numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	1
. 00	number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits 5.00	5
00	number of providers included in this report. Numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	1

Health Financial Systems OT	TAWA REGIONAL HO	SPITAL & HEALT	HCAR	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 14-0110	Peri od:	Worksheet S-8	
		Component	CCN: 14-8649	From 10/01/2022 To 09/30/2023	Date/Time Pre	narod:
		Component	CCN. 14-0049	10 09/30/2023	2/20/2024 3: 40	
			_	RHC I	Cost	
	Fri	i day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINI C	08: 00	17: 00				11. 00
	ро. оо	117.00	I			

	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CN: 14-0110	Peri od:	Worksheet S	8-8	552-
			Component	CCN: 14-8655	From 10/01/202 To 09/30/202			
					RHC I I	Cos		
					1	1. 00		
	Clinic Address and Identification				1			
00	Street		C	1 + 1	1614 E NORRIS	ZIP Code	_	1.
				i ty . 00	2. 00	3. 00		
00	City, State, ZIP Code, County		OTTAWA	. 00		L 61350		2.
						1. 00		
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for	_			0	3.
				Gra	nt Award 1.00	2.00		
	Source of Federal Funds				1.00	2.00	_	
00	Community Health Center (Section 330(d), PHS	Act)						4
00	Migrant Health Center (Section 329(d), PHS Ac							5
0	Health Services for the Homeless (Section 340	O(d), PHS Act)						6
00	Appalachian Regional Commission Look-Alikes							7 8
00	OTHER (SPECIFY)							9
				'				
				. ""	1. 00	2. 00		
00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of o	ther operation	ns in column	N		0	10
		Sun	day	N	Monday	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	-	
00	CLINIC			08: 00	17: 00	08: 00		11
00	Have you received an approval for an exception	on to the produ	ctivity stand	ard?	1. 00 N	2. 00		12
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	lin CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the	N N		0	13
	numbers below.			Prov	ider name	CCN		
					1. 00	2. 00		
00	RHC/FQHC name, CCN	V (A)		V0/11.1	VIV	T 1 1 10 11		14
00	RHC/FQHC name, CCN	Y/N 1 00	V 2.00	XVIII 3 00	XI X 4 00	Total Visit	:s	14
	RHC/FQHC name, CCN Have you provided all or substantially all	Y/N 1.00	V 2.00	XVIII 3.00	XI X 4. 00	Total Visit	:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in			_			S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and			_			:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by			_			:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and			_			:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			_			:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		2.00	3.00			:S	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2. 00 Co	3.00 unty			:S	
00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		2. 00 Co	3.00			TS .	15
00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2.00 Co 4 LASALLE	3.00 unty 00	4.00	5.00 ursday	S.S.	15
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Co 4 LASALLE	3.00 unty 00	4.00	5.00	TS .	15.

Health Financial Systems 0	TTAWA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 14-0110	Peri od:	Worksheet S-8	3
		Component	CCN: 14-8655	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:4	pared: 0 pm
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 00	17: 00				11. 00

	n Financial Systems OTTAV TAL-BASED RHC/FOHC STATISTICAL DATA	NA REGIONAL HOS		CCN: 14-0110	Peri od:	Worksheet S		552-
				CCN: 14-8652	From 10/01/2022 To 09/30/2023			
					RHC III	Cost		РШ
	Clinic Address and Identification					. 00	\dashv	
00	Street				1640 1ST AVENU	 JE	\neg	1.
	150, 50,		С	i ty	State	ZIP Code		
				. 00	2. 00	3. 00		
00	City, State, ZIP Code, County		OTTAWA		I I L	61350-9214	\dashv	2.
						1.00		
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for				0	3.
					nt Award 1.00	2. 00	\dashv	
	Source of Federal Funds			1	1.00	2.00		
00	Community Health Center (Section 330(d), PHS						\Box	4.
00	Migrant Health Center (Section 329(d), PHS Ad							5
00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(u), PHS ACT)						6 7
00	Look-Alikes							8
0	OTHER (SPECIFY)						\perp	9
					1.00	2.00	\dashv	
00	Does this facility operate as other than a ho	ospital-based R	RHC or FOHC? F	nter "Y" for	1. 00 N	2.00	0	10
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operatio	ns in column				
	The state of the s	Sun	day	N	londay	Tuesday		
		from	to	from	to	from	_	
	Facility hours of operations (1)	1.00	2. 00	3.00	4. 00	5. 00	+	
00		08: 00	20: 00	08: 00	20: 00	08: 00	_	11
				•				
00	Have you received an approval for an exception	n to the produ	ictivity stand	and?	1. 00 N	2. 00	-	12
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the	N			13
				Provi	ider name	CCN		
	numbers below.							
					1. 00	2. 00	4	
00	RHC/FQHC name, CCN	V/N	l v					14
00		Y/N 1.00	V 2.00		1. 00 XIX 4. 00	2.00 Total Visits 5.00		14
	RHC/FQHC name, CCN Have you provided all or substantially all			XVIII	XIX	Total Visit	S	
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in			XVIII	XIX	Total Visit	S	
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and			XVIII	XIX	Total Visit	S	
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in			XVIII	XIX	Total Visit	S	
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the			XVIII	XIX	Total Visit	S	
	RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			XVIII	XIX	Total Visit	S	
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		2. 00	XVIII	XIX	Total Visit	S	
00	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		2.00 Co	XVIII 3. 00	XIX	Total Visit	S	15.
. 00	RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00 Co 4 LASALLE	XVIII 3.00	XI X 4. 00	Total Visit	S	15.
. 00	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Co 4 LASALLE Wedr	XVIII 3.00 unty .00	XI X 4. 00	Total Visit: 5.00	S	15.
	RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Co 4 LASALLE	XVIII 3.00	XI X 4. 00	Total Visit	S	15.

Health Financial Systems OTTA	WA REGIONAL HOS	SPITAL & HEALTH	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	Provider CCN: 14-0110		Worksheet S-8	
		Component			Date/Time Pre 2/20/2024 3:4	
	_			RHC III	Cost	
	Fri	day	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	20: 00	08: 00	20: 00		11. 00

Heal th	Financial Systems OTTAWA REGIONAL HOSPITAL & F	HEALTHCAR	In Lie	eu of Form CMS-2	2552-10					
		ider CCN: 14-0110	Peri od: From 10/01/2022 To 09/30/2023		pared:					
				1.00						
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1.00						
	Uncompensated and Indigent Care Cost-to-Charge Ratio									
	Cost to charge ratio (see instructions)			0. 196032	1.00					
	Medicaid (see instructions for each line)			0.170002						
2.00										
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3. 00					
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental pa	payments from Medic	ai d?	Υ	4. 00					
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Me	Medi cai d		0	5. 00					
6.00	Medi cai d charges			127, 948, 305	6.00					
7.00	Medicaid cost (line 1 times line 6)			25, 081, 962	7. 00					
	Difference between net revenue and costs for Medicaid program (see i			6, 436, 273	8. 00					
	Children's Health Insurance Program (CHIP) (see instructions for eac	nch line)								
	Net revenue from stand-alone CHIP			0						
	Stand-alone CHIP charges			0	10.00					
	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00					
	Difference between net revenue and costs for stand-alone CHIP (see i			0	12.00					
	Other state or local government indigent care program (see instructi				12 00					
	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care program			0						
14.00	[10] That ges for patrents covered under state of rocal findigent care proj	ogram (Not included	in times 6 of	0	14.00					
15. 00	State or local indigent care program cost (line 1 times line 14)			0	15. 00					
	Difference between net revenue and costs for state or local indigent	nt care program (se	instructions)	0						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and				10.00					
	instructions for each line)		,	(
17.00	Private grants, donations, or endowment income restricted to funding	ng charity care		0	17. 00					
18.00	Government grants, appropriations or transfers for support of hospi	tal operations		0	18. 00					
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indi	digent care program	s (sum of lines	6, 436, 273	19. 00					
	8, 12 and 16)									
		Uni nsured	Insured	Total (col. 1						
		pati ents	pati ents	+ col . 2)						
		1.00	2. 00	3. 00						
	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	6, 921, 7	78 1, 137, 925	8, 059, 703	20.00					
	Cost of patients approved for charity care and uninsured discounts (
21.00	instructions)	(See 1, 330, 6	1, 137, 923	2, 474, 013	21.00					
22.00	Payments received from patients for amounts previously written off a	as	0 0	0	22. 00					
00	charity care				-2.00					
23.00	Cost of charity care (see instructions)	1, 356, 8	90 1, 137, 925	2, 494, 815	23. 00					
	-	•								

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

4, 679, 802

4, 248, 672

3, 478, 587

280, 234

431, 130

983, 772

9, 914, 860 31.00

24. 0025. 00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25.01

27.00

27.01

28. 00

stay limit

	Financial Systems OTTAWA REGIONAL HOSPITAL	_ & HEALTHC	AR	In Lie	u of Form CMS-2	2552-10			
HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCI		Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-1 Parts I & II Date/Time Pre 2/20/2024 3:4	pared:			
					1. 00				
	PART II - HOSPITAL DATA								
	Uncompensated and Indigent Care Cost-to-Charge Ratio								
1.00	Cost to charge ratio (see instructions)				0. 184192	1.00			
	Medicaid (see instructions for each line)								
2. 00	Net revenue from Medicaid					2.00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?					3.00			
1.00	If line 3 is yes, does line 2 include all DSH and/or supplementa			i d?		4.00			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid	i			5.00			
5. 00	Medi cai d charges					6.00			
7.00	Medicaid cost (line 1 times line 6)					7.00			
3. 00	Difference between net revenue and costs for Medicaid program (see instructions) 8.00 Children's Health Insurance Program (CHIP) (see instructions for each line)								
0.00	Net revenue from stand-alone CHIP	cacii i i iic	.)			9.00			
10. 00	Stand-al one 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	see instruc	ctions)			12.00			
	Other state or local government indigent care program (see instr								
13. 00	Net revenue from state or local indigent care program (Not inclu					13. 00			
4. 00	Charges for patients covered under state or local indigent care 10)	program (N	lot included	in lines 6 or		14. 00			
15. 00	State or local indigent care program cost (line 1 times line 14))				15. 00			
16. 00	Difference between net revenue and costs for state or local indi					16. 00			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)			ent care progran	is (see				
	Private grants, donations, or endowment income restricted to fun					17. 00			
	Government grants, appropriations or transfers for support of ho					18. 00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent c	are programs	(sum of lines		19. 00			
			Uni nsured	Insured	Total (col. 1				
		_	pati ents	pati ents	+ col . 2)				
			1.00	2. 00	3. 00				
	Uncompensated care cost (see instructions for each line)		/ 001 77	1 127 025	0.050.702	20.00			
	Charity care charges and uninsured discounts (see instructions)	.+. (6, 921, 77						
21. 00	Cost of patients approved for charity care and uninsured discoun instructions)	ira (see	1, 274, 93	1, 137, 925	2, 412, 861	21.00			
22. 00	Payments received from patients for amounts previously written o	off as		0 0	0	22. 00			
	charity care								
22 00	Cost of charity care (cos instructions)		1 27/ 02	1 127 025	2 412 041	22 00			

		Uni nsured	Insured	Total (col. 1	1				
		pati ents	pati ents	+ col . 2)					
		1.00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line)				l				
20.00	Charity care charges and uninsured discounts (see instructions)	6, 921, 778	1, 137, 925	8, 059, 703	20. 00				
21. 00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1, 137, 925	2, 412, 861	21. 00					
22.00	Payments received from patients for amounts previously written off as	0	0	0	22. 00				
	chari ty care				l				
23.00	Cost of charity care (see instructions)	1, 274, 936	1, 137, 925	2, 412, 861	23. 00				
				1.00					
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a Length of s	stay limit	N	24. 00				
	imposed on patients covered by Medicaid or other indigent care program?								
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	length of	0	25. 00					
	stay limit				l				
25. 01	Charges for insured patients' liability (see instructions)			0	25. 01				
26.00	Bad debt amount (see instructions)			4, 679, 802	26. 00				
27.00	Medicare reimbursable bad debts (see instructions)			280, 234	27. 00				
27. 01	Medicare allowable bad debts (see instructions)			431, 130	27. 01				
28.00	Non-Medicare bad debt amount (see instructions)			4, 248, 672	28. 00				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		933, 467	29. 00				
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			3, 346, 328	30.00				
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3, 346, 328	31.00				

Peri od: From 10/01/2022 Provider CCN: 14-0110

Worksheet A

In Lieu of Form CMS-2552-10

Cost Center Description						rom 10/01/2022 o 09/30/2023		
Col. 20		Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		O pm
DO DO DO DO DO DO DO DO							Trial Balance	
CENERAL SERVICE COST CENTERS								
ENERAL SERVICE COST-CENTERS 1.00 DOIDO CAP REL COSTS-MULE EQUIP 2.00 DOZDO CAP REL COSTS-MULE EQUIP 3.50 DOZDO CAP REL COSTS-MULE EQUIP 5.00 DOZDO CAP REL COSTS-MULE EQUIP 6.00 DOZDO CAP REL COSTS-MULE EQUIP 6.0			1. 00	2.00	3. 00	4. 00		
2.00		GENERAL SERVICE COST CENTERS					2.22	
0.0000 ORDINO CHER CAP REL COSTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
4.00 0.000 DEPLICATIVE BENEFITS DEPARTMENT 6.26, 396 13, 874, 044 14, 500, 469 740, 605 13, 760, 381 4.00 6.00 0.000		1 1		1, 504, 686	1, 504, 686	788, 204		
5.00 0.0500 AMUNINTRATIVE & GENERAL 1.805, 669 29, 069, 174 30, 874, 843 -2, 974, 862 28, 999, 981 5.00 0.0500 UNITEDIATE & REPAIRS 1.384, 716 3.850, 660 5.223, 376 -911, 200 4, 294, 170 7.00 4, 994, 170 7.00			626 206	12 974 044	14 500 440	740.050		•
0.000 OBOOD MAINTENANCE & REPAIRS 0 306, 522 306, 522 0 306, 522 6.00								
0.000 0.0000 LAUNDRY & LINEN SERVICE								1
9.00 0.0900 HOUSEKEFEN ING 1.307, 656 401, 827 1.709, 483 3.0, 354 1.739, 837 0.00 11.00 0.0000 0.16187Y 926, 541 749, 128 1.675, 669 -1.032, 052 643, 617 10.00 1.000 0.000 1.003, 559 1.053, 559 11.00 1.000 1.000 0.000 0.000 0.000 1.000 0.000	7.00	00700 OPERATION OF PLANT	1, 384, 716	3, 850, 660	5, 235, 376	-941, 206	4, 294, 170	7. 00
10.00 01000 DIETARY 926, 541 749, 128 1,475, 669 1,032, 052 643, 677 10.00 10.00 0.00								
1.00 0100 CAFFTERI		1 1						
13.00 01300 NURSING ADMINISTRATION 1, 403, 320 1, 475, 695 36, 737 1, 491, 832 13.00		1 1						1
14.00 01400 CENTRAL SERVICES & SUPPLY		1 1	٩	ĭ	_			1
16. 00 01600 MEDICAL RECORDS & LIBRARY 0 6.36 6.36 192,710 193,346 16. 00 10			· · · · · · · · · · · · · · · · · · ·					
17.00 01700 SOCIAL SERVICE 91,147 71,890 163,037 1,172,133 1,335,170 17.00	15.00	01500 PHARMACY	1, 021, 095	546, 526	1, 567, 621	23, 702	1, 591, 323	15. 00
INPAIL ENT ROUTH NE SERVICE COST CENTERS 7, 784, 198 3, 597, 241 13, 381, 439 -987, 178 12, 394, 261 30, 00 30, 00 AURTS A PEDITATIC S 7, 784, 198 1, 200, 870 285, 579 1, 486, 440 36, 888 1, 523, 337 31, 00 435, 229 485, 229 43, 31, 00 435, 229 485, 229 48, 31, 502, 337 31, 00 435, 229 485, 229 48, 31, 502, 337 31, 00 435, 329 485, 229 48, 31, 502, 337 31, 00 435, 329 485, 229 48, 31, 502, 337 31, 00 435, 329 485, 229 48, 31, 502, 337 31, 00 435, 329 48			-1					ł
30.00	17. 00		91, 147	71, 890	163, 037	1, 172, 133	1, 335, 170	17. 00
31.00 0.3100 INTERSIVE CARE UNIT 1, 200, 870 285, 579 1, 486, 449 36, 888 1, 523, 337 31.00	20.00		0 704 100	2 507 241	12 201 420	007 170	12 204 241	20 00
143.00 04300 NURSERY 0 0 0 485,229 485,029 485,020 485,0			· · · · · · · · · · · · · · · · · · ·					1
ANCIL LARY SERVICE COST CENTERS 50.00 COOO OPERATIN BROOM 1, 584, 515 3, 897, 946 5, 482, 479 -2, 806, 854 2, 675, 625 50.00 51.00 05100 RECOVERY ROOM 1, 084, 928 106, 573 1, 191, 501 34, 816 1, 226, 317 51.00 53.00 05300 DELL'VERY ROOM LABOR ROOM 959 0 959 677, 562 567, 562 52.00 53.00 05300 ABUSTHESI OLOGY 3, 178, 796 289, 663 3, 468, 459 19, 996 3, 488, 455 53.00 63.00 RADIOLOGY DIAGNOSTI C 3, 575, 911 2, 180, 300 7, 575, 211 1, 415, 653 7, 177, 864 54.00 05400 RADIOLOGY DIAGNOSTI C 3, 575, 911 2, 289, 452 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 238, 915 400, 022 3, 740 403, 762 56.00 05600 RADIOLOGY DIAGNOSTI C 161, 107 200, 245 560, 360 7, 854 588, 214 58, 00 06, 00 06600 PRIST CALL THERAPY 2, 499, 296 142, 241 2, 641, 537 59, 964 2, 737, 501 65, 00 06, 00 060								ı
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1.00 0.5300 AMSTHESI OLOGY 3, 178, 796 299, 663 3, 468, 459 19, 996 3, 488, 455 53. 00 0.5600 RADIOLOGY-DIAGNOSTIC 2, 180, 300 0.5700 C. 100 RADIOLOGY-DIAGNOSTIC 161, 107 238, 915 400, 0.22 3, 740 403, 762 56. 00 0.5700 CT SCAN 589, 602 287, 750 877, 352 13, 686 891, 0.38 57. 00 0.5800 MRI 371, 115 209, 245 580, 360 7, 854 588, 214 58. 00 0.5800 MRI 371, 115 209, 245 580, 360 7, 854 588, 214 58. 00 0.500 RSDR RATIORY THERAPY 877, 251 215, 243 760 6. 590, 980 334, 300 6, 925, 280 60. 00 60. 00 0.500 RSDR RATIORY THERAPY 2, 499, 296 142, 241 2, 641, 537 95, 964 2, 737, 501 66. 00 60. 00 6			· · · · · · · · · · · · · · · · · · ·					1
54.00 05400 RADI DLOGY-DIAGNOSTIC 3,575,911 2,180,300 5,76,211 1,415,653 7,171,864 54.00 65.00 05600 RADI DISTORPE 161,107 238,915 400,022 3,740 403,762 56.00 65.00 05600 RADI DISTORPE 37,111,70 238,915 400,022 3,740 403,762 56.00 65.00 05800 MRI 371,115 209,245 580,360 7,854 588,214 58.00 65.00 05600 LABDRATORY 3,167,220 3,423,760 6,590,90 334,300 6,255,280 60.00 6000 6000 Color PRISTICAL THERAPY 8,77,251 215,243 1,092,494 29,307 1,121,801 65.00 66.00 6000 Color PRISTICAL THERAPY 340,491 6,489 346,980 50,765 397,745 67.00				~				
56. 00 05600 RADI OI ISOTOPE 161, 107 238, 915 400, 022 3, 740 403, 762 56. 00 57. 00 57.00 57		1 1						1
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60.00 06000 LABORATORY 3,167,220 3,423,760 6,590,980 334,300 6,925,280 0,00 0.00		1 1						
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66.00 06600 PHYSI CAL THERAPY 2, 499, 296 142, 241 2, 641, 537 95, 964 2, 737, 501 66, 00 67.00 06700 0CCUPATI ONAL THERAPY 340, 491 6, 489 346, 980 50, 765 397, 745 67, 00 68.00 06800 SPEECH PATHOLOGY 121, 600 4, 937 126, 537 18, 454 144, 991 68, 00 69.00 06900 ELECTROCARDI OLOGY 121, 600 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 -140, 899 -140, 899 2, 135, 263 1, 994, 364 71, 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 1, 391, 045 1, 391, 045 72, 00 75.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 1, 391, 045 1, 391, 045 72, 00 75.00 07500 ASC (NON-DI STI NCT PART) 2, 094, 980 1, 228, 905 3, 323, 885 -1, 217, 702 2, 106, 183 75, 00 76.00 03160 STRESS TESTI NG 0 0 0 0 0 0 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 079, 571 186, 321 3, 265, 892 77, 704 3, 343, 596 76, 01 76.07 07697 CARDI AC REHABI LI TATI ON 235, 705 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 235, 705 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 250, 726 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 250, 726 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 250, 726 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 250, 726 14, 736 250, 441 880, 688 1, 131, 129 76.97 07697 CARDI AC REHABI LI TATI ON 250, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240, 726 240								1
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76. 02 03610 SLEEP LAB 163,740 68,099 231,839 197,815 429,654 76.02 76.97 07697 CARDI AC REHABI LITATION 235,705 14,736 250,441 880,688 1,131,129 76.97 07697 CARDI AC REHABI LITATION 235,705 14,736 250,441 880,688 1,131,129 76.97 076			٥Į	186, 321	,	′	-	
88. 00 08800 RURAL HEALTH CLINIC (RHC) 426, 788 215, 142 641, 930 -165, 124 476, 806 88. 00	76. 02						429, 654	76. 02
88. 00	76. 97		235, 705	14, 736	250, 441	880, 688	1, 131, 129	76. 97
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SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) S3,301,517 S2,702,776 136,004,293 -271,769 135,732,524 118.00 NONREI MBURSABLE COST CENTERS S190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O 91,227 91,227 O 91,227 190.00 19200 19200 19400			_1	_1			_	
113. 00 118. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SOUNDINGE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CIANS' PRI VATE OFFI CES 194. 00 19500 CARDI NAL SLEEP 0 0 0 0 0 113. 00 0 0 0 0 0 0 0 0 113. 00 0 113. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102.00		0	0	() 0	0	102.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 53, 301, 517 82, 702, 776 136, 004, 293 -271, 769 135, 732, 524 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 91, 227 91, 227 0 91, 227 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 24 1, 906, 563 1, 906, 587 1, 242, 038 3, 148, 625 192. 00 194. 00 07950 CARDI NAL SLEEP 0 0 0 0 0 194. 00 194. 01 07951 OTHER NRCC 73, 022 1, 107, 501 1, 180, 523 -970, 269 210, 254 194. 01	113 00			O	(ol ol	0	113 00
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192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 24 1, 906, 563 1, 906, 587 1, 242, 038 3, 148, 625 192. 00 194. 00 07950 CARDI NAL SLEEP 0 0 0 0 0 194. 00 194. 01 07951 OTHER NRCC 73, 022 1, 107, 501 1, 180, 523 -970, 269 210, 254 194. 01		NONREI MBURSABLE COST CENTERS						
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194. 01 07951 OTHER NRCC 73, 022 1, 107, 501 1, 180, 523 -970, 269 210, 254 194. 01			24	1, 906, 563				
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Provider CON 14-0110 Perioder CON 14-0110 Perioder CON 17-0707 Perioder CON 14-0110 Perioder CON 17-0707	Health Financial Systems OTTAN	WA REGIONAL HOS	SPITAL & HEALTHCAR	In Lieu of Form CMS	-2552-10
Cost Center Description		F EXPENSES	Provider CCN: 14-01	10 Period: Worksheet A	
COST Center Description					enared:
STATE ALL SIRVICE COST CINTERS	Cost Center Description				
EMPRIAL SERVICE COST CENTERS 1.00 0000 CAP REL COSTS -BLOB & FIXT 555, 801 4, 116, 518 1.00 0000 CAP REL COSTS -BLOB & FIXT 555, 801 4, 116, 518 2.00 0000 CAP REL COSTS -BLOB & FIXT 555, 801 4, 116, 518 2.00 0000 CAP REL COSTS -BUBLE COUP 1, 011, 724 3, 904, 618 2.00 0000 CAP REL COSTS -BUBLE COUP 1, 011, 725, 507 3, 304 4, 400 3.00 0000 CAP REL COSTS -BUBLE COUP 1, 011, 725, 507 3, 305, 324 4, 400 3.00 0000 CAP REL COSTS -BUBLE COUP 1, 011, 725, 507 3, 306, 522 6, 60 6, 00 0000 CAP REL COSTS -BUBLE COUP 1, 124, 1977 8, 00 0000 CAP REL COSTS -BUBLE					
1.00	CENEDAL CEDALCE COST CENTEDS	6.00	7.00		
2.00 0.0000 CAP RELL COSTS-MINEL EQUIP 1,611,724 3,904,614 2.00 3.00 0.0000 DURL COVER BENEFITS 5.00 0.0000 DURL COVER SERVICE 5.00 0.0000 DURL SERVICE 5.00 DURL COVER SERVICE 5.00 DU		555 801	4 116 518		1 00
3.00 0.0300 GITHER CAP PEL COSTS 0 0 3.00 3.00 5.00					
4.00 00400 EMPLOYEE BENEFITS DEPARTEENT -725, 027 13, 035, 364 4.00 5.00 00500 AMIN ISTRATIVE & GENERAL -3,989, 931 24, 250, 586 7.00 00700 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 0.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 0.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 0.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 0.00 00500 DURATION OF THE STRUCK -7 1 1,739, 766 9.00 1.00 00500 DURATION OF THE STRUCK -7 2,00 0.00 00500 DURATION OF THE STRUCK -7 3,00 0.			1		
0.00 0.000 DORATITION DEPART 0.00 0.000 DERATITION DEPART 0.00 0.000 DERATITION DEPART 0.00 0.000 DERATITION DEPART 0.00 0.000 DERATITION DEPART 0.00 0.000 DETARTY 0.000 0.000 DEDEAT DETART 0.000 0.000 DETARTY 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 DETARTY 0.000 0.000 0.000 DETARTY 0.000 0.000 0.000 0.000 DETARTY 0.000 0.	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-725, 027	13, 035, 354		4. 00
7.00 0.0700 OPERATION OF PLANT		-3, 998, 931			
B. 00 00800 LANIDRY & LINEN SERVICE 0		_			
9.00 00000 HOUSEKEFEN ING 7-71 1,739, 766 9.00 11.00 101000 DETAINY 10.00 10100 DETAINY 10.00 10100 DETAINY 10.00 10100 DETAINY 11.00 13.00 1330 01300 MIRSI NA ADMINISTRATION 1.146, 065 2,637, 867 13.00 1300 10100 DETAINS SERVICES & SUPLY -3,700 575, 451 14.00 16.00 10100 HARRACY -1,800 1,589, 522 15.00 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 522 1,589, 52		-43, 584	,		
10.00 01000 DIETARY		0	,		
11.00 0100 (CAFETRIA			1		•
13.00 01300 NURSING ADMINISTRATION 1,146, 065 2,637,897 13.00 15.00 15.00 PHARMACY -1,000 570, 4515 14.00 14.00 14.00 01400 MEDI CAL RECORDS & LIBRARY 99,978 293,324 16.00 17.00 00100 MEDI CAL RECORDS & LIBRARY 99,978 293,324 16.00 17.00 01700 SOCI AL SERVICE 027,017 1,542,187 17.00 17		_			
14.00 01400 CENTRAL SERVICES & SUPPLY					•
15.00 01500 PHARMACY -1, 800 1, 589, 523 15.00 17.00 01700 SOCI AL SERVICE 207, 017 1, 542, 187 17.00 17.00 SOCI AL SERVICE 207, 017 1, 542, 187 17.00 1.00 17.0					•
16. 00 01600 MEDICAL RECORDS & LIBRARY 99, 978 293, 324 16. 00 170. 00					
INPART ENT ROUTH NE SERVICE COST CENTERS 30.00	· · · · · · · · · · · · · · · · · · ·				
30.00 30000 ADULTS & PEDI ATRICS -2, 543, 892 9, 850, 369 30.00 31.00 03100 NITERSI VE CARE UNIT -5, 456 1,517, 881 31.00 31.00 31.00 NITERSI VE CARE UNIT -5, 456 1,517, 881 31.00 31.00 31.00 31.00 NITERSI VE CARE UNIT -5, 456 1,517, 881 31.00		207, 017	1, 542, 187		17. 00
31.00 0.3100 INTERSI VE CARE UNIT -5,456 1,517,881 31.00					
A3. 00 0.4300 NURSERY					
MOLI LLARY SERVICE COST CENTERS 50.00	· · · · · · · · · · · · · · · · · · ·				•
50.00 05000 0FECATING ROOM 0 2,675,625 5.05 5.0		0	485, 229		43.00
51.00 OS100 RECOVERY ROOM & LABOR ROOM 0 1, 226, 317 55.00		1	2 675 625		50.00
S2 00 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05400 0340					
53.00 06300 ANESTHESI DLOGY -3, 080, 145 408, 310 55.00 56.00 08500 RADI DLOGY-DIA CANDSTIC -1, 038, 416 6, 133, 448 54.00 56.00 08500 RADI DLOGY-DIA CANDSTIC -450 403, 312 55.00 58.00 08500 RADI DLOGY-DIA CANDSTIC -450 403, 312 55.00 58.00 08500 MRI -200 588, 014 38.00 60.00 60500 LGEDRATORY -85,760 6, 839, 520 60.00 60500 RESPIRATORY THERAPY 0, 1, 121, 801 65.00 60500 RESPIRATORY THERAPY 4, 638 2, 742, 139 66.00 60.00					
56. 00 05600 RADI DI SOTOPE -450 40.3, 31.2 56. 00 57.00 057.00 CT SCAN 0 891.038 57.00 58.00 05800 MRI -200 588.014 58.00 60.00 05000 RABPITARTORY -85, 760 6.839, 520 60.00 05000 RESPIRATORY THERAPY 0 1, 121, 801 65.00 66.00 06500 RESPIRATORY THERAPY 4,638 2,742, 139 66.00 66.00 06500 RESPIRATORY THERAPY 1, 013 398, 758 67.00 68.00 08800 SPECH PATHOLOGY -702 144, 289 68.00 68.00 08800 SPECH PATHOLOGY -702 144, 289 68.00 69.00 05000 LECTROCARDI OLOGY -702 144, 289 68.00 69.00 05000 LECTROCARDI OLOGY -702 144, 289 69.00 69.00 07000 LECTROCARDI OLOGY -702 144, 289 69.00 07000 LECTROCARDI OLOGY -702 144, 289 -70.00 07100 ROLO CALL SUPPLIES CHARGED TO PATIENT 0 7,515 70.00 71.00 07100 ROLO CALL SUPPLIES CHARGED TO PATIENT 0 7,941, 364 71.00 71.00 07100 ROLO CALL SUPPLIES CHARGED TO PATIENT -104 2,106, 079 75.00 07500 ASC (NON-DISTINCT PART) -104 47.96, 54 76.00	· · · · · · · · · · · · · · · · · · ·	-3, 080, 145	,		•
57.00 05700 CT SCAN	54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 038, 416	6, 133, 448		54. 00
S8. 00 05800 MR		-450			•
60. 00 06500 06500 RESPI RATORY THERAPY 0 1, 121, 801 05. 00 06500 RESPI RATORY THERAPY 0 1, 121, 801 05. 00 06600 PHYSI CAL THERAPY 4, 638 2, 742, 139 06. 00 07. 00 0700 0CCUPATI ONAL THERAPY 1, 013 398, 758 07. 00 07. 00 0700 0CCUPATI ONAL THERAPY 1, 013 398, 758 07. 00 07. 00 0700 0CCUPATI ONAL THERAPY 1, 013 398, 758 07. 00 07. 00 0700			,		
65. 00 06500 RESPI RATORY THERAPY 0 1.121,801 66. 00 66. 00 66.00 66.00 66.00 66.00 66.00 66.00 67					•
66. 00 06600 PHYSI CAL THERAPY			,		
67. 00 06700 05CUPATI ONAL THERAPY 1, 013 398, 758 67. 00 06800 SPEECH PATHOLOGY -702 144, 289 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 229, 692 69. 00 07		_	,		•
68. 00 06900 06900 06900 06900 069000 0690000 0690000 0690000 0690000 0690000 069000000000 0690000000000			,		•
69.00 06900 LECTROCARDI OLOGY 0 229, 692 69.00 70.00 07000 DELECTROCEPHALOGRAPHY 0 7, 515 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1, 994, 364 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1, 391, 045 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 1, 391, 045 72.00 75.00 07300 DRUGS CHARGED TO PATI ENTS -348, 034 5, 657, 021 73.00 76.00 07500 ASC (NON-DISTINCT PART) -104 2, 106, 079 75.00 76.01 03550 PSYCHIA TRII C/PSYCHOLOGI CAL SERVICES -1, 648, 755 1, 694, 841 76.01 76.01 03550 PSYCHIA TRII C/PSYCHOLOGI CAL SERVICES -1, 648, 755 1, 694, 841 76.01 76.02 03610 SLEEP LAB 0 429, 654 76.02 76.97 07697 CARDI ACR REHABI LI TATI ON -2, 550 1, 128, 579 76.00 76.97 07697 CARDI ACR REHABI LI TATI ON -2, 550 1, 128, 579 76.00 76.97 07697 CARDI ACR REHABI LI TATI ON -2, 550 1, 128, 579 76.00 88.01 08800 RURAL HEALTH CLINI C (RHC) 0 476, 806 88.00 88.01 08800 RURAL HEALTH CLINI C (RHC) 3, 742 1, 899, 952 88.02 90.00 09000 CLINI C -75, 635 614, 789 95.00 91.00 09100 EMERGENCY -3, 067, 174 5, 581, 944 99.00 91.00 09100 EMERGENCY -3, 067, 174 5, 581, 944 99.00 91.00 09100 EMERGENCY -3, 067, 174 5, 581, 944 99.00 92.00 09200 09SERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 0 0 113.00 NTEREST EXPENSE 0 0 0 0 118.00 NONEE IMBURSABLE COST CENTERS 0 0 0 0 110.00 10000 01 TREATMENT PROGRAM 0 0 0 0 110.00 190.00 190.00 01 01 01 01 01 01 01					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 1, 994, 364 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 391, 045 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS -348, 034 5, 657, 021 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) -104 2, 106, 079 75. 00 76. 00 03160 STRESS TESTING 0 0 0 0 0 0 0 0 0					
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 1,391,045 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 75. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS -348,034 5,657,021 73. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 76. 00		0	1, 994, 364		71. 00
75. 00 07500 ASC (NON-DISTINCT PART) -104 2,106,079 75. 00 76. 00 3160 STRESS TESTING 0 0 0 76. 00 76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES -1,648,755 1,694,841 76. 01 76		-			
76. 00 03160 STRESS TESTING					
76. 01					
76. 02 03610 SLEEP LAB 0 429, 654 76. 97 07697 CARDI AC REHABI LI TATI ON -2, 550 1, 128, 579 76. 97 00000000000000000000000000000000000	4 I	_	I -1		
76. 97 O7697 CARDI AC REHABILITATION	· · · · · · · · · · · · · · · · · · ·				
Section Sect					
88. 01			· '		
88. 02		_			
90. 00					
91. 00					
92. 00 07					
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O SPECI AL PURPOSE COST CENTERS O O O O O O O O O	1	-3,007,174	5, 581, 944		
102. 00					72.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		n	O		102.00
113. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 197. 00			-1		1
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 91, 227 190. 00 1920					113. 00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 91, 227 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 148, 625 192. 00 194. 00 0.07950 CARDI NAL SLEEP 0 0 194. 00 194. 01 0.07951 OTHER NRCC 0 210, 254 194. 01	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-13, 337, 882	122, 394, 642		118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 148, 625 194. 00 07950 CARDI NAL SLEEP 0 0 194. 00 194. 01 07951 OTHER NRCC 0 210, 254 194. 01					
194. 00 07950 CARDI NAL SLEEP 0 0 0 194. 01 07951 OTHER NRCC 0 210, 254 194. 01			,		
194. 01 07951 OTHER NRCC 0 210, 254 194. 01		_	1		
			-1		
200.00 10 mc Com of Lines 110 through 1777 -10,007,002 120,044,740		-			
	200.00 TOTAL (SOM OF LINES TTO LINGUIST 177)	10,007,002	1 120,011,170		1200.00

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu of Form CMS-2552-10
RECLASSIFICATIONS

Provider CCN: 14-0110 | Period: From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: 2/20/2024 3: 40 pm

					2/20/2024 3:4	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	112, 700		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00		0.00	0	00 112, 700		4. 00
	B - ALTERNATI VE BIRTH CTR		<u> </u>	112, 700		
1.00	NURSERY	43.00	383, 090	102, 139		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	637, 333	169, 924		2. 00
			1, 020, 423	272, 063		
	C - EKG HOLTER, STRESS, EEG			· '		
1.00	ELECTROCARDI OLOGY	69. 00	229, 692	0		1. 00
2.00	ELECTROENCEPHALOGRAPHY	70.00	7, 515	0		2. 00
3.00	CARDI AC REHABI LI TATI ON	<u>76.</u> 97	361, 024	51 <u>2, 5</u> 42		3. 00
	0		598, 231	512, 542		
	D - OTHER BENEFITS					
1.00	ADMI NI STRATI VE & GENERAL	5. 00	34, 298	0		1.00
2.00	OPERATION OF PLANT	7. 00	19, 991	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	626	0		3.00
4.00	HOUSEKEEPI NG	9.00	19, 670	0		4.00
5. 00 6. 00	DI ETARY NURSI NG ADMINI STRATI ON	10. 00 13. 00	13, 443 20, 926	0		5. 00 6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	6, 907	0		7. 00
8. 00	PHARMACY	15. 00	15, 506	0		8. 00
9. 00	SOCI AL SERVI CE	17. 00	1, 316	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	141, 316	0		10.00
11. 00	INTENSIVE CARE UNIT	31.00	17, 536	0		11. 00
12. 00	OPERATING ROOM	50. 00	22, 875	0		12. 00
13. 00	RECOVERY ROOM	51. 00	15, 663	0		13. 00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	14	0		14. 00
15.00	ANESTHESI OLOGY	53.00	45, 892	0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	52, 426	0		16. 00
17.00	RADI OI SOTOPE	56.00	2, 326	0		17. 00
18.00	CT SCAN	57. 00	9, 277	0		18. 00
19.00	MRI	58. 00	5, 358	0		19. 00
20.00	LABORATORY	60.00	46, 489	0		20. 00
21. 00	RESPI RATORY THERAPY	65. 00	12, 665	0		21. 00
22. 00	PHYSI CAL THERAPY	66.00	36, 935	0		22. 00
23. 00	OCCUPATIONAL THERAPY	67. 00	4, 916	0		23. 00
24. 00	SPEECH PATHOLOGY	68. 00	1, 756	0		24. 00
25. 00	ASC (NON-DISTINCT PART)	75. 00 74. 01	30, 508	0		25. 00
26. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	44, 459	0		26. 00
27. 00	SERVI CES SLEEP LAB	76, 02	2, 364	0		27. 00
28. 00	CARDI AC REHABI LI TATI ON	76. 97	4, 167	0		28. 00
29. 00	RURAL HEALTH CLINIC (RHC)	88. 00	4, 683	0		29. 00
30. 00	RURAL HEALTH CLINIC (RHC)	88. 01	31, 849	0		30.00
31. 00	RURAL HEALTH CLINIC (RHC)	88. 02	20, 418	0		31. 00
32.00	CLINIC	90.00	5, 216	0		32.00
33.00	EMERGENCY	91.00	66, 440	0		33. 00
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	17, 296	0		34.00
35.00	OTHER NRCC	194. 01	1, 054	0		35. 00
	0		776, 581	0		_
	E - MINISTRY ALLOCATIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	651, 361		1.00
2.00	OPERATION OF PLANT	7.00	0	350, 894		2.00
3.00	SOCI AL SERVI CE	17. 00	O	1, 170, 017		3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0	153, 790		4. 00
5.00	PHYSI CAL THERAPY	66.00	0	81, 780		5. 00
6.00	OCCUPATIONAL THERAPY	67. 00	0	10, 742		6. 00
7. 00	SPEECH PATHOLOGY			3, 918		7. 00
	F - C-SECTION		0	2, 422, 502		1
1.00	OPERATING ROOM	50.00	118, 202	31, 515		1. 00
1.00	0		118, 202	31, 515		1.00
	G - MOB HOSPITAL STORAGE		110, 202	31, 313		1
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	28, 376		1.00
00	0		 			
	H - SALARY RECLASS					
1.00	OTHER NRCC	194. 01	0	28, 031		1. 00
2.00		000	0_	0		2. 00
	0 $ -$			28, 031		

Health Financial Systems RECLASSIFICATIONS OTTAWA REGIONAL HOSPITAL & HEALTHCAR

Provider CCN: 14-0110 In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm

					10	09/30/2023	2/20/2024 3: 40 p
	Cost Center	Increases Line #	Salary	Other			
	2. 00	3. 00	4. 00	5. 00			
	I - NORRIS BUILDING OVERHEAD	0.00		0.00			
00	OTHER CAP REL COSTS	3.00	0	71, 429			
00	ADMINISTRATIVE & GENERAL	5. 00	0	91, 643			
00	OPERATION OF PLANT	7. 00	0	21, 399			
00	CLINIC	<u>90.</u> 00	0	1 <u>3, 8</u> 05			4
	0		0	198, 276			
	J - MERCURY CIRCLE BUILDING		_1				
00	SLEEP LAB	<u>76.</u> 02	•	11 <u>8, 623</u>			
-	U PARIOLOGY CRACE		0	118, 623			
	K - RADIOLOGY SPACE	E4 00	٥	2 222			
0	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	0_	<u>2, 333</u> 2, 333			
H	U	S VND DDIICS	U	2, 333			
o İ	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 024, 957			
	PATI ENT	71.00	٩	2,024,757			
o	TATLENT	0.00	o	0			
o l		0.00	Ö	0			
Ĭ	$\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$			2, 024, 957			,
1	M - IMPLANTS		<u> </u>	2,021,707			
c İ	IMPL. DEV. CHARGED TO	72.00	0	1, 391, 045			
	PATI ENTS		1	, - , , - , -			
o		0.00	О	0			2
o		0.00	0	0			
o [0. 00	o	0			4
Ī	0			1, 391, 045			
	N - DRUG CHARGES TO PATIENTS						
0	DRUGS CHARGED TO PATIENTS	73.00	0	31, 761			
0		0.00	0	0			2
0		0.00	0	0			
0		0.00	0	0			4
Į	0		0	31, 761			
	O - PHYSICIAN COST						
0	ADULTS & PEDIATRICS	30. 00	47, 951	0			
- 1	0		47, 951	0			
	P - DISABILITY RECLASS	0.00	ما	205			
	HOUSEKEEPI NG	9. 00	0	335			
	DI ETARY	10.00	0	2, 978			
	ADULTS & PEDIATRICS	30.00	0	19, 742			3
	INTENSIVE CARE UNIT	31.00	0	1, 101			4
	OPERATING ROOM	50.00	0	1, 728			Ę
	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	4, 508			6
	RADI OLOGI - DI AGNOSTI C	56.00	0	5, 271 1, 318			8
	CT SCAN	57. 00	0	262			
	LABORATORY	60.00	0	528			10
	RESPIRATORY THERAPY	65.00	0	3, 684			11
	PHYSI CAL THERAPY	66.00	178	0			12
	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	2, 756			13
	SERVICES	70.01	۷	2, 730			
	EMERGENCY	91. 00	o	9, 940			14
-~	0 +		₁₇₈	54, 151			'-
ŀ	R - STREATOR EXPENSES		170	5., .51			
	CAP REL COSTS-BLDG & FIXT	1.00	0	540, 298			
	CAP REL COSTS-MVBLE EQUIP	2.00	ő	649, 660			
	OTHER CAP REL COSTS	3.00	ő	85, 460			
	OPERATION OF PLANT	7. 00	ő	277, 200			
	SLEEP LAB	76. 02	ő	75, 391			į
	PHYSICIANS' PRIVATE OFFICES	192. 00	ol	26, 139			
	OTHER NRCC	194. 01	O	40, 249			-
	OTHER CAP REL COSTS	3.00	O	20, 544			8
5		0.00	ol	0			
Ī	0			1, 714, 941			
Ì	S - PCI/HTM COST						
[c	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 353, 791			
) [LABORATORY	<u>60.</u> 00	0	<u>260, 7</u> 81			
	0			1, 614, 572			
Ī	T - REHAB ADMINISTRATION						
0	OCCUPATI ONAL THERAPY	67. 00	31, 704	415			
0	SPEECH PATHOLOGY	6800	1 <u>1, 5</u> 62	151			2
	0		43, 266	566			
	U - MEDICAL RECORDS RECLASS						
c [MEDICAL RECORDS & LIBRARY	16. 00	0	192, 536			
				192, 536			

OTTAWA REGIONAL HOSPITAL & HEALTHCAR
Provider CCN: 14-0110 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm

		Increases			 /20/2024 3:40 pm
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
	- PROPERTY TAX THER CAP REL COSTS	3.00	0	120, 522	1.
0 0	THER CAP REL COSTS	0.00	o	120, 522	2
0		0.00	0	0	3
		0.00	o	0	4
0				120, 522	
W	- CAFETERI A	'	- '		
) CA	AFETERI A	11. 00	582, 553	471, 006	1
0			582, 553	471, 006	
	- MINISTRY OSFMG OVERHEAD				
	DMINISTRATIVE & GENERAL	5. 00	0	744, 448	1
0		0.00	0	0	2
0		0.00	0	0	3
0		0. 00 0. 00	0	0	5
5		0.00	0	0	6
5		0.00	o	0	7
			ŏ -	744, 448	,
Z	- FOUNDATION EXP RECLASS		<u> </u>	7	
	DMINISTRATIVE & GENERAL	5.00	0	1, 014, 471	1
	JRSING ADMINISTRATION	13.00	0	351	2
O ME	EDICAL RECORDS & LIBRARY	16. 00	0	174	3
) RA	ADI OLOGY-DI AGNOSTIC	<u>54.</u> 00	0	<u> </u>	4
0			0	1, 015, 746	
	A - TEAM AWARDS		1		
	DMI NI STRATI VE & GENERAL	5. 00	16, 122	0	1
	PERATION OF PLANT	7. 00	12, 152	0	2
	AUNDRY & LINEN SERVICE	8.00	380	0	3
	OUSEKEEPI NG I ETARY	9.00	11, 476	0	4
	JRSING ADMINISTRATION	10.00	8, 131 19, 057	0	5
	ENTRAL SERVICES & SUPPLY	13. 00 14. 00	4, 199	0	7
	HARMACY	15. 00	8, 961	0	8
	OCIAL SERVICE	17. 00	800	0	9
	DULTS & PEDIATRICS	30.00	142, 897	0	10
	NTENSIVE CARE UNIT	31.00	19, 551	Ö	11
	PERATING ROOM	50.00	24, 638	Ö	12
	ECOVERY ROOM	51.00	19, 153	o	13
	ELIVERY ROOM & LABOR ROOM	52.00	8	O	14
	NESTHESI OLOGY	53.00	30, 649	О	15
00 RA	ADI OLOGY-DI AGNOSTI C	54.00	36, 885	О	16
00 RA	ADI OI SOTOPE	56.00	1, 414	О	17
00 CT	T SCAN	57.00	5, 174	О	18
OO MF	1	58. 00	3, 257	0	19
	ABORATORY	60.00	27, 795	0	20
	ESPI RATORY THERAPY	65. 00	16, 642	0	21
	HYSI CAL THERAPY	66.00	21, 934	0	22
	CCUPATI ONAL THERAPY	67.00	2, 988	0	23
	PEECH PATHOLOGY	68.00	1, 067	0	24
	SC (NON-DISTINCT PART) SYCHIATRIC/PSYCHOLOGICAL	75. 00 76. 01	40, 950	0	25
	ERVI CES	76. 01	33, 245	U	26
	LEEP LAB	76. 02	1, 437	0	27
	ARDI AC REHABI LI TATI ON	76. 97	3, 720	o	28
	JRAL HEALTH CLINIC (RHC)	88. 00	2, 847	o	29
	JRAL HEALTH CLINIC (RHC)	88. 01	19, 360	Ö	30
	JRAL HEALTH CLINIC (RHC)	88. 02	12, 412	ō	31
	LINIC	90.00	4, 492	Ö	32
	MERGENCY	91.00	61, 424	0	33
	HYSICIANS' PRIVATE OFFICES	192. 00	10, 514	0	34
	THER NRCC	194. 01	641	<u>o</u>	35
_	OTALS		626, 372	0	
	B - OCC MED		1	_1	
)	EDLOAL CURRILEC SWEETS TO	0.00	0	0	1
	EDICAL SUPPLIES CHARGED TO	71. 00	0	133, 932	3
	ATI ENT	+	_ — — д	_{133, 932}	
	OTALS		U	133, 732	
	HYSICIANS' PRIVATE OFFICES	192. 00	1, 233, 278	498, 520	1
5	OITHIS TRIVATE OITHOUS	0.00	1, 233, 270	478, 520	2
5		0.00	ől	ŏ	3
		— 	1, 233, 278	498, 520	"
	rand Total: Increases		5, 047, 035	13, 735, 664	500

Heal th	Financial Systems	OTTAW	A REGIONAL HOSE	PITAL & HEALT	HCAR	In Lieu	of Form CMS-255	52-10
RECLAS	SIFICATIONS			Provi der (Period: From 10/01/2022	Worksheet A-6	
						To 09/30/2023	Date/Time Prepar	
		Decreases					2/20/2024 3: 40 p	<u>om</u>
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10. 00			
1. 00	A - PROPERTY INSURANCE	0.00	0	0	12			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	99, 245		1		2. 00
3. 00	NURSI NG ADMI NI STRATI ON	13. 00	Ö	2, 930			1	3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	1 <u>0, 5</u> 25			.	4. 00
	O D ALTERNATIVE PLATIL OTP		0	112, 700)			
1. 00	B - ALTERNATIVE BIRTH CTR ADULTS & PEDIATRICS	30.00	1, 020, 423	272, 063	C	1		1. 00
2.00	ADDETS & FEDIATRICS	0.00	1, 020, 423	272,003		l .	1	2. 00
	0		1, 020, 423	272, 063				
	C - EKG HOLTER, STRESS, EEG	T			_	I		
1.00	ASC (NON-DISTINCT PART)	75. 00 0. 00	598, 231 0	512, 542 0			1	1.00
2. 00 3. 00		0.00	0	0				2. 00
			598, 231	512, 542		-		
	D - OTHER BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	761, 515		•		1.00
2. 00 3. 00	ADMI NI STRATI VE & GENERAL HOUSEKEEPI NG	5. 00 9. 00	0	8, 230 792				2.00
4. 00	DI ETARY	10.00	o	67			•	4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	667	C		!	5. 00
6.00	PHARMACY	15. 00	0	765			1	6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	64			1	7.00
8. 00 9. 00	I NTENSI VE CARE UNI T RADI OLOGY-DI AGNOSTI C	31. 00 54. 00	ol Ol	199 802				8. 00 9. 00
10. 00	CT SCAN	57.00	o	765			1	0. 00
11. 00	LABORATORY	60.00	0	765				1.00
12.00	PHYSI CAL THERAPY	66.00	0	853			1	2.00
13. 00 14. 00	ASC (NON-DISTINCT PART) CARDIAC REHABILITATION	75. 00 76. 97	0	263 765			1	3. 00 4. 00
15. 00	EMERGENCY	91.00	0	69				5. 00
16. 00		0.00	o	0)		6. 00
17. 00		0.00	0	0	-)		7. 00
18.00		0.00	0	0	_			8.00
19. 00 20. 00		0. 00 0. 00	0	0	_			9. 00
21. 00		0.00	Ö	0	Ö		1	1.00
22. 00		0.00	0	0	C		2:	2. 00
23. 00		0.00	0	0	C			3. 00
24. 00 25. 00		0. 00 0. 00	0	0				.4. 00 .5. 00
26. 00		0.00	o	Ö	Ö			26. 00
27. 00		0.00	0	0	O			7. 00
28. 00		0.00	0	0	_			8. 00
29. 00 30. 00		0. 00 0. 00	0	0				9. 00 0. 00
31. 00		0.00	0	0				1. 00
32. 00		0.00	o	0	O			2. 00
33. 00		0.00	0	0	C			3. 00
34. 00		0.00	0	0	0			4. 00
35. 00		0.00		00 776, 581		1	3	5. 00
	E - MINISTRY ALLOCATIONS		<u> </u>	770,301				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2, 422, 502	C		-	1.00
2.00		0.00	0	0	0)		2. 00
3.00		0. 00 0. 00	0	0	0			3.00
4. 00 5. 00		0.00	0	0				4. 00 5. 00
6.00		0.00	o	0	Ö			6. 00
7.00		<u> </u>	0	0	C		-	7. 00
	O C CECTION		0	2, 422, 502				
1. 00	F - C-SECTION DELIVERY ROOM & LABOR ROOM	52.00	118, 202	31, 515	C	1		1. 00
1.00	0 ROOM & LABOR ROOM		118, 202 118, 202	3 <u>1, 5</u> 15 31, 515		7		1.00
	G - MOB HOSPITAL STORAGE			51,515				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0_	28, 376				1. 00
	O CALADY DECLASS		0	28, 376				
1. 00	H - SALARY RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 533	C			1. 00
2.00	OTHER NRCC	194. 01	24, 498	s, sss				2. 00
	0		24, 498	3, 533		1		-
	·		•				•	

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 14-0110

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/20/2024 3: 40 pm

						2/20/	/2024 3: 40 pm
		Decreases	6.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary	Other	Wkst. A-7 Ref. 10.00		
	I - NORRIS BUILDING OVERHEAD	7.00	8. 00	9. 00	10.00		
1.00	NORKE S BOT EDING OVERHEAD	0.00	0	0	13		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	198, 276	l I		2. 00
3.00		0.00	O	0			3. 00
4.00		0.00		0	0		4.00
	0		0	198, 276			
	J - MERCURY CIRCLE BUILDING		-1				
1. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	11 <u>8, 6</u> 23			1.00
	K - RADI OLOGY SPACE		U_	118, 623			
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 333	0		1.00
1.00	0		 	$\frac{2,333}{2,333}$			1.00
	L - MED SUPPLIES SOLD IMPLANTS	S AND DRUGS	•	,			
1.00	ADULTS & PEDIATRICS	30.00	0	10, 478	0		1. 00
2.00	OPERATING ROOM	50.00	0	2, 006, 935			2. 00
3.00	ASC (NON-DISTINCT PART)	<u>75.</u> 00	•	<u>7,5</u> 44			3. 00
	O LANGUANITO		0	2, 024, 957			
1. 00	M - IMPLANTS OPERATING ROOM	50.00	O	996, 525	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 980			2.00
3.00	ASC (NON-DISTINCT PART)	75. 00	Ö	170, 580			3. 00
4. 00	CLINIC	90.00	o	200, 960			4. 00
				1, 391, 045			
	N - DRUG CHARGES TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	624			1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 750			2. 00
3.00	MRI	58.00	0	761			3.00
4. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	٥	23, 626			4. 00
	0	+	 	31, 761			
	O - PHYSICIAN COST			2.,.2.			
1.00	ADMINISTRATIVE & GENERAL	5.00	47, 951	0	0		1. 00
	0		47, 951	0			
1 00	P - DI SABI LI TY RECLASS	0.00	225				1 00
1. 00 2. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	335 2, 978	0			1. 00 2. 00
3.00	ADULTS & PEDIATRICS	30.00	19, 742	0			3.00
4. 00	INTENSIVE CARE UNIT	31.00	1, 101	0			4. 00
5.00	OPERATING ROOM	50.00	1, 728	0	0		5. 00
6.00	RECOVERY ROOM	51.00	4, 508	0	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	5, 271	0	0		7. 00
8.00	RADI OI SOTOPE	56.00	1, 318	0	- 1		8. 00
9.00	CT SCAN LABORATORY	57.00	262	0	0		9.00
10. 00 11. 00	RESPI RATORY THERAPY	60. 00 65. 00	528 3, 684	0			10.00
12. 00	PHYSI CAL THERAPY	66.00	3, 004	178	- 1		12.00
13. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	2, 756	0			13. 00
	SERVI CES						
14.00	EMERGENCY	91.00	9, 940	0	0		14. 00
	O CTREATOR EVENUES		54, 151	178			
1. 00	R - STREATOR EXPENSES	0.00	0	0	9		1.00
2. 00		0.00	Ö	0			2. 00
3. 00		0.00	o	0			3. 00
4.00		0.00	О	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	ADMINISTRATIVE & GENERAL	0. 00 5. 00	ol Ol	1, 714, 941	13		8. 00 9. 00
7.00	0			1, 714, 941			7.00
	S - PCI/HTM COST		<u> </u>	., , , , , , , , , , , , , , , , , , ,			
1.00	OPERATION OF PLANT	7. 00	0	1, 614, 572			1.00
2.00		0.00		0	0		2. 00
	O TO DELIAD ADMINISTRATION		o	1, 614, 572			
1. 00	T - REHAB ADMINISTRATION PHYSICAL THERAPY	66.00	43, 266	566	0		1.00
2.00	THISTORE THEMALI	0.00	43, 200 N	0			2.00
50			43, 266	<u>5</u> 66			2.50
	U - MEDICAL RECORDS RECLASS						
1.00	ADMI NI STRATI VE & GENERAL			19 <u>2, 5</u> 36			1. 00
	lo		0	192, 536	l l		

Heal th	Financial Systems	OTTA	VA REGIONAL HOSE	PITAL & HEALTH	In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS						Peri od: Worksheet A-6 From 10/01/2022	
						To 09/30/2023 Date/Time	
		Decreases				2/20/2024	3: 40 pm
	Cost Center	Li ne #	Sal ary	Other N	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	V - PROPERTY TAX	0.00	O	0	13		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 290	0	1	2. 00
3.00	OPERATION OF PLANT	7. 00	0	8, 270	0		3. 00
4.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	103, 962	0		4. 00
	O W - CAFETERIA		0	120, 522			
1. 00	DI ETARY	10.00	582, 553	471, 006	0		1.00
	0		582, 553	471, 006			
1 00	Y - MINISTRY OSFMG OVERHEAD	20.00		1/ 21/		I	1.00
1. 00 2. 00	ADULTS & PEDIATRICS ANESTHESIOLOGY	30. 00 53. 00	0	16, 314 56, 545	0	1	1. 00 2. 00
3. 00	RURAL HEALTH CLINIC (RHC)	88. 00	0	25, 410	0	•	3. 00
4.00	RURAL HEALTH CLINIC (RHC)	88. 01	0	176, 848	0	1	4. 00
5. 00	RURAL HEALTH CLINIC (RHC)	88. 02	0	100, 221	0	1	5. 00
6. 00 7. 00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91. 00 192. 00	0	276, 971 92, 139	0	•	6. 00 7. 00
7.00	0	1 <u>72.</u> 00	— — — — —	744, 448	9		7.00
	Z - FOUNDATION EXP RECLASS						
1.00	OTHER NRCC	194. 01	0	1, 015, 746	0	•	1. 00
2. 00 3. 00		0. 00 0. 00	0	0	0	•	2. 00 3. 00
4. 00		0.00	0	0	0	•	4. 00
00	0			1, 015, 746	=		
	AA - TEAM AWARDS		, o , o = o	اء			
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	626, 372 0	0	0	•	1. 00 2. 00
3. 00		0.00	0	0	0	1	3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0	1	5. 00
6. 00 7. 00		0. 00 0. 00	0	0	0	1	6. 00 7. 00
7. 00 8. 00		0.00	ol Ol	0	0	1	8. 00
9. 00		0.00	Ö	Ö	0	1	9. 00
10.00		0.00	0	0	0	1	10. 00
11.00		0.00	0	0	0	1	11.00
12. 00 13. 00		0. 00 0. 00	0	0	0	1	12. 00 13. 00
14. 00		0.00	0	0	0	1	14. 00
15.00		0.00	0	0	0		15. 00
16. 00		0.00	0	0	0	•	16. 00
17. 00 18. 00		0. 00 0. 00	0	0	0	•	17. 00 18. 00
19. 00		0.00	0	0	0	1	19.00
20.00		0.00	0	0	0	•	20. 00
21. 00		0.00	0	0	0		21. 00
22. 00		0.00	0	0	0	•	22. 00 23. 00
23. 00 24. 00		0. 00 0. 00	0	0	0	1	24. 00
25. 00		0.00	Ö	0	0	•	25. 00
26. 00		0.00	0	0	0	•	26. 00
27. 00		0.00	0	0	0	1	27. 00
28. 00 29. 00		0. 00 0. 00	0	0	0	1	28. 00 29. 00
30.00		0.00	0	0	0	•	30. 00
31.00		0.00	0	0	0		31. 00
32.00		0.00	0	0	0	1	32.00
33. 00 34. 00		0. 00 0. 00	0	0	0	1	33. 00 34. 00
35. 00		0.00	o	0	0	1	35. 00
	TOTALS		626, 372	0			
1. 00	AB - OCC MED	0.00	ol	0	0		1. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	133, 932	0		3. 00
5. 50	TOTALS		 	133, 932	<u> </u>		
	AC - RHC RECLASS						
1.00	RURAL HEALTH CLINIC (RHC)	88.00	95, 610	51, 634	0		1.00
2.00 3.00	RURAL HEALTH CLINIC (RHC) RURAL HEALTH CLINIC (RHC)	88. 01 88. 02	761, 883 375, 785	298, 482 148, 404	0		2. 00 3. 00
	TOTALS		1, 233, 278	498, 520			0.00
500.00	Grand Total: Decreases		4, 348, 925	14, 433, 774			500.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 14-0110 Peri od: Worksheet A-7 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/20/2024 3:40 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 3, 227, 906 0 1.00 0 3, 114, 070 2.00 Land Improvements 0 2.00 69, 469, 445 3.00 Buildings and Fixtures 3, 944, 597 3, 944, 597 3.00 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 36, 707, 486 722, 792 722, 792 52, 057 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 112, 518, 907 4, 667, 389 4, 667, 389 52, 057 8.00 9.00 Reconciling Items 0 9.00 112, 518, 907 Total (line 8 minus line 9) O 52, 057 10.00 4, 667, 389 4, 667, 389 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 3, 227, 906 1.00 2.00 Land Improvements 3, 114, 070 0 2.00 3.00 Buildings and Fixtures 73, 414, 042 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 37, 378, 221 6.00

117, 134, 239

117, 134, 239

0

0

0

Health Financial Systems	OTTAWA REGIONAL HOSPITAL & HEALTH	ICAR	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider C	CN: 14-0110	Peri od: From 10/01/2022	Worksheet A-7 Part II

					o 09/30/2023		
			SL	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	cost denter bescription	Depi eci ati on	Lease	Titterest	instructions)	instructions)	
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	2, 748, 308	0	C	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 504, 686	0	C	0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 252, 994	0	C	0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	· · · · · · · · · · · · · · · · · · ·				
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 748, 308				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 504, 686				2. 00
3.00	Total (sum of lines 1-2)	0	4, 252, 994				3. 00

Health Financial Systems OTT	AWA REGIONAL HOS	SPITAL & HEALTH	ICAR	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 10/01/2022 To 09/30/2023	Worksheet A-7 Part III Date/Time Pre 2/20/2024 3:4	pared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF		<u> </u>
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	73, 414, 042		73, 414, 04:		131, 306	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	37, 378, 221		37, 378, 22		66, 854	2. 00
3.00 Total (sum of lines 1-2)	110, 792, 263		110, 792, 26			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS				_		
1.00 CAP REL COSTS-BLDG & FLXT	140, 805	l .	272, 11		0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	71, 690	l .	138, 54		0	2. 00
3.00 Total (sum of lines 1-2)	212, 495		410, 65		0	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
				instructions)		
DADT III DECONCILIATION OF CADITAL COSTS	11. 00	12.00	13. 00	14. 00	15. 00	

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

131, 306 66, 854 198, 160

140, 805 71, 690 212, 495

4, 116, 518 1. 00 3, 904, 614 2. 00 8, 021, 132 3. 00

0 0 0

1.00

2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES OTTAWA REGIONAL HOSPITAL & HEALTHCAR
Provider CCN: 14-0110 In Lieu of Form CMS-2552-10
Worksheet A-8

				T	0 09/30/2023	Date/Time Prep 2/20/2024 3:40	
				Expense Classification on To/From Which the Amount is			<u>р</u>
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost conten bescription	1.00	2.00	3.00	4. 00	5. 00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	discounts (chapter 8)		0				
5.00	Refunds and rebates of expenses (chapter 8)		Ü		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 244 271		0. 00	0	9. 00 10. 00
	adj ustment	A-8-2	-9, 266, 271				
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12.00	Related organization transactions (chapter 10)	A-8-1	2, 553, 477		0.00	0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-342, 011	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than		0		0.00	О	17. 00
18. 00	patients Sale of medical records and abstracts	В	-3	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	o	19. 00
20. 00	Vending machines		0		0.00		20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)	В	-118, 656	ADMINISTRATIVE & GENERAL	5. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	O	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	А	1, 131, 700	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP	А	194, 485	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32, 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	AMORTIZED CAPITALIZED INTEREST	A	25, 848	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 00

Provider CCN: 14-0110

Peri od: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

				To	09/30/2023	Date/Time Pre 2/20/2024 3:4	
				Expense Classification on	Worksheet A	272072024 3.4	D DIII
				To/From Which the Amount is 1			
					•		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	PHYSICIAN RECRUITING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 02	PHYSICIAN RECRUITING EXPENSE	Α		HOUSEKEEPI NG	9. 00	0	33. 02
33. 03	PHYSICIAN RECRUITING EXPENSE	Α		PHARMACY	15. 00	0	33. 03
33. 04	PHYSICIAN RECRUITING EXPENSE	Α	•	ADULTS & PEDIATRICS	30. 00	0	33. 04
33. 05	PHYSICIAN RECRUITING EXPENSE	A	-200	1	58. 00	0	33. 05
33. 06	PHYSICIAN RECRUITING EXPENSE	A		LABORATORY	60.00	0	33. 06
33. 07	PHYSICIAN RECRUITING EXPENSE	A	-3, 071	PHYSI CAL THERAPY	66.00	0	33. 07
33. 08	PHYSICIAN RECRUITING EXPENSE	A	-1, 071	SPEECH PATHOLOGY	68. 00	0	33. 08
33. 09	PHYSICIAN RECRUITING EXPENSE	A	-10, 000	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	33. 09
				SERVI CES			
33. 10	PHYSICIAN RECRUITING EXPENSE	Α		EMERGENCY	91. 00	0	33. 10
33. 11	TRUSTEE FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	ADVERTI SI NG	A		ADULTS & PEDIATRICS	30. 00	0	33. 12
33. 13	ADVERTI SI NG	A	-24	LABORATORY	60.00	0	33. 13
33. 14	ADVERTI SI NG	A	-91	EMERGENCY	91.00	0	33. 14
33. 15	LOBBYING DUES	A	-28, 702	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	PATIENT TRANSPORTATION	A	-2, 807	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	MEDICALD ASSESSMENT	A	-4, 966, 832	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	MI SCELLANEOUS REVENUES - A&G	В	-4, 625	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	ADVERTI SI NG	A	-1, 231	RURAL HEALTH CLINIC (RHC)	88. 01	0	33. 19
33. 21	CONTRACT PHARMACY	A	-348, 034	DRUGS CHARGED TO PATIENTS	73.00	0	33. 21
33. 22	RENTAL INCOME	В	-33, 451	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 24	COMMUNITY EDUCATION REVENUES	В	-6, 571	NURSING ADMINISTRATION	13.00	0	33. 24
33. 25	DONATI ON	A	-25, 500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	SALARIED PHYS PART B OFFSET	A	-322, 645	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 26
33. 27	OCC MED	A	-36, 876	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 27
33. 28	PSYCHIATRY SALARIES - PSYCH	A	-660, 778	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	33. 28
				SERVI CES			
33. 30	APP -ADULTS AND PEDS	A	-119, 866	ADULTS & PEDIATRICS	30.00	0	33. 30
33. 31	APP BENEFITS	A	-210, 471	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 31
33. 32	SUPPLY CHAIN OTER REV	В	-3, 700	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 32
33. 33	ADULTS AND PEDS OTHER REV	В	-1, 397	ADULTS & PEDIATRICS	30.00	0	33. 33
33. 34	PHYSICIAN RECRUITING	A	-50	RURAL HEALTH CLINIC (RHC)	88. 01	0	33. 34
33. 35	PHYSICIAN RECRUITING	A	-104	ASC (NON-DISTINCT PART)	75. 00	0	33. 35
33. 36	PHYSICIAN RECRUITING	A	-5, 000	ANESTHESI OLOGY	53.00	0	33. 36
33. 37	PHYSICIAN RECRUITING	A	-450	RADI OI SOTOPE	56.00	0	33. 37
33. 38	PHYSICIAN RECRUITING	A	-1, 000	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 38
33. 39	RHC II SALARIES	A	45, 818	RURAL HEALTH CLINIC (RHC)	88. 01	0	33. 39
33. 40	RHC II BENEFITS	A	8, 247	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 40
33. 41	RHC III SALARIES	A	3, 742	RURAL HEALTH CLINIC (RHC)	88. 02	0	33. 41
33. 42	RHC III BENEFITS	A	674	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 42
33. 43	APP PART B SALARIES	A	-5, 456	INTENSIVE CARE UNIT	31.00	0	33. 43
34.00	CRNA SALARIES	A	-1, 311, 454	ANESTHESI OLOGY	53.00	0	34. 00
34. 01	CRNA BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
34.03	MALPRACTICE INSURANCE NOT	A	747, 291	ADMINISTRATIVE & GENERAL	5. 00	0	34. 03
	FUNDED						
34.04	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 04
	(3)						
34.05	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 05
	(3)						
34.06	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 06
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-13, 337, 882				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>
(1) De	scription - all chapter referer	nces in this col	umn pertain to	CMS Pub. 15-1.			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-0110 Peri od: Worksheet A-8-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared: OFFICE COSTS

				10 09/30/2023	2/20/2024 3: 4	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	<u>Б.</u>
			P	Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00			MINISTRY POOLED - BLDG	571, 504		1. 00
2.00			MINISTRY POOLED - EQUIPMENT	1, 417, 239	0	2. 00
3.00		EMPLOYEE BENEFITS DEPARTMENT		651, 361	651, 361	3. 00
3.01			MINISTRY CHG - POOLED ADMIN	9, 517, 558	12, 204, 643	3. 01
3.02			MINISTRY CHG - POOLED A&G	105, 745	164, 520	3. 02
3.03			MINISTRY CHG - POOLED ENGINE	350, 894	350, 894	
3.04		ADMINISTRATIVE & GENERAL	MINISTRY CHG - OSFMG	0	744, 448	3. 04
3. 05		PHYSI CAL THERAPY	MINISTRY CHG - POOLED REHAB	89, 489	81, 780	3. 05
3.06		OCCUPATIONAL THERAPY	MINISTRY CHG - POOLED REHAB	11, 755	10, 742	3. 06
3.07			MINISTRY CHG - POOLED REHAB	4, 287	3, 918	3. 07
3.08		l .	MINISTRY CHG - POOLED PHARMA	153, 790	153, 790	3. 08
3. 09		DRUGS CHARGED TO PATIENTS	MINISTRY CHG - FUNCTIONAL E	501, 690	501, 690	3. 09
3. 10			MINISSTRY DEPRECIATION - OSF	29, 914	29, 914	3. 10
3. 11		ADULTS & PEDIATRICS	MANAGEMENT SVCS OSFMG	6, 748	6, 748	3. 11
3. 12			MANAGEMENT SVCS OSFMG	3, 844	3, 844	3. 12
3. 13			MANAGEMENT SVCS OSFMG	46, 580	46, 580	3. 13
3. 14			MANAGEMENT SVCS OSFMG	319, 730	319, 730	3. 14
3. 15			MANAGEMENT SVCS OSFMG	114, 886	114, 886	3. 15
4.00		EMERGENCY	MANAGEMENT SVCS OSFMG	88, 468	88, 468	4. 00
4. 01	1	ADMINISTRATIVE & GENERAL	PURCHASED SVCS - ST GABRIEL	921, 951	924, 122	4. 01
4. 02 4. 03		ADMINISTRATIVE & GENERAL MEDICAL RECORDS & LIBRARY	MINISTRY CHG - FUNCTIONAL RE MINISTRY CHG - FUNCTIONAL ME	7, 949, 883	5, 232, 650	4. 02 4. 03
4. 03			MINISTRY CHG - FUNCTIONAL ME	292, 517 1, 152, 636	192, 536 0	4. 03 4. 04
4. 04	1	l l	MINISTRY CHG - FUNCTIONAL NO	26, 712	0	4. 04
4. 03			MINISTRY CHG - FUNCTIONAL SA	1, 377, 034	1, 170, 017	4. 03
4. 09		l l	MINISTRY CHG - FUNCTIONAL CL	1, 377, 034	1, 170, 017	4. 00
4. 10			MINISTRY CHG - FUNCTIONAL CA	928, 024	Ö	4. 10
4. 11			MINISTRY CHG - FUNCTIONAL PH		0	4. 11
4. 12		ADMINISTRATIVE & GENERAL	CREDENTI ALI NG	95, 055	75, 755	4. 12
4. 13			PCI ETS RENTAL	2, 223	3, 740	4. 13
4. 14		OPERATION OF PLANT	PCI - HTM - ENGINEERING	900, 948	944, 532	4. 14
4. 15		RADI OLOGY-DI AGNOSTI C	PCI - HTM - I MAGI NG	1, 291, 323	1, 353, 791	4. 15
4. 16			PCI - HTM - LAB	248, 748	260, 781	4. 16
4. 17			SYSTEMS LAB	959, 676	959, 676	4. 17
4. 18		RADI OLOGY-DI AGNOSTI C	PCI - HTM - OUT OF CONTRACT	10, 696	13, 243	4. 18
5.00	TOTALS (sum of lines 1-4).			30, 335, 527	27, 782, 050	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which 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 RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0.00 OSF HEALTHCARE 100.00	6. 00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Heal th F	Financial Systems	OTTAWA REGIONAL HO	SPITAL & HEALT	HCAR	In Lie	eu of Form CMS-	2552-10
		RELATED ORGANIZATIONS AND HOM	ME Provider (CCN: 14-0110	Peri od:	Worksheet A-8	3-1
OFFICE (COSTS				From 10/01/2022 To 09/30/2023		
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	1	Name	Percentage of Ownership	

3.00

4. 00

5. 00

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

1. 00

- 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.

2.00

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.

			2/20/2024 3:4	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	-601, 747	9		1.00
2.00	1, 417, 239	9		2.00
3.00	0	0		3.00
3. 01	-2, 687, 085	0		3. 01
3.02	-58, 775	0		3. 02
3.03	0			3. 03
3.04	-744, 448	0		3. 04
3.05	7, 709			3. 05
3.06	1, 013			3.06
3.07	369	0		3. 07
3.08	0	0		3. 08
3.09	0	0		3. 09
3. 10	0	11		3. 10
3. 11	0	0		3. 11
3. 12	0	0		3. 12
3. 13	0	0		3. 13
3. 14	0	0		3. 14
3. 15	0	0		3. 15
4.00	0			4. 00
4. 01	-2, 171	0		4. 01
4. 02	2, 717, 233			4. 02
4.03	99, 981	0		4. 03
4.04	1, 152, 636	0		4. 04
4.05	26, 712	0		4. 05
4.08	207, 017			4. 08
4.09	177, 989			4. 09
4. 10	928, 024			4. 10
4. 11	14, 630	0		4. 11
4. 12	19, 300	0		4. 12
4. 13	-1, 517	0		4. 13
4. 14	-43, 584	0		4. 14
4. 15	-62, 468			4. 15
4. 16	-12, 033			4. 16
4. 17	0	0		4. 17
4. 18	-2, 547	0		4. 18
5.00	2, 553, 477			5.00

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

Related Organization(s) and/or Home Office		
and/or home office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6.00
7.00		7. 00 8. 00 9. 00
8.00		8.00
9.00		9.00
10.00		10. 00 100. 00
100.00		100.00

Health Financial Systems	OTTAWA REGIONAL HOSPI	TAL & HEALTHCAR	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 14-0110	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 10/01/2022 To 09/30/2023	Date/Time Prepared: 2/20/2024 3:40 pm
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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 Provider CCN: 14-0110

					'	09/30/2023	2/20/2024 3:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	2, 339, 748	· · ·				
2.00		ANESTHESI OLOGY	1, 797, 414					
3.00		RADI OLOGY-DI AGNOSTI C	970, 884		0	271, 400		
4.00		LABORATORY	141, 768			260, 300		
5.00	76. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	980, 592	972, 326	8, 266	181, 300	30	5. 00
	7, 07	SERVI CES	0.550	0.550		404 000		, 00
6.00		CARDIAC REHABILITATION	2, 550			181, 300		
7.00		CLINIC	75, 635			211, 500		
8.00		EMERGENCY	3, 066, 083	3, 066, 083	0	211, 500 0		8. 00
9.00	0.00		0	0	0	0	"	7.00
10. 00 200. 00	0. 00		9, 374, 674	9, 221, 374	152 200	U	1 200	10. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		153, 300 Cost of	Provi der	Physician Cost	
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &	Component	of Malpractice	
		i denti i i ei	LIIIII	Li mi t	Continuing	Share of col.	Insurance	
					Educati on	12	Trisurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0	0		0		1. 00
2.00	53.00	ANESTHESI OLOGY	33, 723	1, 686	0	0	0	2. 00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	3. 00
4.00	60.00	LABORATORY	120, 764	6, 038	0	0	0	4. 00
5.00	76. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	2, 615	131	0	0	0	5. 00
		SERVI CES						
6.00		CARDIAC REHABILITATION	0	0	0	0	0	6. 00
7.00		CLINIC	0	0	0	0	0	
8.00		EMERGENCY	0	0	0	0	0	0.00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	
200.00			157, 102			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	13.00			2, 339, 748		1, 00
2. 00		ANESTHESI OLOGY		33, 723	_	1, 763, 691	•	2. 00
3.00		RADI OLOGY-DI AGNOSTI C		03, 723	37, 240	970, 884		3. 00
4.00		LABORATORY		120, 764	0	69, 703		4. 00
5. 00		PSYCHI ATRI C/PSYCHOLOGI CAL	0	2, 615		977, 977	•	5. 00
3.00	,3.01	SERVI CES		2,010	3,001	, ,,,,		0.00
6.00	76. 97	CARDIAC REHABILITATION	0	0	0	2, 550		6. 00
7.00	90.00	CLINIC	0	0	0	75, 635		7. 00
8.00	91. 00	EMERGENCY	0	0	0	3, 066, 083		8. 00
9.00	0. 00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10. 00
200.00			0	157, 102	44, 897	9, 266, 271		200. 00

Heal th Financial Systems

OTTAWA REGIONAL HOSPITAL & HEALTHCAR

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2022
To 09/30/2023

Date/Time Prepared:
2/20/2024 3: 40 pm

				Τ̈́	09/30/2023	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		2/20/2024 3: 4	O pm
		N . F	DI DO A FLYT	IN IDLE FOLLID	EMBL OVEE		
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1.00	2.00	4. 00	4A	
GENE	ERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	47.	
	OO CAP REL COSTS-BLDG & FIXT	4, 116, 518		1			1. 00
	OO CAP REL COSTS-MVBLE EQUIP	3, 904, 614		3, 904, 614			2.00
	DO EMPLOYEE BENEFITS DEPARTMENT DO ADMINISTRATIVE & GENERAL	13, 035, 354 24, 301, 050	l	1		27, 074, 495	4. 00 5. 00
	00 MAINTENANCE & REPAIRS	306, 522	l	0		306, 522	6. 00
	OO OPERATION OF PLANT	4, 250, 586	l			6, 055, 616	7. 00
	DO LAUNDRY & LINEN SERVICE DO HOUSEKEEPING	444, 897 1, 739, 766	l	1	,	465, 971 2, 142, 465	8. 00 9. 00
	DO DI ETARY	643, 617	l	1		2, 142, 463 877, 313	•
	OO CAFETERI A	711, 548	l			925, 491	11. 00
	OO NURSING ADMINISTRATION	2, 637, 897	36, 393			3, 171, 122	13. 00
	DO CENTRAL SERVICES & SUPPLY DO PHARMACY	575, 451 1, 589, 523	3, 884 0	i		717, 339 1, 890, 077	14. 00 15. 00
	00 MEDICAL RECORDS & LIBRARY	293, 324				323, 030	16.00
	00 SOCIAL SERVICE	1, 542, 187	6, 388			1, 574, 865	17. 00
	ATIENT ROUTINE SERVICE COST CENTERS	0.050.040	100 405	00.040	0 540 000	40 //4 054	00.00
	DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT	9, 850, 369 1, 517, 881	199, 405 17, 520			12, 661, 051 1, 893, 761	30. 00 31. 00
	OO NURSERY	485, 229	l			607, 844	43. 00
	LLARY SERVICE COST CENTERS		·				
	OO OPERATING ROOM	2, 675, 625	l			3, 555, 247	50.00
	DO RECOVERY ROOM DO DELIVERY ROOM & LABOR ROOM	1, 226, 317 658, 521	6, 763 19, 924			1, 547, 458 825, 061	51. 00 52. 00
	OO ANESTHESI OLOGY	408, 310	l	1		516, 625	53. 00
	DO RADI OLOGY-DI AGNOSTI C	6, 133, 448	126, 371	531, 145		7, 822, 683	1
	DO RADIOISOTOPE DO CT SCAN	403, 312	0			449, 410	•
	DO MRI	891, 038 588, 014	19, 193	,		1, 084, 734 714, 251	57. 00 58. 00
	DO LABORATORY	6, 839, 520	l	1		7, 914, 650	60.00
	00 RESPI RATORY THERAPY	1, 121, 801	28, 040				65. 00
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY	2, 742, 139	l			3, 722, 476	66. 00 67. 00
	00 SPEECH PATHOLOGY	398, 758 144, 289	l	1		520, 575 186, 991	68.00
	00 ELECTROCARDI OLOGY	229, 692	l	1	l '	298, 270	•
	DO ELECTROENCEPHALOGRAPHY	7, 515	ł	1	_,	9, 633	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT DO IMPL. DEV. CHARGED TO PATIENTS	1, 994, 364 1, 391, 045	42, 718	1	l i	2, 060, 964 1, 391, 045	71. 00 72. 00
	DO DRUGS CHARGED TO PATIENTS	5, 657, 021	11, 059		· ·	5, 695, 478	1
75. 00 0750	OO ASC (NON-DISTINCT PART)	2, 106, 079				2, 666, 337	75. 00
	50 STRESS TESTING	0	0	1	1	0	76. 00
1	50 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 10 SLEEP LAB	1, 694, 841 429, 654	27, 226 18, 215			2, 180, 397 605, 887	1
	97 CARDI AC REHABI LI TATI ON	1, 128, 579					•
	PATIENT SERVICE COST CENTERS			1			
	DO RURAL HEALTH CLINIC (RHC) DI RURAL HEALTH CLINIC (RHC)	476, 806				623, 712	
	D2 RURAL HEALTH CLINIC (RHC)	3, 004, 936 1, 899, 952		9, 509 0		4, 004, 484 2, 422, 955	
	OO CLINIC	614, 789	l e	Ö		719, 374	
	DO EMERGENCY	5, 581, 944	119, 992	37, 204	464, 880	6, 204, 020	1
	DO OBSERVATION BEDS (NON-DISTINCT PART ER REIMBURSABLE COST CENTERS					0	92.00
	OO OPLOLD TREATMENT PROGRAM	0	0	0	O	0	102. 00
	CIAL PURPOSE COST CENTERS				<u> </u>		.02.00
	OO INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	122, 394, 642	3, 074, 932	3, 732, 862	13, 030, 000	121, 167, 141]118.00]
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	91, 227	15, 235	0	ol	106, 462	190. 00
192. 00 1920	DO PHYSICIANS' PRIVATE OFFICES	3, 148, 625	l		1	3, 531, 275	192. 00
	50 CARDI NAL SLEEP	0	ľ	1	0		194. 00
200. 00	51 OTHER NRCC Cross Foot Adjustments	210, 254	756, 381	59, 079	14, 156	1, 039, 870 0	194. 01 200. 00
201.00	Negative Cost Centers		О	О	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	125, 844, 748	4, 116, 518	3, 904, 614	13, 044, 163		202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 10/01/2022	Part	
To 09/30/2023	Date/Time Prepared:	2/20/2024 3:40 pm

Cost Center Description					''	0 09/30/2023	2/20/2024 3: 4	
		Cost Center Description						
CEMERAL SERVICE COST CENTERS 1.00 0.0000 2.000							0.00	
0.00 0.00		CENEDAL SEDVICE COST CENTERS	5.00	6. 00	7.00	8.00	9.00	
2.00	1 00							1 00
4.00 0.0400 CMPLOYCE BEREFITS DEPARTMENT 4.00 5.00 0.0500 CMM INSTRATIVE & 6.00 1.0500 CMM INSTRATIVE & 6.00 CMM IN					•			1
5.00 OSCOD AMAIN ISTRATIVE & GENERAL 22,074,495 6.00 OSCOD AMAIN ISTRATIVE & REPAIR S 8.4,023 300,545 7.00 0.00 OSCOD OFERATION OF PLANT 1,659,941 99,014 7,814,573 22,577 620,180 8.00 0.00 OSCOD OFERATION SERVICE 127,730 752,575 620,180 2.289,200 0.00 0.00 0.00 OSCOD				•			1	
0.000 0.000 MIA INTERNANCE & REPAIR			27 074 495		•			
0.0000 ORDINO OPERATION OF PLANT 1,659,941 99.016 7,814,573 7.00 80.00 0.000 OLAMONY & LIBEN SERVICE 127,730 592 25,577 620,180 2,789,200 0.00 0.000 0.0000 DITATAY 224.0466 12.766 342,188 0.00 0.00 0.000 0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.000000 0.000000 0.000000 0.000000 0.00000000			1 1	390 545				•
8.00 00800 LANDAY & LINEN SERVICE 127, 730 952 25, 527 620, 180 8.00 0.00					1			
9.00 00000 HOUSEKEPPING 597,284 2, 138 57,313 0 2,789,200 0,00 11.00 01000 DITARY 240,486 12,766 342,188 0,00 0 0 11.00 11.00 01000 DITARY 253,692 5, 182 138,900 0 0 0 11.00 14.00 01000 DRISKA ADMINISTRATION 867,255 4,043 11,566 0 0 12,00 14.00 01000 DRISKA SAMINISTRATION 986,255 4,043 11,566 0 0 12,00 17.00 01000 DRITARI STRVICES & SUPPLY 986,534 4,13 11,566 0 0 12,00 17.00 01000 DRITARI STRVICES & SUPPLY 986,534 4,13 11,566 0 0 10,00 17.00 01000 DRITARI STRVICES & SUPPLY 986,534 4,13 11,566 0 0 0 0 17.00 01000 DRITARI STRVICES & SUPPLY 986,534 22,151 593,754 216,960 637,765 30.00 18.00 03000 ADULTS & PEDIATRICS 3,470,584 22,151 593,754 216,960 637,765 30.00 14.00 03000 ADULTS & PEDIATRICS 3,470,584 22,151 593,754 216,960 637,765 30.00 14.00 03000 MRSELT MINITARI 166,620 1,330 35,650 10,188 0 43.00 14.00 03000 MRSELT MINITARI 166,620 1,330 35,650 10,188 0 43.00 15.00 03000 DRITARI STRVICE COST CENTERS 27,452 27,453 27,452 27,452 27,453 27,452 27,452 27,453 27,452 27,452 27,453 27,453 27			1					
10.00 01000 DIETARY 240, 486 12, 766 342, 188 0 20, 814 10.00 10.0			l					
11.00 0 10100 CAPETERIA 233, 692 5, 182 138, 900 0 0 11.00 14.00 1			· · · · · · · · · · · · · · · · · · ·					•
13.00 0300 MURSI NG ADMIN STRATION 8.09, 255 4.,043 108, 366 0 0 13.00			· · · · · · · · · · · · · · · · · · ·		1			•
14.00 01400 (CENTRAL SERVICES & SUPPLY 196, 634 431 11, 566 0 0 13, 301 13, 00 16.00 0 0 0 0 0 0 0 13, 301 13, 00 16.00 0 0 0 0 0 0 13, 301 13, 00 10, 0			1				0	
15.00 01500 PIJARMACY 518, 100 0 0 13, 301 15, 00 0 170 00 01700 00 16.00 16.00 01700 MEDICAL RECORDS & LIBRARY 88, 548 3,159 84, 660 0 0 16.00 170 170 19, 023 0 0 0 170 170 170 19, 023 0 0 0 170			l		1		0	14.00
17.00 17.0	15. 00		l		l	0	13, 301	15. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS 3, 470, 564 22, 151 593, 754 216, 900 637, 765 30. 00 31. 00 03100 NUTES REPORTED TATE OS 3, 470, 564 51. 10 1, 946 52, 169 42, 002 218, 392 31. 00 43. 00 43.0	16.00	01600 MEDICAL RECORDS & LIBRARY	88, 548	3, 159	84, 690	0		16. 00
30.00	17.00	01700 SOCIAL SERVICE	431, 696	710	19, 023	0	0	17. 00
31.00 03100 INTERSIVE CARE UNIT 16.620 1.330 55.650 10.188 0.43.00		INPATIENT ROUTINE SERVICE COST CENTERS						
A3. 00 04300 NURSERY 106, 620 1, 330 35,650 10, 188 0 42, 00	30.00	03000 ADULTS & PEDI ATRI CS	3, 470, 584	22, 151	593, 754	216, 960	637, 765	30. 00
ANCILLARY SERVICE COST CENTERS 50.00 50.00 0 67.00 159.00 65.00 0 67.000 0 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.000 67.000 67.000 67.000 67.0000 67.000 67.000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.0000 67.00000 67.0000 67.00000 67.00000 67.000000 67.000000 67.0000000 67	31.00	03100 INTENSIVE CARE UNIT	519, 110	1, 946	52, 169	42, 002	218, 392	31.00
50.00 050000 050000 050000 050000 050000 05000	43.00	04300 NURSERY	166, 620	1, 330	35, 650	10, 188	0	43.00
51.00 OS100 RECOVERY ROOM ALBOR ROOM A24, 183 751 20, 138 0 87, 807 51, 00 52, 00 OS200 DELLYERR POOM & LABOR ROOM A26, 162 2, 213 59, 326 16, 948 0 52, 00 53, 00 OS300 ANESTHESI OLOGY 141, 615 0 0 0 0 0 0 0 52, 00 53, 00 OS300 ANESTHESI OLOGY 144, 323 14, 038 376, 288 23, 228 286, 568 54, 00 56, 00 OS600 RADIO INFOCE 123, 190 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
S2.00 05200 DELLUYERY ROOM & LABOR ROOM 226, 162 2, 213 59, 326 16, 948 0 \$2.00 53.00 053.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 054.00 056	50.00	05000 OPERATING ROOM	974, 550	7, 005	187, 776	49, 422	158, 866	50.00
141, 615			424, 183	751	20, 138	0	87, 807	
S4-00 05400 RADIO LOGY-DI AGNOSTIC 2, 144, 323 14, 038 376, 288 23, 228 280, 568 54, 00 65. 00 05600 05600 05600 05600 057, 00 057, 00 057, 00 057, 00 057, 00 057, 00 057, 00 058, 00 05800 08800 MRI 195, 788 2, 132 57, 149 0 53, 427 58, 00 060, 00 06000 LABORATORY 2, 169, 532 9, 605 257, 471 0 287, 639 60, 00 06000 RSPIRATORY THERAPY 391, 965 3, 115 33, 492 0 54, 929 65, 00 06000 RSPIRATORY THERAPY 1, 202, 390 27, 478 736, 546 50, 834 112, 996 66, 00 06000 PSPIRATORY THERAPY 142, 698 1, 629 43, 678 0 32, 525 67, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 06000 SPECKI PATHOLOGY 51, 257 485 13, 008 0 0 0 0 0 0 0 0 0	52.00			2, 213	59, 326	16, 948		52. 00
56. 00 05600 RADI DI SOTOPE 123, 190 0 0 0 0 0 55, 00	53.00		141, 615	0	1	0		53. 00
57.00 05700 05700 05 05 05 05				14, 038	376, 288	23, 228		ł
SB 00 OBSOO MR 195, 788 2,132 57, 149 0 53, 427 58, 00			l	0		0		1
60.00 06000 LABORATORY 2, 169, 532 9, 605 257, 471 0 287, 639 60, 00			l	0	· ·	0		
65.00 06500 RESPI RATORY THERAPY 391, 965 3, 115 83, 492 0 54, 929 65, 00 66.00 06600 PHYSI CAL THERAPY 1, 202, 390 27, 478 736, 546 50, 834 112, 996 66, 00 67.00 06700 OCCUPATI ONAL THERAPY 142, 698 1, 629 43, 678 0 32, 525 67, 00 68.00 06800 SPECH PATHOLOGY 51, 257 485 13, 008 0 41, 805 68, 00 69.00 06900 ELECTROCARDI OLOGY 81, 761 425 11, 403 20, 430 0 69, 00 70.00 07000 ELECTROCARDI OLOGY 81, 761 425 11, 403 20, 430 0 69, 00 70.00 07000 ELECTROCARDI OLOGY 18, 761 425 11, 403 20, 430 0 69, 00 70.00 07000 ELECTROCARDI OLOGY 18, 761 425 11, 403 20, 430 0 69, 00 70.00 07000 ELECTROCARDI OLOGY 18, 761 425 11, 403 20, 430 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 564, 943 4, 745 127, 198 0 0 0 0 0 0 72.00 07200 MPL DEV. CHARGED TO PATI ENTS 381, 308 0 0 0 0 0 0 0 0 75.00 07500 DRUGS CHARGED TO PATI ENTS 1, 561, 222 1, 228 32, 929 0 0 73, 00 75.00 07500 ASC (NON-DISTINCT PART) 730, 886 7, 316 196, 104 17, 955 36, 988 75, 00 76.00 03160 STRESS TESTI NG 0 0 0 0 0 0 0 76.01 03550 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 160, 855 76, 01 76.02 03650 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 160, 855 76, 01 76.07 03650 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 160, 855 76, 01 76.07 03650 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 160, 855 76, 01 76.07 03650 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 0 0 0 0 76.07 03650 PSYCHI ATRIC /PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 0 0 0 0 0 76.00 03600 RUBAL HEALTH CLINIC (RHC) 170, 969 2, 477 66, 402 0 0 0 0 0 0 76.00 03600 RUBAL H						0		1
66.00 06600 PHYSICAL THERAPY 1,020,390 27,478 736,546 50,834 112,996 66.00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06800 059ECH PATHOLOGY 51,257 485 13,008 0 41,805 68.00 06800 06800 059ECH PATHOLOGY 81,761 425 11,403 20,430 0 69.00 0700 07000 050ECTENCEPHALOGRAPHY 2,641 0 0 0 167 0 0 0 0 0 0 0 0 0					1	0		•
67.00 06700 05CUPATIONAL THERAPY 142, 698 1, 629 43, 678 0 32, 525 67. 00 68.00 06800 SPEECH PATHOLOGY 51, 257 485 13, 008 0 41, 805 68. 00 69.00 06900 ELECTROCARDI OLOGY 81, 761 425 11, 403 20, 430 0 69. 00 70.00 07000 ELECTROCARDI OLOGY 81, 761 425 11, 403 20, 430 0 69. 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENT 564, 943 4, 745 127, 198 0 0 71. 00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 381, 308 0 0 0 0 0 0 73.00 07300 DRIUGS CHARGED TO PATI ENTS 381, 308 0 0 0 0 0 0 75.00 07500 ASC (MON-DI STI NCT PART) 730, 886 7, 316 196, 104 17, 955 36, 988 75. 00 76.00 03160 STRESS TESTI NG 0 0 0 0 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81,070 0 160, 855 76. 01 76.02 03610 SLEEP LAB 166, 083 2, 023 54, 237 0 0 0 0 0 76.02 07697 CARDI AC REHABI LITATI ON 358, 417 1, 026 27, 513 8, 028 0 76. 97 76.97 07697 CARDI AC REHABI LITATI ON 358, 417 1, 026 27, 513 8, 028 0 76. 97 88.01 08800 RURAL HEALTH CLINI C (RHC) 1, 097, 693 16, 972 454, 936 0 0 0 0 88. 01 88.02 08802 RURAL HEALTH CLINI C (RHC) 1, 097, 693 16, 972 454, 936 0 0 0 0 0 88.02 08802 RURAL HEALTH CLINI C (RHC) 1, 097, 693 16, 972 454, 936 0 0 0 0 0 99.00 09000 CLLTR REIMBURSABLE COST CENTERS 113, 00 100 090					l		'	•
68.00 06800 SPEECH PATHOLOGY 51, 257 485 13, 008 0 41,805 68.00 69.00 06900 ELECTROCARDI OLOGY 81,761 425 11,403 20,430 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2,641 0 0 167 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 564,943 4,745 127,198 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 381,308 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1,561,222 1,228 32,929 0 0 0 73.00 75.00 07500 ASC (NON-DI STINCT PART) 730,886 7,316 196,104 17,955 36,988 75.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 597,682 3,024 81,070 0 160,855 76.01 76.02 03610 SLEEP LAB 166,083 2,023 54,237 0 0 76.02 76.97 07697 CARDI AC REHABI LITATI ON 358,417 1,026 27,513 8,028 0 76.97 88.00 08800 RURAL HEALTH CLINIC (RHC) 170,969 2,477 66,402 0 0 88.00 88.01 08800 RURAL HEALTH CLINIC (RHC) 1,097,693 16,972 454,936 0 0 0 88.00 89.00 09000 CLINIC 197,192 0 0 0 0 0 0 0 0 89.01 00 09000 DREGENCY 1,700,621 13,329 357,292 115,926 569,886 118.00 100 09100 DREGENCY 1,700,621 13,329 357,292 115,926 569,886 118.00 110.00 19000 19000 DREATMENT PROGRAM 0 0 0 0 0 0 0 110.00 10000 01 DREATMENT PROGRAM 0 0 0 0 0 0 0 110.00 10000 01 DREATMENT PROGRAM 0 0 0 0 0 0 0 110.00 10000 01 DREATMENT PROGRAM 0 0 0 0 0 0 0 0 110.00 19000 19100 O1 DREATMENT PROGRAM 0 0 0 0 0 0 0 0 110.00 19000 01 07,0950 CARDI NAL SLEEP 0 0 0 0 0 0 0 0 0 110.00 19000 01 07,0950 CARDI NAL SLEEP 0 0 0 0 0 0 0 0 0 110.00 19000 01 07,0950 CARDI NAL SLEEP 0 0 0 0 0 0 0 0 0					l			•
69.00 06900 ELECTROCARDI OLOGY 81,761 425 11,403 20,430 0 69.00 70.00			l		l			•
70. 00 07000 LECTROENCEPHALOGRAPHY 2, 641 0 0 167 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 MPL. DEV. CHARGED TO PATIENTS 381, 308 0 0 0 0 72. 00 72. 00 73. 00			· · · · · · · · · · · · · · · · · · ·		1			•
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 564, 943 4,745 127, 198 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 07300 MPL. DEV. CHARGED TO PATIENTS 381, 308 0 0 0 0 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1,561, 222 1,228 32,929 0 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 730,886 7,316 196,104 17,955 36,988 75. 00 76. 00 30.60 STRESS TESTING 0 0 0 0 0 0 0 0 0			· · · · · · · · · · · · · · · · · · ·		I			•
72.00 07200 MPL DEV. CHARGED TO PATIENTS 381,308 0 0 0 0 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,561,222 1,228 32,929 0 0 73.00 73.00 75.00			· · · · · · · · · · · · · · · · · · ·	ŭ	1	.07		•
73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 561, 222 1, 228 32, 929 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 730, 886 7, 316 196, 104 17, 955 36, 988 75. 00 0 0 0 0 0 0 0 0 0			l			0	_	
75.00			l	-	_	0		
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76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 597, 682 3, 024 81, 070 0 160, 855 76. 01 76. 02 03610 SLEEP LAB 166, 083 2, 023 54, 237 0 0 76. 02 76. 97 07697 CARDIAC REHABILITATION 358, 417 1, 026 27, 513 8, 028 0 76. 97 **OUTPATIENT SERVI CE COST CENTERS*** 88. 00 08800 RURAL HEALTH CLINIC (RHC) 170, 969 2, 477 66, 402 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC (RHC) 1, 097, 693 16, 972 454, 936 0 0 0 88. 02 90. 00 09000 CLINIC 197, 192 0 0 0 0 0 0 88. 02 91. 00 09000 CLINIC 17, 700, 621 13, 329 357, 292 115, 926 569, 886 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 118. 00 NONREI MBURSABLE COST CENTERS 113. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29, 183 1, 692 45, 366 0 20, 637 190. 00 191. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29, 183 1, 692 45, 366 0 20, 637 190. 00 192. 00 19200 PHYSI CLANS* PRI VATE OFFI CES 967, 979 29, 990 803, 873 1, 674 0 192. 00 194. 00 07950 CARDIANAL SLEEP 0 0 0 0 0 0 0 194. 00 07950 CARDIANAL SLEEP 0 0 0 0 0 0 194. 01 07951 OTHER NRCC 285, 045 84, 023 2, 252, 232 0 0 194. 01 200. 00 Negative Cost Centers 0 0 0 0 0 0 190. 00 00 00 00 00 00 100 00			1 ' 1	7, 310	190, 104	17, 955		•
76. 02 03610 SLEEP LAB 166,083 2,023 54,237 0 0 76.02 76.97 70.697 0ARDIA CR RHABILITATION 358,417 1,026 27,513 8,028 0 76.97 076.97 0ARDIA CR RHABILITATION 358,417 1,026 27,513 8,028 0 76.97 088.00 08800 RURAL HEALTH CLINIC (RHC) 170,969 2,477 66,402 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC (RHC) 1,097,693 16,972 454,936 0 0 88.01 88. 02 08802 RURAL HEALTH CLINIC (RHC) 664,171 0 0 0 0 0 88.01 90. 00 09000 CLINIC 10 17,7192 0 0 0 46,418 0 90.00 91. 00 09100 EMERGENCY 1,700,621 13,329 357,292 115,926 569,886 91.00 92. 00 09200 DISSERVATION BEDS (NON-DISTINCT PART 0) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			١	2 024	01 070	0		•
76. 97 07697 CARDI AC REHABILITATION 358, 417 1, 026 27, 513 8, 028 0 76. 97			1		1			•
SECOND Continue								•
88. 00	70. 77		330,417	1,020	27,513	0,020	U	10.71
88. 01	88 00		170 969	2 477	66 402	0	0	88 00
88. 02			· · · ·	· ·				
90. 00 09000 CLINIC 197, 192 0 0 46, 418 0 90. 00 91. 00 09100 EMERGENCY 1,700, 621 13,329 357,292 115,926 569,886 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 07HER REIMBURSABLE COST CENTERS 102. 00 10200 0910 ID TREATMENT PROGRAM 0 0 0 0 0 0 08 SPECIAL PURPOSE COST CENTERS 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 25,792,288 274,840 4,713,102 618,506 2,768,563 118. 00 092. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29,183 1,692 45,366 0 20,637 190. 00 192. 00 192. 00 192. 00 192. 00 192. 00 194. 01 07950 CARDI NAL SLEEP 0 0 0 0 0 194. 01 194. 01 07951 OTHER NRCC 285,045 84,023 2,252,232 0 0 194. 01 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0					1			
91. 00 09100 EMERGENCY 1,700,621 13,329 357,292 115,926 569,886 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0				0		_	-	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 102. 00 0THER REI MBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 0 102. 00 0 103. 00 0 0 0 0 0 0 0 0 0				13 329	357 292			
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O			1,700,021	.0,02,	007,272	1.07,720	007,000	1
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O O O O O O	72.00							72.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 SUBTOTALS (SUM OF LINES 1 through 117) 25, 792, 288 274, 840 4, 713, 102 618, 506 2, 768, 563 118. 00 119. 00	102.00		0	0	0	0	0	102.00
113. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LINES 1 through 118. 00 SUBTOTALS (SUM OF LIN			-1	-				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 25,792,288 274,840 4,713,102 618,506 2,768,563 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29,183 1,692 45,366 0 20,637 190.00 192.00 19	113.00							113.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 29, 183 1, 692 45, 366 0 20, 637 190.00 192.0			25, 792, 288	274. 840	4, 713, 102	618, 506	2, 768, 563	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29, 183 1, 692 45, 366 0 20, 637 190. 00 192. 00 19200 194. 01 19200 194. 01 19200 194. 01 194			,		, , , , , ,		,	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 967, 979 29, 990 803, 873 1, 674 0 192. 00 194. 00 194. 01	190.00		29, 183	1, 692	45, 366	0	20, 637	190. 00
194. 00 07950 CARDI NAL SLEEP 0 0 0 0 0 194. 00 194. 01 07951 OTHER NRCC 285, 045 84, 023 2, 252, 232 0 194. 01 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00								
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			l .	0				
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	194. 01	07951 OTHER NRCC	285, 045	84, 023	2, 252, 232	0	0	194. 01
201.00 Negative Cost Centers 0 0 0 0 201.00	200.00	Cross Foot Adjustments						
	201.00	Negative Cost Centers		0	0	0		
			27, 074, 495	390, 545	7, 814, 573	620, 180	2, 789, 200	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

| Peri od: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared:

				То	09/30/2023	Date/Time Pre 2/20/2024 3:4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	у ріп
		10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
GEN	NERAL SERVICE COST CENTERS	10.00	11100	10.00	111.00	.0.00	
2. 00 002 4. 00 004 5. 00 006 6. 00 006 7. 00 007 8. 00 008	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 500 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1	900 HOUSEKEEPI NG	4 400 547					9.00
	000 DI ETARY 100 CAFETERI A	1, 493, 567 0	1, 323, 265				10. 00 11. 00
	BOO NURSING ADMINISTRATION	0	1, 323, 203 37, 619				13. 00
	400 CENTRAL SERVICES & SUPPLY	0	25, 824	0	951, 794		14. 00
15. 00 015	500 PHARMACY	0	29, 242	0	589	2, 451, 309	15. 00
	MEDICAL RECORDS & LIBRARY	0	0	0	30	0	16. 00
	700 SOCIAL SERVICE	0	2, 236	0	7	0	17. 00
	PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS	1, 358, 652	282, 143	2, 014, 057	86, 074	9, 787	30. 00
•	100 INTENSIVE CARE UNIT	84, 746	34, 638		13, 385	1, 834	31. 00
	BOO NURSERY	1, 383	10, 561	0	6, 157	0	43. 00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATI NG ROOM	0	53, 062		17, 539	0	50.00
	100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM	9, 763 0	29, 653 14, 338		11, 986	2, 373 0	51. 00 52. 00
	300 ANESTHESI OLOGY	0	23, 024	102, 314	10, 244 15, 002	38, 576	53. 00
	400 RADI OLOGY-DI AGNOSTI C	108	115, 067		44, 233	30, 370	54. 00
	600 RADI OI SOTOPE	0	4, 702	0	481	66, 769	56.00
	700 CT SCAN	0	19, 657	0	16, 707	50, 910	57. 00
	BOO MRI	0	13, 208	0	6, 594	0	58. 00
	DOO LABORATORY	0	120, 308	0	62, 560	23	60.00
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY	0	27, 906 73, 696	0	25, 690 4, 480	9	65. 00 66. 00
	700 OCCUPATI ONAL THERAPY	0	11, 486		358	0	67. 00
	BOO SPEECH PATHOLOGY	o	4, 779	Ö	0	0	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	О	6, 989	0	0	0	69. 00
1	000 ELECTROENCEPHALOGRAPHY	0	231	0	0	0	70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	260, 321	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0	0	177, 166 3, 750	0 2, 270, 024	72. 00 73. 00
	500 ASC (NON-DISTINCT PART)	0	45, 533		64, 217	2, 270, 024	75. 00
•	160 STRESS TESTING	o	0	0	0 ., 2 . ,	0	76. 00
76. 01 035	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	50, 441	0	433	0	76. 01
	SLEEP LAB	0	5, 499		5, 387	0	76. 02
	697 CARDIAC REHABILITATION TPATIENT SERVICE COST CENTERS	0	18, 373	0	205	0	76. 97
	BOO RURAL HEALTH CLINIC (RHC)	0	9, 019	0	861	0	88. 00
	BO1 RURAL HEALTH CLINIC (RHC)	o	76, 780		5, 341	0	88. 01
	BO2 RURAL HEALTH CLINIC (RHC)	О	38, 878		8, 716	0	88. 02
	DOO CLINIC	0	9, 919		32, 329	0	90.00
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	38, 915	127, 709	911, 571	68, 140	8, 427	91. 00 92. 00
	HER REIMBURSABLE COST CENTERS						92.00
	200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	ECLAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) 	1, 493, 567	1, 322, 520	4, 190, 405	948, 982	2, 451, 309	113. 00 118. 00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	795		192. 00
	950 CARDI NAL SLEEP	0	0	0	О		194. 00
	951 OTHER NRCC	0	745	0	2, 017	0	194. 01
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		^			0	200. 00 201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 493, 567	1, 323, 265	4, 190, 405	951, 794	2, 451, 309	

Heal th Financial Systems In Lieu of Form CMS-2552-10 OTTAWA REGIONAL HOSPITAL & HEALTHCAR Worksheet B
Part I
Date/Time Prepared:
2/20/2024 3:40 pm COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0110 Peri od: From 10/01/2022 To 09/30/2023 Cost Center Description SOCIAL SERVICE MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost

		LI BRARY			Residents Cost & Post		
					Stepdown		
		16.00	17. 00	24. 00	Adjustments 25.00	26. 00	
G	GENERAL SERVICE COST CENTERS	10.00	17.00	21.00	20.00	20.00	
	00100 CAP REL COSTS-BLDG & FIXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
	00600 MAI NTENANCE & REPAI RS						6. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
	01100 CAFETERI A						11. 00
	01300 NURSING ADMINISTRATION						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14.00
1	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	499, 457					15. 00 16. 00
1	01700 SOCIAL SERVICE	0	2, 028, 537				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	33, 330	135, 427	21, 521, 735	0	21, 521, 735	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	3, 547 879	14, 412 3, 573	3, 127, 121 844, 185	0	3, 127, 121 844, 185	
	ANCI LLARY SERVI CE COST CENTERS	0//	3, 373	044, 103	<u> </u>	044, 103	45.00
50.00	05000 OPERATING ROOM	37, 393	151, 933	5, 571, 521	0	5, 571, 521	50. 00
	05100 RECOVERY ROOM	5, 940	24, 135	2, 375, 783	0	2, 375, 783	•
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 463 14, 980	5, 945 60, 865	1, 264, 014 810, 687	0	1, 264, 014 810, 687	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	70, 490	286, 415	11, 177, 473	0	11, 177, 473	
	05600 RADI OI SOTOPE	4, 731	19, 224	668, 507	o	668, 507	56. 00
	05700 CT SCAN	45, 859	186, 334	1, 701, 544	0	1, 701, 544	
	05800 MRI	12, 594	51, 170	1, 106, 313	0	1, 106, 313	
	06000 LABORATORY 06500 RESPI RATORY THERAPY	85, 913 7, 091	348, 241 28, 812	11, 255, 942 2, 052, 933		11, 255, 942 2, 052, 933	
	06600 PHYSI CAL THERAPY	13, 138	53, 383	5, 815, 417	o	5, 815, 417	
	06700 OCCUPATI ONAL THERAPY	2, 223	9, 032	764, 204	О	764, 204	67. 00
	06800 SPEECH PATHOLOGY	580	2, 356	301, 261	0	301, 261	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	3, 984 50	16, 189 203	439, 451 12, 925	0	439, 451 12, 925	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 468	18, 156	3, 040, 795	o	3, 040, 795	
	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 737	27, 374	1, 983, 630	0	1, 983, 630	
	07300 DRUGS CHARGED TO PATIENTS	46, 676	189, 651	9, 800, 958	0	9, 800, 958	
	07500 ASC (NON-DISTINCT PART) 03160 STRESS TESTING	15, 313	62, 217 0	4, 170, 371 0	0	4, 170, 371	75. 00
	03550 PSYCHLATRIC/PSYCHOLOGICAL SERVICES	3, 498	14, 215	3, 091, 615	0	0 3, 091, 615	76. 00 76. 01
	03610 SLEEP LAB	1, 732	7, 035	847, 883	o	847, 883	
	07697 CARDI AC REHABI LI TATI ON	12, 359	50, 216	1, 783, 675	0	1, 783, 675	76. 97
_	OUTPATIENT SERVICE COST CENTERS	1 022	4 155	070 (10		070 (10	00.00
	08800 RURAL HEALTH CLINIC (RHC) 08801 RURAL HEALTH CLINIC (RHC)	1, 023 6, 743	4, 155 27, 397	878, 618 5, 690, 346	0	878, 618 5, 690, 346	•
	08802 RURAL HEALTH CLINIC (RHC)	4, 447	18, 068	3, 157, 235	o	3, 157, 235	
90.00	09000 CLI NI C	2, 033	8, 260	1, 015, 525	O	1, 015, 525	90. 00
	09100 EMERGENCY	50, 243	204, 144	10, 370, 223	0	10, 370, 223	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
_	10200 OPI OI D TREATMENT PROGRAM	O	0	0	0	0	102. 00
S	SPECIAL PURPOSE COST CENTERS		,				
	11300 I NTEREST EXPENSE				_		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	499, 457	2, 028, 537	116, 641, 890	0	116, 641, 890	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	203, 340	O	203, 340	190. 00
192. 00 1	19200 PHYSICIANS' PRIVATE OFFICES		Ö	5, 335, 586	o	5, 335, 586	192. 00
	07950 CARDI NAL SLEEP	0	0	0	0		194. 00
194. 01 C 200. 00	07951 OTHER NRCC Cross Foot Adjustments	0	0	3, 663, 932	0	3, 663, 932	194. 01 200. 00
200.00	Negative Cost Centers	0	0	0			200.00
202. 00	TOTAL (sum lines 118 through 201)	499, 457	2, 028, 537	125, 844, 748	o	125, 844, 748	

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS OTTAWA REGIONAL HOSPITAL & HEALTHCAR Provider CCN: 14-0110

				To	09/30/2023	Date/Time Pre 2/20/2024 3:4	
			CAPI TAL REI	LATED COSTS		2/20/2024 3.4	O pili
		D: 11	DIDO A FLVT	IN /DLE FOULD		EMBL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	CENERAL CERVICE COCT CENTERS	0	1.00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 445	364	8, 809	8, 809	4. 00
	00500 ADMINISTRATIVE & GENERAL	1, 886	592, 364	1, 671, 378	2, 265, 628	344	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	-	1 420 103	0	6.00
	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	33, 557	891, 290 8, 573		1, 439, 183 8, 573	269 8	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	16	l		25, 409	254	9. 00
10.00	01000 DI ETARY	0	114, 919		131, 485	69	10.00
11.00	01100 CAFETERI A	0	46, 648	3, 077	49, 725	111	11. 00
	01300 NURSI NG ADMI NI STRATI ON	4	36, 393		126, 371	274	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	9, 137	3, 884	1	13, 021	93 199	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	46	ł	-,	5, 862 29, 706	0	16.00
	01700 SOCI AL SERVI CE	0	6, 388		6, 388	18	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 104	199, 405		293, 557	1, 714	30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	17, 520 11, 973		27, 218 14, 624	235 73	31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	0	11, 9/3	2, 651	14, 024	/3	43.00
50. 00	05000 OPERATING ROOM	22, 825	63, 062	323, 668	409, 555	332	50.00
	05100 RECOVERY ROOM	0	6, 763		6, 763	212	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19, 924	I	19, 924	99	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	427.045	124 271	,	52, 886 1 305 401	37 695	53.00
56. 00	05600 RADI OI SOTOPE	627, 965	126, 371	531, 145 0	1, 285, 481 0	31	54. 00 56. 00
	05700 CT SCAN	0	Ö	23, 491	23, 491	115	
58. 00	05800 MRI	0	19, 193		19, 193	72	58. 00
	06000 LABORATORY	68, 321	86, 468		229, 839	616	1
65. 00	06500 RESPI RATORY THERAPY	0	28, 040		53, 608	172	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	55	247, 359 14, 669		271, 407 14, 669	478 72	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	4, 369		4, 369	26	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	3, 829	1	3, 829	44	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	1	70. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	42, 718	1	66, 600	0	71. 00 72. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	128	11, 059	0 27, 398	38, 585	0	72.00
	07500 ASC (NON-DISTINCT PART)	0	1		118, 190	298	1
	03160 STRESS TESTING	0	0		0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	302	27, 226		27, 655	309	1
	03610 SLEEP LAB	0	0.240		129, 004	32	
	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	9, 240	0	9, 240	114	76. 97
	08800 RURAL HEALTH CLINIC (RHC)	1, 496	22, 300	1, 504	25, 300	83	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	10, 435	152, 784		172, 728	564	1
	08802 RURAL HEALTH CLINIC (RHC)	4, 350			4, 350	353	
	09000 CLI NI C	843		-	843	70	1
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	13, 631	119, 992	37, 204	170, 827 0	313	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS			,			
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	70/ 101	2 074 022	2 722 0/2	7 (02 005	0.700	113.00
118.00	NONREIMBURSABLE COST CENTERS	796, 101	3, 074, 932	3, 732, 862	7, 603, 895	8, 199	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 235	0	15, 235	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	269, 970		382, 643	0	192. 00
	07950 CARDI NAL SLEEP	0	0	0	0		194. 00
	07951 OTHER NRCC	0	756, 381	59, 079	815, 460	10	194. 01
200. 00 201. 00	1 1		_	0	0	0	200. 00 201. 00
202.00	1 9	796, 101	4, 116, 518		8, 817, 233		202. 00
	, , , , , , , , , , , , , , , , , , ,					-1	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: |

				1	0 09/30/2023	2/20/2024 3:4	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	, p
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	OFNEDAL CEDIUSE COCT CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			T			1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 265, 972					5.00
6. 00	00600 MAI NTENANCE & REPAI RS	7, 032	7, 032	,			6.00
7. 00	00700 OPERATION OF PLANT	138, 928	1, 783				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	10, 690	17				8.00
9. 00	00900 HOUSEKEEPI NG	49, 152	38			86, 442	9. 00
10.00	01000 DI ETARY	20, 127	230			645	10.00
11. 00	01100 CAFETERI A	21, 233	93		0	0	11.00
13. 00	01300 NURSING ADMINISTRATION	72, 752	73		0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	16, 457	8	1		Ō	14. 00
15. 00	01500 PHARMACY	43, 362	O	1	0	412	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	7, 411	57	17, 125	0	0	16. 00
17.00	01700 SOCIAL SERVICE	36, 131	13			0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	290, 455	399	120, 061	8, 553	19, 766	30.00
31.00	03100 INTENSIVE CARE UNIT	43, 447	35	10, 549	1, 656	6, 768	31.00
43.00	04300 NURSERY	13, 945	24	7, 209	402	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	81, 564	126			4, 924	50.00
51. 00	05100 RECOVERY ROOM	35, 502	14			2, 721	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 929	40		668	0	52. 00
53. 00	05300 ANESTHESI OLOGY	11, 852	0	1	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	179, 468	253		916	8, 695	54.00
56. 00	05600 RADI OI SOTOPE	10, 310	0		0	0	56. 00
57. 00	05700 CT SCAN	24, 886	0	1	0	0	57. 00
58. 00	05800 MRI	16, 386	38			1, 656	58. 00
60.00	06000 LABORATORY	181, 578	173			8, 914	60.00
65. 00	06500 RESPIRATORY THERAPY	32, 805	56			1, 702	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	85, 401 11, 943	495 29			3, 502 1, 008	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 290	29			1, 008	68.00
69. 00	06900 ELECTROCARDI OLOGY	6, 843	8	_,		1, 290	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	221	0		7	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 283	85		0	0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	31, 913	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	130, 666	22		0	0	73.00
75. 00	07500 ASC (NON-DISTINCT PART)	61, 171	132				75.00
76. 00	03160 STRESS TESTING	01,171	0		700	0	76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	50, 023	54		0	4, 985	
76. 02	03610 SLEEP LAB	13, 900	36		0	0	76. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	29, 998	18		317	Ō	76. 97
	OUTPATIENT SERVICE COST CENTERS		_				
88. 00	08800 RURAL HEALTH CLINIC (RHC)	14, 309	45	13, 427	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	91, 871	306	91, 991	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	55, 587	0	0	0	0	88. 02
90.00	09000 CLI NI C	16, 504	0	0	1, 830	0	90.00
91.00	09100 EMERGENCY	142, 333	240	72, 247	4, 570	17, 662	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00		2, 158, 658	4, 949	953, 023	24, 384	85, 802	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 442	30				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	81, 015	540		66		192. 00
	07950 CARDI NAL SLEEP	0	0	0	0		194. 00
	07951 OTHER NRCC	23, 857	1, 513	455, 418	0	0	194. 01
200.00			_		_	_	200. 00
201.00		0	7 022	1	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 265, 972	7, 032	1, 580, 163	24, 450	86, 442	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS OTTAWA REGIONAL HOSPITAL & HEALTHCAR Provider CCN: 14-0110

				10	09/30/2023	2/20/2024 3:40	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	<u> Б.</u>
		10.00	11.00	13.00	14.00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
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	221, 749	00.240				10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON		99, 249 2, 822				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		1, 937		33, 855		14. 00
15. 00	01500 PHARMACY	O	2, 193		21	52, 049	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	1	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	168	0	0	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	201 710	21 1/2	107.7(0	2.0/1	200	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	201, 719 12, 582	21, 163 2, 598		3, 061 476	208 39	30. 00 31. 00
43. 00	04300 NURSERY	205	792		219	0	ł
	ANCILLARY SERVICE COST CENTERS			· - ·	_ · · ·)	-	
50.00	05000 OPERATING ROOM	0	3, 980		624	0	
51.00	05100 RECOVERY ROOM	1, 449	2, 224		426	50	ł
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 075		364	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	16	1, 727 8, 630		534 1, 573	819	53. 00 54. 00
56. 00	05600 RADI OLOGI-DI AGNOSTI C	0	353		1, 373	1, 418	1
57. 00	05700 CT SCAN	o	1, 474		594	1, 081	57. 00
58. 00	05800 MRI	0	991	0	235	0	58. 00
60.00	06000 LABORATORY	0	9, 024		2, 225	0	60. 00
65. 00	06500 RESPI RATORY THERAPY	0	2, 093		914	0	65.00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	5, 527 861	0	159 13	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		358	-	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	o	524		Ö	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	17	0	o	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		9, 262	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		6, 301	0	72.00
73. 00 75. 00	O7300 DRUGS CHARGED TO PATIENTS O7500 ASC (NON-DISTINCT PART)	0	0 3, 415	_	133 2, 284	48, 200 54	73. 00 75. 00
76. 00	03160 STRESS TESTING		3, 413	1	2, 284	0	76.00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	3, 783	Ö	15	0	76. 01
76. 02	03610 SLEEP LAB	0	412	0	192	0	76. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 378	0	7	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC (RHC)	O	676	O	31	0	88. 00
	08801 RURAL HEALTH CLINIC (RHC)	0	5, 759		190	0	
	08802 RURAL HEALTH CLINIC (RHC)	o	2, 916	- 1	310	0	
90.00	09000 CLI NI C	0	744		1, 150	0	
91.00	09100 EMERGENCY	5, 778	9, 579	48, 773	2, 424	179	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	O	0	O	o	0	102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	91		<u> </u>	<u> </u>	-	102.00
	11300 I NTEREST EXPENSE						113. 00
118.00		221, 749	99, 193	224, 204	33, 755	52, 049	118. 00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	o	٥	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES		0		28		192. 00
194.00	07950 CARDI NAL SLEEP	O	0	0	o	0	194. 00
	07951 OTHER NRCC		56	0	72		194. 01
200.00			_				200. 00
201. 00 202. 00		221, 749	99, 249	224, 204	33, 855	52, 049	201.00
202.00	1.5 (55 111165 116 till bugir 201)	221,177	, , , 247	1 227, 204	33, 033	52, 647	,_02. 00

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0110 Peri od: Worksheet B From 10/01/2022 Part II 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 54, 300 16.00 01700 SOCIAL SERVICE 17.00 46, 564 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 615 30.00 03000 ADULTS & PEDIATRICS 3,099 1,075,130 1, 075, 130 30.00 03100 INTENSIVE CARE UNIT 385 330 119, 543 0 119, 543 31.00 31.00 43.00 04300 NURSERY 82 37,670 37, 670 43.00 95 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4,056 3, 476 568, 819 0 568, 819 50.00 05100 RECOVERY ROOM 552 65, 950 0 65, 950 51.00 644 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 159 136 58, 864 0 58, 864 52.00 05300 ANESTHESI OLOGY 70.873 70, 873 53 00 1,625 1 393 53 00 6, 553 54.00 05400 RADI OLOGY-DI AGNOSTI C 7,646 1, 576, 015 1, 576, 015 54.00 05600 RADI OI SOTOPE 56.00 513 440 13,082 0 0 0 0 0 0 0 0 0 13,082 56.00 05700 CT SCAN 4, 974 60, 878 60, 878 57.00 4. 263 57.00 05800 MRI 58.00 1.366 1, 171 52, 664 52, 664 58 00 60.00 06000 LABORATORY 9, 447 8, 119 501, 998 501, 998 60.00 06500 RESPIRATORY THERAPY 65 00 769 659 109, 661 109, 661 65 00 66.00 06600 PHYSI CAL THERAPY 1, 221 520, 554 520, 554 66, 00 1.425 06700 OCCUPATIONAL THERAPY 67 00 241 207 37 875 37.875 67 00 13, 095 06800 SPEECH PATHOLOGY 13,095 68.00 63 54 68.00 06900 ELECTROCARDI OLOGY 69.00 432 370 15, 161 15, 161 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 256 256 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 485 415 149, 850 149, 850 71.00 39, 571 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 731 626 0 0 39, 571 72.00 07300 DRUGS CHARGED TO PATIENTS 5,063 4, 339 233, 666 233, 666 73.00 73.00 07500 ASC (NON-DISTINCT PART) 75.00 247, 524 247, 524 1,661 1, 424 75.00 76.00 03160 STRESS TESTING 0 0 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 379 325 103, 921 103, 921 76.01 03610 SLEEP LAB 07697 CARDIAC REHABILITATION 76.02 188 161 154, 892 154, 892 76.02 76. 97 1, 340 1, 149 49, 124 49, 124 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 95 54, 077 0 54, 077 88.00 111 08801 RURAL HEALTH CLINIC (RHC) 364, 767 0 364, 767 88.01 731 627 88.01 88.02 08802 RURAL HEALTH CLINIC (RHC) 482 413 64, 411 0 64, 411 88.02 09000 CLI NI C 0 90.00 220 189 21, 550 21,550 90.00 ol 09100 EMERGENCY 91.00 91.00 4.671 485.045 485, 045 5.449 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 46, 564 SUBTOTALS (SUM OF LINES 1 through 117) 54, 300 6, 866, 486 6, 866, 486 118. 00 NONREIMBURSABLE COST CENTERS 27, 520 190, 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 27 520 192.00 19200 PHYSICIANS' PRIVATE OFFICES 626, 841 0 0 0 626, 841 192. 00 194. 00 07950 CARDI NAL SLEEP 0 0 0 194.00 0

0

54.300

0

46, 564

1, 296, 386

0

0 8, 817, 233 1, 296, 386 194. 01

8, 817, 233 202. 00

0

0 200. 00

0 201.00

194. 01 07951 OTHER NRCC

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

Provider CCN: 14-0110

				T	o 09/30/2023	Date/Time Pre	
		CAPITAL REI	LATED COSTS			2/20/2024 3: 4	O pm
		CALL TAL KEI					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS		(ACCOW. COST)	
				SALARI ES)			
	OFNEDAL CERVILOE COCT OFNEEDO	1.00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	450, 412	1		T .	I	1. (
2.00	00200 CAP REL COSTS-MVBLE EQUIP	430, 412	3, 648, 423				2.0
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	924	340	46, 273, 325			4. 0
5.00	00500 ADMINISTRATIVE & GENERAL	64, 814	1, 561, 716	1, 808, 138	-27, 074, 495	98, 770, 253	5.0
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	306, 522	6.0
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	97, 521 938	480, 589	1, 416, 859 44, 345		6, 055, 616 465, 971	7. C 8. C
9. 00	00900 HOUSEKEEPING	2, 106		1, 338, 467		2, 142, 465	9. 0
10.00	01000 DI ETARY	12, 574		362, 585	0		1
11. 00	01100 CAFETERI A	5, 104		582, 553		925, 491	
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 982		1, 443, 303		3, 171, 122	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	425		489, 559 1, 045, 562			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 112		1, 043, 302	Ö		1
17. 00	01700 SOCIAL SERVICE	699		93, 263	0	•	1
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1	1	
30.00	03000 ADULTS & PEDIATRICS	21, 818		8, 933, 286			30.0
31. 00 43. 00	03100 NTENSI VE CARE UNI T 04300 NURSERY	1, 917 1, 310		1, 236, 856 383, 090			31. 0 43. 0
43.00	ANCILLARY SERVICE COST CENTERS	1,510	2, 477	303, 070		007,044	1 43. 0
50.00	05000 OPERATING ROOM	6, 900	302, 431	1, 748, 502	0	3, 555, 247	50.0
51.00	05100 RECOVERY ROOM	740		1, 115, 235		1,017,100	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 180		520, 112		,	52.0
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 13, 827	49, 416 496, 295	196, 630 3, 659, 952			
56. 00	05600 RADI OI SOTOPE	13,027	470, 273	163, 529			1
57. 00	05700 CT SCAN	0	21, 950	603, 791	0	1	57.0
58. 00	05800 MRI	2, 100		379, 730		7.1,20.	58.0
60.00	06000 LABORATORY	9, 461	70, 126	3, 240, 977	0	.,,	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 068 27, 065		902, 874 2, 515, 076		1, 429, 924 3, 722, 476	65. 0
67. 00	06700 OCCUPATI ONAL THERAPY	1, 605		380, 099		520, 575	1
68. 00	06800 SPEECH PATHOLOGY	478		135, 984	0	186, 991	68.0
69. 00	06900 ELECTROCARDI OLOGY	419	o	229, 692		298, 270	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	7, 515	0	7,000	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 674	22, 315	0	0	2, 060, 964 1, 391, 045	1
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 210	25, 600	0	0	5, 695, 478	
75. 00	07500 ASC (NON-DISTINCT PART)	7, 206		1, 568, 208	0	1	75.0
76. 00	03160 STRESS TESTING	0		0	0	0	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 979		1, 625, 446			
76. 02 76. 97	03610 SLEEP LAB 07697 CARDI AC REHABI LI TATI ON	1, 993 1, 011		167, 541 602, 066		1	
10. 71	OUTPATIENT SERVICE COST CENTERS	1,011	<u> </u>	002,000		1, 307, 330	70. 7
88. 00	08800 RURAL HEALTH CLINIC (RHC)	2, 440	1, 405	436, 695	0	623, 712	88. 0
88. 01	08801 RURAL HEALTH CLINIC (RHC)	16, 717		2, 970, 106		1, 00 1, 10 1	1
88. 02		0	_	1, 855, 317		2, 422, 955	
90.00	09000 CLI NI C 09100 EMERGENCY	0 13, 129	-	371, 007 1, 649, 131		719, 374 6, 204, 020	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 127	34, 703	1, 047, 131		0, 204, 020	92. 0
	OTHER REIMBURSABLE COST CENTERS	'				'	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. (
	SPECIAL PURPOSE COST CENTERS	ı			T	1	
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	224 444	2 497 040	44 222 001	27 074 405	04 002 444	113. (
110.00	NONREI MBURSABLE COST CENTERS	336, 446	3, 487, 940	46, 223, 081	-27, 074, 495	94, 092, 646	1110. (
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 667	0	0	0	106, 462	190. (
192.00	19200 PHYSICIANS' PRIVATE OFFICES	29, 539		25	0	3, 531, 275	192. (
	07950 CARDI NAL SLEEP	00.7(0	1 1	0	0		194. (
	07951 OTHER NRCC	82, 760	55, 203	50, 219	0	1, 039, 870	
200. 00 201. 00							200. (201. (
201. 00 202. 00	1 1 9	4, 116, 518	3, 904, 614	13, 044, 163		27, 074, 495	1
00	Part I)		-, ., ., ., .,	_, _ , , ,			
203.00		9. 139450	1. 070220	0. 281894		0. 274116	
204.00				8, 809		2, 265, 972	204. 0
	Part II)	I	ı l			I	I

Heal th Finar	ncial Systems OTTA	WA REGIONAL HOS	PITAL & HEALTH	CAR	In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		Period: From 10/01/2022	Worksheet B-1	
					To 09/30/2023	Date/Time Pre 2/20/2024 3:4	
		CAPI TAL REI	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00019	0	0. 022942	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 14-0110

				To	09/30/2023	Date/Time Pre 2/20/2024 3:4	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		6. 00	7. 00	8. 00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		l				1 00
1. 00 2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 6. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	384, 674 97, 521	287, 153				5. 00 6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	938	938				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 106 12, 574	2, 106 12, 574	0	63, 117 471	55, 075	9.00
11. 00	01100 CAFETERI A	5, 104	5, 104	0	0	0	11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 982 425	3, 982 425	0	0	0	
15. 00	01500 PHARMACY	0	0	o O	301	0	15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	3, 112 699		0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	21, 818 1, 917		173, 141 33, 519	14, 432 4, 942	50, 100 3, 125	
43. 00	04300 NURSERY	1, 310			0	51	
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	6, 900	6, 900	39, 440	3, 595	0	50.00
51. 00	05100 RECOVERY ROOM	740			1, 987	360	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 180	2, 180	13, 525	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 827	13, 827	18, 537	6, 349	4	1
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
57. 00 58. 00	05700 CT SCAN 05800 MRI	2, 100	2, 100	0	0 1, 209	0	
60.00	06000 LABORATORY	9, 461	9, 461	0	6, 509	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 068 27, 065		0 40, 567	1, 243 2, 557	0	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 605		0	736	ő	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	478 419		0 16, 304	946	0 1 0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	133	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 674	4, 674	0	0	0	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 1, 210	1, 210] 0] 0	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	7, 206		14, 329	837	0	75. 00
76. 00 76. 01	03160 STRESS TESTING 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0 2, 979	0 2, 979	0	0 3, 640	0	
76. 02	03610 SLEEP LAB	1, 993		0	0,010	ő	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	1, 011	1, 011	6, 407	0	0	76. 97
88. 00		2, 440	2, 440	0	0	0	88. 00
88. 01		16, 717		0	0	0	
88. 02 90. 00		0	1	37, 043	0	0	
91.00	09100 EMERGENCY	13, 129	13, 129			1, 435	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.0	10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
113 0	SPECIAL PURPOSE COST CENTERS D 11300 INTEREST EXPENSE		l] 113. 00
118. 0	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	270, 708					118. 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	1, 667 29, 539			467 0		190. 00 192. 00
194.0	07950 CARDI NAL SLEEP	0	0	0	0	0	194. 00
194. 0 200. 0	1 07951 OTHER NRCC Cross Foot Adjustments	82, 760	82, 760	0	0	0	194. 01 200. 00
201. 0							201. 00
202. 0	Cost to be allocated (per Wkst. B, Part I)	390, 545	7, 814, 573	620, 180	2, 789, 200	1, 493, 567	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	1. 015262 7, 032			44. 190947 86, 442	27. 118783 221, 749	
205. 0	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 018280	5. 502861	0. 049402	1. 369552	4. 026310	205. 00
206. 0							206. 00

Health Financial Systems	OTTAWA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:4	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
			LAUNDRY)			
	6. 00	7. 00	8. 00	9. 00	10.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	l l	I	l		l	l

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0110 Peri od: Worksheet B-1 From 10/01/2022 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL (FTES SERVE D) ADMINISTRATION SERVICES & RECORDS & (COSTED **SUPPLY** REQUIS.) LI BRARY (HOURS SUPE (COSTED (TIME SPENT) REQUIS.) RVI SED) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 51, 497 11.00 13.00 01300 NURSING ADMINISTRATION 1, 464 475, 173 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,005 7, 473, 157 14.00 01500 PHARMACY 5, 973, 013 15 00 4, 628 15 00 1, 138 Ω 16.00 01600 MEDICAL RECORDS & LIBRARY 232 595, 014, 037 16.00 01700 SOCIAL SERVICE 17.00 87 53 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 980 228, 385 675, 824 23, 847 39, 726, 431 30.00 03100 INTENSIVE CARE UNIT 1, 348 28, 029 105, 096 4, 227, 511 31.00 31.00 4, 468 43.00 04300 NURSERY 411 48, 345 1, 048, 149 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,065 42, 946 137, 707 44, 568, 083 50.00 05100 RECOVERY ROOM 23, 994 94, 113 5, 782 7, 079, 927 51.00 1, 154 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 558 11, 602 80, 430 1, 744, 058 52.00 05300 ANESTHESI OLOGY 896 117, 787 93, 996 17, 854, 086 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 478 347, 305 78 84, 017, 202 54.00 05600 RADI OI SOTOPE 162, 693 5, 639, 205 56.00 183 3,777 56.00 05700 CT SCAN 131, 177 54, 659, 285 57.00 765 124, 050 57.00 05800 MRI 15, 010, 169 58.00 514 51, 771 58 00 60.00 06000 LABORATORY 4,682 491, 199 55 102, 114, 300 60.00 06500 RESPIRATORY THERAPY 65.00 1,086 201, 709 23 8, 451, 627 65 00 66, 00 06600 PHYSI CAL THERAPY 2,868 0 35, 179 0 15, 659, 390 66,00 06700 OCCUPATIONAL THERAPY 0 67.00 447 2,814 2, 649, 495 67 00 06800 SPEECH PATHOLOGY 691, 236 68.00 186 68.00 0 69.00 06900 ELECTROCARDI OLOGY 272 0 0 4, 748, 966 69.00 07000 ELECTROENCEPHALOGRAPHY 59, 602 70.00 0 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 Ω 2, 043, 950 5, 325, 808 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 1, 391, 045 8, 029, 783 72.00 07300 DRUGS CHARGED TO PATIENTS 29, 445 5, 531, 285 55, 632, 322 73.00 73.00 07500 ASC (NON-DISTINCT PART) 36, 849 6, 202 18, 250, 937 75.00 1, 772 504, 208 75.00 76.00 03160 STRESS TESTING 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 963 3, 399 0 4, 169, 818 76.01 03610 SLEEP LAB 42, 299 2, 063, 773 76.02 214 0 0 76.02 07697 CARDIAC REHABILITATION 76. 97 715 0 1, 612 14, 730, 387 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 351 n 6, 759 0 1, 218, 829 88.00 08801 RURAL HEALTH CLINIC (RHC) 2.988 0 88.01 C 41, 937 8, 036, 688 88.01 88.02 08802 RURAL HEALTH CLINIC (RHC) 1,513 68, 432 0 5, 300, 039 88.02 90.00 09000 CLI NI C 386 253, 836 2, 423, 047 90.00 09100 EMERGENCY 103, 368 20. 534 91.00 91.00 4.970 535, 010 59, 883, 884 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 51, 468 475, 173 7, 451, 078 5, 973, 013 595, 014, 037 118. 00 NONREIMBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 C 6, 242 0 0 192.00 194. 00 07950 CARDI NAL SLEEP 0 0 0 194.00 194. 01 07951 OTHER NRCC 29 15, 837 0 0 194. 01 200 00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 4, 190, 405 202.00 Cost to be allocated (per Wkst. B, 499, 457 202. 00 1, 323, 265 951, 794 2, 451, 309 Part I) 0.000839 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 25. 695963 8.818693 0.127362 0.410397 204.00 Cost to be allocated (per Wkst. B, 99, 249 224, 204 33, 855 52, 049 54, 300 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 1.927277 0.471837 0.004530 0.008714 0.000091 205.00 II)

Health Finan	cial Systems OTTAV	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provider CO	CN: 14-0110	Peri od: From 10/01/2022	Worksheet B-1	
					To 09/30/2023	Date/Time Pre 2/20/2024 3:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES SERVE D)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(HOURS SUPE	(COSTED		(TIME SPENT)	
			RVI SED)	REQUIS.)			
		11. 00	13.00	14.00	15. 00	16. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0110

			10 09/30/2023 Date/lime Pre 2/20/2024 3:4	
	Cost Center Description	SOCI AL SERVI CE	272072021 3.	T
		(TIME SPENT)		
	GENERAL SERVICE COST CENTERS	17. 00		+
	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
	00500 ADMINISTRATIVE & GENERAL			5. 00
1	00600 MAINTENANCE & REPAIRS			6. 00
1	00700 OPERATION OF PLANT			7. 00
1	00800 LAUNDRY & LINEN SERVICE			8.00
1	00900 HOUSEKEEPI NG			9.00
1	01000 DI ETARY 01100 CAFETERI A			10.00
1	01300 NURSI NG ADMI NI STRATI ON			13.00
1	01400 CENTRAL SERVICES & SUPPLY			14. 00
1	01500 PHARMACY			15. 00
1	01600 MEDICAL RECORDS & LIBRARY			16. 00
1	01700 SOCIAL SERVICE	595, 014, 037		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDIATRICS	39, 726, 431		30.00
1	03100 INTENSIVE CARE UNIT	4, 227, 511		31. 00
	04300 NURSERY	1, 048, 149		43. 00
	ANCILLARY SERVICE COST CENTERS			4
1	05000 OPERATING ROOM	44, 568, 083		50.00
	05100 RECOVERY ROOM	7, 079, 927		51.00
1	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 744, 058 17, 854, 086		52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	84, 017, 202		54.00
	05600 RADI OI SOTOPE	5, 639, 205		56. 00
	05700 CT SCAN	54, 659, 285		57. 00
	05800 MRI	15, 010, 169		58. 00
60.00	06000 LABORATORY	102, 114, 300		60.00
	06500 RESPI RATORY THERAPY	8, 451, 627		65. 00
66. 00	06600 PHYSI CAL THERAPY	15, 659, 390		66. 00
1	06700 OCCUPATI ONAL THERAPY	2, 649, 495		67. 00
1	06800 SPEECH PATHOLOGY	691, 236		68. 00
1	06900 ELECTROCARDI OLOGY	4, 748, 966		69. 00
1	07000 ELECTROENCEPHALOGRAPHY	59, 602		70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 325, 808		71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	8, 029, 783 55, 632, 322		72. 00 73. 00
1	07500 ASC (NON-DISTINCT PART)	18, 250, 937		75. 00
1	03160 STRESS TESTING	0		76. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 169, 818		76. 01
	03610 SLEEP LAB	2, 063, 773		76. 02
76. 97	07697 CARDIAC REHABILITATION	14, 730, 387		76. 97
	OUTPATIENT SERVICE COST CENTERS			
	08800 RURAL HEALTH CLINIC (RHC)	1, 218, 829		88. 00
	08801 RURAL HEALTH CLINIC (RHC)	8, 036, 688		88. 01
	08802 RURAL HEALTH CLINIC (RHC)	5, 300, 039		88. 02
	09000 CLI NI C	2, 423, 047		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	59, 883, 884		91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS			72.00
	10200 OPI OI D TREATMENT PROGRAM	0		102. 00
	SPECIAL PURPOSE COST CENTERS			102.00
	11300 I NTEREST EXPENSE			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	595, 014, 037		118. 00
	NONREI MBURSABLE COST CENTERS	,,,		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	07950 CARDI NAL SLEEP	0		194. 00
	07951 OTHER NRCC	0		194. 01
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers	0.000 505		201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 028, 537		202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 003409		203. 00
203.00	Cost to be allocated (per Wkst. B,	46, 564		203.00
204.00	Part II)	40, 304		204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000078		205. 00
	11)			
206.00	NAHE adjustment amount to be allocated			206. 00
	(per Wkst. B-2)			

Health Financial Systems	OTTAWA REGIONAL HOSPI	TAL & HEALTHCAR	In Lie	u of Form CMS-2552-	10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0110	Peri od:	Worksheet B-1	
			From 10/01/2022		
			To 09/30/2023	Date/Time Prepared	
				2/20/2024 3:40 pm	
Cost Center Description	SOCIAL SERVICE				
	(TIME SPENT)				
	17.00				
207.00 NAHE unit cost multiplier (Wkst.	D,	·		207. (00
Parts III and IV)					

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0110 Peri od: Worksheet C From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 21, 521, 735 30 00 03000 ADULTS & PEDIATRICS 21, 521, 735 21, 521, 735 3, 127, 121 3, 127, 121 03100 INTENSIVE CARE UNIT 3, 127, 121 0 31.00 31.00 04300 NURSERY 43.00 844, 185 844, 185 0 844, 185 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 571, 521 5, 571, 521 0 5, 571, 521 50.00 51.00 05100 RECOVERY ROOM 2, 375, 783 2, 375, 783 0 2, 375, 783 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 264, 014 1, 264, 014 0 1, 264, 014 52.00 849, 933 53.00 05300 ANESTHESI OLOGY 810, 687 810, 687 39, 246 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 177, 473 11, 177, 473 0 11, 177, 473 54.00 56.00 05600 RADI OI SOTOPE 668, 507 668, 507 0 668, 507 56.00 o 57.00 05700 CT SCAN 1, 701, 544 1, 701, 544 1, 701, 544 57.00 05800 MRI 0 58.00 1, 106, 313 1, 106, 313 1, 106, 313 58.00 60.00 06000 LABORATORY 11, 255, 942 11, 255, 942 11, 255, 942 60.00 06500 RESPIRATORY THERAPY 65.00 2, 052, 933 2, 052, 933 0 2, 052, 933 65.00 06600 PHYSI CAL THERAPY 66 00 5, 815, 417 5 815 417 5, 815, 417 66 00 67.00 06700 OCCUPATIONAL THERAPY 764, 204 764, 204 764, 204 67.00 06800 SPEECH PATHOLOGY 301, 261 301, 261 0 301, 261 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 439, 451 439, 451 439, 451 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 12, 925 12, 925 12, 925 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 040, 795 3, 040, 795 3, 040, 795 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 983, 630 1, 983, 630 1, 983, 630 72.00 9, 800, 958 73 00 07300 DRUGS CHARGED TO PATIENTS 9 800 958 9, 800, 958 73 00 07500 ASC (NON-DISTINCT PART) 0 75.00 4, 170, 371 4, 170, 371 4, 170, 371 75.00 76.00 03160 STRESS TESTING 0 76.00 0 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 091, 615 3, 091, 615 5, 651 3, 097, 266 76.01 03610 SLEEP LAB 76 02 847.883 847 883 847, 883 76 02 0 76.97 07697 CARDIAC REHABILITATION 1, 783, 675 1, 783, 675 1, 783, 675 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 878, 618 878, 618 878, 618 88.00 08801 RURAL HEALTH CLINIC (RHC) 5, 690, 346 0 5, 690, 346 88.01 5, 690, 346 88 01 88.02 08802 RURAL HEALTH CLINIC (RHC) 3, 157, 235 3, 157, 235 0 3, 157, 235 88.02 1, 015, 525 09000 CLI NI C 0 90.00 1,015,525 1, 015, 525 90.00 91.00 09100 EMERGENCY 10, 370, 223 10, 370, 223 ol 10, 370, 223 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 3, 911, 873 3, 911, 873 3, 911, 873 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 120, 553, 763 120, 553, 763 44, 897 120, 598, 660 200. 00 201.00 Less Observation Beds 3, 911, 873 3, 911, 873 3, 911, 873 201. 00 116, 686, 787 202. 00 0 202.00 Total (see instructions) 116, 641, 890 116, 641, 890 44.897

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0110 Peri od: Worksheet C From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30, 805, 838 30, 805, 838 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 4, 227, 511 4, 227, 511 31.00 04300 NURSERY 1, 048, 149 1, 048, 149 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 5, 128, 086 39, 439, 997 44, 568, 083 0 125011 0.000000 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 422, 264 6, 657, 663 7, 079, 927 0. 335566 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1,643,338 100, 720 1, 744, 058 0.724755 0.000000 52 00 2, 922, 904 17, 854, 086 05300 ANESTHESI OLOGY 14, 931, 182 0.045406 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 4, 159, 406 79, 857, 793 84, 017, 199 0. 133038 54 00 56.00 05600 RADI OI SOTOPE 474, 279 5, 164, 926 5, 639, 205 0.118546 0.000000 56.00 57.00 05700 CT SCAN 8, 100, 727 46, 558, 558 54, 659, 285 0.031130 0.000000 57.00 05800 MRI 13, 830, 670 15, 010, 169 58.00 1, 179, 499 0.073704 0.000000 58.00 60.00 06000 LABORATORY 17, 971, 367 84, 142, 933 102, 114, 300 0.110229 0.000000 60.00 06500 RESPIRATORY THERAPY 4, 508, 638 3, 942, 989 8, 451, 627 0. 242904 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 495, 363 15, 164, 027 15, 659, 390 0.371369 0.000000 66.00 2, 649, 495 06700 OCCUPATIONAL THERAPY 2, 337, 406 0.288434 67.00 312.089 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 119, 192 572,044 691, 236 0. 435829 0.000000 68.00 06900 ELECTROCARDI OLOGY 3, 747, 452 4, 748, 966 0.092536 0.000000 69.00 1,001,514 69.00 07000 ELECTROENCEPHALOGRAPHY 59, 602 0. 216855 0.000000 70.00 34.524 25.078 70.00 1, 099, 660 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 226, 148 5, 325, 808 0.570955 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 947, 191 7, 082, 592 8, 029, 783 0.247034 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 13, 313, 824 42, 318, 498 55, 632, 322 0.176174 0.000000 73.00 75 00 07500 ASC (NON-DISTINCT PART) 1, 057, 837 17, 192, 921 18, 250, 758 0 228504 0.000000 75 00 03160 STRESS TESTING 76.00 C 0.000000 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 7,539 4, 162, 279 4, 169, 818 0.741427 0.000000 76.01 76.01 76.02 03610 SLEEP LAB 23,088 2,040,685 2, 063, 773 0.410841 0.000000 76.02 07697 CARDIAC REHABILITATION 76.97 2, 378, 901 12, 351, 485 14, 730, 386 0. 121088 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 1, 218, 829 1, 218, 829 88.00 0 88 01 08801 RURAL HEALTH CLINIC (RHC) 0 8,036,688 8, 036, 688 88 01 08802 RURAL HEALTH CLINIC (RHC) 88.02 0 5, 300, 039 5, 300, 039 88.02 90.00 09000 CLI NI C 14, 144 2, 408, 903 2, 423, 047 0.419111 0.000000 90.00 91.00 91.00 09100 EMERGENCY 8, 054, 185 51, 829, 699 59, 883, 884 0.173172 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART 8, 920, 773 0.438513 0.000000 92.00 92 00 2.845.063 6,075,710 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 ol 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 114, 296, 120 480, 717, 914 595, 014, 034 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 114, 296, 120 480, 717, 914 595, 014, 034 202.00

Date/Time Prepared: 2/20/2024 3:40 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 43. 00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 125011 50.00 51.00 05100 RECOVERY ROOM 0. 335566 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.724755 52.00 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.047604 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 133038 54.00 56. 00 05600 RADI 0I SOTOPE 0. 118546 56.00 57. 00 | 05700 CT SCAN 0.031130 57.00 58.00 05800 MRI 0.073704 58.00 60.00 06000 LABORATORY 0. 110229 60.00 06500 RESPIRATORY THERAPY 65.00 0. 242904 65.00 66.00 06600 PHYSI CAL THERAPY 0. 371369 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0. 288434 67.00 06800 SPEECH PATHOLOGY 0. 435829 68.00 68.00 06900 ELECTROCARDI OLOGY 0.092536 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 216855 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0. 570955 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 247034 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 176174 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0. 228504 75.00 76. 00 03160 STRESS TESTING 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 0. 742782 76.01 76.02 03610 SLEEP LAB 0.410841 76.02 07697 CARDIAC REHABILITATION 0. 121088 76. 97 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 88.00 88. 01 08801 RURAL HEALTH CLINIC (RHC) 88.01 08802 RURAL HEALTH CLINIC (RHC) 88.02 88.02 90 00 09000 CLI NI C 0 419111 90 00 09100 EMERGENCY 91.00 0. 173172 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.438513 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200 00

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0110 Peri od: Worksheet C From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 21, 521, 735 21, 521, 735 21, 521, 735 3, 127, 121 3, 127, 121 03100 INTENSIVE CARE UNIT 3, 127, 121 0 31.00 31.00 04300 NURSERY 43.00 844, 185 844, 185 0 844, 185 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 571, 521 5, 571, 521 0 5, 571, 521 50.00 51.00 05100 RECOVERY ROOM 2, 375, 783 2, 375, 783 0 2, 375, 783 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 264, 014 1, 264, 014 0 1, 264, 014 52.00 849, 933 53.00 05300 ANESTHESI OLOGY 810, 687 810, 687 39, 246 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 177, 473 11, 177, 473 0 11, 177, 473 54.00 56.00 05600 RADI OI SOTOPE 668, 507 668, 507 0 668, 507 56.00 o 57.00 05700 CT SCAN 1, 701, 544 1, 701, 544 1, 701, 544 57.00 05800 MRI 0 58.00 1, 106, 313 1, 106, 313 1, 106, 313 58.00 60.00 06000 LABORATORY 11, 255, 942 11, 255, 942 11, 255, 942 60.00 06500 RESPIRATORY THERAPY 65.00 2, 052, 933 2, 052, 933 0 2, 052, 933 65.00 06600 PHYSI CAL THERAPY 66 00 5, 815, 417 5 815 417 5, 815, 417 66 00 67.00 06700 OCCUPATIONAL THERAPY 764, 204 764, 204 764, 204 67.00 06800 SPEECH PATHOLOGY 301, 261 301, 261 0 301, 261 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 439, 451 439, 451 439, 451 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 12, 925 12, 925 12, 925 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 040, 795 3, 040, 795 3, 040, 795 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 983, 630 1, 983, 630 1, 983, 630 72.00 9, 800, 958 73 00 07300 DRUGS CHARGED TO PATIENTS 9 800 958 9, 800, 958 73 00 07500 ASC (NON-DISTINCT PART) 0 75.00 4, 170, 371 4, 170, 371 4, 170, 371 75.00 76.00 03160 STRESS TESTING 0 76.00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 091, 615 3, 091, 615 5, 651 3, 097, 266 76.01 03610 SLEEP LAB 76 02 847.883 847 883 847, 883 76 02 0 76.97 07697 CARDIAC REHABILITATION 1, 783, 675 1, 783, 675 1, 783, 675 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 878, 618 878, 618 878, 618 88.00 08801 RURAL HEALTH CLINIC (RHC) 5, 690, 346 0 5, 690, 346 88.01 5, 690, 346 88 01 88.02 08802 RURAL HEALTH CLINIC (RHC) 3, 157, 235 3, 157, 235 0 3, 157, 235 88.02 1, 015, 525 09000 CLI NI C 0 90.00 1,015,525 1, 015, 525 90.00 91.00 09100 EMERGENCY 10, 370, 223 10, 370, 223 ol 10, 370, 223 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 3, 911, 873 3, 911, 873 3, 911, 873 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102, 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 120, 553, 763 120, 553, 763 44, 897 120, 598, 660 200. 00 201.00 Less Observation Beds 3, 911, 873 3, 911, 873 3, 911, 873 201. 00 116, 686, 787 202. 00 0 202.00 Total (see instructions) 116, 641, 890 116, 641, 890 44.897

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0110 Peri od: Worksheet C From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30, 805, 838 30, 805, 838 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 4, 227, 511 4, 227, 511 31.00 04300 NURSERY 1, 048, 149 1, 048, 149 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 5, 128, 086 39, 439, 997 44, 568, 083 0 125011 0.000000 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 422, 264 6, 657, 663 7, 079, 927 0.335566 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1,643,338 100, 720 1, 744, 058 0.724755 0.000000 52 00 2, 922, 904 17, 854, 086 05300 ANESTHESI OLOGY 14, 931, 182 0.045406 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 4, 159, 406 79, 857, 793 84, 017, 199 0. 133038 54 00 56.00 05600 RADI OI SOTOPE 474, 279 5, 164, 926 5, 639, 205 0.118546 0.000000 56.00 57.00 05700 CT SCAN 8, 100, 727 46, 558, 558 54, 659, 285 0.031130 0.000000 57.00 05800 MRI 13, 830, 670 15, 010, 169 58.00 1, 179, 499 0.073704 0.000000 58.00 60.00 06000 LABORATORY 17, 971, 367 84, 142, 933 102, 114, 300 0.110229 0.000000 60.00 06500 RESPIRATORY THERAPY 4, 508, 638 3, 942, 989 8, 451, 627 0. 242904 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 495, 363 15, 164, 027 15, 659, 390 0.371369 0.000000 66.00 2, 649, 495 06700 OCCUPATIONAL THERAPY 2, 337, 406 0.288434 67.00 312.089 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 119, 192 572,044 691, 236 0. 435829 0.000000 68.00 06900 ELECTROCARDI OLOGY 3, 747, 452 4, 748, 966 0.092536 69.00 1,001,514 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 59, 602 0. 216855 0.000000 70.00 34.524 25.078 70.00 1, 099, 660 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 226, 148 5, 325, 808 0.570955 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 947, 191 7, 082, 592 8, 029, 783 0.247034 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 13, 313, 824 42, 318, 498 55, 632, 322 0.176174 0.000000 73.00 75 00 07500 ASC (NON-DISTINCT PART) 1, 057, 837 17, 192, 921 18, 250, 758 0 228504 0.000000 75 00 03160 STRESS TESTING 76.00 C 0.000000 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 7,539 4, 162, 279 4, 169, 818 0.741427 0.000000 76.01 76.01 76.02 03610 SLEEP LAB 23,088 2,040,685 2, 063, 773 0.410841 0.000000 76.02 07697 CARDIAC REHABILITATION 76.97 2, 378, 901 12, 351, 485 14, 730, 386 0. 121088 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 1, 218, 829 1, 218, 829 0.720871 0.000000 88.00 0 88 01 08801 RURAL HEALTH CLINIC (RHC) 0 8,036,688 8, 036, 688 0 708046 0.000000 88 01 08802 RURAL HEALTH CLINIC (RHC) 88.02 0 5, 300, 039 5, 300, 039 0.595700 0.000000 88.02 90.00 09000 CLI NI C 14, 144 2, 408, 903 2, 423, 047 0.419111 0.000000 90.00 91.00 09100 EMERGENCY 8, 054, 185 51, 829, 699 59, 883, 884 0.173172 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 8, 920, 773 0.438513 0.000000 92.00 92 00 2.845.063 6,075,710 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 ol 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 114, 296, 120 480, 717, 914 595, 014, 034 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 114, 296, 120 480, 717, 914 595, 014, 034 202.00

				To 09/30/2023		
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS				• • • • • • • • • • • • • • • • • • •	0.00
31. 00	03100 I NTENSI VE CARE UNI T					1. 00
43.00	04300 NURSERY				4	3.00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATI NG ROOM	0. 000000				0.00
51. 00	05100 RECOVERY ROOM	0. 000000				1. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			I	2. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				3.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				4. 00
56. 00	05600 RADI OI SOTOPE	0. 000000				6. 00
57. 00	05700 CT SCAN	0. 000000			- I	7. 00
58. 00	05800 MRI	0. 000000			- I	8. 00
60.00	06000 LABORATORY	0. 000000				0.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000			· · · · · · · · · · · · · · · · · · ·	5. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			· · · · · · · · · · · · · · · · · · ·	6. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				7. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				8. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			- I	9. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			•	0. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				2. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			• • • • • • • • • • • • • • • • • • •	3. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			• • • • • • • • • • • • • • • • • • •	5. 00
76. 00	03160 STRESS TESTING	0. 000000			• • • • • • • • • • • • • • • • • • •	6. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			• • • • • • • • • • • • • • • • • • •	6. 01
76. 02	03610 SLEEP LAB	0. 000000				6. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			7	6. 97
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0. 000000				8. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0. 000000			I	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0. 000000			· · · · · · · · · · · · · · · · · · ·	8. 02
90.00	09000 CLI NI C	0. 000000				0.00
91. 00	09100 EMERGENCY	0. 000000				1. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			9	2. 00
	OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPI OI D TREATMENT PROGRAM				10	2. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE				· · · · · · · · · · · · · · · · · · ·	3. 00
200.00	,				· · · · · · · · · · · · · · · · · · ·	0.00
201.00	i i					1. 00
202.00	Total (see instructions)				20	2. 00

Health Financial Systems OTTA	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lieu of Form CMS-255		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 10/01/2022 Fo 09/30/2023	Date/Time Pre	pared:
		Ti +l c	XVIII	Hospi tal	2/20/2024 3: 4 PPS	o pm
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	/ Aug us timorre	Related Cost		0 7 001. 1)	
	Part II, col.		(col . 1 - col .			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	'			'		
30. 00 ADULTS & PEDIATRICS	1, 075, 130	0	1, 075, 130	16, 659	64. 54	30. 00
31.00 INTENSIVE CARE UNIT	119, 543		119, 54	1, 205	99. 21	31.00
43. 00 NURSERY	37, 670		37, 670	860	43. 80	43.00
200.00 Total (lines 30 through 199)	1, 232, 343		1, 232, 34	18, 724		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 ADULTS & PEDIATRICS	4, 081					30.00
31.00 INTENSIVE CARE UNIT	553	54, 863				31. 00
43. 00 NURSERY	0	0	1			43. 00
200.00 Total (lines 30 through 199)	4, 634	318, 251				200. 00

	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 14-0110	Peri od:	Worksheet D	
				From 10/01/2022	Part II	
				To 09/30/2023		
		Ti +l c	· XVIII	Hospi tal	2/20/2024 3: 4 PPS	U pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)	. Criai gcs	COT GIIIIT 4)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	568, 819	44, 568, 083	0. 01276	3 1, 803, 562	23, 019	50.00
51. 00 05100 RECOVERY ROOM	65, 950					
52.00 05200 DELIVERY ROOM & LABOR ROOM	58, 864					
53. 00 05300 ANESTHESI OLOGY	70, 873					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 576, 015		1			1
56. 00 05600 RADI 0I SOTOPE	13, 082		1			56. 00
57. 00 05700 CT SCAN	60, 878		1			
58. 00 05800 MRI	52, 664		1			
60. 00 06000 LABORATORY	501, 998					
65. 00 06500 RESPIRATORY THERAPY	109, 661					
66. 00 06600 PHYSI CAL THERAPY	520, 554					
67. 00 06700 OCCUPATI ONAL THERAPY	37, 875					
68. 00 06800 SPEECH PATHOLOGY	13, 095	691, 236	0. 01894	4 57, 527	1, 090	68. 00
69. 00 06900 ELECTROCARDI OLOGY	15, 161		1	2 477, 232	1, 523	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	256		1		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	149, 850	5, 325, 808	0. 02813	7 352, 948	9, 931	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 571				2, 678	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	233, 666					73. 00
75.00 07500 ASC (NON-DISTINCT PART)	247, 524					
76. 00 03160 STRESS TESTING	0	0	0. 00000		0	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	103, 921	4, 169, 818	0. 02492	2 3, 114	78	76. 01
76. 02 03610 SLEEP LAB	154, 892	2, 063, 773	0. 07505	3 23, 088	1, 733	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	49, 124	14, 730, 386	0. 00333	5 1, 219, 369	4, 067	76. 97
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC (RHC)	54, 077	1, 218, 829	0. 04436	8 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC (RHC)	364, 767	8, 036, 688	0. 04538	8 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC (RHC)	64, 411	5, 300, 039	0. 01215	3 0	0	88. 02
90. 00 09000 CLI NI C	21, 550	2, 423, 047	0. 00889	4 5, 968	53	90.00
91. 00 09100 EMERGENCY	485, 045	59, 883, 884	0. 00810	0 3, 643, 818	29, 515	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	195, 422			6 1, 402, 747	30, 729	92. 00
200.00 Total (lines 50 through 199)	5, 829, 565	558, 932, 536		32, 754, 202	257, 774	200. 00

		PITAL & HEALTH			u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provider CO		Period: From 10/01/2022 Fo 09/30/2023	Date/Time Pre	pared:
					2/20/2024 3:4	O pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	O	0		0	0	31.00
43. 00 04300 NURSERY	ol	0		0	0	43.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
p	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,		
		minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	16, 65	9 0.00	4, 081	30.00
31. 00 03100 NTENSI VE CARE UNIT	-	0	1, 20			
43. 00 04300 NURSERY		0	86			1
200.00 Total (lines 30 through 199)	•	0	18, 72			200. 00
Cost Center Description	Inpati ent		10,72	•	1,001	200.00
oost conten bescriptron	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0					31.00
43. 00 04300 NURSERY						43.00
43. UU TU43UUTNUKSEKT	ı U					43. UU
200.00 Total (lines 30 through 199)	0					200.00

 Heal th Financial
 Systems
 OTTAWA REGIONAL HOSPITAL & HEALTHCAR

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 1
 Provider CCN: 14-0110 THROUGH COSTS

					10 09/30/2023	Date/lime Pre 2/20/2024 3:4	
			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 OPERATING ROOM	0	0		0	0	50. 00
51.00	· · · · · · · · · · · · · · · · · · ·	0	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00		0	0		0	0	54.00
56.00		0	0		0	0	56. 00
57.00		0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76.00	03160 STRESS TESTING	0	0		0 0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76. 01
76. 02	03610 SLEEP LAB	0	0		0 0	0	76. 02
76. 97	07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0	0		0 0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0		0 0	0	88. 02
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
91.00	09100 EMERGENCY	0	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lie	eu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT (OUTDATIEN	IT ANCILLARY SERVICE OTHER DASS	Dravidor CCN, 14 0110	Dori od:	Workshoot D

Heal th	Financial Systems OTTA	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Li€	eu of Form CMS-2	2552-10
APP0R1	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	SH COSTS				From 10/01/2022	Part IV	
					To 09/30/2023		pared:
			T' 11	20/11/1		2/20/2024 3: 4	U pm
		1		XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS		1				
50. 00	05000 OPERATING ROOM	0	C	l .	0 44, 568, 083		
51. 00	05100 RECOVERY ROOM	0	C)	0 7, 079, 927		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 1, 744, 058	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	C)	0 17, 854, 086	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 84, 017, 199	0.000000	54. 00
56.00	05600 RADI OI SOTOPE	0	l c	1	0 5, 639, 205	0.000000	56. 00
57.00	05700 CT SCAN	0)	0 54, 659, 285	0.000000	57. 00
58. 00	05800 MRI	0		1	0 15, 010, 169		
60.00	06000 LABORATORY	0			0 102, 114, 300		
65. 00	06500 RESPI RATORY THERAPY	0			0 8, 451, 627		
66. 00	06600 PHYSI CAL THERAPY	0			0 15, 659, 390		
67. 00	06700 OCCUPATI ONAL THERAPY	0			0 2, 649, 495		
68. 00	06800 SPEECH PATHOLOGY	0			0 691, 236		
69. 00	06900 ELECTROCARDI OLOGY	0			0 4, 748, 966		
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0					
	1 1	0		1	0 59, 602		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1	0 5, 325, 808		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		1	0 8, 029, 783	•	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1	0 55, 632, 322		
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	1	0 18, 250, 758		
76. 00	03160 STRESS TESTING	0	C	1	0	0.00000	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(0 4, 169, 818		
76. 02	03610 SLEEP LAB	0	[C)	0 2, 063, 773	0.000000	76. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C		0 14, 730, 386	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	C		0 1, 218, 829	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0	C)	0 8, 036, 688	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	C)	0 5, 300, 039	0.000000	88. 02
90.00	09000 CLI NI C	0	C)	0 2, 423, 047	0.000000	90. 00
91.00	09100 EMERGENCY	0	l c		0 59, 883, 884		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	l c)	0 8, 920, 773		
200.00		0		,	0 558, 932, 536		200. 00
		1	1	1	1	1	

Health Financial Systems	OTTAWA REGIONAL HOSPIT	TAL & HEALTHCAR	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-0110	From 10/01/2022	Worksheet D Part IV Date/Time Prepared:

111100011 00010			To	09/30/2023	Date/Time Prep 2/20/2024 3:40	
		Title	XVIII	Hospi tal	PPS	<u></u>
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	,	Costs (col. 8	_	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	1, 803, 562	0	10, 953, 216	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	164, 578	0	2, 097, 871	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	61, 953	0	7, 575	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	802, 244	0	3, 564, 572	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 168, 096	0	18, 363, 520	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	287, 673	0	1, 779, 971	0	56.00
57. 00 05700 CT SCAN	0. 000000	3, 788, 594	0	9, 974, 575	0	57. 00
58. 00 05800 MRI	0. 000000	579, 840	0	2, 420, 950	0	58. 00
60. 00 06000 LABORATORY	0. 000000	7, 534, 398	0	6, 886, 476	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 692, 422	0	498, 977	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	262, 762	0	15, 130	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	155, 529	0	1, 616	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	57, 527	0	2, 793	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	477, 232	o	1, 020, 000	ol	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	352, 948	0	1, 439, 160	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	543, 386		2, 323, 906		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 193, 096		13, 432, 573		73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	530, 258		4, 560, 274		75. 00
76. 00 03160 STRESS TESTING	0. 000000	0	0	0	0	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	3, 114	0	708, 980	0	76. 01
76. 02 03610 SLEEP LAB	0. 000000	23, 088	0	448, 297		76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	1, 219, 369		3, 623, 189		76. 97
OUTPATIENT SERVICE COST CENTERS	0.00000	., = , =	- 1	2, 522, 121	_	
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0. 000000	0	0	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC (RHC)	0. 000000	0	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC (RHC)	0. 000000	0	0	0	o	88. 02
90. 00 09000 CLI NI C	0. 000000	5, 968	0	1, 304, 839	0	90.00
91. 00 09100 EMERGENCY	0. 000000	3, 643, 818		9, 840, 716		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 402, 747		896, 058		92.00
200.00 Total (lines 50 through 199)		32, 754, 202		96, 165, 234		200. 00
	1	,, 202	١	, , 20 1	٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠, ٠	, ,

96, 165, 234

96, 165, 234

2, 130

2, 130

31, 877

31, 877

14, 962, 361

14, 962, 361 202. 00

200.00

201. 00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

In Lieu of Form CMS-2552-10 Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0110 Peri od: Worksheet D From 10/01/2022 To 09/30/2023 Part V Date/Time Prepared: 2/20/2024 3:40 pm 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 58. 00 | 05800 MRI 0 58.00 06000 LABORATORY 0 60.00 235 60.00 06500 RESPIRATORY THERAPY 0 0000000000000 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 616 73.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 03160 STRESS TESTING 0 76.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 0 76.01 03610 SLEEP LAB 76.02 0 76.02 76. 97 07697 CARDIAC REHABILITATION 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 88.00 08801 RURAL HEALTH CLINIC (RHC) 88. 01 88.01 88. 02 08802 RURAL HEALTH CLINIC (RHC) 88.02 09000 CLI NI C 90.00 0 90.00 09100 EMERGENCY 91 00 0 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

235

235

0

5, 616

5, 616

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

202.00

Health Financial Systems OTTA	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2022 To 09/30/2023	Part Date/Time Pre	narod:
				10 09/30/2023	2/20/2024 3: 4	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 075, 130	0	1, 075, 13	16, 659	64. 54	30.00
31.00 INTENSIVE CARE UNIT	119, 543		119, 54	1, 205	99. 21	31. 00
43. 00 NURSERY	37, 670		37, 67	0 860	43. 80	43.00
200.00 Total (lines 30 through 199)	1, 232, 343		1, 232, 34	18, 724		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	929	59, 958	1			30.00
31.00 INTENSIVE CARE UNIT	83	8, 234				31. 00
43. 00 NURSERY	59	2, 584				43.00
200.00 Total (lines 30 through 199)	1, 071	70, 776	,			200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 14-0110 Period: From 10/01/2022 To 09/30/2023 Title XIX Hospital Cost Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. Part II, col. 8) Part II, col. 8) Provider CCN: 14-0110 Period: From 10/01/2022 To 09/30/2023 Worksheet D Part II Date/Time Prep. 2/20/2024 3: 40 Cost Cost Cost Cost Cost Column 3 x Column 4)	
Cost Center Description Capital Related Cost (from Wkst. C, from Wkst. B, Part I, col. Part II, col. Ratio of Cost of	
Related Cost (from Wkst. C, to Charges Program (column 3 x (from Wkst. B, Part I, col. Charges column 4) Part II, col. 8) 2)	
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4) Part II, col. 8) 2)	
Part II, col. 8) 2)	
26)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
	50.00
	51.00
	52.00
	53.00
	54.00
	56.00
	57.00
	58.00
	60.00
	65.00
66. 00 06600 PHYSI CAL THERAPY 520, 554 15, 659, 390 0. 033242 0 0 0	66.00
	67.00
68. 00 06800 SPEECH PATHOLOGY 13, 095 691, 236 0. 018944 0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 15, 161 4, 748, 966 0. 003192 0 0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 256 59, 602 0. 004295 0 0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 149, 850 5, 325, 808 0. 028137 0 0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 39, 571 8, 029, 783 0. 004928 0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 233, 666 55, 632, 322 0. 004200 0 0	73.00
75. 00 07500 ASC (NON-DISTINCT PART) 247, 524 18, 250, 758 0. 013562 0 0 0	75.00
76. 00 03160 STRESS TESTING 0 0.000000 0 0	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 103, 921 4, 169, 818 0. 024922 0 0	76. 01
	76. 02
76. 97 07697 CARDI AC REHABI LI TATI ON 49, 124 14, 730, 386 0. 003335 0 0	76. 97
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC (RHC) 54, 077 1, 218, 829 0. 044368 0 0	88. 00
	88. 01
	88. 02
	90.00
91. 00 09100 EMERGENCY 485, 045 59, 883, 884 0.008100 0 0	91.00
	92.00
200.00 Total (Lines 50 through 199) 5, 829, 565 558, 932, 536 0 0 0	200.00

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu of Form CMS-25							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F				Peri od:	Worksheet D		
				rom 10/01/2022			
			-	Γο 09/30/2023			
		T: ±1	- VIV	11! 4-1	2/20/2024 3: 4	0 pm	
Ct Ct Diti	N		e XIX	Hospi tal	Cost		
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other Medical		
	Program	Program	Post-Stepdown	Cost			
	Post-Stepdown		Adjustments		Education Cost		
	Adjustments	1.00	0.4	0.00	0.00		
INDATI ENT. DOUTINE CERVI OF COCT OFNITERS	1A	1.00	2A	2. 00	3. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1) 0	0		
31. 00 03100 INTENSIVE CARE UNIT	0	0	1) 0	0		
43. 00 04300 NURSERY	0	0	1	0	0	1 .0.00	
200.00 Total (lines 30 through 199)	0	0	(0		200. 00	
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent		
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days		
	Amount (see	1 through 3,					
	instructions)	minus col. 4)					
	4. 00	5. 00	6. 00	7. 00	8. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	16, 65	9 0.00	929	30.00	
31.00 03100 INTENSIVE CARE UNIT		0	1, 20	0.00	83	31. 00	
43. 00 04300 NURSERY		0	860	0.00	59	43.00	
200.00 Total (lines 30 through 199)		0	18, 72	4	1, 071	200.00	
Cost Center Description	I npati ent						
· ·	Program						
	Pass-Through						
	Cost (col. 7 x						
	col . 8)						
	9. 00						

30. 00 31. 00 43. 00

200. 00

30. 00 | 03000 | ADULTS & PEDIATRICS | 03100 | INTENSIVE CARE UNIT | 43. 00 | 04300 | NURSERY | Total (lines 30 through 199)

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To 09/30/2023 | Date/Time Prepared:
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 OTTAWA REGIONAL HOSPITAL & HEALTHCAR

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Provider CCN: 14-0110 THROUGH COSTS

					10 09/30/2023	2/20/2024 3: 4	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			1		1	
50.00	05000 OPERATI NG ROOM	0	0		0	_	50. 00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	Ü		0	0	54.00
56.00	05600 RADI OI SOTOPE	0	Ü		0	0	56.00
57. 00	05700 CT SCAN	0	Ü		0	0	57. 00
58. 00	05800 MRI	0	Ü		0	0	58. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
	03160 STRESS TESTING	0	0		0	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 01
76. 02	03610 SLEEP LAB	0	0		0	0	76. 02
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	1		1		1	
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0		0 0	_	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)	0	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)	0	0		0	0	88. 02
90.00	09000 CLI NI C	0	0		0	0	90.00
91.00	09100 EMERGENCY	0	O		0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATICAL OUTDA	TLENT ANGLELADY CEDVICE OTHER DACC	D: -I CCN 14 0110	D!I	Wassissian D

Не Peri od: From 10/01/2022 To 09/30/2023 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV Provider CCN: 14-0110 THROUGH COSTS Date/Time Prepared: 2/20/2024 3:40 pm Title XIX Hospi tal Cost Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal Outpati ent (from Wkst. C, (sum of cols. Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 44, 568, 083 0.00000050.00 000000000000000000000000 51.00 05100 RECOVERY ROOM 0 0 7, 079, 927 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 744, 058 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 53 00 17, 854, 086 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 84, 017, 199 0.000000 54.00 56. 00 05600 RADI 0I SOTOPE 5, 639, 205 0.000000 56.00 54, 659, 285 57.00 05700 CT SCAN 0 0 0.000000 57.00 05800 MRI 0 0 58.00 15, 010, 169 0.000000 58.00 60.00 06000 LABORATORY 102, 114, 300 0.000000 60.00 06500 RESPIRATORY THERAPY 0 65.00 0 8, 451, 627 0.000000 65.00 0 06600 PHYSICAL THERAPY Ω 15, 659, 390 0.000000 66 00 66 00 67.00 06700 OCCUPATIONAL THERAPY 0 2, 649, 495 0.000000 67.00 06800 SPEECH PATHOLOGY 691, 236 0.000000 68.00 68.00 4, 748, 966 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 59, 602 0.000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 5, 325, 808 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 029, 783 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 55, 632, 322 0.000000 73.00 73.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 18, 250, 758 0.000000 75.00 76.00 03160 STRESS TESTING 0.000000 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 4, 169, 818 76.01 0.000000 76.01 03610 SLEEP LAB 0 76.02 0 2, 063, 773 0.000000 76.02 07697 CARDIAC REHABILITATION 14, 730, 386 0.000000 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 1, 218, 829 0.000000 88.00 08801 RURAL HEALTH CLINIC (RHC) 00000 0 0 0.000000 88.01 8, 036, 688 88.01 0 88.02 08802 RURAL HEALTH CLINIC (RHC) 0 5, 300, 039 0.000000 88.02 90.00 09000 CLI NI C 2, 423, 047 0.000000 0 90.00 0 0 91.00 09100 EMERGENCY 59, 883, 884 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 8, 920, 773 92.00 92.00 0 0.000000 200.00 Total (lines 50 through 199) 558, 932, 536 200.00

Health Financial Systems	OTTAWA REGIONAL	HOSPI T	AL & HEALTHCAR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER	PASS	Provider CCN: 14-0110	Peri od:	Worksheet D

Cost Center Description	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider Co	F		Worksheet D Part IV Date/Time Pre 2/20/2024 3:4	
Ratio of Cost Coharges Col 6 + Col Charges Col 6 + Col Type Charges Cost Col 8 Cost Col 8 Cost Col 8 Cost Col 8 Cost Col 12 Cost Cost Col 12 Cost Cost Col Cost Cost Col Cost Cost Col Cost C			Titl	e XIX	Hospi tal	Cost	
Charges Col. 6 ÷ col. Col. 6 ÷ col. Col. 6 ÷ col. Col. 5 (col. 8 Col. 5 (col. 8 Col. 5 (col. 8 Col. 5 (col. 8 Col. 10) Costs (col. 9 x col. 10) Costs (col. 9 x col. 12) Costs (col. 9 x col. 10) Costs (col. 9 x col. 12) Costs (col. 9 x col. 10) Costs (col. 9 x col. 12) Costs (col. 9 x col.	Cost Center Description		Inpati ent	I npati ent		Outpati ent	
Costs (col 8 x col 10) x col 10) x col 12)		Ratio of Cost	Program	Program	Program	Program	
NOTITION NOTITION			Charges		Charges		
ARCILLARY SERVICE COST CENTERS		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
ANCILLARY SERVICE COST CENTERS							
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68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66. 00
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200.00 Total (lines 50 through 199) 0 0 0 200.00		0.000000	ū	1	0	0	

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110	Peri od: From 10/01/2022	Worksheet D-1
				Date/Time Prepared: 2/20/2024 3:40 pm
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	2/20/2024 3: 40 PPS	O pm
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l	,		16, 659 16, 659	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	10, 039	3.00
	do not complete this line.	, , , , , , , , , , , , , , , , , , , ,	12.00	·	
4.00	Semi-private room days (excluding swing-bed and observation be			13, 631	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roomsting period	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	<i>,</i>		·	
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	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 newborn days) (see instructions)	the Program (excluding	swing-bed and	4, 081	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar years)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	. 3 3		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
00	reporting period	so till dagi. December di d		0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			21, 521, 735	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)		, , , ,	·	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	1 31 of the cost reportion	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		21, 521, 735	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	ł
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		- /	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•	ļ	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	21, 521, 735	37. 00
	27 minus line 36)	· · · · · · · · · · · · · · · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTAINTO			
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 004 ==	00.05
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 291. 90	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		5, 272, 244	1
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)	*		0 5, 272, 244	40.00
71.00	1.0ta rogram gonorar impatront routine service cost (IIIIe 37		ı	5, 212, 244	1 11.00

Cost Center Description Cost Center Description	1.00 0 Units 3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee	npatient Days Diem C 2.00 0 1,205	To I rage Per P	m 10/01/2022 09/30/2023 Hospital Program Days 4.00 0	Date/Time Prep 2/20/2024 3:40 PPS Program Cost (col. 3 x col. 4) 5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital 3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 6.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.00 Program inpatient ancillary service of Program inpatient cellular therapy act 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.01 Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program Inpatient cost (sum of PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program Inpatient operating cost and IV) 1.00 Program inpatient operating cost medical education costs (line 49 minustrange) 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharge (cont Target amount per discharge (cont Target amount (line 54 x sum of lines)	Units 3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee	Total Avenpatient Days Diem C 2.00 0	rage Per (col. 1 ÷ ol. 2) 3.00 0.00	Program Days 4.00	PPS Program Cost (col. 3 x col. 4) 5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital 3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 6.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.00 Program inpatient ancillary service of Program inpatient cellular therapy act 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.01 Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program Inpatient cost (sum of PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program Inpatient operating cost and IV) 1.00 Program inpatient operating cost medical education costs (line 49 minustrange) 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharges 1.00 Program discharge (cont Target amount per discharge (cont Target amount (line 54 x sum of lines)	Units 3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee	npatient Days Diem C 2.00 0	(col . 1 ÷ ol . 2) 3.00 0.00	4.00	(col. 3 x col. 4) 5.00	42.0
Intensive Care Type Inpatient Hospital 3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT 6.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.00 Program inpatient ancillary service of Program inpatient cellular therapy and Pass THROUGH COST ADJUSTMENTS 9.00 Pass through costs applicable to Program Inpatient costs (sum of Pass Through costs applicable to Program Inpatient operating cost and IV) 2.00 Total Program excludable cost (sum of Total Program inpatient operating cost medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges 5.00 Target amount per discharge (cont Target amount (line 54 x sum of lines)	Units 3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee	2.00	3.00	0	5.00	42.0
Intensive Care Type Inpatient Hospital 3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.00 Program inpatient ancillary service of Program inpatient cellular therapy and Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 9.00 Pass through costs applicable to Program Inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 1.00 Pass through costs applicable to Program Inpatient operating cost and IV) 2.00 Total Program excludable cost (sum of Total Program inpatient operating cost medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges 5.00 Target amount per discharge (cont Target amount (line 54 x sum of lines)	Units 3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee	1, 205				42. (
3.00 INTENSIVE CARE UNIT 4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 6.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8.00 Program inpatient ancillary service of Program inpatient cellular therapy act 9.00 PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program Inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS) 1.00 Pass through costs applicable to Program Inpatient operating cost and IV) 2.00 Total Program excludable cost (sum of Total Program inpatient operating cost medical education costs (line 49 minustranger AMOUNT AND LIMIT COMPUTATION) 4.00 Program discharges 5.00 Target amount per discharge (cont Target amount (line 54 x sum of lines)	3,127,121 ost (Wkst. D-3, col. 3, quisition cost (Workshee		2, 595. 12	553	1, 435, 101	
4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 5.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 3.00 Program inpatient ancillary service of Program inpatient cellular therapy act Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 7.00 Pass through costs applicable to Program Inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS 7.00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minustrange) 7.00 Total Program inpatient operating cosmedical education costs (line 49 minustrange) 7.00 Program discharges 7.00 Total Program discharge 7.00 Program discharges 7.00 Adjustment amount per discharge (cont Target amount (line 54 x sum of lines)	ost (Wkst. D-3, col. 3, quisition cost (Workshee		2, 373. 12	555	1, 435, 101	43.0
SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description B. 00 Program inpatient ancillary service of the program inpatient cellular therapy and the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient cost (sum of the program inpatient operating cost (sum of the program inpatient operating cost (sum of the program inpatient operating cost (sum of the program inpatient operating cost (sum of the program inpatient operating cost (sum of the program inpatient operating cost (sum of the program discharges) Target amount per discharge (sum of the program inpatient amount per discharge (cont the program inpatient amount per discharge (sum of the program inpatient amount per discharge (cont the program inpatient amount per discharge (sum of the program inpatient amount per discharge (cont the program inpatient amount per discharge (sum of the program inpatient amount per discharge (cont the program inpatient amount per discharge (sum of the program inpatient amount per discharge (sum of the program inpatient amount per discharge (sum of the program inpatient amount per discharge (sum of the program inpatient amount per discharge (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the program inpatient costs (sum of the	quisition cost (Workshee	line 200)				44. 0
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 3.00 Program inpatient ancillary service of Program inpatient cellular therapy and Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS) D.00 Pass through costs applicable to Program III) Pass through costs applicable to Program IV) 2.00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minustrance TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines)	quisition cost (Workshee	line 200)				45. (
Cost Center Description 3.00 Program inpatient ancillary service of Program inpatient cellular therapy act Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS) 3.00 Pass through costs applicable to Program in III) 3.00 Pass through costs applicable to Program III) 3.00 Pass through costs applicable to Program III) 4.00 Pass through costs applicable to Program IV) 5.00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges 5.00 Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines)	quisition cost (Workshee	line 200)				46. (47. (
.01 Program inpatient cellular therapy acc00 Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS .00 Pass through costs applicable to Prog. (iii) .00 Pass through costs applicable to Prog. (and IV) .00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges .00 Target amount per discharge (cont. Adjustment amount per discharge (cont. Target amount (line 54 x sum of lines.)	quisition cost (Workshee	line 200)				47.
.01 Program inpatient cellular therapy acc00 Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS .00 Pass through costs applicable to Prog. (iii) .00 Pass through costs applicable to Prog. (and IV) .00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges .00 Target amount per discharge (cont. Adjustment amount per discharge (cont. Target amount (line 54 x sum of lines.)	quisition cost (Workshee	line 200)			1. 00	
Total Program inpatient costs (sum of PASS THROUGH COST ADJUSTMENTS DOO Pass through costs applicable to Program of III) Pass through costs applicable to Program of IV) Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines)			line 10 co	Lump 1)	5, 080, 166 0	1
PASS THROUGH COST ADJUSTMENTS .00 Pass through costs applicable to Prog III) .00 Pass through costs applicable to Prog and IV) .00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges .00 Total Program inpatient operating cosmedical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION Program discharges .00 Total Program discharges .01 Permanent adjustment amount per discharge (cont Adjustment amount per discharge (cont Target amount (line 54 x sum of lines				ruiiir 1)	11, 787, 511	
III) Pass through costs applicable to Prog and IV) Total Program excludable cost (sum of Total Program inpatient operating cos medical education costs (line 49 minumater TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines)	, , , , , , , , , , , , , , , , , , ,	•	•			
.00 Pass through costs applicable to Prog and IV) .00 Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minumatager AMOUNT AND LIMIT COMPUTATION Program discharges .00 Target amount per discharge Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines	ram inpatient routine se	ervices (from Wkst	. D, sum of	Parts I and	318, 251	50.0
and IV) Total Program excludable cost (sum of Total Program inpatient operating cosmedical education costs (line 49 minumarket AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge (cont Target amount (line 54 x sum of lines)	ram inpatient ancillary	services (from Wk	st. D, sum	of Parts II	257, 774	51.
OD Total Program inpatient operating cosmedical education costs (line 49 minumarked and the following transfer amount AND LIMIT COMPUTATION Program discharges Target amount per discharge Permanent adjustment amount per discharge (cont Adjustment amount per discharge (cont Target amount (line 54 x sum of lines)		•				
medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION) OO Program discharges OO Target amount per discharge OP Permanent adjustment amount per discharge (cont) Adjustment amount per discharge (cont) Target amount (line 54 x sum of lines)		ated non-nhysicis	ın anestheti	st and	576, 025 11, 211, 486	1
00 Program discharges 00 Target amount per discharge 01 Permanent adjustment amount per discharge (cont 02 Adjustment amount (line 54 x sum of lines			41103111011		11, 211, 400] 55.
00 Target amount per discharge 01 Permanent adjustment amount per disch 02 Adjustment amount per discharge (cont 00 Target amount (line 54 x sum of lines						١
01 Permanent adjustment amount per disch 02 Adjustment amount per discharge (cont 00 Target amount (line 54 x sum of lines					0.00	
00 Target amount (line 54 x sum of lines					0.00	
					0.00	
		act emount (line F	74 minus lin	o E2)	0	
00 Bonus payment (see instructions)	operating cost and targ	get allibuit (Title :	o iii iius ii iii	e 53)		1
00 Trended costs (lesser of line 53 ÷ li		the cost reporting	period end	i ng 1996,	0.00	
updated and compounded by the market 00 Expected costs (lesser of line 53 ÷ l		prior year cost r	eport, upda	ted by the	0.00	60.
market basket) Oo Continuous improvement bonus payment	(if line 52 · line 54 is	e loss than the la	west of lin	oe 55 plue	0	61.
55. 01, or line 59, or line 60, enter					١	01.
53) are less than expected costs (line	es 54 x 60), or 1 % of t	the target amount	(line 56),	otherwi se		
enter zero. (see instructions) OO Relief payment (see instructions)					0	62.
00 Allowable Inpatient cost plus incenti		tions)			0	1
PROGRAM INPATIENT ROUTINE SWING BED CO		nor 21 of the cost	nononti na	nonind (Coo		١,,
00 Medicare swing-bed SNF inpatient rout instructions) (title XVIII only)	ine costs through Decemb	per 31 of the cost	reporting	period (See	0	64.
00 Medicare swing-bed SNF inpatient rout	ine costs after December	r 31 of the cost r	eporting pe	riod (See	0	65.
instructions)(title XVIII only) Total Medicare swing-bed SNF inpatien	t routine costs (line 4)	1 nlus lina 451/+:	tle Y\/!!! ^	nlv): for	0	66.
CAH, see instructions	t routine costs (IIIIè 04	τριαστιπο σσ <i>)</i> (ti	FIE VALLE OF	y), IUI	١	00.
00 Title V or XIX swing-bed NF inpatient	routine costs through [December 31 of the	cost repor	ting period	0	67.
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient	routine costs after Dec	cember 31 of the d	ost reporti	ng period	0	68.
(line 13 x line 20)				3 11 - 1 - 2		
OO Total title V or XIX swing-bed NF inp. PART III - SKILLED NURSING FACILITY, (0	69.
OD Skilled nursing facility/other nursing			line 37)			70.
00 Adjusted general inpatient routine se	rvice cost per diem (lir		,			71.
00 Program routine service cost (line 9 : 00 Medically necessary private room cost	•	(line 14 v lino 25	()			72. 73.
Total Program general inpatient routing			,			74.
OO Capital-related cost allocated to inp	atient routine service o	costs (from Worksh	ieet B, Part	II, column		75.
26, line 45) 26, line 45) 26, line 45)	75 ÷ line 2)					76.
00 Program capital -related costs (line 9						77.
OO Inpatient routine service cost (line	· ·					78.
00 Aggregate charges to beneficiaries fo 00 Total Program routine service costs fo		· ·	ne 78 minus	line 79)		79. 80.
00 Inpatient routine service costs in	•	se irmitation (III	o 70 milius l			81
00 Inpatient routine service cost limita	tion (line 9 x line 81)				1 '	82
ON Reasonable inpatient routine service on Program inpatient ancillary services)				
00 Program inpatient ancillary services 00 Utilization review - physician compen	(SEE THSTIUCTIONS)					83.
00 Total Program inpatient operating cos	sation (see instructions	s)				83. 84.
PART IV - COMPUTATION OF OBSERVATION I Total observation bed days (see instr	ts (sum of lines 83 thro					83. 84. 85. 86.

3, 028 87. 00 1, 291. 90 88. 00 3, 911, 873 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems OTTA	WA REGIONAL HOS	SPITAL & HEALTH	CAR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Prep 2/20/2024 3:40	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 075, 130	21, 521, 735	0. 04995	6 3, 911, 873	195, 422	90.00
91.00 Nursing Program cost	0	21, 521, 735	0.00000	3, 911, 873	0	91.00
92.00 Allied health cost	0	21, 521, 735	0.00000	3, 911, 873	0	92.00
93.00 All other Medical Education	0	21, 521, 735	0. 00000	3, 911, 873	0	93. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAI	R	In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	-	Provider CCN:	14-0110	Peri od: From 10/01/2022	Worksheet D-3

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 14-0110	Peri od:	Worksheet D-3	
				From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
					2/20/2024 3:4	0 pm
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			7, 353, 805		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			1, 883, 966		31. 00
43.00	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					
50. 00	05000 OPERATING ROOM		0. 1250			1
51. 00	05100 RECOVERY ROOM		0. 3355			1
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 7247!			52. 00
53.00	05300 ANESTHESI OLOGY		0. 04760			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1330:			
56.00	05600 RADI 0I SOTOPE		0. 1185	16 287, 673	34, 102	56. 00
57.00	05700 CT SCAN		0. 0311	3, 788, 594	117, 939	57. 00
58.00	05800 MRI		0. 07370	579, 840	42, 737	58. 00
60.00	06000 LABORATORY		0. 1102:	7, 534, 398	830, 509	60.00
65.00	06500 RESPI RATORY THERAPY		0. 24290	1, 692, 422	411, 096	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 3713		97, 582	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 2884:	155, 529	44, 860	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 43582	57, 527	25, 072	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 0925			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 2168		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5709!			
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2470	·		1
	07300 DRUGS CHARGED TO PATIENTS		0. 1761			1
75. 00	07500 ASC (NON-DISTINCT PART)		0. 22850			1
76. 00	03160 STRESS TESTING		0. 00000		0	76.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 74278			
76. 01	03610 SLEEP LAB		0. 4108			
	07697 CARDI AC REHABI LI TATI ON		0. 12108			76. 02
70. 97	OUTPATIENT SERVICE COST CENTERS		0.1210	00 1, 219, 309	147, 651	70.97
88. 00	08800 RURAL HEALTH CLINIC (RHC)		0.0000	20	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC (RHC)		0. 00000		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC (RHC)		0.0000		0	88. 02
	09000 CLINIC		0. 4191		_	90.00
91. 00	09100 EMERGENCY		0.4191			1
	O9200 OBSERVATION BEDS (NON-DISTINCT PART					
			0. 4385			
200.00		(1: (1)		32, 754, 202		1
201.00		(TINE 61)		0 754 000		201. 00
202.00	Net charges (line 200 minus line 201)		l	32, 754, 202		202. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-0110	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/20/2024 3:40 pm	
		T1 11 \0.0111		550	

	Title XVII	1	Hospi tal	2/20/2024 3: 4 PPS	0 pm
	THE AVII	<u>'</u>	nospi tai	FF3	
	PART A AMERITARY MORNITAL OFFICE OFFICE AND FOLLOWS			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to Octo	ber 1 (s	ee	0	1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after 0	otober 1	(500	10, 837, 929	1. 02
1.02	instructions)	ic tober i	(366	10, 037, 727	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occ	urring p	rior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occ	urring o	n or after	0	1. 04
	October 1 (see instructions)				
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions			0	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructi Managed Care Simulated Payments	ons)		0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see	instruc	tions)	80. 70	4. 00
	Indirect Medical Education Adjustment		,		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost rep or before 12/31/1996. (see instructions)	orting p	eriod ending on	0. 00	5. 00
5. 01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see ins	tructi on	ıs)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for a			0. 00	6. 00
	new programs in accordance with 42 CFR 413.79(e)	1		0.00	
6. 26	Rural track program FTE cap limitation adjustment after the cap-building windo the CAA 2021 (see instructions)	w crosed	under §127 of	0. 00	6. 26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412	. 105(f)(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(i v	()(B)(2) If the	0. 00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE li	mitation	(s) for rural	0. 00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated programs in acco			0.00	7.02
	and 87 FR 49075 (August 10, 2022) (see instructions)		, ,		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopat			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 1998), and 67 FR 50069 (August 1, 2002).	FK 20340	(way 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503	of the A	CA. If the cost	0. 00	8. 01
0.00	report straddles July 1, 2011, see instructions.	l + a a a b i m	a booni tol	0.00	0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed under § 5506 of ACA. (see instructions)	i teachin	ig nospi tai	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of	the CAA	2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line	s 7 and	7 01 plus or	0. 00	9. 00
9.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instruct		7.01, prus of	0.00	7.00
10.00	FTE count for allopathic and osteopathic programs in the current year from you	ır record	ls	0. 00	
11.00	FTE count for residents in dental and podiatric programs.				11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or af	ter Sept	ember 30, 1997,		14. 00
	otherwise enter zero.				
15. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)				15. 00 16. 00
16. 00 17. 00	Adjustment for residents in initial years of the program (see instructions) Adjustment for residents displaced by program or hospital closure				17. 00
18. 00	Adjusted rolling average FTE count			0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0	21. 00 22. 00
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 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 und	ler 42 CF	R 412. 105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			0. 00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23	or line	24 (see	0.00	
	instructions)				
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see	instruct	ions)	6. 98	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	instiuct	1 0/13)	34. 82	
32. 00	Sum of lines 30 and 31			41. 80	32. 00
33.00	Allowable disproportionate share percentage (see instructions)			23. 70	33.00
34. 00	Disproportionate share adjustment (see instructions)			642, 147	34.00

		IOSPITAL & HEALTHCAR		u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0110	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prep 2/20/2024 3:40			
		Title XVIII	Hospi tal	PPS	<u>o p</u>		
			Prior to 10/1	On/After 10/1			
			1. 00	2.00			
	Uncompensated Care Payment Adjustment						
35. 00	Total uncompensated care amount (see instructions)		0				
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is z	zoro ontor zoro on this lin	0. 000000000 ne) 0	0. 000114111	1		
35. 02	(see instructions)	zero, enter zero on this iri	ie) U	784, 448	35.02		
35. 03		al UCP (see instructions)	0	784, 448	35. 03		
	Total UCP adjustment (sum of columns 1 and 2 on line 35.0	*	784, 448		36. 00		
	Additional payment for high percentage of ESRD beneficiar	ry discharges (lines 40 thro	ough 46)				
40. 00	Total Medicare discharges (see instructions)		0		40. 00		
			Before 1/1	On/After 1/1			
	I=		1. 00	1. 01			
41.00	Total ESRD Medicare discharges (see instructions)		0	0			
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see inst Divide line 41 by line 40 (if less than 10%, you do not o		0.00	0	41. 01 42. 00		
43. 00	Total Medicare ESRD inpatient days (see instructions)	quarity for adjustment)	0.00		43. 00		
44. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0.00000		44. 00		
	days)	,, .					
45.00	Average weekly cost for dialysis treatments (see instruct		0.00	0.00	45. 00		
46.00	Total additional payment (line 45 times line 44 times lin	ne 41.01)	0		46. 00		
47. 00	Subtotal (see instructions)		12, 264, 524		47. 00		
48. 00	Hospital specific payments (to be completed by SCH and MD	DH, small rural hospitals	0		48. 00		
	only. (see instructions)			Amount			
				1. 00			
49. 00	Total payment for inpatient operating costs (see instruct	tions)		12, 264, 524	49. 00		
50.00	Payment for inpatient program capital (from Wkst. L, Pt.	I and Pt. II, as applicable	e)	814, 588	50.00		
51.00	Exception payment for inpatient program capital (Wkst. L,	Pt. III, see instructions)		0	51. 00		
52. 00	Direct graduate medical education payment (from Wkst. E-4	4, line 49 see instructions)		0			
53.00	Nursing and Allied Health Managed Care payment			0			
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			21, 179 0	1		
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	1		
55. 01	Cellular therapy acquisition cost (see instructions)	116 07)		0	55. 01		
56.00	Cost of physicians' services in a teaching hospital (see	intructions)		0	56. 00		
57.00	Routine service other pass through costs (from Wkst. D, F	Pt. III, column 9, lines 30	through 35).	0	57. 00		
58. 00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0			
59. 00	Total (sum of amounts on lines 49 through 58)			13, 100, 291	1		
60.00	Primary payer payments			5, 469	1		
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries	ninus iine 60)		13, 094, 822 1, 388, 236	1		
63. 00	Coinsurance billed to program beneficiaries			53, 501	1		
64. 00	Allowable bad debts (see instructions)			198, 931	1		
65.00				129, 305			
66.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		177, 131	66. 00		
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			11, 782, 390	67. 00		
68. 00	Credits received from manufacturers for replaced devices	• •	•	0			
69.00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction	ons)	0			
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Dem	constration) adjustment (see	instructions)	0	70. 00 70. 50		
70. 30	N95 respirator payment adjustment amount (see instruction	, ,	: Thistructions)	0	1		
70. 73	Demonstration payment adjustment amount before sequestrat			0	70. 73		
70. 88	SCH or MDH volume decrease adjustment (contractor use onl			Ö			
70. 89	Pioneer ACO demonstration payment adjustment amount (see				70. 89		
70. 90	HSP bonus payment HVBP adjustment amount (see instruction			0			
	HSP bonus payment HRR adjustment amount (see instructions	5)		0			
70. 91							
70. 92	Bundled Model 1 discount amount (see instructions)		` '				
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 0 0	70. 93		

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In L	ieu of Form CMS-2552-10
CALCULATION OF DELMBURGEMENT SETTLEMENT		Dravi dan CCN, 14 0110	Doni od.	Waskahaat F

	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od:	Worksheet E	
				From 10/01/2022 To 09/30/2023	Part A Date/Time Prep 2/20/2024 3:40	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
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 in the corresponding federal year for the period ending on or af			2023	408, 886	70. 97
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			12, 191, 276	71.00
71. 01	Sequestration adjustment (see instructions)				243, 826	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72. 00	Interim payments				11, 892, 608	
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only)	2 72 and			E4 042	73. 01 74. 00
	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			54, 842	
74. 01	Balance due provider/program-PARHM (see instructions)				070 450	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accorda	nce with			273, 152	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
70.00	plus 2.04 (see instructions)	0. 2.00			, and the second second second second second second second second second second second second second second se	70.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	ucti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94. 00	The rate used to calculate the time value of money (see instr	uctions)			0.00	94.00
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)				0	100.00
	IIVDD Adiustment for ICD Denus Dormant			_		
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)	`			0.0000000000	101. 00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)				
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)			0	101. 00 102. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)				0. 0000	101. 00 102. 00 103. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	stmant		0. 0000	101. 00 102. 00
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102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju			0.0000	101. 00 102. 00 103. 00 104. 00
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102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrations) Is this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin. Medicare discharges (see instructions)) ration) Adju riod under t			0.0000	101. 00 102. 00 103. 00 104. 00 200. 00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st		0.0000	101. 00 102. 00 103. 00 104. 00 200. 00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin. Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	nt 5-year demonst	0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
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102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount) ration) Adju riod under t e 49)	he 21st	nt 5-year demonst	0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration be century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under t e 49)	he 21st	nt 5-year demonst	0.0000 0.rration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, linedicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49)	he 21st	nt 5-year demonst	0.0000 0.rration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
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102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) Is this the first year of the current 5-year demonstration peroperated (See instructions) Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin. Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjustment factor (see instructions) Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line Low-volume adjustment (see instructions)	ration) Adjuriod under te 49) first year ructions) line 59)	of the curre	nt 5-year demonst	0.0000 0.rration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00
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102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions) Is this the first year of the current 5-year demonstration peroperated (See instructions) Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin. Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjustment factor (see instructions) Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line Low-volume adjustment (see instructions)	ration) Adjuriod under te 49) first year ructions) line 59)	of the curre	nt 5-year demonst	0.0000 0.rration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00

Health Financial Systems

In Lieu of Form CMS-2552-10

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 14-0110 Peri od: Worksheet E From 10/01/2022 Part A Exhibit 4 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XVIII Hospi tal Period Prior Total (Col 2 W/S E, Part A Amounts (from Pre/Post Peri od to 10/01 Part A) On/After 10/01 through 4) line Entitlement 0 1 00 2 00 3 00 4 00 5 00 1.00 DRG amounts other than outlier 1.00 1.00 payments 1.01 DRG amounts other than outlier 1.01 1.01 payments for discharges occurring prior to October 1 1 02 10 837 929 10 837 929 10, 837, 929 1.02 DRG amounts other than outlier 1 02 payments for discharges occurring on or after October DRG for Federal specific 1.03 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific 1.04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 Outlier payments for 2.00 2 00 2.00 discharges (see instructions) 2.01 Outlier payments for 2.02 2.01 discharges for Model 4 BPCI Outlier payments for 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for 2.04 2.03 discharges occurring on or after October 1 (see instructions) Operating outlier 3.00 3.00 2.01 reconciliation C 4.00 Managed care simulated 3.00 4.00 payments Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 5.00 A, line 21 (see instructions) IME payment adjustment (see 0 6.00 22.00 0 C 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 С 0 6. 01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 7.00 (see instructions) 8.00 IME adjustment (see 28.00 8.00 C instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 C 9.00 lines 6 and 8) Total IME payment for managed 9.01 29.01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate 33 00 0 2370 0.2370 0 2370 0 2370 10.00 share percentage (see instructions) Di sproporti onate share 0 11.00 34.00 642, 147 642, 147 642, 147 11.00 adjustment (see instructions) 11. 01 Uncompensated care payments 36.00 784, 448 0 784, 448 784, 448 11. 01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment 0 12.00 46.00 0 12.00 (see instructions) 13 00 47 00 0 Subtotal (see instructions) 12, 264, 524 12, 264, 524 12, 264, 524 13 00 Hospital specific payments 48.00 14.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 15.00 49 00 12, 264, 524 0 12, 264, 524 12, 264, 524 15 00 operating costs (see instructions) Payment for inpatient program 50.00 814.588 814.588 814, 588 16.00 capital (from Wkst. L, Pt. I, if applicable)

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 14-0110 Peri od: Worksheet E From 10/01/2022 Part A Exhibit 4
Date/Time Prepared: 09/30/2023 2/20/2024 3:40 pm Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 21, 179 21, 179 21, 179 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 13, 100, 291 13, 100, 291 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 814, 588 0 814, 588 814, 588 20.00 Model 4 BPCI Capital DRG other 0 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 21.01 2.01 0 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 C 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 C 0 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 814, 588 0 814, 588 814, 588 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5.00 1.00 2.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.031212 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 408, 886 29.00 70.97 408, 886

100.00

(transfer amount to Wkst. E,

adjustments to Wkst. E, Pt. A.

Pt. A, line) 100.00 Transfer low volume

Provider CCN: 14-0110

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 10/01/2022 Part A Exhibit 5 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm Title XVIII Hospi tal PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 4.00 1.00 2.00 3. 00 0 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 10.837.929 10. 837. 929 10.837.929 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 O 0 2 02 prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on 2.04 0 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.2370 0.2370 0. 2370 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 642.147 0 642.147 642.147 11.00 instructions) 11.01 Uncompensated care payments 36 00 784, 448 0 784, 448 784, 448 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 O 12.00 instructions) 47.00 13 00 Subtotal (see instructions) 0 12, 264, 524 12, 264, 524 12, 264, 524 13 00 14.00 Hospital specific payments (completed by SCH 48.00 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 0 12, 264, 524 12, 264, 524 15.00 15.00 12, 264, 524 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 814.588 0 814, 588 814, 588 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 21, 179 21, 179 21, 179 17.00 C 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 0 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions) 19.00 **SUBTOTAL** 13, 100, 291 13, 100, 291 19. 00

Health Financial Systems OTTA	WA REGIONAL HOS	PITAL & HEALTH	CAR	In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co		Period: From 10/01/2022 To 09/30/2023	Date/Time Prep 2/20/2024 3:40	pared:
		Title	: XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	814, 588		0 814, 588	814, 588	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2.00	0		0	0	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	О		0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0. 0000		24. 00
25.00 Di sproporti onate share adjustment (see i nstructi ons)	11.00	0		0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	814, 588		0 814, 588	814, 588	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	408, 886		408, 886	408, 886	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	o		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	0		0	0	31. 00
31.00 HRR adjustment (see First detroits) 31.01 HRR adjustment for HSP bonus payment (see	70. 91	0		0	0	31.00
instructions)	70. 71	0		0	· ·	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lieu of Form CMS-2552-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-0110		Worksheet E Part B Date/Time Prepared: 2/20/2024 3:40 pm	

PART B		Titl Maria		2/20/2024 3: 4	0 pm
Note Note		Title XVIII Hospita		PPS	
Note Note				1 00	
		PART R - MEDICAL AND OTHER HEALTH SERVICES		1.00	
Medical and other services relatured under OPPS (see instructions) 14, 80, 36, 12, 00	1.00		\neg	5, 851	1.00
4.001 Outlier payment (see instructions) 4.001 Outlier preceded lated another (see instructions) 0.0000 0.0000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0				-	1
Autilier reconcil latinal amount (see Instructions)	3.00	OPPS or REH payments		13, 807, 088	3. 00
## 5.00 Chief of the hospit foll specific payment to cost ratio (see instructions) 0.00 5.00				66, 629	•
Line 2 Times Line 5 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·			1
Sum of Files 3					1
Transitional corridor payment (see instructions)				_	1
Ancil lary service other pass through costs from West. D. Pt. IV. col. 13. Iline 200 0 9.00					
10.00 Organ acquisitions 5,851 11.00 Concentration 6,851		· • · · · · · · · · · · · · · · · · · ·			1
1.00					1
Reusenable Charges 34,007 12,00 April (arry service charges (see instructions) 34,007 13,00 14,00 14,0	11.00	Total cost (sum of lines 1 and 10) (see instructions)		5, 851	11. 00
13.00 Organ acquist fron charges (from Wist. D-4, Pt. III. col. 4, line 69)					
14.00				34, 007	
Customary charges				24 007	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00	14.00			34,007	14.00
16.00 Asount's that would have been real ized from patients Itale For payment for services on a chargebasis	15. 00		sis	0	15.00
had such payment been made in accordance with 42 CFR \$413.13(e)*					
18.00 Total customery charges (see Instructions) 34,007 18.00 18.00 18.00 18.00 18.00 18.10					
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 28, 156 19.00					1
Instructions				-	
20.00 Excess of reasonable cost over customary charges (complete only If I ine 11 exceeds line 18) (see 0 20.00 1.5	19. 00			28, 156	19.00
instructions	20 00			0	20 00
1.00 Lesser of cost or charges (see instructions) 0.20.00	20.00			0	20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 13,873,717 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 13,873,717 25.00 COMPUTATION OF RELINBURSCHINT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,502,190 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 11,377,378 27.00 27.00 Control (Cines 2) and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Deductibles and coinsurance amounts (From Wkst. E-4, line 50) 0.28,00 EFF facility payment amount 28.50 29.00 ESF for Cate graduate medical education payments (From Wkst. E-4, line 36) 0.29,00 0.00	21. 00			5, 851	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 40, 1, 8 and 9)	22.00	Interns and residents (see instructions)		0	22. 00
COMPUTATION OF RELIBEDRESSEINT SETTLEMENT COMPUTATION OF RELIBEDRESSEIN OF CAH, see Instructions) 0.0 25.00				_	
25.00 Deductibles and coinsurance amounts (For CAH, see instructions) 2.502, 190 26.00 26.00 00 26.00 00 25.00 25.00 26.00 25.00 26.	24. 00			13, 873, 717	24. 00
26.00 Deductibles and Colnsurance amounts relating to amount on line 24 (For CAH, see instructions) 2,502,190 26.00	25 00			0	1 25 00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 11, 377, 378 27. 00					1
Instructions		· · · · · · · · · · · · · · · · · · ·	عد		
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27, 28, 28. 50 and 29) 11, 377, 378 30. 00 31. 00 Primary payer payments 50 31. 00 32. 00 Subtotal (line 30 minus lines 31) 50 31. 00 32. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33. 00 34. 00 Allowable Bad debts (see instructions) 232, 199 34. 00 35. 00 Adjusted relimbursable bad debts (see instructions) 204, 916 36. 00 36. 00 Allowable bad debts for equal eligible beneficiaries (see instructions) 204, 916 36. 00 37. 00 Subtotal (see instructions) 204, 916 36. 00 38. 00 MSP-LCC reconcilitation amount from PS&R 11, 528, 257 37. 00 39. 50 Ploneer ACD demonstration payment adjustment (see instructions) 9. 59. 00 39. 50 39. 75 PS respirator payment adjustment amount (see instructions) 9. 39. 90 99. 90 80. 200 99. 90 99. 90 90. 90 90. 90 90. 90	27.00		~	11, 377, 370	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 20.0	28.00			0	28. 00
30.00 Subtotal (sum of lines 27, 28, 28.50 and 29)	28. 50				
31.00 Primary payer payments 50 31.00 Subtotal (line 30 minus line 31) 11.377.328 32.00 Subtotal (line 30 minus line 31) 11.377.328 32.00 Composite rate ESRD (From Wist. I5, line 11) 0 33.00 3					1
32.00 Subtotal (fine 30 minus line 31) 11,377,328 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 232,199 34.00 35.00 Allowable bad debts (see instructions) 150,292 35.00 37.00 Subtotal (see instructions) 204,916 36.00 37.00 Subtotal (see instructions) 11,528,257 37.00 38.00 MPS-LCC recordilation amount from PS&R 11,528,257 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 Poneer ACO demonstration payment adjustment (see instructions) 0 39.57 39.57 Demonstration payment adjustment amount before sequestration 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.90 30.0					
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					1
33.00 Composite rate ESRD (from Wkst. i-5, line 11) 33.00 Allowable bad debts (see instructions) 232,199 34.00 35.00 Adjusted relimbursable bad debts (see instructions) 150,929 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 204,916 36.00 38.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 11,528,257 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Poneer ACO demonstration payment adjustment (see instructions) 39.55 N95 respirator payment adjustment amount (see instructions) 0 39.97 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90	32.00			11, 377, 320	32.00
14.00	33. 00			0	33.00
36. 00 Al Towable bad debts for dual eligible beneficiaries (see instructions) 204,916 36. 00 37. 00 Subtotal (see instructions) 11,528,257 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39. 75 39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 01 Sequestration adjustment (see instructions) 11, 528, 257 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 230, 56 40. 01 40. 02 Sequestration adjustment (see instructions) 11, 528, 257 40. 00 40. 01 Interim payments 11, 350, 668 40. 01 41. 01 Interim payments 11, 350, 668 41. 01 42. 01 Interim payments 11, 350, 668 42. 01				232, 199	ł
37.00 Subtotal (see instructions) 11,528,257 37.00 38.00 MSP-LCC reconcilitation amount from PS&R 0 38.00 38.00 39.00 MSP-LCC reconcilitation amount from PS&R 0 38.00 39.00 70 70 70 70 70 70 70	35.00	Adjusted reimbursable bad debts (see instructions)		150, 929	35. 00
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 3					
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 39.00 39.00 39.50 39.					
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.75 39.97 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.99 39.99				_	
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39. 97 Demonstration payment adjustment amount before sequestration 39. 97 39. 98 39. 97 39. 98 39. 97 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 39. 9				n	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 11, 528, 257 40. 00 40. 01 Sequestration adjustment (see instructions) 230, 565 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 01 Interim payments 11, 350, 668 41. 00 41. 01 Interim payments-PARHM 41. 01 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 01 43. 00 Balance due provider/program (see instructions) 42. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25, 878 44. 00 44. 00 Fills. 2 10 <td< td=""><td></td><td></td><td></td><td>_</td><td></td></td<>				_	
40.00 Subtotal (see instructions) 11,528,257 40.00 40.01 Sequestration adjustment (see instructions) 230,565 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 0 40.03 41.00 Interim payments 11,350,668 41.00 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 43.01 Bal ance due provider/program (see instructions) -52,976 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25,878 25,878 44.00 Sil15.2 2 TO BE COMPLETED BY CONTRACTOR 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 93.00<				0	39. 98
40. 01 Sequestration adjustment (see instructions) 230, 565 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 11, 350, 668 41. 00 41. 00 Interim payments 11, 350, 668 41. 00 41. 01 Interim payments-PARHM 0 42. 01 42. 00 Tentative settlement (for contractors use only) 0 42. 01 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) -52, 976 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25, 878 25, 878 44. 00 To BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00	39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25, 878 44. 00 \$\frac{1}{5}15. 2\$ \text{TO BE COMPLETED BY CONTRACTOR} 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00					
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 41. 350, 668 41. 00 41. 01 Interim payments-PARHM 41. 01 Tentative settlement (for contractors use only) 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25, 878 44. 00 15. 2 25, 878			ļ		1
11, 350, 668 41. 00 1				0	1
41.01 Interim payments-PARHM				11 250 660	1
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25,878 44.00 Solve To BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 43.00 43.01 44.00 95.01 97.02 97.03 97.04 97.04 97.04 97.05 97.06 97.07 97.07 97.08 97.09 97.09 97.00 97.00 97.00 97.00 97.00 97.00 97.00				11, 330, 000	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 25,878 44.00 Solve To BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00				0	1
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44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{25,878}{\$115.2}\$ 44.00 \frac{8115.2}{\$TO BE COMPLETED BY CONTRACTOR}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)				-52, 976	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,			ł
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)	44. 00			25, 878	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00					1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90 00			n	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,			•
93.00 Time Value of Money (see instructions) 0 93.00					
94.00 Total (sum of lines 91 and 93) 0 94.00		,			
	94. 00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 14-0110	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Pre 2/20/2024 3:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems

OTTAWA REGIONAL HOSPITAL & HEALTHCAR

In Lieu of Form CMS-2552-10

Provider CCN: 14-0110

Period:
From 10/01/2022
To 09/30/2023

Part I
Date/Time Prepared:
2/20/2024 3: 40 pm

Provider CN: 14-0110

In Lieu of Form CMS-2552-10

Provider CN: 14-0110

Period:
From 10/01/2022
To 09/30/2023

In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
2/20/2024 3: 40 pm

Provider CN: 14-0110

In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
2/20/2024 3: 40 pm

Provider CN: 14-0110

In Lieu of Form CMS-2552-10

Part I
Date/Time Prepared:
2/20/2024 3: 40 pm

Provider CN: 14-0110

Part I
Date/Time Prepared:
2/20/2024 3: 40 pm

Provider CN: 14-0110

Interin payments payable on individual bills, either Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment 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)						2/20/2024 3: 40) piii
mm/dd/yyyy							
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.100 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.00			I npati en	t Part A	Par	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.100 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Inter-im payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero to List separately each retracative lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 2.0				2. 00		4.00	
Inter-im payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero to List separately each retracative lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 2.0	1.00	Total interim payments paid to provider		11, 827, 225		11, 325, 394	1. 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1.00 1	2.00						2. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero that its separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1) Program to Provider AJUSTMENTS TO PROVIDER 05/03/2023 65, 383 05/03/2023 25, 274 3.0							
write "NONE" or enter a zero .0							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)	3 00						3. 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	0.00						0.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 05/03/2023 65, 383 05/03/2023 25, 274 3.0 0 0 0 3.0 3.0 3.0 3.0 0 0 0 3.0 3.0 3.0 3.0 0 0 0 3.0 3.0 3.0 3.0 3.0 0 0 0 3.0							
ADJUSTMENTS TO PROVIDER		Program to Provider	l				
3.03 3.03 3.04 3.05 3.05 3.06 3.06 3.07 3.08 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.00	3 01		05/03/2023	65 383	05/03/2023	25 274	3 ∩1
3.03 3.04 3.05 3.05 3.06 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00		ADJUSTIMENTS TO TROVIDER	03/03/2023	•			
3.04 0 0 0 3.0				-		- 1	
3.00 Provider to Program				-		- 1	
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.5						1 - 1	
3.50 ADJUSTMENTS TO PROGRAM	3.05			C		0	3. 05
3.51 0							
3.52 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.53 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.55 Subtotal (sum of lines 3.01-3.49 minus sum of lines 4.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.01-5.49 minus sum of lines 5.01-5.49 minus sum of lines 5.55 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 6.00 Su		ADJUSTMENTS TO PROGRAM		_			
3.53 3.54 0 0 0 3.5 3.54 3.59 3.50-3.98 3.50-3							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 11,892,608 11,350,668 4.00 (transfer to Wkst. E or wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				_		1 - 1	3. 52
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 5-3. 98) 25, 274 3. 9 3. 50-3. 98) 11, 350, 668 4. 0 10 10 10 10 10 10 10				_		1 - 1	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program liability (see liable) Total Medicare program liability (see liab	3.54			C		0	3. 54
11, 350, 668 4.00 11, 350, 668 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 11, 350, 668 4.00 (transfer to Wkst. E or Wkst.	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		65, 383		25, 274	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.0 Program to Provider 0 0 5.0 5.01 TENTATIVE TO PROVIDER 0 0 5.0 5.02 0 0 0 5.0 5.03 Provider to Program 0 0 5.0 5.50 TENTATIVE TO PROGRAM 0 0 5.5 5.51 0 0 0 5.5 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 5.5 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 5.5 5.5 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.0 54,842 0 6.0 6.0 6.02 SETTLEMENT TO PROGRAM 0 52,976 6.0 7.0 7.0 7.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			11, 892, 608		11, 350, 668	4. 00
TO BE COMPLÉTED BY CONTRACTOR		· ·					
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					1		
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATI VE TO PROVIDER O O O S. 0 O O S. 5 O O O O O O O O O	5. 00						5. 00
Program to Provider							
TENTATIVE TO PROVIDER							
5.02 0			T	_	T	_	
Description Description		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.03			C		0	5. 03
5.51 5.52 5.52 5.52 5.52 5.52 5.50 5.55 5.50				_	T	_	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.99		TENTATIVE TO PROGRAM					
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 54,842 0 6.00 SETTLEMENT TO PROGRAM 0 52,976 6.00 7.00 Total Medicare program liability (see instructions) 11,947,450 11,297,692 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				-			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				_		- 1	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			C		0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00							
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 11,947,450 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				54, 842			6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 02	SETTLEMENT TO PROGRAM					6. 02
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		11, 947, 450			7. 00
0 1.00 2.00							
8.00 Name of Contractor 8.0		T.,	()	1. 00	2.00	
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems OTTAWA REGIONAL HOSPI	TAL & HEALTHCAR	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-0110 Period: From 10/01/2022 To 09/30/2023 Part 2/20				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00					
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
22 00	0.00 Polance due provider (line 9 (or line 10) minus line 30 and line 31) (see instructions)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR In Lieu o			u of Form CMS-2	552-10		
OUTLIE	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 14-0110 Period: Wo					
	From 10/01/2022 To 09/30/2023 D					
		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 i	nstructions)	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	ructions)		0	3.00	
4.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)		О	4.00	
5.00 The rate used to calculate the time value of money (see instructions)					5.00	
6.00 Time value of money for operating expenses (see instructions)					6.00	
7. 00	Time value of money for capital related expenses (see instruc	ctions)		0	7. 00	

Health Financial Systems OTTAWA REGIONAL
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/20/2024 3: 40 pm

OH y)					2/20/2024 3:4	0 pm
		General Fund	Speci fi c	Endowment Fund	Pl ant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	45, 867, 085	0	0	0	1. 00
2. 00	Temporary investments	1 43,007,009	l _	o	0	2. 00
3. 00	Notes recei vabl e	l o		o	0	3. 00
4.00	Accounts receivable	71, 767, 287	0	O	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-47, 930, 188	0	0	0	6. 00
7.00	Inventory	2, 808, 609	0	0	0	7. 00
8.00	Prepai d expenses	14, 391		0	0	8. 00
9.00	Other current assets	1, 974, 263		0	0	9. 00
10.00	Due from other funds	0		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	74, 501, 447	0	0	0	11. 00
12. 00	FI XED ASSETS Land	3, 227, 906	O	ol	0	12. 00
13. 00	Land improvements	3, 114, 070		0	0	13. 00
14. 00	Accumulated depreciation	-2, 729, 417		0	0	14. 00
15. 00	Bui I di ngs	75, 198, 304		o	0	15. 00
16. 00	Accumulated depreciation	-42, 937, 352		o	0	16. 00
17.00	Leasehold improvements	0	0	О	0	17. 00
18.00	Accumul ated depreciation	0	0	o	0	18. 00
19.00	Fi xed equi pment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	37, 378, 221	0	0	0	23. 00
24. 00	Accumulated depreciation	-27, 731, 592	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00 26. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation		0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	2, 678, 002		Ö	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	48, 198, 142		o	0	30. 00
	OTHER ASSETS			-1		
31.00	Investments	15, 855, 068	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	1, 487, 759		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	17, 342, 827		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	140, 042, 416	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	2 205 077	O	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	3, 285, 077 238, 407		ol Ol	0	38.00
39. 00	Payroll taxes payable	230, 407	1	0	0	39.00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	360, 330	Ö	o	0	41. 00
42. 00	Accel erated payments	0			_	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9, 327, 646	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13, 211, 460	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	0		0	0	
48. 00	Unsecured Loans	0 700 440	I -	0	0	48. 00
49. 00	Other long term liabilities	723, 169		0	0	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49)	723, 169		0	0	50. 00 51. 00
31.00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	13, 934, 629	l o	<u> </u>	0	31.00
52. 00	General fund balance	126, 107, 787				52. 00
53. 00	Specific purpose fund	120, 107, 707	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			o		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			o		55. 00
56.00	Governing body created - endowment fund balance			o		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	126, 107, 787		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	140, 042, 416	0	0	0	60. 00
	[59]	I		I		I

Health Financial Systems In Lieu of Form CMS-2552-10 OTTAWA REGIONAL HOSPITAL & HEALTHCAR STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 14-0110 Peri od: Worksheet G-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/20/2024 3:40 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period 1.00 79, 393, 627 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 56, 635, 183 2.00 3.00 Total (sum of line 1 and line 2) 136, 028, 810 0 3.00 4.00 MI SCELLANEOUS 729, 360 4.00 0 0 5.00 0 5.00 0 0 0 0 6.00 6.00 7.00 0 0 0 0 7.00 8.00 0 8.00 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 729, 360 10.00 Subtotal (line 3 plus line 10) 136, 758, 170 11.00 11.00 0 EQUITY TRANSFER 10, 650, 383 12.00 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 10, 650, 383 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 126, 107, 787 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

		6. 00	7. 00	8. 00	
1.00	Fund balances at beginning of period	0		0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2. 00
3.00	Total (sum of line 1 and line 2)	0		0	3. 00
4.00	MI SCELLANEOUS		0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00			0		8. 00
9.00			0		9. 00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11. 00	Subtotal (line 3 plus line 10)	0		0	11. 00
12.00	EQUITY TRANSFER		0		12.00
13.00			0		13. 00
14.00			0		14. 00
15.00			0		15. 00
16.00			0		16. 00
17.00			0		17. 00
18.00	Total deductions (sum of lines 12-17)	0		0	18. 00
19. 00	Fund balance at end of period per balance	0		0	19. 00
	sheet (line 11 minus line 18)				

 Heal th Financial
 Systems
 OTTAWA REGIONAL HOSPITAL & HEALTHCAR

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 1
 Provider CCN: 14-0110

		To	09/30/2023	Date/Time Pre 2/20/2024 3:4	
	Cost Center Description	Inpatient	Outpati ent	Total	, p
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	34, 596, 992		34, 596, 992	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				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				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	34, 596, 992		34, 596, 992	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	4, 227, 511		4, 227, 511	11. 00
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)	4 007 544		4 007 544	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	4, 227, 511		4, 227, 511	16. 00
17. 00	11-15)	20 024 502		20 024 502	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	38, 824, 503 67, 278, 325	40E 071 124	38, 824, 503 473, 149, 459	17. 00 18. 00
19. 00	Outpatient services	8, 170, 207	405, 871, 134 60, 314, 312	68, 484, 519	19.00
20. 00	RURAL HEALTH CLINIC (RHC)	8, 170, 207	1, 218, 829	1, 218, 829	20.00
	RURAL HEALTH CLINIC (RHC)		8, 036, 688	8, 036, 688	
	RURAL HEALTH CLINIC (RHC)		5, 300, 039	5, 300, 039	20. 01
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	3, 300, 037	3, 300, 03 <i>7</i>	21. 00
22. 00	HOME HEALTH AGENCY		٩	O	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PROFESSI ONAL FEES	1, 296, 873	20, 449, 295	21, 746, 168	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	115, 569, 908	501, 190, 297	616, 760, 205	28. 00
	G-3, line 1)	., ,			
	PART II - OPERATING EXPENSES	1	'		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		139, 182, 630		29. 00
30.00	ADD (SPECIFY)	0			30. 00
31.00		0			31. 00
32.00		0			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)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00	T	0	_		41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		139, 182, 630		43. 00
	to Wkst. G-3, line 4)	1			l

	Financial Systems OTTAWA REGIONAL HOSPI ENT OF REVENUES AND EXPENSES	TAL & HEALTHCAR Provider CCN: 14-0110	Period:	u of Form CMS-2 Worksheet G-3	2552-10
STATEN	FIGURE CON. 14-0110 PERIOD. W				
			To 09/30/2023		
				2/20/2024 3: 4	O pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		616, 760, 205	1.00
2.00	Less contractual allowances and discounts on patients' accour			430, 865, 735	2. 00
3.00	Net patient revenues (line 1 minus line 2)			185, 894, 470	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		139, 182, 630	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	•		46, 711, 840	5. 00
	OTHER I NCOME		,		
6.00	Contributions, donations, bequests, etc			3, 707, 613	6. 00
7.00	Income from investments			1, 687, 197	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			342, 011	14. 00
15.00	Revenue from rental of living quarters			442, 896	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			1, 376	18. 00
19. 00				0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUES			928, 923	
24. 01	COMMUNITY HEALTH EDUCATION			47, 838	24. 01
24. 02	OTHER (SPECIFY)			0	24. 02
24. 03	RISK VALUE BASED REVENUE			1, 431, 785	
24. 04	CONTRACT PHARMACY			591, 292	
24 05	CONTRID OF EVCELL ASSETS OVER LIAD			7/12 /12	1 24 05

24. 05

25.00

742, 412

9, 923, 343

0 24.50

0 28. 00

56, 635, 183 26. 00 0 27. 00

56, 635, 183 29. 00

24. 04 CONTRACT PHARMACY
24. 05 CONTRIB OF EXCELL ASSETS OVER LIAB
24. 50 COVID-19 PHE Funding
25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)
27. 00 OTHER EXPENSES (SPECIFY)
28. 00 Total other expresses (sum of line 27 as

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)

	Financial Systems OTTAWA REGIONAL HOSPI ATION OF CAPITAL PAYMENT	Provider CCN: 14-0110	Peri od:	u of Form CMS-2 Worksheet L	
			From 10/01/2022 To 09/30/2023		
		Title XVIII	Hospi tal	PPS	о рііі
		THE AVIII	1103pi tai	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			814, 588	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			0	
2.01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	40. 93	
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7.00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	patient days (Worksheet E	, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0. 00	8.00
9. 00	Sum of lines 7 and 8	uctions)		0.00	
10. 00	Allowable disproportionate share percentage (see instructions	s)		0.00	
11. 00	Disproportionate share adjustment (see instructions)	3)		0.00	1
12. 00	Total prospective capital payments (see instructions)			814, 588	
12.00	Total prospective capital paymente (coo metractions)				12:00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST			0	1 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions)			0	
3.00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total impatrent program capital cost (Time 3 x Time 4)			0	3.00
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	1
6. 00	Percentage adjustment for extraordinary circumstances (see in	netructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	1
8. 00	Capital minimum payment level (line 5 plus line 7)	y consumstances (rine 2)		0	
9.00	Current year capital payments (from Part I, line 12, as appli	i cabl e)		Ö	
9.00	Current year comparison of capital minimum payment level to d		less line 9)	0	
10.00	Carryover of accumulated capital minimum payment level over of			0	
	icali yover or accumulated capital illillillilli payliletti level over c				
10.00	Worksheet L, Part III, line 14)				
10.00			ne 11)	0	12. 00
10. 00 11. 00	Worksheet L, Part III, line 14)	ayments (line 10 plus lir		0	12. 00 13. 00
10. 00 11. 00 12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus lir r the amount on this line	·)		13. 00

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

th Financial Systems	OTTAWA REGIONAL HOSPITAL & HEALTHCAR	In Lieu of Form CMS-2552-10

Heal th	Financial Systems OTTAW	A REGIONAL HOSI	PITAL & HEALTH	CAR	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-0110	Peri od:	Worksheet M-1	
			Component	CCN: 14-8649	From 10/01/2022 To 09/30/2023	Date/Time Pre	narod:
			Component	CCN. 14-0049	10 07/30/2023	2/20/2024 3: 4	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassi fied	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
		1 00	2.00	2.00	4.00	4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Physician	193, 103	0	193, 10	-43, 117	149, 986	1.00
2. 00	Physician Assistant	173, 103	0		0 -43, 117	147, 700	2.00
3.00	Nurse Practitioner	65, 240	0	65, 24	-14, 075		3.00
4. 00	Visiting Nurse	0	0	00,2	0 0	0 0	4. 00
5. 00	Other Nurse	153, 586	0	153, 58	-30, 174		5. 00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	o	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	o	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	o	0		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	411, 929	0	411, 92	-87, 366	324, 563	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12. 00
13. 00	Other Costs Under Agreement	0	1, 579			1, 579	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	1, 579			1, 579	14. 00
15. 00	Medical Supplies	0	40, 776			40, 776	15. 00
16. 00	Transportation (Health Care Staff)	0	475	47	75 0	475	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	17. 00
18.00	Professional Liability Insurance	0	1, 558			1, 558	18.00
19. 00 20. 00	Other Health Care Costs Allowable GME Costs	U	28, 026	28, 02	26 0	28, 026	19. 00 20. 00
20.00	Subtotal (sum of lines 15 through 20)	0	70, 835	70, 83	0	70, 835	21.00
21.00	Total Cost of Health Care Services (sum of	411, 929	70, 835 72, 414				21.00
22.00	lines 10, 14, and 21)	411, 727	12,414	404, 32	-07, 300	370, 711	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24. 00
25.00	Optometry	o	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27) FACILITY OVERHEAD						
29. 00	FACILITY OVERHEAD Facility Costs	O	9, 584	9, 58	34 0	9, 584	29. 00
30.00	Administrative Costs	14, 859	9, 584 133, 144				
31. 00	Total Facility Overhead (sum of lines 29 and	14, 859	142, 728				31.00
51.00	30)	11,007	112,720	107, 30	,,,,,,	, ,, 02 /] 31. 50
32.00	Total facility costs (sum of lines 22, 28	426, 788	215, 142	641, 93	-165, 124	476, 806	32. 00
	and 31)		•				
	·	•					

Provider CCN: 14-0110 | Peri od: From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: 2/20/2024 3:40 pm

			33.143.131.13			2/20/2024 3: 4	: 40 pm	
					RHC I	Cost		
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)					
		6. 00	7. 00					
	ACILITY HEALTH CARE STAFF COSTS							
	Physi ci an	-1, 203	148, 783				1. 00	
2.00 Pł	Physician Assistant	0	0	1			2. 00	
3. 00 Nu	lurse Practitioner	-140	51, 025				3. 00	
4. 00 Vi	isiting Nurse	0	0	1			4. 00	
	Other Nurse	0	123, 412				5. 00	
6. 00 CI	Clinical Psychologist	0	0				6. 00	
7. 00 CI	Clinical Social Worker	0	0				7. 00	
8. 00 La	aboratory Techni ci an	0	0				8. 00	
9.00 01	Other Facility Health Care Staff Costs	0	0				9. 00	
10. 00 St	Subtotal (sum of lines 1 through 9)	-1, 343	323, 220				10.00	
11. 00 Pł	Physician Services Under Agreement	0	0				11. 00	
12. 00 Pł	Physician Supervision Under Agreement	0	0				12.00	
13.00 01	Other Costs Under Agreement	0	1, 579				13.00	
14. 00 St	Subtotal (sum of lines 11 through 13)	0	1, 579				14.00	
15. 00 Me	ledical Supplies	0	40, 776				15. 00	
16. 00 Tr	ransportation (Health Care Staff)	0	475				16. 00	
17. 00 De	Depreciation-Medical Equipment	0	0				17. 00	
18. 00 Pr	Professional Liability Insurance	0	1, 558				18. 00	
19. 00 01	Other Health Care Costs	0	28, 026				19. 00	
20. 00 AI	Ilowable GME Costs						20. 00	
	Subtotal (sum of lines 15 through 20)	0	70, 835				21. 00	
22. 00 To	otal Cost of Health Care Services (sum of	-1, 343	395, 634				22. 00	
Li	ines 10, 14, and 21)							
	OSTS OTHER THAN RHC/FQHC SERVICES							
23. 00 Pt	Pharmacy	0	0				23. 00	
24. 00 De	Dental	0	0				24. 00	
, ,	ptometry	0	0				25. 00	
	el eheal th	1, 343	1, 343				25. 01	
	Chronic Care Management	0	0				25. 02	
	dl other nonreimbursable costs	0	0				26. 00	
	lonallowable GME costs						27. 00	
28. 00 To	otal Nonreimbursable Costs (sum of lines 23	1, 343	1, 343				28. 00	
	through 27)							
	ACILITY OVERHEAD							
	acility Costs	0	.,	1			29. 00	
	dministrative Costs	0	70, 245				30.00	
	otal Facility Overhead (sum of lines 29 and	0	79, 829	1			31. 00	
	(0)							
	otal facility costs (sum of lines 22, 28	0	476, 806				32. 00	
lar	ind 31)			I			1	

Health Financial Systems	OTTAWA REGIONAL HOSPITAL & HEALTHCAR	1	n Lieu of Form CMS-2552-10
ANIAL VIOLO OF HOODI THE BLOCK BUILD (FOLIO COOTS)	B 11 000 11 0110	n	101 1 1 1 1 1

ANALYSIS OF HOSPITAL-BASED RIKC/FORC COSTS	Health Financial Systems OTTAWA REGIONAL HOSPITAL & HEALTHCAR				CAR	In Lieu of Form CMS-2552-10				
Compensation Chira 1-865 To 09/307/203 Date/Time Preparence 22/20/2042 23 do ne 22/20/2042 23 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do ne 22/20/2043 24 do 22/20/2043 24/										
Compensation Other Costs Total (col. 1 Reclassificat Trial Balance (col. 3 + col. 4)				Component						
Compensation Other Costs Total (col. 1 Reclassified Trial Balance (col. 3 + col. 2) Reclassified Trial Balance (col. 3 + col. 4 + col. 2) Reclassified Re						RHC II		o piii		
FACILITY HEALTH CARE STAFF COSTS			Compensation	Other Costs	Total (col					
FACILITY HEALTH CARE STAFF COSTS			oomponoa er on	01						
FACILITY HEALTH CARE STAFF COSTS					,					
FACILITY HEALTH CARE STAFF COSTS										
1,000			1.00	2. 00	3. 00	4. 00	5. 00			
2.00										
3.00			1, 065, 206	_		6 -238, 085				
A. 00 Visiting Nurse		1 3	0			0				
5.00		ų.	453, 377	_	1	7 -107, 635				
Color Colo			0		l .	0				
2.00			973, 518	_	1	8 -263, 744	l			
8. 00			0	_		0	1			
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0,0 0 0 0 0 0 0 0 0 0 0 0 0 0			20, 643	0	20, 64	3 364				
10. 00 Subtotal (sum of lines 1 through 9) 2,512,744 0 2,512,744 -609,100 1,903,644 10. 00			0	0		0	1			
11.00 Physician Services Under Agreement 0 0 0 0 0 0 11.00			0 510 744	0	0 510 74	0 0				
12.00		`	2,512,744	0	2,512,74	-609, 100				
13.00 Other Costs Under Agreement 0 8,634 8,634 0 8,634 13.00			U O	0		0	1			
14.00 Subtotal (sum of lines 11 through 13) 0 8,634 8,634 8,634 0 8,634 14.00 15.00 Medical Supplies 0 389,456 389,456 0 389,456 15.00 17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 18.00 Professional Liability Insurance 0 10,091 10,091 0 10,091 18.00 19.00 Other Heal th Care Costs 0 71,231 71,231 0 71,231 19.00 20.00 Allowable GME Costs 0 472,778 472,778 0 472,778 20.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 11			0	0 624	0 62	٥	1			
15.00 Medical Supplies			0							
16. 00 Transportation (Health Care Staff) 0 2,000 2,000 0 2,000 10.00 17.00 17. 00 Depreciation-Medical Equipment 0 0 0 0 0 0 17.00 18.00 18. 00 Professional Liability Insurance 0 10,091 10,091 0 10.091 18.00 19. 00 Other Health Care Costs 0 71,231 71,231 0 71,231 19.00 20. 00 Allowable GME Costs 0 472,778 472,778 0 472,778 0 21.00 21. 00 Subtotal (Sum of lines 15 through 20) 0 472,778 481,412 2,994,156 -609,100 2,385,056 22. 00 Total Cost of Health Care Services (sum of 2,512,744 181,412 2,994,156 -609,100 2,385,056 23. 00 Pharmacy 0 0 0 0 0 0 0 23.00 25. 00 Optometry 0 0 0 0 0 0 0 25.00 25. 01 Telehealth 0 0 0 0 0 0 0 0 25.01 25. 02 Chronic Care Management 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0							
17. 00 Depreciation-Medical Equipment 0 0 0 0 0 17. 00			o O				1			
18.00 Professional Liability Insurance 0 10,091 10,091 0 10,091 19.00 10,091 19.00 10,091 19.00 10,091 19.00 10,091 19.00 19.00 10,091 19.00 19.			Ö	2, 000	2,00	0 0	2,000			
19.00 Other Health Care Costs 0 71, 231 71, 231 0 71, 231 19.00 20.00 20.00 21.00 21.00 22.0			ol	10. 091	10.09	1 0	10. 091			
20. 00 All lowable GME Costs 0 472,778 472,778 0 472,778 21. 00 22. 00 22. 00 22. 00 23. 00 24. 00 23. 00 24. 00 25. 00 25. 00 25. 00 25. 00 26. 00 26. 00 26. 00 27.			ol							
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Doptometry Do		· ·		,	· ·		,			
I ines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	21. 00	Subtotal (sum of lines 15 through 20)	o	472, 778	472, 77	8 0	472, 778	21. 00		
I ines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	22.00	Total Cost of Health Care Services (sum of	2, 512, 744	481, 412	2, 994, 15	6 -609, 100	2, 385, 056	22. 00		
23. 00 Pharmacy		lines 10, 14, and 21)								
24. 00 Dental 0 0 0 0 0 0 0 24. 00 25. 00 Optometry 0 0 0 0 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 0 0 0 0 0 25. 00 25. 02 Chronic Care Management 0 0 0 0 0 0 0 0 0 25. 01 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 0 25. 02 27. 00 Nonallowable GME costs 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		COSTS OTHER THAN RHC/FQHC SERVICES				<u></u>				
25. 00 Optometry 0 0 0 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 0 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 0 0 0 0 25. 01 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 0 26. 00 27. 00 Nonallowable GME costs 0 0 0 0 0 0 0 0 0 28. 00 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 28. 00 28. 00 29. 00 Eactlity Overhead (sum of lines 29 and 30. 00 Administrative Costs 3 389, 983 705, 856 7 1, 152, 248 -576, 905 575, 343 31. 00 32. 00 Total facility costs (sum of lines 22, 28 2, 902, 727 1, 243, 677 4, 146, 404 -1, 186, 005 2, 960, 399 32. 00			0	_						
25. 01 Tel eheal th		ų .	0	0		0				
25. 02 Chronic Care Management 0 0 0 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 26. 00 27. 00 Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28. 00 29. 00 Facility OverHEAD 29. 00 Administrative Costs 389, 983 705, 856 1, 095, 839 -576, 905 518, 934 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 389, 983 762, 265 1, 152, 248 -576, 905 575, 343 31. 00 32. 00 Total facility costs (sum of lines 22, 28 2, 902, 727 1, 243, 677 4, 146, 404 -1, 186, 005 2, 960, 399 32. 00		1 '	0	0		0				
26. 00		1	0	0		0				
27. 00 Nonallowable GME costs 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 00			0	0		0				
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28.00 through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 0 56,409 56,409 0 56,409 29.00 30.00 Administrative Costs 389,983 705,856 1,095,839 -576,905 518,934 30.00 31.00 Total Facility Overhead (sum of lines 29 and 389,983 762,265 1,152,248 -576,905 575,343 31.00 30.00 Total facility costs (sum of lines 22, 28 2,902,727 1,243,677 4,146,404 -1,186,005 2,960,399 32.00			U	0		0	0			
through 27) FACILITY OVERHEAD 29. 00 Facility Costs Administrative Costs 389, 983 705, 856 1, 095, 839 -576, 905 518, 934 30. 00 31. 00 Total Facility Costs (sum of lines 29 and 389, 983) 32. 00 Total facility costs (sum of lines 22, 28 2, 902, 727 1, 243, 677 4, 146, 404 -1, 186, 005 2, 960, 399 32. 00				0			_			
FACILITY OVERHEAD 29. 00 Facility Costs 30. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 389, 983) 30. 00 Total facility costs (sum of lines 22, 28 2, 902, 727 1, 243, 677 4, 146, 404 -1, 186, 005 2, 960, 399 32. 00	28.00	`	۷	U		0	0	28.00		
29. 00 Facility Costs										
30.00 Administrative Costs 389,983 705,856 1,095,839 -576,905 518,934 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 2,902,727 1,243,677 4,146,404 -1,186,005 2,960,399 32.00	29. 00		0	56, 409	56, 40	9 0	56, 409	29. 00		
30) 32.00 Total facility costs (sum of lines 22, 28 2,902,727 1,243,677 4,146,404 -1,186,005 2,960,399 32.00	30.00		389, 983	705, 856	1, 095, 83	9 -576, 905	518, 934	30. 00		
30) 32.00 Total facility costs (sum of lines 22, 28 2,902,727 1,243,677 4,146,404 -1,186,005 2,960,399 32.00	31.00	Total Facility Overhead (sum of lines 29 and	389, 983	762, 265						
		30)								
and 31)	32. 00		2, 902, 727	1, 243, 677	4, 146, 40	4 -1, 186, 005	2, 960, 399	32. 00		
		and 31)	l		l		1			

			Component	CCN: 14-8655	То	09/30/2023	Date/Time Pro 2/20/2024 3:4	
						RHC II	Cost	то рііі
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)	4				
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7.00					_
1. 00	FACILITY HEALTH CARE STAFF COSTS	23, 677	850, 79	ol				1.00
2. 00	Physician Physician Assistant	23,077	030, 79	0				2.00
3. 00	Nurse Practitioner	3, 230	348, 97	2				3. 00
4. 00	Visiting Nurse	3, 230 N	340, 77.	0				4.00
5. 00	Other Nurse	0	709, 77	4				5. 00
6. 00	Clinical Psychologist	0	107, 11	0				6.00
7. 00	Clinical Social Worker	-159	20, 84	8				7. 00
8. 00	Laboratory Techni ci an	0	20,01	0				8.00
9. 00	Other Facility Health Care Staff Costs	0		0				9.00
10.00	Subtotal (sum of lines 1 through 9)	26, 748	1, 930, 39	2				10.00
11. 00	Physician Services Under Agreement	0	.,,	0				11.00
12. 00	Physician Supervision Under Agreement	0		ol .				12. 00
13. 00	Other Costs Under Agreement	0	8, 63	4				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8, 63	4				14.00
15.00	Medical Supplies	0	389, 45	6				15. 00
16.00	Transportation (Health Care Staff)	0	2, 00	o				16. 00
17.00	Depreciation-Medical Equipment	0		o				17. 00
18.00	Professional Liability Insurance	0	10, 09	1				18. 00
19.00	Other Health Care Costs	0	71, 23	1				19. 00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	472, 77	8				21. 00
22. 00	Total Cost of Health Care Services (sum of	26, 748	2, 411, 80	4				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES		Γ	_1				
23. 00	Pharmacy	0	l	0				23. 00
24. 00	Dental	0		0				24. 00
25. 00	Optometry	10.071	40.07	0				25. 00
25. 01	Tel eheal th	19, 071	19, 07					25. 01
25. 02	Chronic Care Management	0						25. 02 26. 00
26. 00 27. 00	All other nonreimbursable costs Nonallowable GME costs	U	'	U				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	19, 071	19, 07	1				28.00
26.00	through 27)	19,071	19,07	'				20.00
	FACILITY OVERHEAD			1				
29. 00	Facility Costs	0	56, 40	9				29. 00
30.00	Administrative Costs	-1, 282						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-1, 282		1				31.00
2 20	30)	., 202						
32.00	Total facility costs (sum of lines 22, 28	44, 537	3, 004, 93	6				32. 00
	and 31)							

Health Financial Systems	OTTAWA REGIONAL HOSPITAL &	ι HEALTHCAR	In Lieu	u of Form CMS-2552-10

Heal th	Financial Systems OTTAW	A REGIONAL HOS	PITAL & HEALTH	CAR	In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
					From 10/01/2022		
			Component	CCN: 14-8652	To 09/30/2023		
					BUO III	2/20/2024 3: 4	0 pm
		0 1:	011 0 1	T 1 1 (1 (RHC III	Cost	
		Compensation	Other Costs		Reclassificati	Reclassified	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	879, 315	0	879, 31	5 -158, 716	720, 599	1.00
2. 00	Physician Assistant	873	0	1			2.00
3.00	Nurse Practitioner	159, 281	0	1		138, 218	3.00
4. 00	Visiting Nurse	137, 201	0	137, 20	0 -21,003	130, 210	4. 00
5.00	Other Nurse	546, 196	0	546, 19	6 -121, 805	424, 391	5.00
6. 00	Clinical Psychologist	340, 170	0	340, 19	-121, 603	424, 391	6.00
7. 00	Clinical Social Worker		0		0	0	7.00
8. 00	Laboratory Techni ci an		0		0	0	8.00
9.00	Other Facility Health Care Staff Costs		0		0	0	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	1, 585, 665	0	1, 585, 66	5 -301, 568	-	10.00
11. 00	Physician Services Under Agreement	1, 363, 663	110			1, 204, 077	11. 00
12. 00	Physician Supervision Under Agreement		110	l .	0 0	0	12.00
13. 00	Other Costs Under Agreement		1, 700	1	-	1, 700	
14. 00	Subtotal (sum of lines 11 through 13)		1, 700			1, 810	14. 00
15. 00	Medical Supplies		127, 467	1		127, 467	•
16. 00	Transportation (Health Care Staff)		1, 454			1, 454	
17. 00	Depreciation-Medical Equipment	Ö	1, 434	1, 43	0 0	0	17. 00
18. 00	Professional Liability Insurance	Ö	6, 621	6, 62	1 0	6, 621	18. 00
19. 00	Other Health Care Costs		99, 160			99, 160	1
20. 00	Allowable GME Costs	Ĭ	77, 100	77, 10		77, 100	20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	234, 702	234, 70	2	234, 702	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 585, 665	236, 512	1			22. 00
22.00	lines 10, 14, and 21)	1, 303, 003	230, 312	1,022,17	-301, 300	1, 320, 007	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23. 00	Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental	ol	0	,	0		24. 00
25. 00	Optometry	ol	0	,	0	0	25. 00
25. 01	Tel eheal th	ol	0	i	o o	Ō	25. 01
25. 02	Chronic Care Management	ol	0	i	o o	0	25. 02
26. 00	All other nonreimbursable costs	ol	0	,	0	0	26. 00
27. 00	Nonallowable GME costs					-	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	ol	0	,	0 0	0	28. 00
	through 27)					-	
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	11, 412	11, 41	2 0	11, 412	29. 00
30.00	Administrative Costs	227, 562	426, 639	654, 20	1 -290, 012	364, 189	30.00
31.00	Total Facility Overhead (sum of lines 29 and	227, 562	438, 051			375, 601	31.00
	30)			1			
32.00	Total facility costs (sum of lines 22, 28	1, 813, 227	674, 563	2, 487, 79	0 -591, 580	1, 896, 210	32. 00
	and 31)						

Provider CCN: 14-0110 | Period: | Worksheet M-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: | 2/20/2024 | 2:40 pm:

			55.11			2/20/2024 3: 4	0 pm
					RHC III	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						1
1. 00	Physi ci an	-1, 593	719, 006				1. 00
2.00	Physician Assistant	0	889	•			2. 00
3.00	Nurse Practitioner	3, 405	141, 623				3. 00
4.00	Visiting Nurse	0	0				4. 00
5. 00	Other Nurse	0	424, 391				5. 00
6.00	Clinical Psychologist	0	0	1			6. 00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	1, 812	1, 285, 909				10. 00
11. 00	Physician Services Under Agreement	0	110	•			11. 00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	1, 700				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	1, 810				14. 00
15.00	Medi cal Supplies	0	127, 467				15. 00
16.00	Transportation (Health Care Staff)	0	1, 454				16. 00
17.00	Depreciation-Medical Equipment	0	0				17. 00
18.00	Professional Liability Insurance	0	6, 621				18. 00
19.00	Other Health Care Costs	0	99, 160				19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	234, 702				21. 00
22.00	Total Cost of Health Care Services (sum of	1, 812	1, 522, 421				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0				23. 00
24. 00	Dental	0	0	•			24. 00
25. 00	Optometry	0	0	ı			25. 00
25. 01	Tel eheal th	1, 930	1, 930				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26.00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	1, 930	1, 930				28. 00
	through 27)]
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	11, 412				29. 00
30.00	Administrative Costs	0	364, 189				30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	375, 601				31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	3, 742	1, 899, 952				32. 00
	and 31)						

		NA REGIONAL HOS				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre 2/20/2024 3:4	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 47					1. 00
2.00	Physician Assistant	0.00		_,			2. 00
3.00	Nurse Practitioner	0. 28					3. 00
4.00	Subtotal (sum of lines 1 through 3)	0. 75			2, 562	2, 562	ı
5.00	Visiting Nurse	0. 00	l e			0	
6.00	Clinical Psychologist	0.00	l e			0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7.02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	0. 75	2, 373			2, 562	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VICES		005 (04	
	Total costs of health care services (from Wk					395, 634	1
11.00	Total nonreimbursable costs (from Wkst. M-1,						11.00
12.00	Cost of all services (excluding overhead) (s					396, 977	
13.00	Ratio of hospital -based RHC/FQHC services (I			04)		0. 996617	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		79, 829	1
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			401, 812	l
16.00	Total overhead (sum of lines 14 and 15)					481, 641	
17. 00	Allowable GME overhead (see instructions)						17. 00
18.00		110 (1.1	10 1:. 1	0)		481, 641	l
19. 00						480, 012	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	sum of tines 10	and 19)		875, 646	20.00

Heal th	Financial Systems OTTA	WA REGIONAL HOS	PITAL & HEALTH	CAR	In Lie	eu of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component (From 10/01/2022 To 09/30/2023		
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col . 1 x col .		
		1.00	2.00	2.00	3)	4	
	VISITS AND PRODUCTIVITY	1.00	2. 00	3. 00	4. 00	5. 00	
	Positions						1
1. 00	Physi ci an	2. 70	10, 367	4, 20	11, 340		1.00
2. 00	Physician Assistant	0.00	10, 307				2.00
3. 00	Nurse Practitioner	2. 55	-				3. 00
4.00	Subtotal (sum of lines 1 through 3)	5. 25	17, 761		16, 695		
5. 00	Visiting Nurse	0.00	. , , , , 0		10,070	0	5. 00
6. 00	Clinical Psychologist	0.00	0			l ol	6.00
7.00	Clinical Social Worker	0. 32	225			225	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FOHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	5. 57	17, 986			17, 986	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00						2, 411, 804	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					19, 071	11. 00
12.00	Cost of all services (excluding overhead) (s					2, 430, 875	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 992155	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		574, 061	
	Parent provider overhead allocated to facili	ty (see instruc	tions)			2, 685, 410	

5, 645, 704 20. 00

16.00 17. 00

18.00

3, 259, 471

3, 259, 471 3, 233, 900 19. 00

16.00 Total overhead (sum of lines 14 and 15)
17.00 Allowable GME overhead (see instructions)

18.00 Enter the amount from line 16
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

		550.01.1.1.100	D. T			6.5	
	Financial Systems OTTA TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	WA REGIONAL HOS	Provider C		In Lie Period:	eu of Form CMS-2 Worksheet M-2	
ALLOCA	TITON OF OVERHEAD TO HOSFITAL-BASED KIR/TURE S	SERVI GES			From 10/01/2022 To 09/30/2023		pared:
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1.00	Physi ci an	3. 26					1.00
2. 00	Physician Assistant	0. 01		, , ,			2. 00
3.00	Nurse Practitioner	1. 95	· ·	· ·	· ·		3. 00
4.00	Subtotal (sum of lines 1 through 3)	5. 22			17, 808	1	ı
5. 00	Visiting Nurse	0. 00				0	
6.00	Clinical Psychologist	0. 00				0	
7. 00	Clinical Social Worker	0. 00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	5. 22	13, 983			17, 808	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWARIE COCT APPLICABLE T	O HOCDITAL DACE	D DUC (FOUR CED	VII CEC		1. 00	
10.00	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES					1, 522, 421	10 00
11. 00	0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1, 522, 421	1
12. 00	Cost of all services (excluding overhead) (s	·	,			1, 524, 351	
12.00	Ratio of hospital -based RHC/FQHC services (I					0. 998734	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			no 21)		375, 601	
	Parent provider overhead allocated to facili			116 31)		1, 257, 283	1
	Tatal everbeed (our of lines 14 and 15)		. (1 0113)			1, 207, 200	

1, 632, 884

1, 632, 884

1, 630, 817

3, 153, 238 20. 00

16.00

17. 00

18.00

19.00

16.00 Total overhead (sum of lines 14 and 15)

17.00 Allowable GME overhead (see instructions)
18.00 Enter the amount from line 16

19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

Hoal th	Financial Systems OTTAWA REGIONAL HOSPI	TAL & HEALTHCAD	In Lie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0110	Peri od:	Worksheet M-3	2332 10
SERVI C		Component CCN: 14-8649	From 10/01/2022 To 09/30/2023	Date/Time Pre	
		Title XVIII	RHC I	2/20/2024 3: 40 Cost	0 pm
		II the Aviii	KIIC I	COST	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			875, 646	
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			47, 632 828, 014	2. 00 3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	ilius IIIIe 2)		2, 562	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			2, 562	6. 00
7.00	Adjusted cost per visit (line 3 divided by line 6)			323. 19	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126.00	8. 00
9.00	Rate for Program covered visits (see instructions)	,	113. 00		1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	600	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr		0	75, 600 0	12.00
13. 00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions		0	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	75, 600	16. 00
16. 01	Total program charges (see instructions)(from contractor's re	•		181, 074	
16. 02	Total program preventive charges (see instructions) (from prov			3, 245	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			1, 355 52, 456	1
10.04	(Titles V and XIX see instructions.)	and roy trines . ooy		32, 430	10.04
16. 05	Total program cost (see instructions)		0	53, 811	16. 05
17. 00	Primary payer amounts			72	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 675	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		33, 831	19. 00
19.00	records)	ns) (ITOM CONTRACTOR		33, 631	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			53, 739	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		11, 921	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			65, 660	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	i de ti olis)		0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99				0	
26. 00	Net reimbursable amount (see instructions)			65, 660	
26. 01	Sequestration adjustment (see instructions)			1, 313	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 52 201	
28. 00	Tentative settlement (for contractor use only)			52, 281 0	27. 00 28. 00
29. 00		02, 27, and 28)		12, 066	
30. 00				0	30.00
	chapter I, §115.2				

	Financial Systems OTTAWA REGIONAL HOSPI			u of Form CMS-2	
SERVI (LATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0110	Peri od: From 10/01/2022	Worksheet M-3	
JLIVIV).LJ	Component CCN: 14-8655	To 09/30/2023	Date/Time Prep 2/20/2024 3:40	
		Title XVIII	RHC I I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			5, 645, 704	1. 00
2. 00	Cost of injections/infusions and their administration (from W			532, 874	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		5, 112, 830	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1: 0)		17, 986	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		17.004	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			17, 986 284. 27	6. 00 7. 00
7.00	Adjusted cost per visit (Time 3 divided by Time 0)		Cal cul ati on		7.00
			Car car a troir	51 Eriii t (1)	
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)	, , , , , , , , , , , , , , , , , , ,	113. 00	126. 00	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	0	3, 883	10.00
11. 00	Program cost excluding costs for mental health services (line	*	0	489, 258	
12.00	Program covered visits for mental health services (from contra	•	0	31	
13.00	Program covered cost from mental health services (line 9 x li		0	3, 906	
14. 00 15. 00	Limit adjustment for mental health services (see instructions	•	0	3, 906	14. 00 15. 00
16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	493, 164	
16. 01	Total program charges (see instructions) (from contractor's re	•	\[\]	1, 084, 381	
16. 02	Total program preventive charges (see instructions)(from prov	•		10, 249	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	-		4, 661	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			368, 339	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	373, 000	
17. 00	Primary payer amounts	(6		407	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		28, 079	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		209, 211	19. 00
	records)	(207,211	
20. 00	Net Medicare cost excluding vaccines (see instructions)			372, 593	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		100, 753	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			473, 346	l .
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)		0	
25. 99	Demonstration payment adjustment amount before sequestration	3)		0	
26. 00	Net reimbursable amount (see instructions)			473, 346	
26. 01	Sequestration adjustment (see instructions)				26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	l
27. 00	Interim payments			212, 635	
28. 00	Tentative settlement (for contractor use only)			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.4			251, 244	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-II		0	30.00

Heal th Financial Systems	OTTAWA REGIONAL HOSPI SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	TAL & HEALTHCAR Provider CCN: 14-0110	In Lie	u of Form CMS-2 Worksheet M-3	
SERVICES	SETTLEMENT FOR HOSPITAL-BASED RHC/FUHC	Component CCN: 14-8652	From 10/01/2022 To 09/30/2023	Date/Time Pre	
		·		2/20/2024 3: 4	
		Title XVIII	RHC III	Cost	
				1. 00	
	FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1	of hospital-based RHC/FQHC Services (fro			3, 153, 238	
1	fusions and their administration (from W			74, 157	2.00
1	excluding injections/infusions (line 1 m st. M-2, column 5, line 8)	Thus Time 2)		3, 079, 081 17, 808	3. 00 4. 00
,	er agreement (from Wkst. M-2, column 5,	line 9)		17, 608	
6.00 Total adjusted visits	•			17, 808	
1	t (line 3 divided by line 6)			172. 90	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023) 2. 00	
8.00 Per visit payment lim	t (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	113.00	126. 00	8. 00
1 3	red visits (see instructions)		113. 00	126. 00	
CALCULATION OF SETTLE	IENT				
0	s excluding mental health services (from	•	0	1, 904	
1 0	g costs for mental health services (line	•	0	239, 904	
	s for mental health services (from contr from mental health services (line 9 x li		0	0	
, 3	mental health services (inne 9 x in	,	0	0	
, ,	ation Pass Through Cost (see instruction	•		O	15. 00
	um of lines 11, 14, and 15, columns 1, 2		0	239, 904	
16.01 Total program charges	(see instructions)(from contractor's re-	cords) (508, 621	16. 01
	ve charges (see instructions)(from prov	•		9, 395	1
	ve costs ((line 16.02/line 16.01) times			4, 432	
16.04 Total Program non-pre (Titles V and XIX see	ventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		171, 498	16.04
16.05 Total program cost (· · · · · · · · · · · · · · · · · · ·		0	175, 930	16 05
17.00 Primary payer amounts	,				17. 00
18.00 Less: Beneficiary de	ductible for RHC only (see instructions)	(from contractor		21, 099	18.00
records)	6 800 (500)) (G		05 (05	40.00
19.00 Beneficiary coinsuran records)	ce for RHC/FQHC services (see instruction	ns) (from contractor		95, 625	19.00
	uding vaccines (see instructions)			175, 774	20.00
	nes and their administration (from Wkst.	M-4, line 16)		20, 189	
22.00 Total reimbursable Pr	ogram cost (line 20 plus line 21)			195, 963	22.00
23.00 Allowable bad debts (· ·			0	
1 3	bad debts (see instructions)			0	
1	or dual eligible beneficiaries (see inst	ructions)		0	
	E INSTRUCTIONS) (SPECIFY) tion payment adjustment (see instruction	5)		0	
	adjustment amount before sequestration	~ <i>,</i>		0	
26.00 Net reimbursable amou				195, 963	
26.01 Sequestration adjustm	,			3, 919	
1	adjustment amount after sequestration			0	
27.00 Interim payments	(for contractor use sale)			170, 915	
1	(for contractor use only) /program (line 26 minus lines 26.01, 26.	02 27 and 20)		0 21, 129	
•	rprogram (fine 26 minus fines 26.01, 26.7 nallowable cost report items) in accorda			21, 129	l
chapter I, §115.2	.a aabi a cost i aport i tolla) i il decol da	WI CIT OMO TUD. 10-11,		U	1 33.00

OMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/20/2024 3:40	pared:
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	323, 220	323, 22	20 323, 220	323, 220	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 003110	0. 00675	0. 000000	0. 000000	2.00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 005	2, 18	0	0	3.00
. 00	Injections/infusions and related medical supplies costs (from your records)	14, 585	3, 74		0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	15, 590	5, 93		0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	395, 634	395, 63			6.00
. 00	Total overhead (from Wkst. M-2, line 19)	480, 012	480, 01	12 480, 012	480, 012	7.00
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 039405	0. 01499	0. 000000	0.000000	8.00
. 00	Overhead cost - injection/infusion (line 7 x line 8)	18, 915	7, 19		0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	34, 505	13, 12	27 0	0	10.00
1.00	Total number of injections/infusions (from your records)	70	15		0	
2.00	Cost per injection/infusion (line 10/line 11)	492. 93	86. 3	0.00	0.00	
3. 00	Number of injection/infusion administered to Program beneficiaries	17	2	41 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 380	3, 54	41 0	0	14.00
	1	'			COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)	•		47, 632	15.00
6. 00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		11, 921	16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount					1

Heal th	Financial Systems OTTAWA REGIONAL HOS	SPITAL & HEALTH	CAR	In Li€	eu of Form CMS-2	2552-10
СОМРИТ	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	CN: 14-0110 CCN: 14-8655	Peri od: From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
		T: +1 o	VVI I I	DIIC II	2/20/2024 3: 4	0 pm
		PNEUMOCOCCAL	XVIII INFLUENZA	RHC II COVI D-19	Cost MONOCLONAL	
		VACCI NES	VACCINES	VACCINES	ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 930, 392			1, 930, 392	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 004638	0. 0076	0. 001603	0.000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	8, 953	14, 7	21 3, 094	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	168, 147	32, 7	24 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	177, 100	47, 4	45 3, 094	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2, 411, 804	2, 411, 8	2, 411, 804	2, 411, 804	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	3, 233, 900	3, 233, 9	3, 233, 900	3, 233, 900	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 073431	0. 0196	0. 001283	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	237, 469	63, 6	17 4, 149	0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	414, 569	111, 0	7, 243	0	10. 00
11. 00	Total number of injections/infusions (from your records)	807	1, 3			
12.00	Cost per injection/infusion (line 10/line 11)	513. 72	83.	59 25. 96	0.00	12. 00
13. 00	Number of injection/infusion administered to Program beneficiaries	130	3	82 77	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0		13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	66, 784	31, 9	70 1, 999		14. 00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
				1.00	ADMI NI STRATI ON	
15 00	Total cost of injections/infusions and their administration	a costs (sum of	columns 1	1.00	2. 00 532, 874	15. 00
15.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		532, 874	15.00
16. 00	Total Program cost of injections/infusions and their admini	stration costs			100, 753	16. 00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amour	nt to Wkst. M-3	, line 21)			l

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC Component C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Prep 2/20/2024 3:40	
		Title	XVIII	RHC III	Cost	o piii
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 285, 909 0. 001168	1, 285, 90 0. 00121		1, 285, 909 0. 000000	1. 00 2. 00
3. 00	lnjection/infusion health care staff cost (line 1 x line 2)	1, 502	1, 55	56 0	0	3. 0
4. 00	Injections/infusions and related medical supplies costs (from your records)	29, 170	3, 57	76 0	0	4. 0
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	30, 672	5, 13	32 0	0	5. 0
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 522, 421	1, 522, 42		1, 522, 421	6.0
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 630, 817	1, 630, 81		1, 630, 817	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 020147	0. 00337		0. 000000	8. 0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	32, 856	5, 49		0	9.0
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	63, 528	10, 62	29 0	0	10. 0
11.00	Total number of injections/infusions (from your records)	140	14		0	
2.00	Cost per injection/infusion (line 10/line 11)	453. 77	73. 3	0.00	0.00	
3. 00	Number of injection/infusion administered to Program beneficiaries	39	3	0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. C
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	17, 697	2, 49	92 0	0	14. 0
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
F 00				1. 00	2.00	45.0
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			74, 157	
16.00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		20, 189	16.0

Health Financial Systems	OTTAWA REGIONAL HOSPI	TAL & HEALTHCAR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASE SERVICES RENDERED TO PROGRAM BENEFICE		Provider CCN: 14-0110	Peri od: From 10/01/2022	Worksheet M-5
SERVICES RENDERED TO TROCKAW BENEFICE	ANT ES	Component CCN: 14-8649		

		Component CCN: 14-8649	10 09/30/2023	2/20/2024 3: 40	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
	<u> </u>		1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			52, 281	1. 00
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting			0	2. 00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3. 00
	revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)	Also show date of each			
	Program to Provider				
3. 01	1 rogi am to 1 rovi aoi			0	3. 01
3. 02				o o	3. 02
3. 03				o	3. 03
3. 04				o	3. 04
3. 05				o o	3. 05
	Provider to Program				
3.50				0	3. 50
3.51				0	3. 51
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		52, 281	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		
5. 00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 00
	Program to Provider		<u>'</u>		
5. 01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 51
5.52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER			12, 066	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			64, 347	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00		0	1. 00	2. 00	0.0-
8.00	Name of Contractor				8. 00

Health Financial Systems	OTTAWA REGIONAL HOSPIT	AL & HEALTHCAR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0110 Component CCN: 14-8655	From 10/01/2022	

		Component con. 14-8033	10 097 307 2023	2/20/2024 3: 40	
			RHC II	Cost	-
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			212, 635	1. 00
2.00	Interim payments payable on individual bills, either submitte	ed or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting pe				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount B				3.00
	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				0	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3.0
3.05				0	3. 0!
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 52
3.53				0	3. 53
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfe	er to Worksheet M-3, line		212, 635	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		6		
5.00	List separately each tentative settlement payment after desk	review. Also show date of	Г		5. 00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
5. 01	Program to Provider			0	5. 01
5. 02				0	5. 02
5. 02					5. 02
5.05	Provider to Program			0	5. 0.
5. 50	1 TOVI GCT TO TITOGI GIII			0	5. 50
5. 51				l ől	5. 5
5. 52				0	5. 5:
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	8)		0	5. 9
6.00	Determined net settlement amount (balance due) based on the	*			6. 00
6. 01	SETTLEMENT TO PROVIDER	3331 . 3poi t. (1)		251, 244	6. 0
6. 02	SETTLEMENT TO PROGRAM			201, 211	6. 0
7. 00	Total Medicare program liability (see instructions)			463, 879	7. 00
	Total mod. od. o program reductivity (soo restricted)		Contractor	NPR Date	,. 00
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	OTTAWA REGIONAL HOSPI	TAL & HEALTHCAR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASE SERVICES RENDERED TO PROGRAM BENEFICE		Provider CCN: 14-0110	Peri od: From 10/01/2022	Worksheet M-5
SERVICES RENDERED TO FROGRAM BENEFICE.	ANT ES	Component CCN: 14-8652		

		Component Con. 14-8032	10 07/30/2023	2/20/2024 3: 40	
			RHC III	Cost	-
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			170, 915	1. 00
2.00	Interim payments payable on individual bills, either submitt	ed or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting p				
	"NONE" or enter a zero	·			
3.00	List separately each retroactive lump sum adjustment amount				3. 00
	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				0	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3.51				0	3. 5
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	8)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	er to Worksheet M-3, line		170, 915	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	review. Also show date of	f		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.0
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 5
5.52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	,		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.00
6. 01	SETTLEMENT TO PROVIDER			21, 129	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			192, 044	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8.00	Name of Contractor			1	8.00