This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-4014 Worksheet S Period: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 11/14/2023 2:41 pm PART I - COST REPORT STATUS Provider 1.[X] Electronically prepared cost report Date: 11/14/2023 Time: 2:41 pm use only] Manually prepared cost report 2.Γ 3. $\begin{bmatrix} 0 \end{bmatrix}$ If this is an amended report enter the number of times the provider resubmitted this cost report 4. $\begin{bmatrix} F \end{bmatrix}$ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 6. Date Received: Contractor 5. [1]Cost Report Status 10.NPR Date: (1) As Submitted
7. Contractor No.
(2) Settled without Audit
(3) Settled with Audit
(4) Final Report for this Provider CCN
(5) Il. Contractor's Vendor Code:
(6) Il. Contractor's Vendor Code:
(7) Il. Contractor's Vendor Code:
(8) Initial Report for this Provider CCN
(9) If line 5, column 1 is 4: Enter number of times reopened = 0-9. use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THE OTIS R. BOWEN CENTER (15-4014) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC	
		1	2	SIGNATURE STATEMENT	
1	Jay I	Baumgartner	Υ	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	Jay Baumgartner			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			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	HOSPITAL	0	0	5	0	42,180	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	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
200.00	TOTAL	0	0	5	0	42,180	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.

In Lieu of Form CMS-2552-10 Health Financial Systems THE OTIS R. BOWEN CENTER

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/14/2023 2:41 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street:9 PEQUIGNOT DR PO Box: 1.00 2.00 City: PIERCETON State: IN Zip Code: 46562 County: KOSCIUSKO 2.00 Component Name CCN CBSA Provider Date Payment System (P, T, 0, or N) Number Number Туре Certified V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 THE OTIS R. BOWEN 154014 99915 03/14/1979 Ν 0 3.00 Hospital CENTER Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital-Based NF 10.00 11.00 11.00 Hospital-Based OLTC 12.00 Hospital-Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospital-Based Hospice 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 06/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 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. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Ν this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 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) 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 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

In Lieu of Form CMS-2552-10 Health Financial Systems THE OTIS R. BOWEN CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/14/2023 2:41 pm In-State In-State Out-of Out-of Medicaid Other Medicaid Medicaid Medicaid State State HMO days paid days eligible Medicaid Medicaid days unpaid paid days eligible days unpaid 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24 00 0 n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 2 27.00 enter the effective date of the geographic reclassification in column 2.

35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Beginning: Ending: 1.00 2.00 36.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) $38.00\ |$ If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or 40.00 Ν Ν 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

In Lieu of Form CMS-2552-10 Health Financial Systems THE OTIS R. BOWEN CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/14/2023 2:41 pm XVIII XIX 1.00 2.00 3.00 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 N any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME Direct GMF TMF 1.00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted Unweighted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 0.00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 'Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	THE OTI	IS R. BOWE	N CENTER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA	Provider CC		Period: From 07/01/2022 To 06/30/2023		pared:
				Unweighted	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				FTES Nonprovider Site		col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Ye							
64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to resident FTEs that trained in yof (column 1 divided by (column	s yes, or your facili mber of unweighted now otations occurring in e number of unweighted our hospital. Enter in	ty trained n-primary all nonpr d non-prim n column 3	I residents care covider nary care the ratio	0.0	0.00	0.000000	64.00
or (cordinir 1 divided by (cordinir	Program Name		am Code	Unweighted	Unweighted	Ratio (col.	
	3			FTEs Nonprovider	FTES in	3/ (col. 3 + col. 4))	
				Site			
CF 00 Enter in column 1 if line 62	1.00	2	.00	3.00	4.00	5.00	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					Unweighted	Ratio (col.	65.00
				Unweighted FTEs	FTES in	1/ (col. 1 +	
				Nonprovider	Hospital	col. 2))	
				Site			
Section 5504 of the ACA Current	Year FTE Residents in	n Nonnrovi	ider Setting	1.00	for cost report	3.00	
beginning on or after July 1, 2	010						
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospin (column 1 divided by (column 1)	occurring in all nonp unweighted non-prima tal. Enter in column	rovider se ry care re 3 the rati structions	ettings. esident o of	0.0	00 0.00 Unweighted	0.000000 Ratio (col.	66.00
				FTES Nonprovider Site	FTES in Hospital	3/ (col. 3 + col. 4))	
	1.00	2	.00	3.00	4.00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0.00	0.000000	67.00

				Period: From 07/01/2 To 06/30/2		Workshee Part I Date/Tin 11/14/20	ne Pre	pared
						1.00	0	
8.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 For a cost reporting period beginning prior to October 1, 202 MAC to apply the new DGME formula in accordance with the FY 2 (August 10, 2022)?	22, did you o	btain permiss	ion from yo		N		68.00
	(Magase 10, 1011).				1.00	2.00	2 00	
	Inpatient Psychiatric Facility PPS				1.00	7 2.00	3.00	
	Is this facility an Inpatient Psychiatric Facility (IPF), or Enter "Y" for yes or "N" for no.	does it cont	ain an IPF su	bprovider?	Υ			70.0
1.00	If line 70 is yes: Column 1: Did the facility have an approve recent cost report filed on or before November 15, 2004? Ent 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility traprogram in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ent Column 3: If column 2 is Y, indicate which program year begar (see instructions) Inpatient Rehabilitation Facility PPS	ter "Y" for y ain residents ter "Y" for y	es or "N" for in a new tea es or "N" for	no. (see ching no.	N	N	0	71.0
5.00	Is this facility an Inpatient Rehabilitation Facility (IRF),	or does it c	ontain an IRF		N			75.0
6.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approve recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new team	, 2004? Enter	"Y" for yes	or "N" for			0	76.0
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	Column 3: If	column 2 is	Υ,				
	,	<u> </u>				1.00	<u> </u>	
	Long Term Care Hospital PPS						J	
1.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEFRA Providers			g period? E	nter	N N		80.0 81.0
5.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	d unit) under	42 CFR Secti	on	no.	N		85.0 86.0
7.00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under section			N		87.0
				Approved Permaner Adjustme (Y/N)	nt	Number Approv Perman Adjustm	ved ent	
3 00	Column 1: Is this hospital approved for a permanent adjustmen	nt to the TEE	RA target	1.00		2.00		88.0
	amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	s, complete c	ol. 2 and lin					0010
			Wkst. A Line No.	Effectiv Date	/e	Approv Perman Adjustr Amount Discha	nent nent Per	
2 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A li	ino numbor	1.00	2.00		3.00		89.0
	on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tamper discharge.	based. period rget amount	0.0				Ü	05.0
	Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	ent to the						
				1.00		2.00		
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital	services? F	nter "Y" for	N		N		90.0
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through th			N N		Y		91.0
	full or in part? Enter "Y" for yes or "N" for no in the appliance title XXIX NF patients occupying title XXIII SNF beds (due	icable column		IN IN				92.0
.00	re title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicat Does this facility operate an ICF/IID facility for purposes o	ole column.		. Al		N		92.0
Ω	"Y" for yes or "N" for no in the applicable column.			N N		N		
		and "N" E				l N		94.0
1.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column. If line 94 is "Y", enter the reduction percentage in the appl			0.00		0.00	0	95.0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE CO	THE OTIS R. E	Provider Co	CN: 15-4014		iod: m 07/01/2022 06/30/2023	u of Form CMS Worksheet S- Part I Date/Time Pr 11/14/2023 2	2 epared:
				_	V	XIX	
98.00 Does title V or XIX follow Me	dicare (title XVIII) for the	intarns and res	idents nost	-	1.00 Y	2.00 Y	98.00
stepdown adjustments on Wkst. column 1 for title V, and in 98.01 Does title V or XIX follow Me	B, Pt. I, col. 25? Enter "Y" column 2 for title XIX.	for yes or "N'	' for no in				
<pre>C, Pt. I? Enter "Y" for yes o title XIX.</pre>	r "N" for no in column 1 for	title V, and ir	n column 2 fo		Y	Y	98.01
8.02 Does title V or XIX follow Me bed costs on Wkst. D-1, Pt. I for title V, and in column 2	V, line 89? Enter "Y" for yes for title XIX.	or "N" for no	in column 1		Y	Y	98.02
Does title V or XIX follow Me reimbursed 101% of inpatient for title V, and in column 2	services cost? Enter "Y" for				N	N	98.03
8.04 Does title V or XIX follow Me outpatient services cost? Ent in column 2 for title XIX.				nd	N	N	98.04
8.05 Does title V or XIX follow Me Wkst. C, Pt. I, col. 4? Enter column 2 for title XIX.	dicare (title XVIII) and add "Y" for yes or "N" for no in	back the RCE di column 1 for t	isallowance o citle V, and	on in	Y	Υ	98.05
8.06 Does title V or XIX follow Me Pts. I through IV? Enter "Y" column 2 for title XIX.	dicare (title XVIII) when cos for yes or "N" for no in colu	t reimbursed fo mn 1 for title	or Wkst. D, V, and in		Y	Υ	98.06
Rural Providers							105.00
05.00 Does this hospital qualify as 06.00 If this facility qualifies as for outpatient services? (see	a CAH, has it elected the alinstructions)				N N		105.00
07.00 Column 1: If line 105 is Y, i training programs? Enter "Y" Column 2: If column 1 is Y a approved medical education pr Enter "Y" for yes or "N" for	for yes or "N" for no in colu nd line 70 or line 75 is Y, d ogram in the CAH's excluded	mn 1. (see ins o you train I&F IPF and/or IRF	structions) Rs in an		N		107.0
08.00 Is this a rural hospital qual CFR Section §412.113(c). Ente	ifying for an exception to the		edule? See 4	12	N		108.0
		Physical	Occupation	-1	Speech	Bocninatony	
		Physical 1.00	Occupation 2.00	al	Speech 3.00	Respiratory 4.00	
09.00 If this hospital qualifies as therapy services provided by for yes or "N" for no for eac	outside supplier? Enter "Ý"	1.00	Occupations 2.00 N	al	Speech 3.00 N	Respiratory 4.00 N	
therapy services provided by	outside supplier? Enter "Ý"	1.00	2.00	al	3.00	4.00 N	
therapy services provided by for yes or "N" for no for eac	outside supplier? Enter "Ý" h therapy. in the Rural Community Hospi cost reporting period? Enter	1.00 N tal Demonstrati "Y" for yes or	2.00 N ion project ((§410	3.00 N	4.00	109.0
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A,	outside supplier? Enter "Ý" h therapy. in the Rural Community Hospi cost reporting period? Enter	1.00 N tal Demonstrati "Y" for yes or	2.00 N ion project ((§410	3.00 N N OA yes, 1 215, as	4.00 N	109.00
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F)	outside supplier? Enter "Ý" h therapy. in the Rural Community Hospi cost reporting period? Enter lines 200 through 218, and W a CAH, did it participate in CHIP) demonstration for this of column 1. If the response to o	tal Demonstrati "Y" for yes or orksheet E-2, l	2.00 N ion project ("N" for no. lines 200 thr community period? Ente enter the n column 2.	(§410) If rough	3.00 N	4.00 N	110.00
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F"Y" for yes or "N" for no in integration prong of the FCHI Enter all that apply: "A" for	outside supplier? Enter "Ý" h therapy. in the Rural Community Hospi cost reporting period? Enter lines 200 through 218, and W a CAH, did it participate in CHIP) demonstration for this of column 1. If the response to o	tal Demonstrati "Y" for yes or orksheet E-2, l	2.00 N Ton project ("N" for no. lines 200 thr Community period? Enter enter the n column 2. s; and/or "C'	(§410) If rough	3.00 N N DA yes, 1.215, as	1.00 N	110.0
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F"Y" for yes or "N" for no in integration prong of the FCHI Enter all that apply: "A" for for tele-health services. 12.00 Did this hospital participate (PARHM) demonstration for any period? Enter "Y" for yes or "Y", enter in column 2, the demonstration. In column 3, participation in the demonstration.	outside supplier? Enter "Ÿ" h therapy. in the Rural Community Hospicost reporting period? Enter lines 200 through 218, and we a CAH, did it participate in CHIP) demonstration for this column 1. If the response to P demo in which this CAH is participate in the Pennsylvania Rural Heportion of the current cost "N" for no in column 1. If a the hospital began particenter the date the hospital coation, if applicable.	tal Demonstrati "Y" for yes or orksheet E-2, l the Frontier Cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the	2.00 N ion project ("N" for no. lines 200 thr community period? Ente enter the n column 2.	(§410) If rough	3.00 N N OA yes, 1.215, as	4.00 N	110.0
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F"Y" for yes or "N" for no in integration prong of the FCHI Enter all that apply: "A" for for tele-health services. 12.00 Did this hospital participate (PARHM) demonstration for any period? Enter "Y" for yes or "Y", enter in column 2, the demonstration. In column 3, participation in the demonstration for any period? Enter "S" for yes or "Y", enter in column 2, the demonstration. In column 1, if column 1 is column 1 is column 1 is column 1 is column 2 is "for short term hospital or "9 psychiatric, rehabilitation a	in the Rural Community Hospicost reporting period? Enter lines 200 through 218, and we a CAH, did it participate in CHIP) demonstration for this column 1. If the response to P demo in which this CAH is participate in the Pennsylvania Rural Heaportion of the current cost "N" for no in column 1. If a the hospital began partice enter the date the hospital coation, if applicable. Information provider? Enter "Y" for yes easy, enter the method used (A, E", enter in column 3 either 8" percent for long term care nd long term hospitals provide	tal Demonstrati "Y" for yes or orksheet E-2, l the Frontier of cost reporting column 1 is y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes	2.00 N Ion project ("N" for no. lines 200 thr Community period? Enter enter the n column 2. s; and/or "C' 1.00	(§410) If rough	3.00 N N DA yes, 1.215, as	1.00 N	110.00
therapy services provided by for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F"Y" for yes or "N" for no in integration prong of the FCHI Enter all that apply: "A" for for tele-health services. 12.00 Did this hospital participate (PARHM) demonstration for any period? Enter "Y" for yes or "Y", enter in column 2, the demonstration. In column 3, participation in the demonstr Miscellaneous Cost Reporting 15.00 Is this an all-inclusive rate in column 1. If column 1 is y in column 2. If column 2 is "for short term hospital or "9 psychiatric, rehabilitation a the definition in CMS Pub.15-16.00 Is this facility classified a "N" for no.	in the Rural Community Hospicost reporting period? Enter lines 200 through 218, and we a CAH, did it participate in CHIP) demonstration for this column 1. If the response to P demo in which this CAH is p. Ambulance services; "B" for a line for the current cost "N" for no in column 1. If ate the hospital began particenter the date the hospital cation, if applicable. Information provider? Enter "Y" for yes es, enter the method used (A, E", enter in column 3 either 8" percent for long term care nd long term hospitals provide1, chapter 22, §2208.1. s a referral center? Enter "Y"	tal Demonstrati "Y" for yes or orksheet E-2, l the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on " for yes or	2.00 N Son project ("N" for no. lines 200 thr Community period? Enter the n column 2. s; and/or "c' 1.00 N	(§410) If rough	3.00 N N DA yes, 1.215, as	1.00 N	110.00
for yes or "N" for no for eac 10.00 Did this hospital participate Demonstration) for the current complete Worksheet E, Part A, applicable. 11.00 If this facility qualifies as Health Integration Project (F "Y" for yes or "N" for no in integration prong of the FCHI Enter all that apply: "A" for for tele-health services. 12.00 Did this hospital participate (PARHM) demonstration for any period? Enter "Y" for yes or "Y", enter in column 2, the d demonstration. In column 3, participation in the demonstr Miscellaneous Cost Reporting 15.00 Is this an all-inclusive rate in column 1. If column 1 is y in column 2. If column 2 is " for short term hospital or "9 psychiatric, rehabilitation a the definition in CMS Pub.15- 16.00 Is this facility classified a	in the Rural Community Hospicost reporting period? Enter lines 200 through 218, and we a CAH, did it participate in CHIP) demonstration for this column 1. If the response to P demo in which this CAH is p. Ambulance services; "B" for a line for the current cost "N" for no in column 1. If ate the hospital began particenter the date the hospital cation, if applicable. Information provider? Enter "Y" for yes es, enter the method used (A, E", enter in column 3 either 8" percent for long term care nd long term hospitals provide1, chapter 22, §2208.1. s a referral center? Enter "Y"	tal Demonstrati "Y" for yes or orksheet E-2, l the Frontier (cost reporting column 1 is Y, articipating in additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on " for yes or	2.00 N Ion project ("N" for no. lines 200 thr Community period? Enter the n column 2. s; and/or "C' 1.00 N	(§410) If rough	3.00 N N DA yes, 1.215, as	1.00 N	110.00 1110.00 1111.00 112.00 116.00 117.00

In Lieu of Form CMS-2552-10 Health Financial Systems THE OTIS R. BOWEN CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Period: Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/14/2023 2:41 pm Premiums Losses Insurance 1.00 2.00 3.00 118.01 List amounts of malpractice premiums and paid losses: 503,452 0118.01 1.00 2.00 118.02 Are malpractice premiums and paid losses reported in a cost center other than the 118.02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA 120.00 N Ν §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 122.00 the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional 123.00 services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes Ν 125.00 and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00|If this is a Medicare-certified liver transplant program, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00|If this is a Medicare-certified pancreas transplant program, enter the certification 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 (OPO), enter the OPO 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, 140.00 Ν 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 3.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: Contractor's Name: Contractor's Number: 141.00 142.00 Street: PO Box: 142.00 143.00 City: 143.00 State: zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 Υ 1.00 2.00 145.00 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 145.00 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? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provider (CCN: 15-4014		: 7/01/2022 6/30/2023	Worksheet S- Part I Date/Time P 11/14/2023	repared
						1.00	_
147.00 was there a change in the statist	ical basis? Enter "Y" fo	r ves or "N" fo	or no.			N	147.0
148.00 was there a change in the order o						N	148.0
149.00 was there a change to the simplif				for no.		N	149.0
	-	Part A	Part B	Т	itle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
.55.00 Hospital	N TOT HO TOT CUCH COMP	N N	N N	DI (500 1	N N	N	155.0
L56.00Subprovider - IPF		N	N N		N	N	156.0
L57.00 Subprovider - IRF		N	N N		N	N	157.0
.58.00 SUBPROVIDER							158.0
L59.00 SNF		N	N		N	N	159.0
160.00 HOME HEALTH AGENCY		N	N		N	N	160.0
L61.00 CMHC			N		N	N	161.0
						1.00	_
Multicampus						2.00	
.65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more cam	npuses in di	fferent C	BSAs?	N	165.0
Effect 1 101 yes of N 101 hor	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
L66.00 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	00166.0
						1.00	-
Health Information Technology (HI	T) incentive in the Amer	ican Recovery a	and Reinvest	ment Act			
.67.00 Is this provider a meaningful use	05 is "Y") and is a mean	ingful user (li			r the	N	167.0 168.0
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, d ? Enter "Y" for yes or "	oes this provid N" for no. (see	: instructio	ns)			168.0
69.00 If this provider is a meaningful transition factor. (see instructi		nd is not a CAF	(line 105	is "N"),	enter the	0.	00169.0
	·				ginning	Ending	
					1.00	2.00	
.70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endin	g date for the	reporting				170.0
					1.00	2.00	
71.00 If line 167 is "Y", does this pro	vider have any days for	individuals enr	olled in		N	2.00	0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, P umn 1. If column 1 is ye	t. I, line 2, c	ol. 6? Ente				

In Lieu of Form CMS-2552-10 Health Financial Systems THE OTIS R. BOWEN CENTER HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-4014 Period: Worksheet S-2 From 07/01/2022 Part II 06/30/2023 Date/Time Prepared: 11/14/2023 2:41 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in 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 Program? If Ν 2.00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 4.00 Α or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 7.00 Ν 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 10.00 Ν cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 **Bad Debts** Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 13.00 Ν period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. 15.00 Ν Part B Part A Y/N Y/N Date Date 3.00 1.00 2.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 10/13/2023 Υ 10/13/2023 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for 17.00 N N 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) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 Ν Ν Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

OSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/14/2023 2:	epared
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1 00	
	COMPLETED BY COST RETMOLIBSED AND TEERA HOSPITALS ONLY (EYCE	DT CUTI DDENC	UOCRTTAL C)		1.00	-
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PI CHILDRENS	HUSPITALS)			+
2 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.0
3.00	Have changes occurred in the Medicare depreciation expense			ring the cost	N N	23.0
3.00	reporting period? If yes, see instructions.	uue to appiai	sais made du	i ilig the cost	IN	23.0
4.00	were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost r	eporting period?	N	24.0
5.00		the cost repo	rting period	? If yes, see	N	25.0
6.00		e cost report	ing period?	If yes, see	N	26.0
7.00	has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27.0
3.00	Interest Expense Were new loans, mortgage agreements or letters of credit en	itered into du	ring the cos	t reporting	N	28.0
9.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service	Reserve Fund)	N	29.0
0.00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see	N	30.0
1.00	instructions. Has debt been recalled before scheduled maturity without is	suance of new	debt? If ye	s, see	N	31.0
2 00	instructions. Purchased Services Have changes or new agreements occurred in patient care ser	vices furnish	ed through c	ontractual		32.0
	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	ictions.	-		:	33.0
	Provider-Based Physicians					
4.00	Were services furnished at the provider facility under an a	ırrangement wi	th provider-	based physicians?	Y	34.0
5.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provider-based	N	35.0
	physicians during the cost reporting period? If yes, see in	structions.				
				Y/N	Date	
	ACC - Contra			1.00	2.00	
	Home Office Costs					30.0
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	نادينا اممسمسم	homo - ££4	N N		36.0
7.00		epared by the	nome office	·		37.0
3.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			f		38.0
9.00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.			S,		39.
0.00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40.
		1.	.00	2.	00	1
	Cost Report Preparer Contact Information					
1.00		MICHAEL		ALESSANDRINI		41.0
2.00	respectively. Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.0
	preparer.					
3.00	ļ! !	317.713.7959		MALESSANDRINI@		43.0

Health	Financial Systems THE OTIS R. I	BOWEN CENTER	In Lie	u of Form CMS-2552	2-10
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-4014	Period: From 07/01/2022 To 06/30/2023		
		2.00			
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	DIRECTOR		41	1.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respectively.				
42.00	Enter the employer/company name of the cost report			12	2.00
42.00				42	2.00
	preparer.				
43.00	Enter the telephone number and email address of the cost			43	3.00
	report preparer in columns 1 and 2, respectively.				

THE OTIS R. BOWEN CENTER

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared: Health Financial Systems THE OTISHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-4014

Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Trips Trips Trips					Т	o 06/30/2023	Date/Time Pre 11/14/2023 2:	
Component Worksheet A Line No. of Beds Bed Days Available Trips Title V				<u> </u>				
Component No. of Seeds Red Days CAH/REH Hours Title V							O/P Visits /	
PART I - STATISTICAL DATA 1.00 2.00 3.00 4.00 5.00								
PART I - STATISTICAL DATA		Component		No. of Beds		CAH/REH Hours	Title V	
PART I = STATISTICAL DATA								
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8			1.00	2.00	3.00	4.00	5.00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1.00	4 00		20.00	20	7 200	0.00		4 00
Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1.00		30.00	20	7,300	0.00	0	1.00
For the portion of LDP room available beds) MMO and other (see instructions) 2.00 3.00 MMO IRF Subprovider 4.00 6.00 Mospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 6.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 6.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Mospital Adults & Peds. Swing Bed NF 0 9.00 0 9.00 Mospital Adults & Peds. Swing Bed NF 0 9.00 Mospital Adults & Peds. Swing Bed NF 0 9.00 Mospital Adults & Peds.		, ·						
2.00								
3.00	2 00							2 00
4.00		1						
5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 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 15.00 CAH visits 20 7,300 0.00 0 14.00 15.00 CAH visits 15.10 15.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 20.00 10.00 OTHER LONG TERM CARE 21.00 20.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOME HEALTH AGENCY 23.00 24.10 HOSPICE (non-distinct part) 30.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 26.25 27.00 Total (sum of lines 14-26) 0 28.00 28.00 Observation Bed Days 0 28.00 28.00 Observation Bed Days 0 28.00 20.00 Other Value 20.00		· ·						
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.10 Reh hours and visits 15.10 Reh hours and visits 16.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 19.00 SUBPROVIDER - IRF 19.00 SUBPROVIDER - IRF 19.00 SUBPROVIDER - IRF 19.00 SILLED NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CWHC 25.00 CMCAL - CWHC 26.05 REDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 0 16.00 10.00 TOTAL OR TERM CARE 20 CAPPART OF THE AGENCY 21.00 TOTAL CORD TERM CARE 22.00 CMCAL - CWHC 25.00 Total (sum of lines 14-26) 20 CAPPART OF THE AGENCY 20 TOTAL (sum of lines 14-26) 20 CAPPART OF THE CORD TERM CARE 21.00 CMCAL - CWHC 22.00 CMCAL - CWHC 23.00 CMCAL - CWHC 24.00 CAPPART OF THE CAPPART OF TH		· ·					0	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.10 CAH visits 15.10 REH hours and visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CMC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 TOTAL (sum of lines 14-26) 20 Observation Bed Days 7,300 0.00 0,00 0,00 0,00 0,00 0,00 0,00							-	
beds) (see instructions) 8.00				20	7.300	0.00		
8.00 O OCRONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 USURINITENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 15.10 CAH visits 15.10 Reh hours and visits 15.10 Reh hours and visits 15.10 Subprovider - Ipf 17.00 Subprovider - Ipf 17.00 Subprovider - Irf 18.00 Subprovider - Irf 18.00 Subprovider - Irf 19.00 Subprovider - Irf 19.00 Sublance of Care o					,,,,,,	0.00		
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1	8.00							8.00
11.00 SURGICAL INTENSIVE CARE UNIT 12.00	9.00	CORONARY CARE UNIT						9.00
12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 14.00 15.00 15.00 16.00 15.00 15.10 15.10 15.10 15.10 16.00 17.00 18.00 19.00	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00	11.00	SURGICAL INTENSIVE CARE UNIT						11.00
14.00 Total (see instructions) 15.00 CAH visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.05 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 20 Observation Bed Days 20 0 14.00 21.00 0.00 21.00 0.00 2	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15.00 CAH visits REH hours and visits SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 89.00 28.00 Observation Bed Days 0 15.00 15.10 16.00 17.00 18.00 19.00 20.00	13.00	NURSERY						13.00
15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 23.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 15.10 16.00 17.00 17.00 18.00 19.0	14.00	Total (see instructions)		20	7,300	0.00	0	14.00
16.00 SUBPROVIDER - IPF	15.00	CAH visits					0	
17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 20 Observation Bed Days 21.00 22.00 23.00 24.00 25.00 26.25 27.00 26.25 27.00 28.00 28.00								
18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 18.00 19.00 20.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.05 27.00 26.05 27.00 28.00								
19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 19.00 20.00 21.00 22								
20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 HOSPICE 24.10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 CMHC - CMHC 25.00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0bservation Bed Days 20 0 28.00								
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 4.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.02 FEDERALLY QUALIFIED HEALTH CENTER 70 Observation Bed Days 21.00 22.00 23.00 24.10 25.00 24.10 25.00 26.25 27.00 28.00								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.02 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 22.00 23.00 23.00 24.00 25.00 26.25 27.00 28.00								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 23.00 24.00 24.00 24.00 24.10 25.00 26.25 27.00 28.00								
24.00 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 20 28.00 Observation Bed Days 24.10 24.10 24.10 24.10 24.10 25.00 26.00 25.00 26.00 26.00 26.00 26.00 26.00 26.25 27.00 28.00								
24.10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 20 20 28.00 Observation Bed Days 24.10 25.00 20.00 22.00 28.00 28.00								
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 25.00 26.00 26.00 26.00 27.00 28.00			20.00					
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 26.00			30.00					
26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26.25 27.00 Total (sum of lines 14-26) 20 27.00 28.00 Observation Bed Days 0 28.00								
27.00 Total (sum of lines 14-26) 20 27.00 28.00 Observation Bed Days 20 28.00			89 00				0	
28.00 Observation Bed Days		1	03.00	20			V	
				20			0	
		1						
30.00 Employee discount days (see instruction) 30.00		· ·						
31.00 Employee discount days - IRF								
32.00 Labor & delivery days (see instructions) 0 0 32.00	32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room 32.01								
outpatient days (see instructions)		outpatient days (see instructions)						
33.00 LTCH non-covered days 33.00	33.00							33.00
33.01 LTCH site neutral days and discharges 33.01								
34.00 Temporary Expansion COVID-19 PHE Acute Care 30.00 0 0 34.00	34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

Health Financial Systems THE OTI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER

Period: Worksheet S-3 From 07/01/2022 Part I Date/Time Prepared: Provider CCN: 15-4014

				1	0 06/30/2023	Date/Time Pre 11/14/2023 2:	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equivalents	
		_,, .	, -,	,,			
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	502	245	4,559			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	490				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	1			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7.00	Total Adults and Peds. (exclude observation	502	245	4,559			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	502	245	,	0.00	1,158.25	
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	HOSPICE			_			24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC		_	_			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27.00	Total (sum of lines 14-26)		_		0.00	1,158.25	
28.00			0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF	_	_	0			31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32.01	Total ancillary labor & delivery room			0			32.01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days	0					33.00
33.01	, , , , , , , , , , , , , , , , , , , ,	0	^	_			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		I	34.00

Health Financial SystemsTHE OTIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER

Provider CCN: 15-4014 Period: Worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

				10	06/30/2023	11/14/2023 2:	
		Full Time		Disch	arges		
		Equivalents			ŭ .		
	Component	Nonpaid	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	71	46	831	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
2 00	for the portion of LDP room available beds)			0	100		2.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider			0	108 0		2.00 3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				o l		5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	71	46	831	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00 21.00
21.00 22.00	OTHER LONG TERM CARE						22.00
23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01							32.01
	outpatient days (see instructions)						
33.00	1			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care				ا		34.00

	Financial Systems	THE OTIS R. BOV	_			u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co		Period:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	narodi
					10 00/30/2023	11/14/2023 2:	
	Cost Center Description	Salaries	Other	Total (col.	L Reclassificat		TI PIII
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1		1 355,542	355,543	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 13,276,613	13,276,613	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	15,633,399	8,943,189	24,576,58	8 -3,965,518	20,611,070	5.00
7.00	00700 OPERATION OF PLANT	0	0		0 854,070	854,070	7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 328,321	328,321	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,981,860	1,405,289	6,387,14	9 -890,678	5,496,471	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	0		0 91,765	91,765	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 227,068	227,068	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	14,753,405	4,469,264	19,222,66	9 -6,673,300	12,549,369	
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0	0	90.01
	OTHER REIMBURSABLE COST CENTERS	<u>, </u>					
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00		35,368,664	14,817,743	50,186,40	7 3,603,883	53,790,290	118.00
	NONREIMBURSABLE COST CENTERS				_		
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
	19201 RESIDENTIAL	34,186,844	5,281,706	39,468,55			
	19202 MRO	0	0		0 4,500,268		
	19203 METHODONE CLINIC	0	0		0		192.03
	19204 FQHC	7,115,595	1,881,456	, ,	, ,		
	19205 BRC	1,355,146	845,411	, ,	,		
	19206 BUSINESS RENTAL	0	1,831,818	1,831,81			
	07950 RENTAL SPACE	0	0		0		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	78,026,249	24,658,134	102,684,38	3 0	102,684,383	200.00

Health Financial SystemsTHE OTIS RRECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER Provider CCN: 15-4014

Period: Worksheet A From 07/01/2022

				To 06/30/2023 Date/Time P	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-355,542	1		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13,276,613		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-654,225	19,956,845		5.00
7.00	00700 OPERATION OF PLANT	0	854,070		7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5,851	322,470		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,008,026	3,488,445		30.00
	ANCILLARY SERVICE COST CENTERS				
	06000 LABORATORY	0	91,765		60.00
	07300 DRUGS CHARGED TO PATIENTS	0	227,068		73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	-2,211,151	10,338,218		90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0		90.01
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		102.00
	SPECIAL PURPOSE COST CENTERS				
118.00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	-5,234,795	48,555,495		118.00
	NONREIMBURSABLE COST CENTERS				
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192.00
	19201 RESIDENTIAL	0	32,835,275		192.01
	19202 MRO	0	4,500,268		192.02
	19203 METHODONE CLINIC	0	0		192.03
	19204 FQHC	0	7,808,152		192.04
	19205 BRC	0	1,952,595		192.05
	19206 BUSINESS RENTAL	0	1,797,803		192.06
	07950 RENTAL SPACE	0	0		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-5,234,795	97,449,588		200.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER Provider CCN: 15-4014

Period: Worksheet A-6
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

					10 00/30/2023	11/14/2023 2:41 pm
		Increases		·		
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SALARIES RECLASS					
1.00	OPERATION OF PLANT	7.00	854,070	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	<u>16.</u> 00	328,321	0		2.00
	0		1,182,391	0		
	B - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13,276,613		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	13,276,613		
	C - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	355,542		1.00
	FIXT					
2.00		0.00	0	0		2.00
	0		0	355,542		
	E - MRO EXPENSE					
1.00	MRO	1 <u>92.</u> 02	3,453,957	<u>1,046,3</u> 11		1.00
	0		3,453,957	1,046,311		
	F - PHARMACY RECLASS		-1			
1.00	DRUGS CHARGED TO PATIENTS			227,068		1.00
	0		0	227,068		
	G - LABORATORY RECLASS		-1			
1.00	LABORATORY			9 <u>1,7</u> 65		1.00
	0		0	91,765		
500.00	Grand Total: Increases		4,636,348	14,997,299		500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER Provider CCN: 15-4014

Period: Worksheet A-6
From 07/01/2022
To 06/30/2023 Date/Time Prepared:

							11/14/2023 2:41 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SALARIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,182,391	0	0		1.00
2.00		0.00	0	0	0)	2.00
	0		1,182,391	0)		
	B - BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	2,783,127	0	0)	1.00
2.00	ADULTS & PEDIATRICS	30.00	571,845	0	0)	2.00
3.00	CLINIC	90.00	2,173,032	0	0)	3.00
4.00	RESIDENTIAL	192.01	6,633,275	0	0)	4.00
5.00	FQHC	192.04	867,372	0	0)	5.00
6.00	BRC	192.05	247,962	0	0)	6.00
	0		13,276,613	0)		
	C - INTEREST RECLASS						
1.00	FQHC	192.04	0	321,527		-	1.00
2.00	BUSINESS RENTAL	<u> </u>	0	3 <u>4,0</u> 15			2.00
	0		0	355,542	!		
	E - MRO EXPENSE						
1.00	CLINIC	90.00	<u>3,453,9</u> 57	<u>1,046,3</u> 11)	1.00
	0		3,453,957	1,046,311	-		
	F - PHARMACY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	22 <u>7,0</u> 68			1.00
	0		0	227,068	8		
	G - LABORATORY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	9 <u>1,7</u> 65		0	1.00
	0		0	91,765		1	
500.00	Grand Total: Decreases		17,912,961	1,720,686	5		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS THE OTIS R. BOWEN CENTER Provider CCN: 15-4014

				То	06/30/2023	Date/Time Pre 11/14/2023 2:	
				Acquisitions		11/11/2023 21	TI PIII
		Beginning	Purchases	Donation	Total	Disposals and	
		Balances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	7,377,486	1,599,071	0	1,599,071	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,145,496	3,572,133	0	3,572,133	200,000	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	17,253,104	7,780,671	0	7,780,671	4,126,113	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,776,086	12,951,875	0	12,951,875	4,326,113	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,776,086	12,951,875	0	12,951,875	4,326,113	10.00
		Ending	Fully				
		Balance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	8,976,557	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	45,517,629	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	20,907,662	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	75,401,848	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	75,401,848	0				10.00

Health	Financial Systems	THE OTIS R. BOWEN CENTER			In Lieu of Form CMS-2552		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider	CCN: 15-4014	Period: From 07/01/2022 To 06/30/2023		pared:
				SUMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1		0	0	0	1.00
3.00	Total (sum of lines 1-2)	1		0	0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capital-Relat	(sum of cols				
		ed Costs (see	9 through 14				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0		1	-		1.00
3.00	Total (sum of lines 1-2)	0		1			3.00
	•	•					•

Health	Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 07/01/2022 Fo 06/30/2023		oared:
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	·
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	75,801,848	0	75,801,848	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	75,801,848	0	75,801,848	1.000000	0	3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relat				
			ed Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	() 1	0	1.00
3.00	Total (sum of lines 1-2)	0	0	[() 1	0	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)		(sum of cols.	
			instructions)		ed Costs (see instructions)	9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
-	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(0	1	1.00
3.00	Total (sum of lines 1-2)	0	0	(0	1	3.00

	·			Francis Classification on t		11/14/2023 2:	TI DIII
				Expense Classification on V To/From Which the Amount is t			
				10/11 om Willen ene Amount 13 e	o be Aujusteu		
	Cost Center Description	Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
	·	(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP		- 1	NEW CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXI			
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)						
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
4.00	discounts (chapter 8)		ď		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)						
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
7.00	stations excluded) (chapter		۷		0.00	U	7.00
	21)						
8.00	Television and radio service		0		0.00	0	8.00
	(chapter 21)						
9.00	Parking lot (chapter 21)		0		0.00	0	
10.00	Provider-based physician adjustment	A-8-2	-2,756,418			0	10.00
11.00	1 -		o		0.00	0	11.00
11.00	(chapter 23)		ď		0.00	Ü	11.00
12.00	Related organization	A-8-1	0			0	12.00
	transactions (chapter 10)					_	
13.00 14.00	1 1		0		0.00	0	
15.00	Cafeteria-employees and guests Rental of quarters to employee		0		0.00	0	1
13.00	and others		ď		0.00	O	13.00
16.00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than						
17.00	patients				0.00		17.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	1.		0		0.00	0	18.00
20.00	abstracts				3.33	· ·	=0.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
20.00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of		0		0.00	0	
21100	interest, finance or penalty		ď		0.00	Ü	
	charges (chapter 21)						
22.00	· ·		0		0.00	0	22.00
	overpayments and borrowings to						
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
23.00	therapy costs in excess of	7 0 3	ď	cost center bereted	03.00		23.00
	limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
	therapy costs in excess of						
25.00	limitation (chapter 14)		0	*** Cost Center Deleted ***	114.00		25.00
23.00	physicians' compensation		ď	cost center bereted	114.00		23.00
	(chapter 21)						
26.00	Depreciation - NEW CAP REL	1		NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT			FIXT	3 60	_	37.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		n	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		ő	50.000	0.00	0	
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
	therapy costs in excess of						
30 00	limitation (chapter 14)			ADULTS & DEDTATRICS	30.00		30.99
30.99	Hospice (non-distinct) (see instructions)		ال	ADULTS & PEDIATRICS	30.00		30.99

Health Financial Systems ADJUSTMENTS TO EXPENSES		THE OTIS R. E		Period:	u of Form CMS-2 Worksheet A-8	
				From 07/01/2022		
				то 06/30/2023	Date/Time Pre 11/14/2023 2:	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
	' - (a. d.					
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech	A-8-3		*** Cost Center Deleted ***		3.00	31.00
pathology costs in excess of		_				
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 PROMOTIONAL, PUBLIC RELATION,	A	-262,011	ADMINISTRATIVE & GENERAL	5.00	0	33.00
DONATI 33.01 PROMOTIONAL, PUBLIC RELATION,	A	_12 770	ADULTS & PEDIATRICS	30.00	0	33.01
DONATI	A	-13,770	ADOLIS & FEDIATRICS	30.00	0	33.01
33.02 PROMOTIONAL, PUBLIC RELATION,	A	-35,145	CLINIC	90.00	0	33.02
DONATI		,				
33.03 ADVERTISING - MARKETING	Α		ADMINISTRATIVE & GENERAL	5.00		
33.04 ADVERTISING - MARKETING	A	-14,986		90.00		33.04
33.05 INTEREST INCOME	В	-355,542	NEW CAP REL COSTS-BLDG &	1.00	11	33.05
35.00 RENTAL INCOME	В	-18,707	FIXT	90.00	0	35.00
36.00 MISC INCOME	В		ADMINISTRATIVE & GENERAL	5.00	0	
38.00 MISC INCOME	B		ADULTS & PEDIATRICS	30.00	0	38.00
39.00 SALE OF MEDICAL RECORDS	В		MEDICAL RECORDS & LIBRARY	16.00	0	
40.00 MISC INCOME	В	-2,489	CLINIC	90.00	0	40.00
41.00 HOSPITAL ASSESSMENT FEE	В	-1,377,511	ADULTS & PEDIATRICS	30.00	0	41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
(3)						
50.00 TOTAL (sum of lines 1 thru 49))	-5,234,795				50.00
(Transfer to Worksheet A,						
column 6, line 200.) (1) Description - all chapter refere						

⁽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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER

Provider CCN: 15-4014 Period: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

							10 06/30/2023	11/14/2023 2:	
	Wkst. A Line #	Cost	Center/Physician	Total	Professional	Provider	RCE Amount	Physician/Prov	
			Identifier	Remuneration	Component	Component		ider Component	
								Hours	
	1.00		2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS &	PEDIATRICS	627,484	594,435	33,049	181,300	121	1.00
2.00	90.00	CLINIC		2,200,947	2,063,448	137,499	181,300	677	2.00
3.00	0.00			0	0	0	0	0	3.00
4.00	0.00			0	0	0	0	0	4.00
5.00	0.00			0	0	0	0	0	5.00
6.00	0.00			0	0	0	0	0	6.00
7.00	0.00			0	0	0	0	0	7.00
8.00	0.00			0	0	0	0	0	8.00
9.00	0.00			0	0	0	0	0	9.00
10.00	0.00			0	0	0	0	0	10.00
200.00				2,828,431					200.00
	Wkst. A Line #		Center/Physician	Unadjusted RCE		Cost of	Provider	Physician Cost	
			Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
					Limit	Continuing	Share of col.	Insurance	
						Education	12		
	1.00		2.00	8.00	9.00	12.00	13.00	14.00	
1.00			PEDIATRICS	10,547		6,505	343		1.00
2.00		CLINIC		59,010	2,951	33,830		0	2.00
3.00	0.00			0	0	0	0	0	3.00
4.00	0.00			0	0	0	0	0	4.00
5.00	0.00			0	0	0	0	0	5.00
6.00	0.00			0	0	0	0	0	6.00
7.00	0.00			0	0	0	0	0	7.00
8.00	0.00			0	0	0	0	0	8.00
9.00	0.00			0	0	0	0	0	9.00
10.00	0.00			0	0	0	0	0	10.00
200.00				69,557				0	200.00
	Wkst. A Line #		Center/Physician	Provider	Adjusted RCE	RCE	Adjustment		
			Identifier	Component	Limit	Disallowance			
				Share of col.					
	1 00		2.00	14 15.00	16.00	17.00	18.00		
1.00	1.00	ADULTE 8	PEDIATRICS	15.00	10,890				1.00
2.00		CLINIC	PEDIATRICS	0	61,123				2.00
3.00	0.00			0	01,123	70,370	2,139,824		3.00
4.00	0.00			0	0	0	0		4.00
5.00	0.00			0	0	0	0		5.00
6.00	0.00			0	0	0	0		6.00
7.00	0.00					0			7.00
8.00	0.00					0	0		8.00
9.00	0.00				0	0	0		9.00
10.00	0.00					0	0		10.00
200.00	0.00				72,013	98,535	2,756,418		200.00
200.00	I	I		1	1 /2,013	30,333	2,730,418		200.00

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-4014	Period: Worksheet B

	ELECTION GENERAL SERVICE COSTS		riovidei c	F	rom 07/01/2022 o 06/30/2023	Part I Date/Time Pre 11/14/2023 2:	
			CAPITAL				
	Cost Conton Description	Not Evenences	RELATED COSTS	EMBL OVEE	Subtotal	ADMINITCED ATTV	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	
		Allocation	LIVI	DEPARTMENT		E & GENERAL	
		(from Wkst A		DEFARIMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1	1				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13,276,613	1	13,276,614			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	19,956,845	0	2,392,441	22,349,286	22,349,286	5.00
7.00	00700 OPERATION OF PLANT	854,070	0	175,123	1,029,193	306,280	7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	322,470	0	67,321	389,791	115,999	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,488,445	0	904,252	4,392,697	1,307,231	30.00
	ANCILLARY SERVICE COST CENTERS						
	06000 LABORATORY	91,765		0	91,765	27,309	60.00
	07300 DRUGS CHARGED TO PATIENTS	227,068	0	0	227,068	67,574	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	10,338,218		, , , , ,	12,209,544	3,633,463	
90.01	09001 PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
	OTHER REIMBURSABLE COST CENTERS				_		
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS	40 555 405	1	F 410 463	40, 600, 344	F 457 056	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	48,555,495	1	5,410,463	40,689,344	5,457,856	1118.00
102 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
	19201 RESIDENTIAL	32,835,275	0	5,649,744	38,485,019		
	19202 MRO	4,500,268	0	708,217	5,208,485	1,550,003	
	19203 METHODONE CLINIC	4,300,200	0	700,217	3,200,403		192.03
	19204 FOHC	7,808,152	0	1,281,167	9,089,319		
	19205 BRC	1,952,595	0	227,023			
	19206 BUSINESS RENTAL	1,797,803	0	227,023	1,797,803	,	
	07950 RENTAL SPACE	1,737,803	0		1,757,803		194.00
200.00		0	0	٥	0	0	200.00
201.00			0	0	0	0	201.00
202.00		97,449,588	1	13,276,614	97,449,588		
	i i i i i i i i i i i i i i i i i i i	3.,113,300			5.,115,500	,5.5,200	1-0-100

lealth Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/14/2023 2:	pared: 41 pm
Cost Center Description	OPERATION OF PLANT	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	7.00	16.00	24.00	25.00	26.00	

						11/14/2023 2:	41 pm
	Cost Center Description	OPERATION OF	MEDICAL	Subtotal	Intern &	Total	
		PLANT	RECORDS &		Residents		
			LIBRARY		Cost & Post		
					Stepdown		
					Adjustments		
		7.00	16.00	24.00	25.00	26.00	
-	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	1,335,473					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	37,282	543,072				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	62,023	30,513	5,792,464	0	5,792,464	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	0	119,074	0	119,074	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	294,642	0	294,642	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	410,244	116,883	16,370,134	0	16,370,134	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0	0	0	0	90.01
	OTHER REIMBURSABLE COST CENTERS						
102.00	0 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	509,549	147,396	22,576,314	0	22,576,314	118.00
	NONREIMBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	1 19201 RESIDENTIAL	81,184	288,997	50,308,069	0	50,308,069	
	2 19202 MRO	69,050	50,829	6,878,367	0	6,878,367	
	3 19203 METHODONE CLINIC	0	0	0	0		192.03
	4 19204 FQHC	146,656	42,270	11,983,154	0	11,983,154	192.04
192.0	5 19205 BRC	60,036	13,580	2,901,871	0	2,901,871	192.05
192.0	5 19206 BUSINESS RENTAL	0	0	2,332,815	0	2,332,815	192.06
194.00	07950 RENTAL SPACE	468,998	0	468,998	0	468,998	194.00
200.00	Cross Foot Adjustments			0	0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,335,473	543,072	97,449,588	0	97,449,588	202.00

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-4014 Period: Worksheet B From 07/01/2022 Part II

06/30/2023 Date/Time Prepared: 11/14/2023 2:41 pm CAPITAL RELATED COSTS ADMINISTRATIV Cost Center Description Directly NEW BLDG & Subtotal EMPLOYEE Assigned New **BENEFITS** F & GENERAL FTXT Capital DEPARTMENT Related Costs 1.00 2A 4.00 5.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 413,095 0 413,095 0 413,095 5.00 00700 OPERATION OF PLANT 5,662 7.00 0 7.00 0 0 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 0 0 2,144 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 189,282 0 189,282 0 24,164 30.00 ANCILLARY SERVICE COST CENTERS 60.00 | 06000 | LABORATORY 0 0 0 0 505 60.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,249 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 | 09000 CLINIC 444,381 444,381 0 67,165 90.00 09001 PARTIAL HOSPITALIZATION 90.01 90.01 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1,046,758 1 1,046,759 0 100,889 118.00 NONREIMBURSABLE COST CENTERS 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 192.01 19201 RESIDENTIAL 942,937 0 942,937 1 211,674 192.01 28,652 192.02 0 192.02 19202 MRO 193,250 0 193,250 192.03 19203 METHODONE CLINIC 0 192.03 0 0 0 50,000 192.04 192.04 19204 FQHC 353,696 0 353,696 0 192.05 19205 BRC 103,274 0 103,274 0 11,990 192.05 0 9,890 192.06 192.06 19206 BUSINESS RENTAL 0 483,718 0 0 194.00 194.00 07950 RENTAL SPACE 0 483,718 200.00 Cross Foot Adjustments 0 200.00 0 201.00 201.00 Negative Cost Centers 0 0 0 202.00 3,123,634 413,095 202.00 TOTAL (sum lines 118 through 201) 3.123.633

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu of Form CMS-2552		
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-4014	Period:	Worksheet B	

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/14/2023 2:	
	Cost Center Description	OPERATION OF	MEDICAL	Subtotal	Intern &	Total	
		PLANT	RECORDS &		Residents		
			LIBRARY		Cost & Post		
					Stepdown		
					Adjustments		
		7.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	Г		Т	T		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	5,662					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	158	2,302				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	263	127	213,83	6 0	213,836	30.00
	ANCILLARY SERVICE COST CENTERS						
	06000 LABORATORY	0	0	50		505	
	07300 DRUGS CHARGED TO PATIENTS	0	0	1,24		1,249	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	1,739	488			513,773	
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0	0	90.01
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1	2,160	615	729,36	3 0	729,363	118.00
	NONREIMBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
	19201 RESIDENTIAL	344	1,242	1,156,19		1,156,198	
	19202 MRO	293	212	222,40	7 0	222,407	
	19203 METHODONE CLINIC	0	0		0		192.03
	19204 FQHC	622	176	404,49	4 0	404,494	
192.05	19205 BRC	255	57	115,57	6 0	115,576	192.05
	19206 BUSINESS RENTAL	0	0	9,89		. ,	192.06
	07950 RENTAL SPACE	1,988	0	485,70	6 0	485,706	
200.00					0		200.00
201.00	Negative Cost Centers	0	0		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,662	2,302	3,123,63	4 0	3,123,634	202.00

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-4014	Period: Worksheet B	-1		

From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/14/2023 2:41 pm CAPITAL RELATED COSTS OPERATION OF Cost Center Description NEW BLDG & **EMPLOYEE** Reconciliatio ADMINISTRATIV **RENEFTTS** E & GENERAL PI ANT FTXT n (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) (GROSS COST) FEET) SALARIES) 1.00 4.00 5A 5.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 470,666 1.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,000 64,749,636 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 21,275 11,667,881 -22,349,286 75,100,302 5.00 7.00 1,500 1,029,193 00700 OPERATION OF PLANT 854,070 444,891 7.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 12,420 328,321 0 389,791 12,420 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 20,662 4,410,015 0 4,392,697 20.662 30.00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS 60.00 06000 LABORATORY 0 0 91,765 0 60.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 227,068 0 73.00 77.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 136,666 9,126,416 0 12,209,544 136,666 90.00 09000 CLINIC 90.01 09001 PARTIAL HOSPITALIZATION 0 90.01 0 0 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS -22,349,286 169,748 118.00 195,523 26,386,703 18,340,058 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 192.01 19201 RESIDENTIAL 27,045 27,553,569 38,485,019 27,045 192.01 23,003 192.02 192.02 19202 MRO 23,003 0 5,208,485 3,453,957 192.03 19203 METHODONE CLINIC 0 0 192.03 192.04 19204 FQHC 48,856 6,248,223 0 9,089,319 48,856 192.04 1,107,184 20,000 192.05 192.05 19205 BRC 0 2,179,618 20,000 192.06 19206 BUSINESS RENTAL 0 0 192.06 1,797,803 0 194.00 07950 RENTAL SPACE 156,239 0 156,239 194.00 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 1,335,473 202.00 202.00 Cost to be allocated (per Wkst. B, 1 13,276,614 22.349.286 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000002 0.205045 0.297592 3.001798 203.00 Cost to be allocated (per Wkst. B, 413,095 5,662 204.00 204.00 Part II) 0.012727 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.005501 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lieu	ı of Form CMS-25!	52-10
COST ALLOCATION - STATISTICAL BASIS		Provider	CCN: 15-4014	From 07/01/2022		
				To 06/30/2023	Date/Time Prepa 11/14/2023 2:41	rea: L pm
Cost Center Description	MEDICAL					

			1	From 07/01/2022	
				To 06/30/2023	Date/Time Prepared:
					11/14/2023 2:41 pm
	Cost Center Description	MEDICAL			
	·	RECORDS &			
		LIBRARY			
		(GROSS			
		REVENUE)			
		16.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
	01600 MEDICAL RECORDS & LIBRARY	151 100 246			16.00
10.00		151,100,246			10.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0 400 111			30.00
30.00	03000 ADULTS & PEDIATRICS	8,490,111			30.00
	ANCILLARY SERVICE COST CENTERS				
	06000 LABORATORY	0			60.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			77.00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	32,521,700			90.00
90.01	09001 PARTIAL HOSPITALIZATION	0			90.01
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0			102.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41,011,811			118.00
	NONREIMBURSABLE COST CENTERS	, , , , , ,			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0			192.00
	19201 RESIDENTIAL	80,406,020			192.01
	19202 MRO	14,142,863			192.02
	19203 METHODONE CLINIC	0			192.03
	19204 FOHC	11,761,171			192.04
	19205 BRC	3,778,381			192.05
	19206 BUSINESS RENTAL	0,776,361			192.06
	07950 RENTAL SPACE	0			194.00
200.00		U			200.00
201.00	-5	542 072			201.00
202.00	1 7	543,072			202.00
	Part I)				
203.00		0.003594			203.00
204.00		2,302			204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0.000015			205.00
	II)				
206.00	NAHE adjustment amount to be allocated				206.00
	(per Wkst. B-2)				
207.00	NAHE unit cost multiplier (Wkst. D,				207.00
	Parts III and IV)				
	· · · · · ·				•

Health	Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/14/2023 2:	
			Title	XVIII	Hospital	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Disallowance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,792,464		5,792,4	22,159	5,814,623	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	119,074		119,0	74 0	119,074	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	294,642		294,6	12 0	294,642	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	16,370,134		16,370,1	76,376	16,446,510	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0			0	0	90.01
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0			0	0	102.00
200.00	Subtotal (see instructions)	22,576,314	0	22,576,3	L4 98,535	22,674,849	200.00
201.00	Less Observation Beds	0		1	0		201.00
202.00	Total (see instructions)	22,576,314	0	22,576,3	L4 98,535	22,674,849	202.00

Health	Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2022 To 06/30/2023		
				XVIII	Hospital	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8,490,111		8,490,11	1		30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	128,343	0	128,34	3 0.927779	0.000000	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	317,687	0	317,68	7 0.927460	0.000000	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	32,521,700	32,521,70	0.503360	0.000000	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0.000000	0.000000	90.01
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
200.00	Subtotal (see instructions)	8,936,141	32,521,700	41,457,84	1		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,936,141	32,521,700	41,457,84	1		202.00

Health Financial Systems	THE OTIS R. BOW	EN CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4014	Period: From 07/01/2022	Worksheet C Part I	
			To 06/30/2023	Date/Time Pre	
				11/14/2023 2:	41 pm_
		Title XVIII	Hospital	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY	0.927779				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.927460				73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.505709				90.00
90.01 09001 PARTIAL HOSPITALIZATION	0.000000				90.01
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOID TREATMENT PROGRAM					102.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023		pared: 41 pm
		Titl	e XIX	Hospital	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj.		Disallowance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	5,792,464		5,792,46	22,159	5,814,623	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	119,074		119,07	'4 0	119,074	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	294,642		294,64	12 0	294,642	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	16,370,134		16,370,13	76,376	16,446,510	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0			0	0	90.01
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0			0	0	102.00
200.00 Subtotal (see instructions)	22,576,314	0	22,576,31	98,535	22,674,849	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	22,576,314	0	22,576,31	98,535	22,674,849	202.00

Health	Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2022 To 06/30/2023		
				e XIX	Hospital	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8,490,111		8,490,11	1		30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	128,343	0	128,34	3 0.927779	0.000000	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	317,687	0	317,68	7 0.927460	0.000000	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0.000000	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	32,521,700	32,521,70	0.503360	0.000000	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0.000000	0.000000	90.01
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
200.00	Subtotal (see instructions)	8,936,141	32,521,700	41,457,84	1		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,936,141	32,521,700	41,457,84	1		202.00

Health Financial Systems	THE OTIS R. BOW	/EN CENTER	In Lie	of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4014	Period: From 07/01/2022 To 06/30/2023		ared:
		Title XIX	Hospital	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY	0.000000				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000				90.00
90.01 09001 PARTIAL HOSPITALIZATION	0.000000				90.01
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOID TREATMENT PROGRAM				1	L02.00
200.00 Subtotal (see instructions)				2	200.00
201.00 Less Observation Beds				2	201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023		pared: 41 pm
		Title	XVIII	Hospital	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	213,836 213,836		213,83 213,83			30.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	-	3		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	502	·	1			30.00
200.00 Total (lines 30 through 199)	502	23,544				200.00

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 11/14/2023 2:	
			XVIII	Hospital	PPS	
Cost Center Description	Capital	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	505	128,343	0.00393	5 1,716	7	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,249	317,687	0.00393	27,592	108	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	513,773	32,521,700	0.01579	8 0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0	0	0.00000	0	0	90.01
200.00 Total (lines 50 through 199)	515,527	32,967,730		29,308	115	200.00
90.00 09000 CLINIC 90.01 09001 PARTIAL HOSPITALIZATION	0	0	0.00000	0	0 0 115	90.01

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 07/01/2022 To 06/30/2023		epared: :41 pm
			XVIII	Hospital	PPS	
Cost Center Description	Nursing Program Post-Stepdown	Nursing Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>		
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	4,55			30.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30.00

Health	Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023		pared: 41 pm
				XVIII	Hospital	PPS	
	Cost Center Description	Non Physician	Nursing	Nursing	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						
60.00	06000 LABORATORY	0	0		0 0	0	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0	0	90.01
200.00	Total (lines 50 through 199)	0	0		0	0	200.00

Health	Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period: From 07/01/2022	Worksheet D Part IV	
THROUG	H COSTS				To 06/30/2023		pared: 41 pm
			Title	XVIII	Hospital	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0	0		0 128,343	0.000000	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 317,687	0.000000	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 32,521,700	0.000000	90.00
90.01	09001 PARTIAL HOSPITALIZATION	0	0		0	0.000000	90.01
200.00	Total (lines 50 through 199)	0	0		0 32,967,730		200.00
		•		•			

Health Financial Systems	THE OTIS R. BO	WEN CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provider Co	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospital	PPS	
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	0.000000	1,716		0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	27,592		0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0		0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0		0 531,364	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION	0.000000	0		0	0	90.01
200.00 Total (lines 50 through 199)		29,308		0 531,364	0	200.00

Health Finar	ncial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-4014	Period: From 07/01/2022 To 06/30/2023		nared:
						11/14/2023 2:	
			Title	XVIII	Hospital	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
			Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.			. Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCIL	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0.927779	0		0	0	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.927460	0		0	0	73.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0		0	0	77.00
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0.503360	531,364		0 0	267,467	90.00
90.01 09001	PARTIAL HOSPITALIZATION	0.000000	0		0	0	90.01
200.00	Subtotal (see instructions)		531,364		0	267,467	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		531,364		0 0	267,467	202.00

Health Financ	ial Systems	THE OTIS R. B	OWEN CENTER		In Lie	of Form CMS-	2552-10
APPORTIONMENT	T OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-4014	Period: From 07/01/2022	Worksheet D Part V	
					то 06/30/2023	Date/Time Pre 11/14/2023 2:	
			Title	XVIII	Hospital	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ARY SERVICE COST CENTERS						
	LABORATORY	0	0				60.00
	DRUGS CHARGED TO PATIENTS	0	0				73.00
77.00 07700 A	ALLOGENEIC HSCT ACQUISITION	0	0				77.00
	IENT SERVICE COST CENTERS						1
90.00 09000		0	0				90.00
	PARTIAL HOSPITALIZATION	0	0				90.01
	Subtotal (see instructions)	0	0				200.00
	Less PBP Clinic Lab. Services-Program	0					201.00
1 1	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		From 07/01/2022	Worksheet D-1 Date/Time Prepared: 11/14/2023 2:41 pm

		Ti+lo W/TTT	Hocni+al	11/14/2023 2:	41 pm
	Cost Center Description	Title XVIII	Hospital	PPS	
	cost conten sesser sperson			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS			4 550	1 00
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-	, ,		4,559 4,559	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days	4,339	3.00
3.00	do not complete this line.	lys). If you have only pr	Tvace Toom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		4,559	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	. 0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	m days) +hmaysh Dasamhay	21 of the cost	0	7.00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through becember	31 OF THE COST	U	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m davs) after December	R1 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 t	o the Program (excluding	g swing-bed and	502	9.00
	newborn days) (see instructions)	- 4 - 1			
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		ce room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT		l	0	10.00
17.00		es through December 31 o	of the cost	0.00	17.00
	reporting period	3			
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
10.00	reporting period			0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
20.00	reporting period	s areer becomber 31 or	life cose	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	is)		5,814,623	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	. 0	22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost report	ing period (line	0	24.00
24.00	7 x line 19)	i si or the cost report	ing period (Tine	v	24.00
25.00		31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
26.00				0	
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5,814,623	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ud and observation had ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	d and observation bed th	iai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	71 77		0.00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line $34 \times 1i$) Private room cost differential adjustment (line $3 \times 1i$) Average per diem private room cost differential adjustment (line $3 \times 1i$) Private room cost differential adjustment (line $3 \times 1i$) Private room cost differential adjustment (line $3 \times 1i$) Private room cost differential (line 3	ne si)		0.00	35.00 36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
27.00	27 minus line 36)	p acc room cost u		5,017,023	300
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			1,275.42	
39.00	3 3 1			640,261	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 640,261	
71.00	Trocar frogram general impactent foutthe service cost (fille 35	1 THE 40)	I	040,201	71.00

	Financial Systems ATION OF INPATIENT OPERATING COST	THE OTIS R. B		CN: 15-4014	Period:	u of Form CMS-1 Worksheet D-1	
					From 07/01/2022 To 06/30/2023		
			-1.7			11/14/2023 2:	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	·	Inpatient	Inpatient	Diem (col. 3	ı İ	(col. 3 x	
		Cost 1.00	Days 2.00	÷ col. 2)	4.00	col. 4) 5.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wk					27,182	48.00
	Program inpatient cellular therapy acquisiti				, column 1)	0	
19.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.	01)(see instru	uctions)		667,443	49.00
0.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	23,544	50.00
51 00	III) Pass through costs applicable to Program inp	atient ancilla	rv services (f	From Wkst D	sum of Parts II	115	51.00
	and IV)		1, 30, 1,000	TO MASEL D,	34m 01 141 C3 11		
52.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		olated non-nh	veician anost	hotist and	23,659 643,784	
33.00	medical education costs (line 49 minus line		eraceu, non-pi	iysician anest	meerse, and	043,784] 33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge		0.00	54.00			
	Permanent adjustment amount per discharge			55.01			
	Adjustment amount per discharge (contractor			55.02			
	Target amount (line 54 x sum of lines 55, 55	1-ma [2]	0				
58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	11ne 53)	0				
	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,						59.00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by th						60.00
	market basket)					0.00	
61.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61.00
	53) are less than expected costs (lines 54 x						
62 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
C4 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ta thursel Bas	21 -£ +1		iid (C	0	64.00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dec	ember 31 of tr	ie cost report	ing period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reportin	g period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost r	eporting period	0	67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	3				0	68.00
00.00	(line 13 x line 20)	e costs after	December 31 01	the cost rep	of cring per rou	0	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil)		70.00
	Adjusted general inpatient routine service c		line 70 ÷ line	2)			71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x l	line 35)			72.00
	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B,	Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	76)					77.00
	Inpatient routine service cost (line 74 minu		anaud da :	ada)			78.00
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79.00
	Inpatient routine service costs for comp		cost rimitatil	(TINE 70 IIII	1143 THE 13)		81.00
82.00	Inpatient routine service cost limitation (1	ine 9 x line 8					82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84.00
	, o c	COCC INSCIUCTI					

85.00 86.00

0 87.00

0.00 88.00

85.00 Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

88.00 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

87.00 Total observation bed days (see instructions)

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023	Date/Time Pre 11/14/2023 2:	
		Title	XVIII	Hospital	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	213,836	5,814,623	0.03677	6 0	0	90.00
91.00 Nursing Program cost	0	5,814,623	0.00000	0	0	91.00
92.00 Allied health cost	0	5,814,623	0.00000	0	0	92.00
93.00 All other Medical Education	o	5,814,623	0.00000	0 0	0	93.00

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-4014	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/14/2023 2:41 pm
	-1.1		

		Title XIX	Hospital	Cost	11 piii
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			4,559 4,559	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days	4,339	3.00
	do not complete this line.	, o, i i i , ou c c, p.	, ,		3.00
4.00	Semi-private room days (excluding swing-bed and observation b			4,559	
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) areer becomber	JI OF CHE COSE	Ĭ	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
3.00	reporting period	m days) after December 3)1 of the cost	0	8.00
3.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) arter becember s	of of the cost	U	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	245	9.00
	newborn days) (see instructions)			_	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11.00			room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	ce room days)	0	12.00
13.00	through December 31 of the cost reporting period	V only (including privat	a noom days)	0	13.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			U	13.00
L4.00	, , , ,			0	14.0
15.00				0	15.0
6.00	, , ,			0	16.0
7 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	es through December 31 c	of the cost	0.00	17.0
.,.00	reporting period	es em ough becember 51 c	in the cost	0.00	17.0
8.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0
	reporting period			0.00	10.0
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	tne cost	0.00	19.00
20.00	, , , , , , , , , , , , , , , , , , , ,	s after December 31 of t	the cost	0.00	20.00
	reporting period				
21.00	,			5,792,464	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 line 17)	er 31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23.00
	x line 18)				
24.00		r 31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25.00
23.00	x line 20)	or the cost reporting	, per rou (Trile o		23.00
26.00	, ,			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5,792,464	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	narges)	0	28.00
29.00		a and observation bed er	iai ges)	0	
30.00				0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	rtions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5,792,464	37.0
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
88.00	Adjusted general inpatient routine service cost per diem (see			1,270.56	38.0
	Program general inpatient routine service cost (line 9 x line			311,287	
	Medically necessary private room cost applicable to the Progr			211 207	
+1.00	Total Program general inpatient routine service cost (line 39	+ IIIIe 40)		311,287	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	THE OTIS R. B	Provider (CCN: 15-4014	Period:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2022 To 06/30/2023		
			Ti+	le XIX	Hospital	11/14/2023 2: Cost	41 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42.0
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.0
	CORONARY CARE UNIT						44.0
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1 00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			1.00	48.0
	Program inpatient cellular therapy acquisiti				, column 1)	0	1
9.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	uctions)		311,287	49.0
0.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sur	n of Parts I and	0	50.0
1.00	III) Pass through costs applicable to Program inp	ationt ancilla	ry sorvices (t	From What D	sum of Barts II	0	51.0
1.00	and IV)	attent antitia	ry services (i	TIOIII WKSC. D, S	Sum of Parts II	U	31.0
	Total Program excludable cost (sum of lines		7			0	
3.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-pr	nysician anestr	netist, and	0	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0 00	54.0
	Permanent adjustment amount per discharge						55.0
	Adjustment amount per discharge (contractor	use only)					55.0
	Target amount (line 54 x sum of lines 55, 55					0	1
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and to	arget amount ((line 56 minus	Tine 53)	0	1
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	m the cost rep	orting period	ending 1996,	0.00	
	updated and compounded by the market basket)						
0.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 tro	om prior year	cost report, i	ipdated by the	0.00	60.0
51.00	Continuous improvement bonus payment (if lin					0	61.0
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 \times						
	enter zero. (see instructions)	,, // .			,,		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instr	uctions)			0	1
3.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistri	uccions)				03.0
54.00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	ing period (See	0	64.0
5.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Deceml	ber 31 of the	cost reporting	g period (See	0	65.0
	instructions)(title XVIII only)	ma sasta (lina	64 mlus lima	65) (+i+] o)(///	rr amly), for	0	66.0
00.00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (Tine	64 plus line	65)(LILIE XVII	ii only); lor	0	66.0
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through	h December 31	of the cost re	eporting period	0	67.0
8.00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after I	December 31 of	f the cost rend	orting period	0	68.0
	(line 13 x line 20)			•	or ering per roa	Ü	00.0
9.00	Total title V or XIX swing-bed NF inpatient					0	69.0
0.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.0
	Adjusted general inpatient routine service c		line 70 ÷ line	2)			71.0
	Program routine service cost (line 9 x line	•	m (line 14 v l	lino 25)			72.0
	Medically necessary private room cost applic Total Program general inpatient routine serv						74.0
	Capital-related cost allocated to inpatient				Part II, column		75.0
6.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
	Program capital-related costs (line 73 - 11						77.0
8.00	Inpatient routine service cost (line 74 minu	s line 77)					78.0
	Aggregate charges to beneficiaries for exces						79.
	Total Program routine service costs for comp		cost limitatio	on (line 78 mir	nus line 79)		80.
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (1		1)				81.
	Reasonable inpatient routine service costs (83.
4.00	Program inpatient ancillary services (see in	structions)					84.
- 00	Utilization review - physician compensation						85

85.00 86.00

0 87.00

0.00 88.00

85.00 Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

88.00 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Total observation bed days (see instructions)

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
		Titl	e XIX	Hospital	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	213,836	5,792,464	0.03691	6 0	0	90.00
91.00 Nursing Program cost	0	5,792,464	0.00000	0	0	91.00
92.00 Allied health cost	0	5,792,464	0.00000	0	0	92.00
93.00 All other Medical Education	0	5,792,464	0.00000	0 0	0	93.00

Health Financial Systems	THE OTIS R. BOWEN CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 07/01/2022 To 06/30/2023		pared:
	Title	XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS			900,679		30.00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY		0.92777	9 1,716	1,592	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.92746	0 27,592	25,590	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC		0.50570	9 0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION		0.00000	0	0	90.01
200.00 Total (sum of lines 50 through 94 and	96 through 98)		29,308	27,182	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			29,308		202.00

Health Financial Systems	THE OTIS R. BOWEN CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN		Period: From 07/01/2022	Worksheet D-3	
			то 06/30/2023	Date/Time Pre 11/14/2023 2:	
	Title	XIX	Hospital	Cost	
Cost Center Description	R	atio of Cost	Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS			440,954		30.00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY		0.927779	9 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.927460	0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC		0.503360	0	0	90.00
90.01 09001 PARTIAL HOSPITALIZATION		0.00000	0	0	90.01
200.00 Total (sum of lines 50 through 94 and	96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00
	'				

PART B - MEDICAL AND OTHER HEALTH SERVICES
PART B - MEDICAL AND OTHER HEALTH SERVICES
1.00 Medical and other services (see instructions) 0 1.20.0 Medical and other services erimbursed under OPPS (see instructions) 270,992 3.00 0.00
2.00 Medical and other services reimbursed under OPPS (see instructions) 267,467 2, 270,992 3, 3, 3, 3, 3, 3, 3, 5, 3, 6, 3, 6, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,
3.00 OPPS Or REH payments 270,992 3.4
4.01 Outlier reconciliation amount (see instructions) 0.000 5.00 1.0
5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.
Line 2 times line 5 0 6.
Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.
Transitional corridor payment (see instructions) 0 8.
9,00 Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200 0 0 10.
11.00 Total cost (sum of lines 1 and 10) (see instructions) 0 11.
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Total reasonable charges (from wkst. D-4, Pt. III, col. 4, line 69) 13.10 Total reasonable charges (sum of lines 12 and 13) 14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 Total reasonable charges 14.00 Total reasonable charges 14.00 Total reasonable charges 14.00 Total reasonable charges 15.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 15.00 Total customary charges (from patients liable for payment for services on a chargebasis 0 16.00 Total customary charges (see instructions) 0.000000 17.00 Total customary charges (see instructions) 0.000000 17.00 Total customary charges (see instructions) 18.00 Total customary charges (see instructions) 18.00 Total customary charges (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 19.00
Reasonable charges 12.00 Agrillary service charges (from wkst. D-4, Pt. III, col. 4, line 69) 12.01 Agreement of the charges (sum of lines 12 and 13) 12.02 Agreement actually collected from patients liable for payment for services on a charge basis 13.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 14.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 16.01 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17.00 Ratio of line 15 to line 16 (not to exced 1.000000) 18.00 Total customary charges (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 19.00 Excess of charges (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 19.00 Excess of charges (see instructions) 20.00 Excess of cases and coinsurance amounts (for CAH, see instructions) 20.00 Excess of cases and coinsurance amounts (for CAH, see instructions) 20.00 Excess of cases and coinsurance
12.00 Ancillary service charges 0 12.
13.00 Organ acquisition charges (from wkst. D-4, Pt. III, col. 4, line 69) 0 13.
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15. 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 15. 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17. 18.00 Total customary charges (see instructions) 0.000000 18. 18.00 Total customary charges (see instructions) 0.000000 18. 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.000000 19. 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.000000 19. 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 0.000000 19. 18.00 Total customary charges (see instructions) 0.000000 19. 18.00 Total customary charges (see instructions) 0.000000 19. 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 0.000000 19. 19.00 Lesser of cost or charges (see instructions) 0.0000000 19. 19.00 Lesser of cost or charges (see instructions) 0.0000000000000000000000000000000000
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 10. 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 10. 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 10. 16. 17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 18. 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 10.01 Exsers of cost or charges (see instructions) 10.02 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 10.02 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are completed only if line 11 exceeds line 18) (see instructions) are constructed only if line 11 exceeds line 18) (see instructions)
had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Excess of customary charges (see instructions) 20.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.01 Interns and residents (see instructions) 23.02 Cost of physicians' services in a teaching hospital (see instructions) 24.03 Cost of physicians' services in a teaching hospital (see instructions) 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts (for CAH, see instructions) 270.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 20.10 Primary payer payment 20.10,670 21.10 Deductibles and coinsurance amounts 22.20 Composite rate ESRD (from Wkst. E-4, line 36) 28.20 Direct graduate medical education costs (from Wkst. E-4, line 36) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 20.00 Primary payer payments 20.00 Deductibles and coinsurance amounts 20.00 Deductibles and coinsurance amounts 20.00 Subtotal (ine 30 minus line 31) 20.00 Subtotal (ine 30 minus line 31) 20.00 Subtotal (ine 30 minus line 31) 20.01 Composite rate ESRD (from Wkst. E-5, line 11) 20.01 Subtotal (ine 30 minus line 31) 20.02 Subtotal (ine 30 minus line 31) 20.03 Subtotal (see instructions) 20.04 June debts (see instructions) 20.05 June development adjustment (see instructions) 20.06 June development adjustment (see instructions) 20.07 Subtotal (see instructions) 20.0
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17. 18.00 18. 19.00 Excess of customary charges (see instructions) 18. 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10
18.00 Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 22.01 Interns and residents (see instructions) 23.02 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 28.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.50 REH facility payment amount 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 20.10 Primary payer payments 20.10 Primary payer payments 20.10 Allowable bad debts (see instructions) 20.10 Allowable bad debts (see instructions) 31.00 Adjusted reimbursable bad debts (see instructions) 32.00 Subtotal (see instructions) 33.00 Adjusted reimbursable bad debts (see instructions) 34.00 Allowable bad debts (see instructions) 35.00 Subtotal (see instructions) 36.00 Allowable bad debts (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.57 Pioneer ACO demonstration payment adjustment (see instructions) 39.57 Pioneer ACO demonstration payment adjustment (see instructions) 39.57 Pioneer ACO demonstration payment adjustment (see instructions)
Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.01 Interns and residents (see instructions) 22.02 (cost of physicians' services in a teaching hospital (see instructions) 22.03 (cost of physicians' services in a teaching hospital (see instructions) 22.04 (computation of REIMBURSEMENT SETTLEMENT) 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from wkst. E-4, line 50) 28.00 Direct graduate medical education costs (from wkst. E-4, line 50) 29.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 Adjusted reimbursable bad debts (see instructions) 33.00 (COSMOSILE (See instructions) 34.00 Allowable bad debts (see instructions) 35.00 Allowable bad debts (see instructions) 36.00 Allowable bad debts (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.75 N95 respirator payment adjustment decent amount (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions)
instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 22.300 Cost of physicians' services in a teaching hospital (see instructions) 22.400 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 270, 992 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts (for CAH, see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.50 REH facility payment amount 29.00 ESRD direct medical education costs (from Wkst. E-4, line 50) 29.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 30.00 Subtotal (line 30 minus line 31) 31.00 Primary payer payments 32.00 Omposite rate ESRD (from Wkst. I-5, line 11) 33.00 ALLOWABLE BAD DEBTS EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 31.00 Omposite rate ESRD (from Wkst. I-5, line 11) 32.00 Allowable bad debts (see instructions) 33.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.50 Prioneer ACO demonstration payment adjustment (see instructions) 39.50 Prioneer ACO demonstration payment adjustment (see instructions) 39.57 N95 respirator payment adjustment (see instructions) 39.57 N95 respirator payment adjustment (see instructions) 39.58
instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 22.01 Interns and residents (see instructions) 22.02 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 22.02 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 22.03 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 22.04 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 28.00 Direct graduate medical education payments (from wkst. E-4, line 50) 28.00 ESRO direct medical education costs (from wkst. E-4, line 50) 29.00 ESRO direct medical education costs (from wkst. E-4, line 36) 20.01 Subtotal (sum of lines 27, 28, 28.50 and 29) 20.02 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 20.03 Adjusted reimbursable bad debts (see instructions) 30.04 Allowable bad debts (see instructions) 31.05 Subtotal (see instructions) 32.06 Allowable bad debts (see instructions) 33.07 ON MSP-LCC reconciliation amount from PS&R 33.00 ON MSP-LCC reconciliation amount from PS&R 34.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 35.07 N95 respirator payment adjustment (see instructions) 35.08 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 36.09 Allowable bad debts demanded to the subtructions) 37.00 Subtotal (see instruction payment adjustment demand (see instructions) 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.75 N95 respirator payment adjustment amount (see instructions)
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23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 270,992 24. COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 25.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 Direct graduate medical education costs (from Wkst. E-4, line 50) Direct graduate medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 31.00 Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9 ioneer ACO demonstration payment adjustment (see instructions) 39.75 respirator payment adjustment (see instructions) 39.75 respirator payment adjustment (see instructions) 39.75
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Direct graduate medical education payments (from wkst. E-4, line 50) REH facility payment amount 28. 29.00 ESRD direct medical education costs (from wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) O 39.
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30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 201,670 30. 31.00 Primary payer payments 201,670 31. 32.00 Subtotal (line 30 minus line 31) 201,670 32.
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39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.
39.75 N95 respirator payment adjustment amount (see instructions) 0 39.
20.07
39.97 Demonstration payment adjustment amount before sequestration 0 39.
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.
39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.
40.00 Subtotal (see instructions) 201,670 40.01 Sequestration adjustment (see instructions) 4,033 40.
40.02 Demonstration payment adjustment amount after sequestration 0 40.
40.03 Sequestration adjustment-PARHM pass-throughs 40.
41.00 Interim payments 197,632 41.
41.01 Interim payments-PARHM 41.
42.00 Tentative settlement (for contractors use only) 0 42.
42.01 Tentative settlement-PARHM (for contractor use only) 42.01 Tentative settlement-PARHM (for contractor use only)
43.00 Balance due provider/program (see instructions) 5 43.
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2. chapter 1. 43.01 Balance due provider/program-PARHM (see instructions)
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. §115.2
TO BE COMPLETED BY CONTRACTOR
90.00 Original outlier amount (see instructions) 0 90.
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.
92.00 The rate used to calculate the Time Value of Money 0.00 92.
93.00 Time Value of Money (see instructions)
94.00 Total (sum of lines 91 and 93) 0 94.

Health Financial Systems	THE OTIS R. BOWE	EN CENTER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4014	Period:	Worksheet E	
			From 07/01/2022		
			To 06/30/2023	Date/Time Pre	epared:
				11/14/2023 2	
		Title XVIII	Hospital	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200.00

Health Financial Systems THE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED THE OTIS R. BOWEN CENTER

Provider CCN: 15-4014

				10 00/30/2023	11/14/2023 2:4	
		Title	XVIII	Hospital	PPS	
		Inpatien	t Part A	Par	t B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	-	1.00	Amount 2.00	3.00	4.00	
.00 Tot	tal interim payments paid to provider	1.00	381,55		197,632	1.0
	terim payments payable on individual bills, either		361,33	0	197,032	2.0
	omitted or to be submitted to the contractor for			٥	ا	۷.(
	rvices rendered in the cost reporting period. If none,					
	ite "NONE" or enter a zero					
	st separately each retroactive lump sum adjustment					3.
	bunt based on subsequent revision of the interim rate					٥.
	r the cost reporting period. Also show date of each					
	ment. If none, write "NONE" or enter a zero. (1)					
	gram to Provider					
	JUSTMENTS TO PROVIDER			0	0	3.
02	, coments to thorse			Ö	0	3.
03				Ö	l ől	3.
04				o o	ا	3.
05				Ö	اة	3.
	vider to Program			<u> </u>		٥.
	JUSTMENTS TO PROGRAM			0	0	3.
51	70011121110 10 1110010111			0	0	3.
52				0	ا	3
3				0	l ől	3
54				0	ا	3
	ototal (sum of lines 3.01-3.49 minus sum of lines		1	0	ا	3
	50-3.98)				Ĭ	٠.
	tal interim payments (sum of lines 1, 2, and 3.99)		381,55	3	197,632	4.
	ransfer to Wkst. E or Wkst. E-3, line and column as					
	propriate)					
то і	BE COMPLETED BY CONTRACTOR			•		
00 Lis	st separately each tentative settlement payment after					5.
des	sk review. Also show date of each payment. If none,					
wri	ite "NONE" or enter a zero. (1)					
Pro	gram to Provider					
01 TEN	NTATIVE TO PROVIDER			0	0	5
02				0	0	5.
03				0	0	5
	vider to Program					
	NTATIVE TO PROGRAM		1	0	0	5
51				0	0	5.
52				0	0	5.
5.5	ototal (sum of lines 5.01-5.49 minus sum of lines 50-5.98)			0	0	5
	termined net settlement amount (balance due) based on e cost report. (1)					6
)1 SET	ITLEMENT TO PROVIDER			0	5	6.
D2 SET	ITLEMENT TO PROGRAM			0	0	6.
4	tal Medicare program liability (see instructions)		381,55	3	197,637	7.
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	
00 Nam	ne of Contractor					8.

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	From 07/01/2022 To 06/30/2023	Worksheet E-3 Part II Date/Time Prepared: 11/14/2023 2:41 pm
	-1.1	 	

PART II - MEDICAME PART A SENVICES - IPF PPS			Title XVIII	Hospital	PPS	
Next TIF - MODICARE PART A SERVICES - IPE PPS 1.00 1						
Net Federal IPP PPS Payments (excluding outlier, ECT, and medical education payments)					1.00	
Next PIF PPS cut Payments 0 2.00	1 00		-1 -4		474 446	1 00
Net IPF PPS ECT Payments 0, 3,00			cal education payments)		′ '	
Jumesighted intern and resident FTE count in the most recent cost report filed on or before November 1, 2004. (see instructions) 15, 2004. (see instructions) 15, 2004. (see instructions) 15, 2004. (see instructions) 1, 2004.		1			- 1	
15, 2004. (see instructions) 4.01. capture and processes for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CPR \$42.424(d)(1)(iii)(F)(1) or (2) (see instructions) 5.00 6.00 Current year's unweighted FTE count for IZR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 6.00 Current year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 8.00 8.00 1.00 1.00 1.00 1.00 1.00			st report filed on or h	efore November	- 1	
4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRR §412.424(D(1)(iii)(F(1) or (2) (see instructions) 0.00 5.00	4.00		se report titled on or b	CTOTE NOVEINDET	0.00	4.00
CER \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4.01		for residents that wer	e displaced by	0.00	4.01
New Teaching program adjustment. (See instructions)		program or hospital closure, that would not be counted without	a temporary cap adjust	ment under 42		
Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)						
teaching program" (see instructions) 7.00 Current year's unweighted I&Rs FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00						
Current year's unweighted 1&R FTE count for residents within the new program growth period of a "new to teaching program" (see instructions) 1.0,00 8.00	6.00		ne new program growth p	eriod of a "new	0.00	6.00
teaching program" (see instructions) 10.00	7 00				0.00	7 00
	7.00		ie new program growth p	eriod of a new	0.00	7.00
0.00 Average Daily Census (see instructions) 0.0000000 0.00 10.00 Teaching Adjustment Factor (f(1+ (line 8/line 9)) raised to the power of .5150 -1}. 0.0000000 0.00	8 00		ent (see instructions)		0.00	8 00
10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}, 0.000000 10.00 1		1	iene (see miseracerons)			
11.00			ne power of .5150 -1}.			
Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)						
14.00	12.00				474,446	12.00
15.00 Cost of physicians' services in a teaching hospital (see instructions) 0 15.00	13.00	Nursing and Allied Health Managed Care payment (see instruction	1)		0	13.00
16.00 Subtotal (see instructions) 474,446 16.00 17.0	14.00	Organ acquisition (DO NOT USE THIS LINE)				14.00
17.00 Primary payer payments 4.969 17.00 19.			ıctions)		- 1	
18.00 beductibles 58.100 19.00 beductibles 58.100 58.100 19.00 beductibles 58.100 19.00					, ,	
19.00						
20.00 Subtotal (line 18 minus line 19) Coinsurance 22,037 21.00 22.00 22.003 22.00 23.00 2		,				
21.00 Coinsurance 22.037 21.00 22.00 Subtotal (line 20 minus line 21) 389,340 22.00 389,340 22.00 23.00 24.00						
22.00					, ,	
Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 23.00						
24.00			os) (soo instructions)			
25.00			(see mistructions)			
26.00 Subtotal (sum of lines 22 and 24) 389,340 26.00 27.00		1 3	ictions)		- 1	
27.00 Direct graduate medical education payments (see instructions) 0 27.00 28.00 Other pass through costs (see instructions) 0 28.00 0 29.00 0 0 0 0 0 0 0 0 0						
28.00 Other pass through costs (see instructions)					,	
30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.00 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 Recovery of accelerated depreciation. 0 30.98 Recovery of accelerated depreciation. 0 30.98 Demonstration payment adjustment amount before sequestration 10 30.99 Total amount payable to the provider (see instructions) 11.00 Demonstration payment adjustment (see instructions) 12.00 Demonstration payment (see instructions) 13.00 Demonstration payment adjustment amount after sequestration 13.00 De						
30.50 Recovery of accelerated depreciation. 0 30.98 Recovery of accelerated depreciation. 0 30.98 30.99 Demonstration payment adjustment amount before sequestration 0 30.98 30.99 Demonstration payment adjustment amount before sequestration 30.99 Total amount payable to the provider (see instructions) 389,340 31.00 Sequestration adjustment (see instructions) 7,787 31.01 Demonstration payment adjustment amount after sequestration 31.00 Sequestration adjustment amount after sequestration 0 31.02 32.00 Interim payments 381,553 32.00 33.00 Total accordance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 0 33.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 0 33.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 \$115.2 TO BE COMPLETED BY CONTRACTOR 0 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 51.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)	29.00	Outlier payments reconciliation			0	29.00
30.98 Recovery of accelerated depreciation. 30.98 Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Demonstration payment adjustment (see instructions) Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions) Total amount payable to the provider (see instructions) Total amount payabl	30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.00
30.99 Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) 389,340 31.00 31.01 Sequestration adjustment (see instructions) 52.00 Interim payment adjustment amount after sequestration Total amount payable to the provider (see instructions) Total amount after sequestration Total amount squarter feet saturation Total amount payable to the provider (see instructions) Total amount payable to the provider (see instructions) Total amount after sequestration Total amount payable to the provider (see instructions) Total amount after sequestration Total amount after	30.50	Pioneer ACO demonstration payment adjustment (see instructions)	1		0	30.50
31.00 31.01 Total amount payable to the provider (see instructions) 389,340 31.00 31.01 Sequestration adjustment (see instructions) 31.02 Demonstration payment adjustment amount after sequestration 31.02 Interim payments 381,553 32.00 33.00 Total amount payable to the provider (see instructions) 31.02 Demonstration payment adjustment amount after sequestration 31.02 Interim payments 381,553 32.00 31.02 Sequestration adjustment (for contractor use only) 31.02 Sequestration payment adjustment (for contractor use only) 32.00 Entative settlement (for contractor use only) 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 35.00 Original outlier amount from Worksheet E-3, Part II, line 2 00utlier reconciliation adjustment amount (see instructions) 00utlier reconciliation adjustment amount (see instructions) 00utlier reconciliation adjustment amount (see instructions) 01utlier value of Money (see instructions) 0200 Time Value of Money (see instructions) 0300 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 0900 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 00000000 99.00		· · · · · · · · · · · · · · · · · · ·				
31.01 Sequestration adjustment (see instructions) 31.02 Demonstration payment adjustment amount after sequestration 31.02 32.00 Interim payments 32.00 Interim payments 381,553 32.00 381,553 32.00 381,00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		, , , , , , , , , , , , , , , , , , , ,				
31.02 Demonstration payment adjustment amount after sequestration 32.00 Interim payments 381,553 32.00 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 \$1.15.2 \$115.2 \$10.00 Outlier amount from Worksheet E-3, Part II, line 2 0 0utlier reconciliation adjustment amount (see instructions) 0 51.00 Outlier reconciliation adjustment amount (see instructions) 0 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00					, , , , , , , , , , , , , , , , , , ,	
32.00 Interim payments 32.00 Interim payment 32.						
33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 S115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		, , , , , , , , , , , , , , , , , , , ,			~	
34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 S115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		' '				
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 §115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		1	32 and 33)		- 1	
\$\frac{\sqrt{\sqrt{115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}{\text{50.00}}\$ 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 Time Value of Money (see instructions) 63.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.0000000 99.00				chanter 1.	- 1	
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 51.00 Outlier reconcilitation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	33.00		20 11 21 21 2 2 2 2 7	apcc,		55.00
51.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00						
The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0	50.00
53.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00						
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00						
COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53.00					53.00
99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00			EGINNING ON OR BEFORE	MAY 11, 2023 (TH	E END OF THE	
99.01 Calculated Teaching Adjustment Factor for the current year. (see instructions) 0.000000 99.01	99.00		ately preceding Februa	ry 29, 2020.	0.000000	99.00
	99.01	Calculated Teaching Adjustment Factor for the current year. (se	ee instructions)		0.000000	99.01

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4014	Period: Worksheet E-3 From 07/01/2022 Part VII To 06/30/2023 Date/Time Prepared:

		'	0 00/30/2023	11/14/2023 2:	41 pm	
		Title XIX	Hospital	Cost		
		·	Inpatient	Outpatient		
			1.00	2.00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	VICES FOR TITLES V OR XI	X SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	311,287		1.00		
2.00	Medical and other services		·	0	2.00	
3.00	Organ acquisition (certified transplant programs only)		0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)		311,287	0	4.00	
5.00	Inpatient primary payer payments		0		5.00	
6.00	Outpatient primary payer payments			0		
7.00	Subtotal (line 4 less sum of lines 5 and 6)		311,287	0		
	COMPUTATION OF LESSER OF COST OR CHARGES		311,101		1	
	Reasonable Charges				1	
8.00	Routine service charges		440,954		8.00	
9.00	Ancillary service charges		140,334	0		
	Organ acquisition charges, net of revenue		0	U	10.00	
	Incentive from target amount computation		0		11.00	
	Total reasonable charges (sum of lines 8 through 11)		440,954	0		
12.00			440,934	U	12.00	
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	a complete on a change	0	0	13.00	
13.00		services on a charge	٥	U	13.00	
14.00	basis Amounts that would have been realized from patients liable for	nayment for convices on	0	0	14.00	
14.00			٥	U	14.00	
15.00	a charge basis had such payment been made in accordance with 'Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413.13(e)	0.000000	0.000000	15.00	
	Total customary charges (see instructions)		440,954	0.000000		
		ly if line 16 eyeards	129,667	0		
17.00	line 4) (see instructions)	ry ii line 16 exceeds	129,007	U	17.00	
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line		0	18.00	
10.00	, , , ,	ry ii iine 4 exceeds iine	U	U	10.00	
10 00	16) (see instructions)			0	10.00	
	Interns and Residents (see instructions)		0	0		
	Cost of physicians' services in a teaching hospital (see inst		211 207	-		
21.00	Cost of covered services (enter the lesser of line 4 or line 1		311,287	0	21.00	
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.	0	22.00	
	Other than outlier payments		0	0		
	Outlier payments		-	U	-3.00	
	Program capital payments		0		24.00	
	Capital exception payments (see instructions)		0	0	25.00	
	Routine and Ancillary service other pass through costs		0	0		
	Subtotal (sum of lines 22 through 26)		0	0		
	Customary charges (title V or XIX PPS covered services only)		0	0		
29.00	Titles V or XIX (sum of lines 21 and 27)		311,287	0	29.00	
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				30.00	
	Excess of reasonable cost (from line 18)		211 207	0		
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	311,287	0		
	Deductibles		0	0		
	Coinsurance		0	0		
	Allowable bad debts (see instructions)		0	0	5	
	Utilization review		0		35.00	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	311,287	0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0		
	Subtotal (line 36 ± line 37)		311,287	0		
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00	
	Total amount payable to the provider (sum of lines 38 and 39)		311,287	0		
	Interim payments		269,107	0		
42.00	Balance due provider/program (line 40 minus line 41)		42,180	0		
	[and the cure bulle 15 3	1	^	43.00	
43.00	Protested amounts (nonallowable cost report items) in accordanchapter 1, §115.2	ice with CMS Pub 15-2,	0	0	43.00	

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 15-4014 | Period: | Worksheet G | From 07/01/2022 | To 06/30/2023 | Date/Time Pr

	ype accounting records, complete the General Fund column			rom 07/01/2022 o 06/30/2023		pared:
		General Fund	Specific Purpose Fund	Endowment Fund	11/14/2023 2: Plant Fund	41 pm
		1.00	2.00	3.00	4.00	
4 00	CURRENT ASSETS	45 433 330	1			1 00
1.00 2.00	Cash on hand in banks	15,433,238	(0	0	1.00
3.00	Temporary investments Notes receivable	0			0	
4.00	Accounts receivable	24,194,752			0	
5.00	Other receivable	202,790	1	Ö	0	
6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7.00	Inventory	0	(0	0	
8.00	Prepaid expenses	1,438,898		0	0	
9.00 10.00	Other current assets	0			0	
11.00	Due from other funds Total current assets (sum of lines 1-10)	35,900,835			0	
11.00	FIXED ASSETS	33,300,033		,		11.00
12.00	Land	8,976,557	(0	0	12.00
13.00	Land improvements	0	(0	0	13.00
14.00	Accumulated depreciation	-1,001,327		0	0	
15.00	Buildings	48,872,130		0	0	
16.00 17.00	Accumulated depreciation Leasehold improvements	-14,722,814			0	
18.00	Accumulated depreciation	0			0	1
19.00		Ö		ol ol	0	1
20.00	Accumulated depreciation	0		Ö	0	1
21.00	Automobiles and trucks	0	(0	0	21.00
22.00	Accumulated depreciation	0	(0	0	
23.00	Major movable equipment	17,553,159		0	0	
24.00	Accumulated depreciation	-12,260,578		0	0	
25.00 26.00	Minor equipment depreciable Accumulated depreciation	0			0	
27.00	HIT designated Assets	0			0	1
28.00	Accumulated depreciation	Ö		o o	0	
29.00	Minor equipment-nondepreciable	0	(0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	47,417,127	(0	0	30.00
21 00	OTHER ASSETS	F1 272 417		0	0	21 00
31.00 32.00	Investments Deposits on leases	51,273,417			0	
33.00	Due from owners/officers	Ö		ol ol	0	1
34.00	Other assets	450,632		0	0	
35.00	Total other assets (sum of lines 31-34)	51,724,049			0	
36.00	Total assets (sum of lines 11, 30, and 35)	135,042,011	. (0	0	36.00
37.00	CURRENT LIABILITIES	1 022 021		0	0	37.00
	Accounts payable Salaries, wages, and fees payable	1,032,921			0	
39.00	Payroll taxes payable	291,793		ol ol	0	1
	Notes and loans payable (short term)	0		0	0	1
41.00	Deferred income	248,484	. (0	0	41.00
	Accelerated payments	0			_	42.00
	Due to other funds	0 420 103			0	
44.00 45.00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	9,420,183 10,993,381			0	
73.00	LONG TERM LIABILITIES	10,555,561		· U	0	75.00
46.00	Mortgage payable	0	(0	0	46.00
47.00	Notes payable	9,021,276	(0	0	47.00
48.00	Unsecured loans	0	(0	0	
49.00	Other long term liabilities	5,280,163			0	
50.00 51.00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	14,301,439 25,294,820			0	
31.00	CAPITAL ACCOUNTS	23,234,020		,		31.00
52.00	General fund balance	109,747,191				52.00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00 57.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.00 57.00
58.00	Plant fund balance - reserve for plant improvement,				0	1
55.00	replacement, and expansion				Ü	
59.00	Total fund balances (sum of lines 52 thru 58)	109,747,191	1	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	135,042,011		0	0	60.00
	[59]	l	I	1		I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 THE OTIS R. BOWEN CENTER

Provider CCN: 15-4014 Period: Worksheet G-1 From 07/01/2022

					то 06/30/2023	Date/Time Pre 11/14/2023 2:	pared: 41 pm
		General	Fund	Special	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0	94,952,074 14,795,117 109,747,191		(0 0 0	1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 109,747,191		0 0 0	0 0 0	7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00	Deductions (debit adjustments) (specify)	0 0 0 0 0			0 0 0 0 0	0 0 0 0 0 0	14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 109,747,191			0	18.00 19.00
		Endowment Fund	Plant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		1.00 2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	0	0 0 0		0		6.00 7.00 8.00 9.00 10.00
11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0	0 0 0 0 0		0		11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

THE OTIS R. BOWEN CENTER

Health Financial Systems T STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-4014

				то 06/30	1/2023	3 Date/Time Pre 11/14/2023 2:	
	Cost Center Description		Inpatient	Outpati	ent	Total	•
	<u> </u>		1.00	2.00)	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospital		8,490,11	1		8,490,111	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		0 400 11	1		0 400 111	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		8,490,11	1		8,490,111	10.00
11.00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT			1		T	11.00
12.00	CORONARY CARE UNIT						12.00
	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	linos		0		0	
10.00	11-15)	Tilles		٥			10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		8,490,11	1		8,490,111	17.00
18.00	Ancillary services	, I	446,03		(1 ' '	ı
19.00	Outpatient services		,		21,700		
20.00				0	, , , , ,	1	1
	FEDERALLY QUALIFIED HEALTH CENTER			Ö	Ċ	1	ı
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	CMHC						24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	İ					25.00
26.00	HOSPICE						26.00
27.00	C/C 5 REV			0 1	11,050	0 11,050	ı
27.01	PHYSICIANS' PRIVATE OFFICES			0 80,40	06,020		
27.02	RESIDENTIAL	İ		0	. (0	27.02
27.03	CSP	İ		0	(0	27.03
27.04	MRO			0 14,14	2,86	14,142,863	27.04
27.05	FQHC			0 11,76	1,17	1 11,761,171	27.05
27.06	BRC			0 3,77	78,381	1 3,778,381	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	8,936,14	1 142,62	1,185	5 151,557,326	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES			T		-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			102,68	4,383	3	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	Total additions (sum of lines 20 25)			U	C		35.00 36.00
36.00 37.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0			37.00
38.00	DEDUCT (SPECIFT)			0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				Ö			41.00
42.00	Total deductions (sum of lines 37-41)			<u> </u>	(ol	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		102,68	34.38	3	43.00
	to Wkst. G-3, line 4)	, ,		,00	,		
		'				•	

STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-4		Worksheet G-3	
			From 07/01/2022 To 06/30/2023	Date/Time Pre 11/14/2023 2:	
		7 71 70		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I			151,557,326	
2.00	Less contractual allowances and discounts on p	atients' accounts		59,196,106	
3.00	Net patient revenues (line 1 minus line 2)	7.1 (2)		92,361,220	
4.00	Less total operating expenses (from Wkst. G-2,			102,684,383	
5.00	Net income from service to patients (line 3 min	nus line 4)		-10,323,163	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			13,481	
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous	s communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase discounts			0	10.00
	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guest	S		0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supp			0	16.00
	Revenue from sale of drugs to other than patie			0	17.00
	Revenue from sale of medical records and abstra			0	18.00
	Tuition (fees, sale of textbooks, uniforms, et			0	19.00
20.00	3,,,,	canteen		0	20.00
21.00				0	21.00
	Rental of hospital space			0	22.00
23.00				0	23.00
24.00	INVESTMENT INCOME			0	24.00
24.01	DONATIONS			0	24.01
24.02	STATE, FEDERAL, AND LOCAL FUNDS			11,618,362	24.02
24.03	GAIN (LOSS) ON DISPOSAL OF PROPERTY			-122,293	
24.04	CONTRIBUTION OF PROPERTY AND EQUIPME			0	24.04
24.05	MEDICAID FUNDS			7,575,000	24.05
24.06	OTHER			2,246,464	24.06
24.07	UNREALIZED GAIN ON INVESTMENTS			0	24.07
24.08	OTHER INCOME			153,430	24.08
24 50	COVID-19 PHE Funding			l n	24 50

24.50 0

25.00

21,484,444

11,161,281 26.00

-3,633,836 27.00 -3,633,836 28.00 14,795,117 29.00

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 LOSS ON UREALIZED GAINS
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)