This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-4014 Worksheet S Peri od: From 07/01/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: 11/18/2020 3:44 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/18/2020 Ti me: 3:44 pm Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

## PART II - CERTIFICATION

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 the Balance Sheet and Statement of Revenue and Expenses prepared by THE OTIS R. BOWEN CENTER (15-4014) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned) JAY BAUMGARTNER

Officer or Administrator of Provider(s)

SENIOR VICE PRESIDENT -FINANCIAL SER

Title

(Dated when report is electronically signed.)

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 971	601	0	422, 504	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - 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	1, 971	601	0	422, 504	200.00

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

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/18/2020 3:44 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 850 N. HARRISON 1.00 PO Box: 1.00 State: IN Zi p Code: 46580-County: KOSCIUSKO 2.00 City: WARSAW 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Туре 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 4 03/14/1979 3.00 CENTER Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - 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 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 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) 07/01/2019 06/30/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Ν 22.01 Ν 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) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be 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 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν 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

repor Does count yes c 23.00 Whi ch bel ow if da repor	rting period occurring on or after October 1. (s this hospital contain at least 100 but not more ted in accordance with 42 CFR 412.105)? Enter in or "N" for no. h method is used to determine Medicaid days on I w? In column 1, enter 1 if date of admission, 2 ate of discharge. Is the method of identifying t rting period? In column 2, enter "Y" for yes or	ee instruct than 499 b column 3, ines 24 and if census d he days in he prior co	ions) peds (as "Y" for  l/or 25 lays, or 3 this cost		3 1	N		23. 00
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO days	Medi cai d	
		paru uays	unpai d	paid days			days	
			days	para days	unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	1
in-st Medic out-c out-c 4, Me	his provider is an IPPS hospital, enter the tate Medicaid paid days in column 1, in-state caid eligible unpaid days in column 2, of-state Medicaid paid days in column 3, of-state Medicaid eligible unpaid days in column edicaid HMO paid and eligible but unpaid days in mn 5, and other Medicaid days in column 6.		0	0	0	O	C	24.00
MCRI F32 - 1	6. 4. 169. 4							

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/18/2020 3:44 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00  $\cap$ 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 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39 00 N N 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 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40 00 N Ν no in column 2, for discharges on or after October 1. (see instructions) XVIII 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) 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 Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? 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), MA 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 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. 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 Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 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 adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems THE OTI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OWEN CENTER Provider C		Period: From 07/01/2019	Worksheet S-2 Part I	
	Y/N	I ME	Direct GME	To 06/30/2020	Date/Time Pre 11/18/2020 3: Direct GME	
61.00 Did your hospital receive FTE slots under ACA	1. 00	2. 00	3.00	4. 00	5.00	61.0
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 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.0
pl.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
21.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).  1.05 Enter the difference between the baseline primary						61.0
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) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.0
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	e Unweighted	Unwei ghted	
				IME FTE Count	Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4. 00	61.1
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 2
			1.00			
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruction).  2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression, the second reaching Hospitals that Claim Residents in Nonprovide	ctions) n Teach gram. (:	ing Health Cer see instructio	nter (THC) int			62.0
3.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this d			N	63.0
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and before the second of the period that begins on or after July 1, 2009 and before the second of the period of the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trai n-prima all no non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0. (	0.00	0. 000000	64.0

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Peri od: Worksheet S-2 From 07/01/2019 Part I 06/30/2020 Date/Time Prepared: 11/18/2020 3:44 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1. 00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3. 00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider'	Y			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most	N	N	0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovider? Enter "Y" for yes and "N" for no.				

alth Financial Systems THE OTIS R. BOWEN CENTER SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Pr	eri od:	u of Form CMS Worksheet S-	
	rom 07/01/2019	Part I	repare
	1.0	0 2.00 3.00	5
Olumn 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	0	76.
		1.00	
Long Term Care Hospital PPS  On Is this along term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	peri od? Enter	N N	80. 81.
TEFRA Providers  OU Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes  OU Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85 86
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87
	V	XIX	
Title V and XIX Services	1. 00	2. 00	
OD Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	90
00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91
Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N 	92
ODOES this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  ODOES title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N N	N N	93
applicable column.  On If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95
00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N N	96
OD If line 96 is "Y", enter the reduction percentage in the applicable column.  Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y	0. 00 Y	97
Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	Y	98
title XIX.  O2 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
O3 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98
for title V, and in column 2 for title XIX.  O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Y	98
column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,  Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in  column 2 for title XIX.  Rural Providers	Y	Y	98
.00 Does this hospital qualify as a CAH? .00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N N		105 106
for outpatient services? (see instructions)  .00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)  Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?	N		107
Enter "Y" for yes or "N" for no in column 2. (see instructions) 8.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108

Health Financial Systems THE OTIS R. BC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	_		eriod: rom 07/01/2019	u of Form CMS Worksheet S- Part I	
			o 06/30/2020	Date/Time Pr	
	Physi cal	Occupati onal	Speech	11/18/2020 3 Respiratory	
	1. 00	2. 00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 0
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable.	"Y" for yes o	or "N" for no. I	f yes,	N	110. 0
			1.00	2.00	+
11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this construction for the second of the FCHIP demonstration promption of the FCHIP demonstration promption of the FCHIP demonstration promption of the FCHIP demonstration of the services; "B" for action of the services of the services of the services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.0
		1.00	2.00	3. 00	
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.33	5.00	112.0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "Ger short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provider	B, or E only) 93" percent (includes	N			0115.0
the definition in CMS Pub.15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y"  "N" for no.	for yes or	N			116.0
17.00  s this facility legally-required to carry malpractice insu  "Y" for yes or "N" for no.	rance? Enter	Y			117.0
18.00 is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.0
it the portey is craim made. Enter 2 if the portey is decail	rence.	Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	+
18.01 List amounts of malpractice premiums and paid losses:		335, 175			0118.0
18.02 Are malpractice premiums and paid losses reported in a cost	contor other	than tho	1. 00 N	2. 00	118. 0
Administrative and General? If yes, submit supporting schedand amounts contained therein.  19.00 D0 NOT USE THIS LINE			IN IN		119.0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, " ualifies for	Y" for yes or the Outpatient	N	N	120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	N		121.0
22.00 Does the cost report contain healthcare related taxes as detained Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.  Transplant Center Information			N		122.0
25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N	l" for no. If	N		125. C
26.00  f this is a Medicare certified kidney transplant center, et in column 1 and termination date, if applicable, in column 2		ification date			126.0
27.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certi	fication date			127. 0
28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certi	fication date			128.0
		ication date in	ı		129.0
129.00 If this is a Medicare certified lung transplant center, ento column 1 and termination date, if applicable, in column 2.	er the certifi				
129.00 If this is a Medicare certified lung transplant center, ente	enter the ce umn 2.	erti fi cati on			130. 0 131. 0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	THE OTIS R. BO	Provi der CC	CN: 15-4014			wof Form CMS- Worksheet S- Part I Date/Time Pro 11/18/2020 3	2 epared:
					1. 00	2. 00	+
132.00 If this is a Medicare certified i in column 1 and termination date,			ication date	Э	1. 00	2. 00	132.00
133.00 Removed and reserved 134.00 If this is an organ procurement o and termination date, if applicab	rganization (OPO), enter t		in column 1				133. 00 134. 00
All Providers  40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. If e home office chain number	yes, and home . (see instruc	office cost	ts	N		140.00
1.00  If this facility is part of a cha		lines 141 thro	ough 143 the	name ar	3.00 nd address	of the home	
office and enter the home office 41.00 Name:	Contractor name and contra	ctor number.	Contrac	tor's Nu	ımher:		141. 0
42. 00 Street:	PO Box:		Contrac	101 3 110	amber.		142. 0
43. 00 Ci ty:	State:		Zi p Code	e:			143.00
						1. 00	
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144.00
					4 00	0.00	4
45.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no in clude Medicare utilization	column 1. If	column 1 is		1.00	2.00	145.00
46.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	gy changed from the previon column 1. (See CMS Pub.			f	N		146. 0
						1. 00	+
47.00 Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			N	147.00
48.00 Was there a change in the order o						N	148.00
149.00 Was there a change to the simplif	ied cost finding method? E					N	149. 00
		Part A	Part B	T	Title V	Title XIX	4
Does this facility contain a prov	ider that qualifies for an	1.00	2.00	cation (	3.00	4.00	-
or charges? Enter "Y" for yes or							
55. 00Hospi tal		N	N		N	N	155. 0
56.00 Subprovi der - IPF		N	l N		N	N	156. 0
57.00 Subprovi der - I RF		N	N N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N N		N	N	159. 0
60.00 HOME HEALTH AGENCY 61.00 CMHC		N	N N		N N	N N	160. 0
61. ООДСМИС			<u> IN</u>		IN	IN	161. 0
						1. 00	
Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more camp	uses in diff	ferent (	CBSAs?	N	165. 00
PETTO I TOT YES OF IN TOT HO.	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	1
66.00  f   line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0 166. 0
						1. 00	
Health Information Technology (HI				ent Act			
67.00 Is this provider a meaningful use	r under §1886(n)? Enter "	Y" for yes or	"N" for no.			N	167. 00
68.00 If this provider is a CAH (line 1			e 167 is "Y'	'), ente	er the		168. 00
reasonable cost incurred for the			n mustic c	1.	adob!		1/0 0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)					usni p		168. 0°
69.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and				enter the	0.0	0169. 0

Health Financial Systems THE OTIS R. BOWEN CENTER					eu of Form CMS-2552-10			
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4014 Per					Worksheet S-2			
	Fr To				Part I Date/Time Pre 11/18/2020 3:			
			В	Begi nni ng	Endi ng			
				1. 00	2. 00			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170. 00		
				1. 00	2. 00			
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					0	171. 00		

Heal th	Financial Systems THE OTIS R. E	BOWEN CENTER		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 07/01/2019	Worksheet S-2	
				To 06/30/2020	Date/Time Pre	
				Y/N	11/18/2020 3: Date	44 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente	er all dates in	the	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in	corumn 2. (See	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu		N			2.00
	voluntary or "I" for involuntary.	IIIII 3, V 101				
3. 00	Is the provider involved in business transactions, includi		N			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members	of the board				
	of directors through ownership, control, or family and oth	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2.00	3. 00	
4. 00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer	etified Dublic	Υ	A	I	4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,	T	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	erent from	l N			5. 00
J. 00	those on the filed financial statements? If yes, submit re		14			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	s N		6. 00
7. 00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see i	nstructi ons		N		7. 00
8. 00	Were nursing school and/or allied health programs approved		d during the	N		8.00
0.00	cost reporting period? If yes, see instructions.					0.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than	I & Din an An	nroved	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.		proved	IN IN		11.00
					Y/N	
	Bad Debts				1. 00	
12.00	Is the provider seeking reimbursement for bad debts? If ye	s, see instruc	tions.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection	policy change	during this co	ost reporting	N	13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	f ves. see ins	structi ons.	N	14. 00
	Bed Complement					
15. 00	Did total beds available change from the prior cost report		yes, see inst t A		N N T B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Υ	09/22/2020	Y	09/22/2020	16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through	,	0772272020	'	0772272020	10.00
	date of the PS&R Report used in columns 2 and 4 .(see					
17. 00	instructions) Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	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	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I	1	I	I

	_ AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-4014	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Pre 11/18/2020 3:	epared:	
		Descr	ipti on	Y/N	Y/N		
		(	0	1. 00	3. 00		
	f line 16 or 17 is yes, were adjustments made to PS&R eport data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
21. 00 Wa	as the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21.00	
re	ecords? If yes, see instructions.						
					1. 00		
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCENDITED REPORTED FOR THE PROPERTY OF	PT CHILDRENS	HOSPI TALS)			-	
_	ave assets been relifed for Medicare purposes? If yes, see	instructions			N	22.0	
3. 00 Ha	ave changes occurred in the Medicare depreciation expense eporting period? If yes, see instructions.			ıring the cost	N	23.0	
4.00 We	ere new leases and/or amendments to existing leases entere f yes, see instructions	ed into during	this cost r	reporting period?	N	24.0	
5. 00 Ha	ave there been new capitalized leases entered into during nstructions.	the cost repo	rting period	l? If yes, see	N	25.0	
6.00 We	ere assets subject to Sec. 2314 of DEFRA acquired during the nstructions.	ne cost report	ing period?	If yes, see	N	26.0	
cc	as the provider's capitalization policy changed during the opy.	e cost reporti	ng period? I	f yes, submit	N	27.0	
8. 00 We	nterest Expense ere new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cos	st reporting	N	28.0	
9. 00 Di							
0. 00 Ha							
1.00 Ha	nstructions. as debt been recalled before scheduled maturity without is nstructions.	ssuance of new	debt? If ye	es, see	N	31.0	
2.00 Ha	urchased Services ave changes or new agreements occurred in patient care ser rrangements with suppliers of services? If yes, see instru f line 32 is yes, were the requirements of Sec. 2135.2 app	ıcti ons.	•			32.0	
nc	o, see instructions. Tovi der-Based Physicians		Tig to compet	in the Brading.		] 00.0	
4. 00 Ar	re services furnished at the provider facility under an ar	rangement wit	h provider-b	ased physicians?	Υ	34.0	
5.00   I f	f yes, see instructions. fline 34 is yes, were there new agreements or amended exi	sting agreeme	nts with the	e provi der-based	N	35.0	
ph	hysicians during the cost reporting period? If yes, see in	nstructi ons.		Y/N	Date		
				1. 00	2. 00		
	ome Office Costs						
	ere home office costs claimed on the cost report?			N		36.0	
l f	f line 36 is yes, has a home office cost statement been pr f yes, see instructions.					37.0	
	f line 36 is yes , was the fiscal year end of the home off he provider? If yes, enter in column 2 the fiscal year end			of		38.0	
	f line 36 is yes, did the provider render services to othe ee instructions.	er chain compo	nents? If ye	es,		39.0	
	00	-					
Co	ost Report Preparer Contact Information		00	2.			
1013		MI CHAEL		ALESSANDRI NI		41.0	
1. 00 Er				11			
1. 00 Er he re 2. 00 Er	especti vel y.	BLUE AND CO.,	LLC			42.0	

Health Financial Systems THE OTIS R.	BOWEN CENTER	In Lieu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-4014	Period: Worksheet S- From 07/01/2019 Part II To 06/30/2020 Date/Time Pro	
		11/18/2020 3	:44 pm
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DI RECTOR		41.00
held by the cost report preparer in columns 1, 2, and 3,			
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

 
 Heal th Fi nancial
 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-4014

						То	06/30/2020	Date/Time Prepared: 11/18/2020 3:44 pm			
								1/P Days /	T	трш	
								0/P Visits /			
								Tri ps			
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V			
		Line Number 1.00		2. 00	Available 3.00		4. 00	5. 00	+		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			16		6	0, 00	3.00	1	1. 00	
1.00	8 exclude Swing Bed, Observation Bed and	55. 55		10	0,00		0.00		1	1.00	
	Hospice days) (see instructions for col. 2										
	for the portion of LDP room available beds)										
2.00	HMO and other (see instructions)								ı	2.00	
3.00	HMO IPF Subprovider								ı	3.00	
4.00	HMO IRF Subprovider									4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF							C		5.00	
6.00	Hospital Adults & Peds. Swing Bed NF							C		6.00	
7.00	Total Adults and Peds. (exclude observation			16	5, 85	6	0. 00	C		7.00	
	beds) (see instructions)								1		
8. 00	INTENSIVE CARE UNIT								1	8.00	
9.00	CORONARY CARE UNIT								l	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			1.6	F 0F		0. 00	_	- 1	13.00	
14.00	Total (see instructions)			16	5, 85	О	0.00	C		14.00	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF							C		15. 00 16. 00	
17. 00	SUBPROVIDER - I FF									17. 00	
18. 00	SUBPROVI DER									18. 00	
19. 00	SKILLED NURSING FACILITY									19. 00	
20.00	NURSING FACILITY									20.00	
21. 00	OTHER LONG TERM CARE								- 1	21. 00	
22. 00	HOME HEALTH AGENCY									22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								1:	23. 00	
24. 00	HOSPI CE									24. 00	
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10	
25.00	CMHC - CMHC								1:	25. 00	
26.00	RURAL HEALTH CLINIC								1:	26. 00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						C	) :	26. 25	
27.00	Total (sum of lines 14-26)			16						27. 00	
28.00	Observation Bed Days							C	) :	28. 00	
29. 00	Ambul ance Trips									29. 00	
30.00	Employee discount days (see instruction)									30. 00	
31. 00	Employee discount days - IRF									31. 00	
32.00	Labor & delivery days (see instructions)			0		0				32.00	
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)									32. 01	
33.00	LTCH non-covered days									33. 00	
33. 01	LTCH site neutral days and discharges								:	33. 01	

Provider CCN: 15-4014

Peri od: Worksheet S-3 From 07/01/2019 Part I To 06/30/2020 Date/Ti me Prepared: 11/18/2020 3:44 pm

						11/18/2020 3:	44 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
				•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	452	517	3, 249			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)	ol	353				2.00
3. 00	HMO IPF Subprovider	ام	0				3.00
4. 00	HMO IRF Subprovider	ol	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o	0	ł			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0				6.00
7. 00	Total Adults and Peds. (exclude observation	452	517				7.00
7.00	beds) (see instructions)	452	317	3,247			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	1						12.00
13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
	1	452	517	2 240	0.00	1 245 (0	
14.00	Total (see instructions)	452	517	3, 249	0. 00	1, 245. 69	ł
15.00	CAH visits	U	U	0			15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			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	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0. 00	1, 245. 69	27. 00
28.00	Observation Bed Days		0	0			28. 00
29.00	Ambul ance 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)	o	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	O					33. 01
		. '		•	•	•	•

Provider CCN: 15-4014

				To	06/30/2020	Date/Time Pre 11/18/2020 3:	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	82	64	661	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	74		2.00
3. 00	HMO IPF Subprovi der				0		3.00
4. 00	HMO IRF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13.00
14.00	Total (see instructions)	0. 00	0	82	64	661	
15. 00	CAH visits						15.00
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
31.00							
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days	}		o	}		33.00
	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
33. UI	LION SITE HEULT AT MAYS AND UTSCHALGES	I I		ı o	I		J 33. UT

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10										
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der Co	CN: 15-4014	Peri od:	Worksheet A	2552-10				
				From 07/01/2019 To 06/30/2020						
Cost Center Description	Sal ari es	0ther		1 Reclassificat						
			+ col . 2)	i ons (See	Trial Balance					
				A-6)	(col. 3 +- col. 4)					
	1.00	2. 00	3.00	4.00	5. 00					
GENERAL SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	J. 00					
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1		1 15, 331	15, 332	1.00				
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	o	0		0 11, 185, 043		4.00				
5. 00 00500 ADMINISTRATIVE & GENERAL	11, 591, 325	6, 566, 770	18, 158, 09	1		5.00				
7.00 00700 OPERATION OF PLANT	0	0		0 654, 972	654, 972	7. 00				
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 295, 412	295, 412	16.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30. 00 03000 ADULTS & PEDIATRICS	3, 574, 285	1, 540, 026	5, 114, 31	-538, 201	4, 576, 110	30.00				
ANCILLARY SERVICE COST CENTERS										
60. 00   06000   LABORATORY	0	0		0 29, 652						
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 121, 908	121, 908	73. 00				
90. 00 O9000 CLINIC	15, 454, 902	3, 907, 357	19, 362, 25	-9, 627, 180	9, 735, 079	90.00				
90. 00   09000   CETNIC 90. 01   09001   PARTI AL HOSPI TALI ZATI ON	15, 454, 902	3, 907, 337 N		-9,021,100 0	9, 735, 079	1				
SPECIAL PURPOSE COST CENTERS	<u> </u>	0		0 0	0	70.01				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	30, 620, 512	12, 014, 154	42, 634, 66	-1, 013, 306	41, 621, 360	118.00				
NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,						
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192. 00				
192. 01 19201 RESI DENTI AL	35, 087, 799	5, 132, 677	40, 220, 47	-6, 537, 507	33, 682, 969	192. 01				
192. 02 19202 MRO	0	0		0 7, 550, 813		1				
192. 03 19203 METHODONE CLI NI C	0	0		0	•	192. 03				
194. 00 07950 RENTAL SPACE	0	0	00.055	0		194. 00				
200.00   TOTAL (SUM OF LINES 118 through 199)	65, 708, 311	17, 146, 831	82, 855, 14	12 0	82, 855, 142	200.00				

Health Financial Systems	THE OTIS R. BOW	EN CENTER		In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TR	I AL BALANCE OF EXPENSES	Provi der CCN: 15-4014	Peri od:	Worksheet A

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	)F EXPENSES	Provider CCN: 15-4014		Period: From 07/01/2019	Worksheet A	
					To 06/30/2020	Date/Time Pr	
						11/18/2020	3:44 pm
	Cost Center Description		Net Expenses				
		(See A-8)	For				
		4 00	Allocation				
	CENEDAL CEDULAE CACE CENTERS	6. 00	7. 00				
1 00	GENERAL SERVICE COST CENTERS	15 221	1				1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-15, 331	11 105 040				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	11, 185, 043				4.00
5. 00	00500 ADMINI STRATI VE & GENERAL	-323, 508	14, 684, 344				5.00
7.00	00700 OPERATION OF PLANT	0	654, 972				7.00
16. 00		0	295, 412				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 004 000	0.054.040				
30.00	03000 ADULTS & PEDIATRICS	-1, 324, 298	3, 251, 812				30.00
	ANCILLARY SERVICE COST CENTERS		22 (52				
	06000 LABORATORY	0	29, 652				60.00
/3.00	07300 DRUGS CHARGED TO PATIENTS	0	121, 908				73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	-2, 442, 765	7, 292, 314				90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0				90. 01
	SPECIAL PURPOSE COST CENTERS						
118.00	, , ,	-4, 105, 902	37, 515, 458				118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
	1 19201 RESI DENTI AL	0	33, 682, 969				192. 01
	2 19202 MRO	0	7, 550, 813				192. 02
	3 19203 METHODONE CLINIC	0	0				192. 03
	07950 RENTAL SPACE	0	0				194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-4, 105, 902	78, 749, 240				200. 00

Health Financial Systems

THE OTIS R. BOWEN CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-4014

Period: From 07/01/2019

From 07/01/2019

					To 06/30/2020 Date/Time Pr	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	A - SALARIES RECLASS					
1.00	OPERATION OF PLANT	7. 00	654, 972	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	1600	<u>295, 4</u> 12	0		2.00
	0		950, 384	0		
	B - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	11, 185, 043		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
	0		0	11, 185, 043		
	C - INTEREST RECLASS	<u> </u>				
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	15, 331		1.00
	FI XT					
	0		0	15, 331		
	E - MRO EXPENSE					
1. 00	MRO	1 <u>92.</u> 02	<u>6, 027, 0</u> 38	<u>1, 523, 7</u> 75		1.00
	0		6, 027, 038	1, 523, 775		
	F - PHARMACY RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS	73.00		12 <u>1, 9</u> 08		1.00
	0		0	121, 908		
	G - LABORATORY RECLASS					
1.00	LABORATORY	6000	•_	2 <u>9, 6</u> 52		1.00
	0		0	29, 652		
500.00	Grand Total: Increases		6, 977, 422	12, 875, 709		500.00

Health Financial Systems

THE OTIS R. BOWEN CENTER

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-4014

Period: From 07/01/2019

Worksheet A-6

					То	06/30/2020 Date/Tim	e Prepared: 20 3:44 pm
		Decreases		L		117 107 20	20 0. 11 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - SALARIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	950, 384	0	0		1.00
2.00		0.00	0	0	0		2. 00
	0		950, 384	0			
	B - BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	2, 199, 859	0	0		1.00
2.00	ADULTS & PEDIATRICS	30. 00	371, 310	0	0		2. 00
3.00	CLI NI C	90. 00	2, 076, 367	0	0		3. 00
4.00	RESI DENTI AL	<u> </u>	<u>6, 537, 5</u> 07	0	0		4.00
	0		11, 185, 043	0			
	C - INTEREST RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00		1 <u>5, 3</u> 31			1.00
	0		0	15, 331			
	E - MRO EXPENSE						
1.00	CLINIC	90.00	<u>6, 027, 038</u>	1, 52 <u>3, 7</u> 75			1.00
	0		6, 027, 038	1, 523, 775			
	F - PHARMACY RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00		12 <u>1, 9</u> 08			1.00
	0		0	121, 908			
	G - LABORATORY RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	•	2 <u>9, 6</u> 52			1.00
	0		0	29, 652			
500.00	Grand Total: Decreases		18, 162, 465	1, 690, 666			500.00

				To	06/30/2020	Date/Time Prep 11/18/2020 3:4	
				Acqui si ti ons		117 107 2020 3.	TT PIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	3, 676, 918	312, 631	0	312, 631	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	29, 618, 228	1, 658, 986	0	1, 658, 986	0	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	14, 949, 923	2, 348, 278	0	2, 348, 278	3, 177, 559	
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	48, 245, 069	4, 319, 895	0	4, 319, 895	3, 177, 559	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	48, 245, 069	4, 319, 895	0	4, 319, 895	3, 177, 559	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART 1 ANALYSIS OF SUMMED IN SARITAL ASSE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	3, 989, 549	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	31, 277, 214	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	0	0				5.00
6.00	Movable Equipment	14, 120, 642	0				6.00
7.00	HIT designated Assets	40 207 405	0				7.00
8.00	Subtotal (sum of lines 1-7)	49, 387, 405	0				8.00
9.00	Reconciling Items	40 207 405	0				9.00
10. 00	Total (line 8 minus line 9)	49, 387, 405	U			I	10.00

Health Financial Systems	THE OTIS R. BOWEN CENTER			In Lieu of Form CMS-2552-1				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020	Worksheet A-7 Part II Date/Time Pre 11/18/2020 3:	pared:		
		Sl	JMMARY OF CAP	I TAL				
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	<u>RKSHEET A, COLUI</u>	MN 2, LINES 1	and 2					
1.00 NEW CAP REL COSTS-BLDG & FLXT	1	0	)	0	0	1.00		
3.00 Total (sum of lines 1-2)	1	0	)	0 0	0	3.00		
	SUMMARY 0	F CAPITAL						
Cost Center Description	Other	Total (1)						
	Capi tal -Rel at	(sum of cols.						
	ed Costs (see	9 through 14)						
	instructions)							
	14. 00	15. 00						
PART II - RECONCILIATION OF AMOUNTS FROM WOR	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 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	1			3.00		

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lieu of Form CMS-2552			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
			1	From 07/01/2019 To 06/30/2020		narod:	
			'	00/30/2020	11/18/2020 3:		
	COMF	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI					
Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col. 2)				
	1. 00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS O		2.00	0.00	1. 00	0.00		
1. 00 NEW CAP REL COSTS-BLDG & FLXT	49, 387, 405	0	49, 387, 405	1.000000	0	1.00	
3.00 Total (sum of lines 1-2)	49, 387, 405	0	49, 387, 405	1. 000000	0	3.00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel at					
	6, 00	ed Costs 7.00	through 7) 8.00	9. 00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS O		7.00	0.00	9.00	10.00		
1.00 NEW CAP REL COSTS-BLDG & FLXT	LIVIEKS 0	0		) 1	0	1. 00	
3.00 Total (sum of lines 1-2)	o o	Ö		1	o l	3. 00	
		Sl	JMMARY OF CAPI	TAL			
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
		(see	instructions)				
		instructions)		ed Costs (see	9 through 14)		
	11 00	12.00	12.00	instructions)	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS O	11. 00	12. 00	13. 00	14. 00	15. 00		
1.00 NEW CAP REL COSTS-BLDG & FIXT	LIVILING	0		0	1	1. 00	
3.00 Total (sum of lines 1-2)		ĺ	`	1		3. 00	

0 \*\*\* Cost Center Deleted \*\*\*

0 \*\*\* Cost Center Deleted \*\*\*

OADULTS & PEDIATRICS

19 00

67.00

30.00

0.00

28 00

29.00

30.00

30.99

instructions)

Non-physician Anesthetist Physicians' assistant

Adjustment for occupational

therapy costs in excess of limitation (chapter 14)

Hospice (non-distinct) (see

A-8-3

28.00

29.00

30.00

30.99

Heal th	Health Financial Systems		THE OTIS R. E	BOWEN CENTER	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES			F	Period: From 07/01/2019 To 06/30/2020	Worksheet A-8 Date/Time Pre 11/18/2020 3:	pared:	
				Expense Classification on To/From Which the Amount is				
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00	
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00	
33. 00	PROMOTIONAL, PUBLIC RELATION, DONATI	А	-114, 765	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00	
33. 02	PROMOTIONAL, PUBLIC RELATION, DONATI	Α	-13, 078		90. 00	0	00.02	
	ADVERTISING - MARKETING	Α		ADMINISTRATIVE & GENERAL	5. 00	0	00.00	
	ADVERTISING - MARKETING	Α	-47, 241		90. 00		00.0.	
35. 00	INTEREST INCOME	В		NEW CAP REL COSTS-BLDG & FIXT	1. 00	11		
36.00	MISC INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	00.00	
38. 00	RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	5. 00		00.00	
39. 00	RENTAL INCOME	В	-30, 751		90.00		39. 00	
41.00	MISC INCOME	В	-16, 155		90.00	0	1 00	
42.00	HOSPITAL ASSESSMENT FEE	В		ADULTS & PEDIATRICS	30.00	0	12.00	
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4, 105, 902				50.00	

<sup>(1)</sup> 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.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

| Period: | Worksheet A-8-2 | From 07/01/2019 | To 06/30/2020 | Date/Time Prepared: Provi der CCN: 15-4014

							To 06/30/2020	Date/Time Pre 11/18/2020 3:	
	Wkst. A Line #	Cost Ce	enter/Physi ci an	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			denti fi er	Remuneration	Component	Component		ider Component	
								Hours	
	1.00		2.00	3. 00	4.00	5. 00	6. 00	7.00	
1. 00	30.00	ADULTS & PE	EDI ATRI CS	572, 454	543, 83	1 28, 62	3 181, 300	113	1.00
2.00	90.00	CLINIC		2, 395, 984	2, 255, 31	1 140, 67	3 181, 300	679	2.00
3.00	0.00			0		o	o c		3. 00
4.00	0.00			0		o	ol c	o	4.00
5.00	0.00			0		o	o c	o	5. 00
6.00	0.00			0		o	ol c	o	6. 00
7.00	0.00			0		o	ol c	o	7. 00
8.00	0.00			0		o	ol c	o	8. 00
9.00	0.00			0		o	ol c	o	9. 00
10.00	0.00			0		o	ol c	o	10.00
200.00				2, 968, 438	2, 799, 14	2 169, 29	6	792	200.00
	Wkst. A Line #	Cost Ce	enter/Physi ci an	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
			denti fi er			E Memberships	& Component	of Mal practice	
					Limit	Continuing	Share of col.	Insurance	
						Educati on	12		
	1. 00		2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00	30.00	ADULTS & PE	EDI ATRI CS	9, 849	49		1 290	0	1.00
2.00	90. 00	CLINIC		59, 184	2, 95	9 21, 46	7 1, 260	0	2.00
3.00	0.00			0		0	0	0	3.00
4.00	0.00			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	1 "	10.00
200.00				69, 033				0	200.00
	Wkst. A Line #		enter/Physi ci an	Provi der	Adjusted RCE		Adjustment		
		I c	denti fi er	Component	Limit	Di sal I owance	:		
				Share of col.					
	1.00		0.00	14	1/ 00	47.00	10.00	1	
1 00	1.00	ADULTS & PE	2. 00	15. 00 0	16. 00 10, 13	17. 00	18.00		1.00
1.00			EDIAIRICS	0				1	1.00
2. 00 3. 00	90.00	CLINIC		0	60, 44	4 80, 22 0	1	1	2.00
				0		0		1	3.00
4.00	0.00			0		0			4.00
5. 00	0.00			0					5.00
6. 00	0.00			0		0			6.00
7. 00	0.00			0		0			7.00
8. 00 9. 00	0. 00 0. 00			0		0			8. 00 9. 00
9. 00 10. 00	0.00			0					10.00
				0	70, 58	0 3 98, 71	3 2, 897, 855	<u>'</u>	200.00
200. 00	1	1		0	J 70, 58	ار ۶۵٫/۱	ol 2, 891, 855	Pl	∠UU. UU

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	THE OTIS R. B	Provi der CC		Period: From 07/01/2019 To 06/30/2020		pared:
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
OFNEDAL CEDIMOR COCT OFNEDO	0	1. 00	4. 00	4A	5. 00	
GENERAL SERVICE COST CENTERS	1 11, 185, 043 14, 684, 344 654, 972 295, 412 3, 251, 812	0 0 0	11, 185, 04 1, 731, 62 134, 36 60, 60	16, 415, 973 3 789, 335 12 356, 014	207, 878 93, 759	7. 00 16. 00
60. 00 06000 LABORATORY	29, 652	0		0 29, 652	7, 809	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	121, 908	o		0 121, 908	32, 105	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	7, 292, 314	0	1, 508, 10	8, 800, 422	2, 317, 662	
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0		0 0	0	90. 01
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	37, 515, 458	1	4, 091, 77	0 30, 422, 184	3, 688, 648	118.00
NONREI MBURSABLE COST CENTERS		ام			_	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 000	0		0 0		192.00
192. 01 19201  RESI DENTI AL 192. 02 19202  MRO	33, 682, 969 7, 550, 813		5, 856, 86 1, 236, 40			
192. 02 19202 MRO 192. 03 19203 METHODONE CLINIC	7, 550, 813	0	1, 230, 40	0 8, 787, 218		192. 02
194.00 07950  RENTAL SPACE	0	0		0		194. 00
200.00 Cross Foot Adjustments		ď		0	o o	200.00
201.00 Negative Cost Centers		0		0 0	n	201.00
202.00 TOTAL (sum lines 118 through 201)	78, 749, 240		11, 185, 04	78, 749, 240		

Heal th	Financial Systems	THE OTIS R. BO	OWEN CENTER		In lie	u of Form CMS-	2552_10
	LLOCATION - GENERAL SERVICE COSTS	THE OTTS K. DO	Provi der CC	F	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part I	epared:
	Cost Center Description	OPERATION OF PLANT	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		7. 00	16. 00	24.00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS						
4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 4.00 5.00
	00700 OPERATION OF PLANT	997, 213					7.00
	01600 MEDICAL RECORDS & LIBRARY	50, 147	499, 920				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	30, 147	477, 720				10.00
30. 00	03000 ADULTS & PEDIATRICS	84, 928	21, 168	5, 044, 41	0	5, 044, 411	30.00
	ANCILLARY SERVICE COST CENTERS		-	07.44		07.444	
	06000 LABORATORY	0	0	37, 46			
	07300 DRUGS CHARGED TO PATIENTS	0	0	154, 013	3 0	154, 013	73. 00
	OUTPATIENT SERVICE COST CENTERS				_		
	09000 CLINIC	256, 105	165, 193	11, 539, 382		,	
	09001 PARTI AL HOSPI TALI ZATI ON	0	0	(	0	0	90. 01
	SPECIAL PURPOSE COST CENTERS				_		4
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	391, 180	186, 361	16, 775, 267	7 0	16, 775, 267	<u>_</u> 1118. 00
	NONREI MBURSABLE COST CENTERS		اء				
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	٥ -		192.00
	19201 RESI DENTI AL	143, 723	313, 559			50, 410, 261	
	19202 MRO	254, 572	0	11, 355, 974		11, 355, 974	
	19203 METHODONE CLINIC	82, 207	0	82, 207			192. 03
	07950 RENTAL SPACE	125, 531	U	125, 53	0	125, 531	
200.00	Cross Foot Adjustments			(			200.00
201.00	Negative Cost Centers	007 212	400,000	70 740 040	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	997, 213	499, 920	78, 749, 240	0	78, 749, 240	1202.00

Health Financial Systems	THE OTIS R. BOWEN CE	ENTER	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Pro		Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Prepared: 11/18/2020 3:44 pm

					o 06/30/2020	Date/Time Pre	pared:
						11/18/2020 3:	44 pm
			CAPI TAL				
		l	RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
		Assigned New	FLXT		BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
		0	1. 00	2A	4. 00	5. 00	
	SENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1	1	1		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	328, 607	0	328, 607	0	328, 607	5.00
7.00	00700 OPERATION OF PLANT	o	0	0	0	4, 161	7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	0	0	0	1, 877	16.00
I	NPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	167, 881	0	167, 881	0	20, 608	30.00
Δ	NCILLARY SERVICE COST CENTERS						1
60.00	06000 LABORATORY	0	0	0	0	156	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	0	643	73.00
C	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	405, 137	0	405, 137	0	46, 396	90.00
90. 01	09001 PARTIAL HOSPITALIZATION	o	0	0	0	0	90. 01
S	SPECIAL PURPOSE COST CENTERS						1
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	901, 625	1	901, 626	0	73, 841	118. 00
N	IONREI MBURSABLE COST CENTERS						1
192.001	9200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 1	9201 RESI DENTI AL	1, 239, 755	0	1, 239, 755	1	208, 440	192. 01
192. 02 1	9202 MRO	416, 824	0	416, 824	0	46, 326	192. 02
192. 03 1	9203 METHODONE CLINIC	o	0	0	0	0	192. 03
194.000	07950 RENTAL SPACE	o	0	0	0	0	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 558, 204	1	2, 558, 205	1	328, 607	
	1 . (	_, _, _, _,	·	_,,,	1 1	1 222,007	

Heal th	Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der CC		Period: From 07/01/2019 To 06/30/2020		pared: 44 pm
	Cost Center Description	OPERATION OF PLANT	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		7. 00	16. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS						1
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	4, 161					7. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	209	2, 086				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00	03000 ADULTS & PEDIATRICS	354	89	188, 93	2 0	188, 932	30.00
	ANCILLARY SERVICE COST CENTERS	1 0	ما		ما ا	4=1	
60.00	06000 LABORATORY	0	0	15		156	
/3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	64	3 0	643	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0/0	(02	452.20	,F	452.205	00.00
90. 00 90. 01	09000   CLI NI C   09001   PARTI AL HOSPI TALI ZATI ON	1, 069 0	693 0	453, 29	0 0	453, 295 0	1
90.01	SPECIAL PURPOSE COST CENTERS	l d	U		0	0	90.01
118. 00		1, 632	782	643, 02	6 0	643, 026	110 00
110.00	NONREI MBURSABLE COST CENTERS	1, 032	/02	043, 02	.0  0	043, 020	1110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	O		0 0	0	192. 00
	19201 RESIDENTIAL	600	1, 304	1, 450, 10	-	1, 450, 100	
	19202 MRO	1, 062	1, 304	464, 21		464, 212	
	19203 METHODONE CLINIC	343	0	34			192. 03
	07950 RENTAL SPACE	524	0	52			194.00
200.00		327	ĭ	32	0		200.00
201.00		0	٥		0		201.00
202.00	1 1 9	4, 161	2, 086	2, 558, 20	5 0	2, 558, 205	
	1 (3)	1, 10,1	,,		-1		

Heal th Finar	ncial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-:	2552-10
	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					rom 07/01/2019	D-+- /T: D	
					To 06/30/2020	Date/Time Pre 11/18/2020 3:	parea: 44 nm
		CAPI TAL				117 107 2020 0.	
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
OFNED	ALL CERVILOE COCT OFNITERS	1. 00	4. 00	5A	5. 00	7. 00	
	AL SERVICE COST CENTERS	272 024		I	1		1 00
	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	273, 834	E4 E22 240				1.00 4.00
	ADMINISTRATIVE & GENERAL	3, 000	54, 523, 268	•	(2 222 247		5.00
	OPERATION OF PLANT	26, 725 1, 500	8, 441, 082 654, 972			242 400	
	MEDICAL RECORDS & LIBRARY	12, 200	295, 412			242, 609 12, 200	
	TENT ROUTINE SERVICE COST CENTERS	12, 200	275, 412		330, 014	12, 200	10.00
	ADULTS & PEDIATRICS	20, 662	3, 202, 975		3, 908, 880	20, 662	30.00
	LARY SERVICE COST CENTERS	20,002	3, 202, 713		3, 700, 000	20,002	30.00
	LABORATORY	0	0		29, 652	0	60.00
	DRUGS CHARGED TO PATIENTS	l ol	0			0	
	TIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			,		
90.00 09000		62, 307	7, 351, 497	(	8, 800, 422	62, 307	90.00
90. 01 09001	PARTI AL HOSPI TALI ZATI ON	0	0	(	0	0	90. 01
	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	126, 394	19, 945, 938	-16, 415, 973	14, 006, 211	95, 169	118. 00
	MBURSABLE COST CENTERS						
	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
	RESI DENTI AL	34, 966	28, 550, 292			34, 966	1
192. 02 19202		61, 934	6, 027, 038		8, 787, 218	61, 934	
	METHODONE CLINIC	20, 000	0		۲	20, 000	
200.00	RENTAL SPACE	30, 540	0		0	30, 540	
200.00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	1	11, 185, 044		16, 415, 973	997, 213	
202.00	Part I)	'	11, 165, 044		10, 413, 973	997, 213	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000004	0. 205143		0. 263358	4. 110371	203 00
204. 00	Cost to be allocated (per Wkst. B,	0.000004	0. 203 143		328, 607		204.00
201.00	Part II)				020,007	1, 101	201.00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 005272	0. 017151	205.00
	[11)						
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)			l			l

Health Fina	ancial Systems	THE OTIS R. BOW	VEN CENTER	Inlie	ı of Form CMS-2552-10
	ATION - STATISTICAL BASIS	THE OTTO IX. DOI	Provider CCN: 15-4014	Peri od:	Worksheet B-1
				From 07/01/2019 To 06/30/2020	Date/Time Prepared:
	Cost Center Description	MEDI CAL			11/18/2020 3: 44 pm
		RECORDS &			
		LI BRARY			
		(GROSS REVENUE)			
		16. 00			
GENE	RAL SERVICE COST CENTERS	10.00			
1.00 0010	OO NEW CAP REL COSTS-BLDG & FLXT				1.00
4.00 0040	O EMPLOYEE BENEFITS DEPARTMENT				4.00
	OO ADMINISTRATIVE & GENERAL				5. 00
	O OPERATION OF PLANT				7.00
	MEDICAL RECORDS & LIBRARY	149, 890, 513			16. 00
	TIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS	6, 347, 226			30.00
	LLARY SERVICE COST CENTERS	0, 347, 220			30.00
	O LABORATORY	0			60.00
	OD DRUGS CHARGED TO PATIENTS	o			73.00
OUTP	ATIENT SERVICE COST CENTERS				
90.00 0900		49, 533, 125			90.00
	1 PARTIAL HOSPITALIZATION	0			90. 01
	I AL PURPOSE COST CENTERS	55 000 054			110.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	55, 880, 351			118. 00
	O PHYSICIANS' PRIVATE OFFICES	0			192. 00
	11 RESI DENTI AL	94, 010, 162			192.00
192. 02 1920		0			192. 02
192. 03 1920	3 METHODONE CLINIC	0			192. 03
194. 00 0795	O RENTAL SPACE	0			194. 00
200. 00	Cross Foot Adjustments				200. 00
201.00	Negative Cost Centers	400.000			201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	499, 920			202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 003335			203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	2, 086			204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000014			205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207. 00
ı	1. a. to 1.11 and 1.1)				I

Health Fina	ancial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider Co		Peri od: From 07/01/2019 To 06/30/2020		pared: 44 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	O ADULTS & PEDIATRICS	5, 044, 411		5, 044, 4	11 18, 484	5, 062, 895	30.00
ANCI	LLARY SERVICE COST CENTERS						
60.00 0600	O LABORATORY	37, 461		37, 4	51 0	37, 461	60.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	154, 013		154, 0	13 0	154, 013	73.00
OUTF	ATIENT SERVICE COST CENTERS						
90.00 0900	O CLI NI C	11, 539, 382		11, 539, 3	80, 229	11, 619, 611	90.00
90. 01 0900	1 PARTIAL HOSPITALIZATION	0			0 0	0	90. 01
200.00	Subtotal (see instructions)	16, 775, 267	0	16, 775, 2	67 98, 713	16, 873, 980	200. 00
201.00	Less Observation Beds	0			0	0	201. 00
202.00	Total (see instructions)	16, 775, 267	0	16, 775, 2	98, 713	16, 873, 980	202.00

Health Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 07/01/2019 To 06/30/2020		pared:
					11/18/2020 3:	44 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7.00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 159, 237		6, 159, 23	7		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	36, 692	0	36, 69	1. 020958	0. 000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	151, 297	0	151, 29	7 1. 017951	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				<u>.                                      </u>		
90. 00 09000 CLI NI C	0	24, 414, 409	24, 414, 40	9 0. 472646	0.000000	90.00
90. 01 09001 PARTIAL HOSPITALIZATION	o	0		0.000000	0.000000	90. 01
200.00 Subtotal (see instructions)	6, 347, 226	24, 414, 409	30, 761, 63	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 347, 226	24, 414, 409	30, 761, 63	5		202. 00

Heal th Finar	ncial Systems	ems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2!				
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020		
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS					30.00
ANCI L	LARY SERVICE COST CENTERS					
60.00 06000	LABORATORY	1. 020958				60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1. 017951				73.00
OUTPA	TIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0. 475933				90.00
90. 01 09001	PARTIAL HOSPITALIZATION	0. 000000				90. 01
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. BO	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 15-4014	Period: From 07/01/2019 To 06/30/2020		
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 044, 411		5, 044, 41	1 18, 484	5, 062, 895	30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	37, 461		37, 46	0 0	37, 461	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	154, 013		154, 0°	3 0	154, 013	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	11, 539, 382		11, 539, 38	80, 229	11, 619, 611	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	o			0	0	90. 01
200.00 Subtotal (see instructions)	16, 775, 267	0	16, 775, 26	98, 713	16, 873, 980	200.00
201.00 Less Observation Beds	O			0	0	201.00
202.00 Total (see instructions)	16, 775, 267	0	16, 775, 26	98, 713	16, 873, 980	202.00

Health Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 07/01/2019 To 06/30/2020		pared:
					11/18/2020 3:	44 pm
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	6, 159, 237		6, 159, 23	7		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	36, 692	0	36, 69	2 1. 020958	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	151, 297	0	151, 29	7 1. 017951	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	24, 414, 409	24, 414, 40	9 0. 472646	0. 000000	90.00
90. 01   09001 PARTI AL HOSPI TALI ZATI ON	0	0		0.000000	0.000000	90. 01
200.00 Subtotal (see instructions)	6, 347, 226	24, 414, 409	30, 761, 63	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 347, 226	24, 414, 409	30, 761, 63	5		202. 00

Health Finar	ncial Systems	THE OTIS R. BOV	VEN CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020		pared: 44 pm	
			Title XIX	Hospi tal	Cost		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11. 00					
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS					30.00	
ANCI L	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0. 000000				60.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 000000				73.00	
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0. 000000				90.00	
90. 01 09001	PARTIAL HOSPITALIZATION	0. 000000				90. 01	
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
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part I Date/Time Pre 11/18/2020 3:	pared: 44 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /	
	(from Wkst. B, Part II,		Related Cost (col. 1 -		col . 4)	
	col. 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	188, 932	0	188, 93			
200.00 Total (lines 30 through 199)	188, 932		188, 93	2 3, 249		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
LANDATI ENT. DOUTLANE, DEDIVLOE, DOOT, DENTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	450	0, 00,				
30. 00 ADULTS & PEDIATRICS	452					30.00
200.00 Total (lines 30 through 199)	452	26, 284				200.00

Health Financial Systems	THE OTIS R. BOWEN CENTER			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 07/01/2019 To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t 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	156	36, 692	0. 00425	2 2, 604	11	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	643	151, 297	0. 00425	0 15, 525	66	73.00
OUTPATIENT SERVICE COST CENTERS				<u>.</u>		
90. 00 09000 CLI NI C	453, 295	24, 414, 409	0. 01856	7 0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0	0. 00000	0	0	90. 01
200.00 Total (lines 50 through 199)	454, 094	24, 602, 398		18, 129	77	200.00

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	TS Provi der C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	
		Ti +Lo	e XVIII	Hospi tal	11/18/2020 3: PPS	44 pm
Cost Center Description	Nursi ng	Nursing		n Allied Health	All Other	
cost center bescription	School	School	Post-Stepdow		Medical	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0	0	00.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		Inpati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)	/ 00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
			1 2 24	0 00	450	20.00
	0	0	3, 24			
200.00   Total (lines 30 through 199)  Cost Center Description	Inpati ent	0	3, 24	9	452	200.00
cost center bescriptron	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	THE OTIS R. BO	WEN CENTER		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PASS	Provi der CC	CN: 15-4014	Period: From 07/01/2019 To 06/30/2020		pared: 44 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School Post-Stepdown Adjustments		Allied Health Post-Stepdown Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00   06000   LABORATORY 73. 00   07300   DRUGS CHARGED TO PATIENTS	0	0		0 0	0	60.00 73.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	0	73.00
90. 00  09000   CLI NI C	0	0		0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0		0		90. 01
200.00 Total (lines 50 through 199)	l Ol	0		0	0	200.00

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS	S Provider C		Period: From 07/01/2019 To 06/30/2020		pared: 44 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00   06000   LABORATORY	0	0		0 36, 692	0.000000	60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 151, 297	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 24, 414, 409	0.000000	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0		0 0	0.000000	90. 01
200.00 Total (lines 50 through 199)	0	0		0 24, 602, 398		200.00

Health Financial Systems THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provi der Co		Peri od: From 07/01/2019 To 06/30/2020		pared: 44 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program		
	to Charges (col. 6 ÷	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9		
	col . 7) 9.00	10. 00	x col. 10) 11.00	12.00	x col. 12) 13.00		
ANCILLARY SERVICE COST CENTERS							
60. 00 06000 LABORATORY	0. 000000	2, 604		0 0	0	60.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	15, 525		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0. 000000	0		0 1, 186, 233	0	90.00	
90. 01 09001 PARTIAL HOSPITALIZATION	0. 000000	0		0 0	0	90. 01	
200.00 Total (lines 50 through 199)		18, 129		0 1, 186, 233	0	200. 00	

Health Financial Systems	THE OTIS R. E	BOWEN CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od: From 07/01/2019	Worksheet D Part V	
				To 06/30/2020		pared: 44 pm
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	1. 020958	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 017951	0	1	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 472646	1, 186, 233		0	560, 668	90.00
90. 01   09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	0	)	0 0	0	90. 01
200.00 Subtotal (see instructions)		1, 186, 233		0 0	560, 668	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		1, 186, 233		o o	560, 668	202.00

Health Financial Systems	THE OTIS R. BO	OWEN CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIC	ES AND VACCINE COST	Provi der Co	CN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020		
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
60. 00  06000  LABORATORY	0	0				60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	0				90.00
90. 01   09001   PARTI AL HOSPI TALI ZATI ON	0	0				90. 01
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Pro	gram   0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

	Financial Systems	THE OTIS R. BOW			u of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Pre		
				10 00/30/2020	11/18/2020 3:		
			Title XVIII	Hospi tal	PPS		
	Cost Center Description						
					1. 00		
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days a				3, 249		
2.00	Inpatient days (including private room days,				3, 249	2.00	
3. 00	Private room days (excluding swing-bed and oldo not complete this line.	oservation bed da	ays). If you have only p	rivate room days,	0	3.00	
4.00	Semi-private room days (excluding swing-bed a	and observation b	oed days)		3, 249	4.00	
5. 00	Total swing-bed SNF type inpatient days (incl reporting period	uding private ro	oom days) through Decemb	er 31 of the cost	0	5. 00	
6. 00	Total swing-bed SNF type inpatient days (incl reporting period (if calendar year, enter 0 o		oom days) after December	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period						
8. 00							
9. 00	Total inpatient days including private room (newborn days) (see instructions)	452	9. 00				
10. 00	Swing-bed SNF type inpatient days applicable through December 31 of the cost reporting per	0	10.00				
11. 00	Swing-bed SNF type inpatient days applicable December 31 of the cost reporting period (if	to title XVIII	only (including private	room days) after	0	11.00	
12. 00	Swing-bed NF type inpatient days applicable through December 31 of the cost reporting per	to titles V or XI		te room days)	0	12.00	
13. 00	Swing-bed NF type inpatient days applicable after December 31 of the cost reporting period	to titles V or XI			0	13.00	
14 00	Medically necessary private room days applica				0	14.00	
	Total nursery days (title V or XIX only)		am (exer during eming bed	dayo	0		
	Nursery days (title V or XIX only)					16.00	
	SWING BED ADJUSTMENT					10.00	
17. 00	Medicare rate for swing-bed SNF services appl reporting period	icable to servi	ces through December 31	of the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services appl reporting period	icable to servi	ces after December 31 of	the cost	0. 00	18. 00	
19. 00	Medicaid rate for swing-bed NF services appli reporting period	cable to service	es through December 31 o	f the cost	0. 00	19.00	
20. 00	Medicaid rate for swing-bed NF services appli reporting period	cable to service	es after December 31 of	the cost	0. 00	20.00	
21. 00	Total general inpatient routine service cost	(see instruction	ne)		5, 062, 895	21.00	
	Swing-bed cost applicable to SNF type service			ting period (line			
23. 00	5 x line 17) Swing-bed cost applicable to SNF type service	es after Decembe	31 of the cost reporti	ng period (line 6	0	23. 00	
24. 00	x line 18)   Swing-bed cost applicable to NF type services	s through Decembe	er 31 of the cost report	ing period (line	0	24. 00	
25. 00	7 x line 19) Swing-bed cost applicable to NF type services	s after December	31 of the cost reporting	g period (line 8	0	25. 00	
26. 00	x line 20) Total swing-bed cost (see instructions)		(1)		0	26.00	

1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	3, 249 3, 249 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-pri vate room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	3, <u>2</u> 49 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	452	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5, 062, 895 •	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line $(x,y)$ ) x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $7 \times 1$ line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 $\times$ line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0 5, 062, 895	
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)		33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5, 062, 895	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 558. 29	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	704, 347	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 704, 347	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	/04, 34/	41.00

Cost Desire Description		Financial Systems	THE OTIS R. E		CN. 1E 4014		u of Form CMS-2	
Cost Center Description	COMPUI	ATTON OF INPATTENT OPERATING COST		Provider C	.CN: 15-4014		Worksheet D-1	
Cost Center Description					. V0/II I		11/18/2020 3:	
Impatient   Impatient   Impatient   Diem Cod   1		Cost Center Description	Total					
1.00   2.00   3.00   4.00   5.00   5.00		· ·	•	•	Diem (col. 1		(col. 3 x	
Interest vs. Care Type Inpatient Rospital Units 4.0 (INTERSIVE CAME. UNIT 4.0 (CORRESPONDED VS. CAME. UNIT 4.0 (CORRESPONDED VS. CAME. (SPECIFY) 4						4. 00		
A3.00   INTERSIVE CARE (BUIT   44.00   CORRENA CARE (BUIT   45.00   BURNINTERSIVE CARE (BUIT   45.00   BURNINTERSIVE CARE (BUIT   45.00   BURNINTERSIVE CARE (BUIT   45.00   CORT (BUIT   47.00   CO	42. 00	NURSERY (title V & XIX only)						42.00
45.00   SURPAY INTENSIVE CARE UNIT   46.00   SURGICAL NITERSIVE CARE UNIT   46.00   SURGICAL NITERSIVE CARE UNIT   46.00   SURGICAL NITERSIVE CARE UNIT   47.00   1.00	43. 00							43.00
46.00   SURRICAL INTERSIVE CARE UNIT     46.00   Cost Center Description   1.00								44.00
47.00   OTHER SPECIAL CARE (SPECIFY)		1						46.00
1.00		OTHER SPECIAL CARE (SPECIFY)						47. 00
49.00   Pass through costs applicable to Program inpatient routine services (from Wast. D, sum of Parts I and 26.284   111)		Cost Center Description					1. 00	
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 111)  51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 77 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 77 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 77 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 77 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 77 51.00 Pass through Cost Science (from West. D. sum of Parts II 77 51.00 Pass through Cost Science (from West. D. sum of Parts II 77 51.00 Pass Cost Science (from West. D. sum of Parts II 77 51.00 Pass Cost Science (from West. D. sum of Parts II 77 51.00 Pass Cost Pass Co								1
50.00 Pass through costs applicable to Program inpatient routine services (From West. D. sum of Parts I and 17.51.00 Pass through costs applicable to Program inpatient ancillary services (From West. D. sum of Parts II and IV)  51.00 Pass through costs applicable to Program inpatient ancillary services (From West. D. sum of Parts II and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and edication costs (IIn e4 pm inus I ine 52)  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and target amount (IIn e 56 minus IIne 53)  58.00 Bonus payment (see instructions)  59.00 Difference between adjusted inpatient operating cost and target amount (IIne 56 minus IIne 53)  59.00 Difference between adjusted inpatient operating cost and target amount (IIne 53 minus IIne 53)  59.00 Difference between adjusted inpatient operating cost and target amount (IIne 53 minus IIne 53)  59.00 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the market basket  60.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Lesser of IInes 53/54 or 55 from prior year cost report (Ine 54 pm ine 1996)  61.00 Relief payment (see instructions)  62.00 Relief payment (see instructions)  62.00 Relief payment (see instructions)  63.00 Relief payment (see instructions)  64.00 Medicare swing-bed SN ii papatient routine costs after December 31 of the cost reporting period (See instructions) (III to Viri XI swing-bed SN iinpatient routine costs (IIne 64 plus IIne 65) (III to XVIII only)  69.00 Intal Inter Viri XI swing-bed SN inpatient routine costs (IIne 64 plus IIne 65) (III to XVIII only)  69.00 Intal Inter Viri XI swing-bed SN inpatient routine costs (IIne 64	49.00		41 through 48)	(see instructi	ons)		722, 810	49.00
9.1.00 Pasis through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II and Program excludable cost (sum of lines 50 and 51)  7.0.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and edical education costs (line 49 minus line 52)  7.0.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and edical education costs (line 44 minus line 52)  7.0.00 Target amount (line 54 x line 55)  7.0.00 Target amount per discharge  9.0.00 S5.00  9.00 Target amount (line 54 x line 55)  9.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  9.00 Difference between adjusted inpatient operating period ending 1990, updated and compounded by the market basket on market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated and compounded by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated by the market basket on the same period ending 1990, updated period ending 1990, updated period ending 1990, updated perio	50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	26, 284	50.00
and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 606,449 63.00 modical education costs (line 40 minus line 52)  54.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 606,449 63.00 modical education costs (line 40 minus line 52)  54.00 Program discharges  0.01 St. 00 Program discharges  0.05.00 Target amount (line Musted inpatient operating cost and target amount (line 56 minus line 53) 0.05.00 Days and the second line of the second	51. 00		atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	77	51.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (Line 49 minus Line 52)	F2 00		FO 1 F1)				27. 271	F2 00
TARGET AMOUNT AND LIMIT COMPUTATION  1 A0 0 Program discharges 1 Computations 1 C				elated, non-ph	ysician anest	hetist, and		
54.00   Program discharges   0.   54.00   55.00   Target amount per discharge   0.0   55.00   Target amount per discharge   0.0   55.00   Target amount (line 54 x line 55)   0.5   56.00   Target amount (line 54 x line 55)   0.5   56.00   Target amount (line 54 x line 55)   0.5   56.00   56.0			52)	·				
56.00   Target amount (Tine 54 x Tine 55)   0.56.00   57.00   Borus payment (see instructions)   0.57.00   58.00   Borus payment (see instructions)   0.58.00   58.00   Borus payment (see instructions)   0.58.00   58.00   59.00   Easer of Tines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   69.00   61.00   If Tine 53/54 is less than the lower of Tines 55, 59 or 60 enter the Tesser of S0% of the amount by which operating costs (Tine 53) are Tess than expected costs (Tine 54 x 60), or 1% of the target amount (Tine 56), otherwise enter zero (see Instructions)   0.61.00   63.00   11.00	54.00						0	54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Bosspayment (see instructions) 0 58.00 lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the morket basket 0.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 lesser of lines 53/54 or 55 from prior year costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 lesser of lines 53/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 53/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 53/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55, otherwise enter zero (see instructions) 0 63.00 lesser of lines 54/54 or 55/54 or 55								
Section   Sect		, ,	ing cost and t	arget amount (	line 56 minus	line 53)		1
market basket  0.00 Losser of lines 53/54 or 55 from prior year cost report, updated by the market basket  0.00 lf lines 53/54 is less than the lower of lines 55. 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  0.00 Allowable Inpatient cost plus incentive payment (see instructions)  0.01 Allowable Inpatient cost plus incentive payment (see instructions)  0.01 Allowable Inpatient cost plus incentive payment (see instructions)  0.01 Allowable Inpatient cost plus incentive payment (see instructions)  0.02 Allowable Inpatient cost plus incentive payment (see instructions)  0.03 Allowable Inpatient cost plus incentive payment (see instructions)  0.04 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (till te XVIII only)  0.05 Allowable Inpatient pout in costs after December 31 of the cost reporting period (see instructions) (till te XVIII only)  0.06 Allowable Inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  0.07 Allowable (see instructions)  0.08 Allowable (are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  0.09 Allowable (see instructions)  1.00 Allowable (see instruction								
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions)  67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 10 x line 20)  70.00 Skiled nursing facility/other nursing facility/file routine service cost (line 37)  71.00 Adjusted general inpatient routine service costs (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost (line 74 minus line 77)  76.00 Program capital-related costs (line 9 x line 76)  77.00 Program capital-related cost (line 75 + line 2)  78.00 Program inpatient routine service cost (see instructions)  80.00	59.00		0.00	59.00				
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  0. 62.00  Relief payment (see instructions)  0. 63.00  Allowable Inpatient cost plus incentive payment (see instructions)  0. 63.00  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (tille XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (tille XVIII only)  Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAMI (see instructions)  65.00  Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions)  67.00  CAMI (see instructions)  67.00  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART IIII - SALILED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00  Algority and service cost (line 9 x line 71)  72.00  Program routine service cost (line 9 x line 71)  73.00  Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00  Total Program general inpatient routine service costs (fine 72 + line 2)  75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00  Part of which we service cost (line 9 x line 70)  77.00  Program capital-related costs (line 9 x line 70)  80.00  Total Program routine service cost (line 9 x line 70)  80.00  Total Program routine service cost (line 10 x line 80)  80.								
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26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Pogram inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						Part II column		74.00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  77. 00 Total Program inpatient routine service costs (from provider records) 87. 00 Adjusted general inpatient routine 9 x line 81) 88. 00 Adjusted general inpatient routine 9 x line 81) 88. 00 Adjusted general inpatient cost per diem (line 27 ÷ line 2) 88. 00 O O O O O O O O O O O O O O O O O O	73.00	' · · · · · · · · · · · · · · · · · ·	routine servic	c costs (Trom	worksheet b,	rar t 11, coramir		
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Oscillation (line 78 minus line 79) 89.00 Security (line 78 minus line 79) 80.00 Security (lin		1						76.00 77.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 October 10 in 10	78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		, 55 5	•	•	,	nus line 79)		
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  84.00 84.00 84.00 85.00 86.00 86.00 87.00 88.00	81.00	Inpatient routine service cost per diem limi	tati on		(11116 70 1111	nds Title 77)		81.00
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 88.00		1 .		· .				82. 00 83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	84.00	Program inpatient ancillary services (see in	structions)	ŕ				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  0.00 88.00		1	•					85. 00 86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
		1	•	÷ line 2)				1
0 07.00								1

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 44 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	188, 932	5, 062, 895	0. 03731	7 0	0	90.00
91.00 Nursing School cost	0	5, 062, 895	0.00000	0	0	91.00
92.00 Allied health cost	0	5, 062, 895	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 062, 895	0.00000	0 0	0	93.00

111 4-	Figure 1 Contains	DOWEN CENTED	la lia		2552 10
	Financial Systems THE OTIS R. ATION OF INPATIENT OPERATING COST	BOWEN CENTER  Provi der CCN: 15-4014	Peri od:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST	Provider CCN: 15-4014	From 07/01/2019	worksneet D-1	
			To 06/30/2020	Date/Time Pre	pared:
				11/18/2020 3:	44 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-be	d days, excluding newborn)		3, 249	1.00
2.00	Inpatient days (including private room days, excluding s	wing-bed and newborn days)		3, 249	2.00
3.00	Private room days (excluding swing-bed and observation b		rivate room davs.	0	3.00
	do not complete this line.	3, 3			
4.00	Semi-private room days (excluding swing-bed and observat	ion bed days)		3, 249	4.00
5.00	Total swing-bed SNF type inpatient days (including priva	te room days) through Decemb	er 31 of the cost	0	5.00
	reporting period	<i>,</i> , 3			
6.00	Total swing-bed SNF type inpatient days (including priva	te room days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line	2)			
7.00	Total swing-bed NF type inpatient days (including privat	e room days) through Decembe	r 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including privat	e room days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line				
9. 00	Total inpatient days including private room days applica	ble to the Program (excludin	g swing-bed and	517	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XV	III only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see in	structions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XV		room days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar ye			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V through December 31 of the cost reporting period	or xix only (including priva	te room days)	Ü	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V	or VIV only (including prive	to room dove)	0	13.00
13.00	after December 31 of the cost reporting period (if calen			U	13.00
14. 00	Medically necessary private room days applicable to the			0	14.00
15. 00	Total nursery days (title V or XIX only)	Trogram (exertaining swring bea	uays)	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to s	ervices through December 31	of the cost	0.00	17.00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to s	ervices after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to se	rvices through December 31 o	f the cost	0.00	19.00
	reporting period	-			
20.00	Medicaid rate for swing-bed NF services applicable to se	rvices after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instru	ctions)		5, 044, 411	21.00
22. 00	Swing-bed cost applicable to SNF type services through D	ecember 31 of the cost repor	ting period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after Dec	ember 31 of the cost reporti	ng period (line 🏻	0	23. 00
0.4	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through De	cember 31 of the cost report	ing period (line	0	24. 00
25 00	7 x line 19)	mbon 21 of thet	a ported (1: o	2	25 00
25. 00	Swing-bed cost applicable to NF type services after Dece	mber 31 of the cost reportin	g perioa (iine 8	0	25. 00

	Cost Center Description		
	DADT I ALL DOWLDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 249	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 249	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0, 217	3. 00
	do not complete this line.	-	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 249	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	۷	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ĭ	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	517	9.00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	o	12. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	۷	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	o	14.00
15.00		0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00		0. 00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	17.00
20.00		0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	5, 044, 411	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00		0	23. 00
24.00	X   line 18)	o	24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $  7 \times  $ line 19)	۷	24. 00
25. 00	,	0	25. 00
23.00	In line 20)	ĭ	23.00
26.00	,	o	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 044, 411	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
	Private room charges (excluding swing-bed charges)	0	29.00
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	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	33. 00 34. 00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37. 00
	27 minus line 36)		
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 552. 60	
39.00	Program general inpatient routine service cost (line 9 x line 38)	802, 694	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)	902 604	40.00
<del>4</del> 1.00	Total Trogram general impatrent routine service cost (Time 37 + Time 40)	802, 694	41.00

Provider COST   Provider COS		nancial Systems	THE OTIS R. B		CN: 1E 4014		u of Form CMS-2	
Cost Center Description	COMPUTATIO	ON OF INPAILENT UPERAITING COST		Provider C			Worksheet D-1 Date/Time Pre	
Cost Center Description				Ti +1	Ti tl o VIV		11/18/2020 3:	
		Cost Center Description	Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	42. 00 NUF	RSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
44.00   CORONARY CARE UNIT					I			12.00
46.00   SURGICAL INTENSIVE CARE UNIT   46.00   CORT Center Description   47.00   Total Program Inpattent costs (sum of lines 41 through 48) (see instructions)   1.00   47.00   Total Program Inpattent costs (sum of lines 41 through 48) (see instructions)   60.00   68.00   69.0	4							
17.00   Program input lent and ill any service cost (Rist. D.3. col. 3. line 200)   1.00	1							ł
1.00								1
49.00   Program inpatient ancillary service cost (Wikst. D-3, col. 3, line 200)   60, 00		Cost Center Description					1 00	
PASS THROUGH COST ADJUSTMENTS   0   50.00   Pass through costs applicable to Program Inpatient routine services (from West. D. sum of Parts I and 151.00   111)   111	48. 00 Pro	ogram inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)				48. 00
50.00   Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and III)			41 through 48)	(see instructi	ons)		802, 694	49. 00
51.00   Pass through costs applicable to Program Inpatient and Illary services (from Wkst. D. sum of Parts II and Individual program excludable cost (sum of lines 50 and 51)   0   51.00   10   52.00   10   53.00			atient routine	servi ces (fro	m Wkst. D, su	n of Parts I and	0	50.00
			-+:+:		W D		0	F1 00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  54.00 Program discharges  55.00 Target amount (line 54 x line 55)  55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  56.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  57.00 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the 56.00 Difference of lines 53/54 or 55 from prior year cost reporting period ending 1996, updated and compounded by the 67.00 Difference of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  62.00 Relief payment (see instructions)  63.00 Relief payment (see instructions)  64.00 Relief payment (see instructions)  65.00 Relief payment (see instructions)  66.00 Total Program Minatient routine costs through December 31 of the cost reporting period (See Instructions)  67.00 Medicare swing-bed SNF inpatient routine costs fire 54 plus line 65) (title XVIII only). For CAH (see instructions)  68.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See CAH (see instructions))  68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See CAH (see instructions))  69.00 Total rune for XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Minus 12 x line 19)  69.00 Total rune for XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total rune for XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total rune for XIX swing-bed NF inpatient routine costs (line 75 + line 27)  79.00 Period den duran gradient proventine service costs (line 75 + line 28)  79.00 Period den duran gr			atrent andiria	y services (i	TOIII WKSt. D,	Sum of Parts II	U	51.00
medical education costs (line 49 annus line 52)		•	,	alatad nan ah	voi oi on oncoti	notict and		
54.00   Program discharges   0.0   54.00				erateu, non-pn	ysi ci aii aliesti	letist, and	U	33.00
55.00   Target amount per discharge   0.00   55.00   57.00							0	E4 00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 house payment (see instructions) 0 58.00 bous payment (see instructions) 0 58.00 bous payment (see instructions) 0 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report. Updated by the market basket 0.00 60.00 lesser of lines 53/54 is less than the lower of lines 55.59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 62.00 Relief payment (see instructions) 0 63.00 Allowable Inpatient cost plus Incentive payment (see Instructions) 0 63.00 lalowable Inpatient cost plus Incentive payment (see Instructions) 0 64.00 ledicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 0 66.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (line 12 x line 19) 0 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 0 66.00 Total full voir XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 72 + line 2) 71.00 Payment routine service cost (line 97 + line 2) 71.00 Payment routine service cost (line 97 + line 2) 71.00 Payment routine service cost (line 97 + line 2) 71.00 Payment routine service cost (line 97 + line 2) 71.00 Payment routine service cost (line 97 + line 2) 71.00 Paym								
58.00 Bonus payment (see Instructions)  59.00 Lesser of Ilnes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Lesser of Ilnes 53/54 or 55 from prior year cost report, updated by the market basket  60.01 Lesser of Ilnes 53/54 is less than the lower of Ilnes 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Ilne 53) are less than expected costs (Ilnes 54 x 60), or 1% of the target amount (Ilne 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Relief payment (see instructions)  65.00 Relief payment (see instructions)  66.00 Relocant INPATIENT ROUTINE SWIN GED COST  64.00 Relief payment (see instructions)  65.00 Relocare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt E XVIII only)  65.00 Medicare swing-bed SWF inpatient routine costs (Ilne 64 plus line 65) (title XVIII only). For CAM (See instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Inte 12 x Ilne 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ilne 13 x Ilne 20)  69.01 Title V or XIX swing-bed NF inpatient routine costs (Ilne 67 + Ilne 68)  69.02 PART III - SKILLED NURSIN EFACILITY, OMIC ROUTINE SWING ALITY (Ilne 68)  69.03 PART III - SKILLED NURSIN EFACILITY (SMIC ROUTINE)  70.00 Program routine service cost (Ilne 9 x Ilne 71)  70.00 Program routine service cost (Ilne 9 x Ilne 71)  70.00 Program routine service cost (Ilne 75 + Ilne 2)  70.00 Program routine service cost (Ilne 74 minus Ilne 77)  70.00 Program capital-related costs (Ilne 75 x Ilne 2)  70.00 Program capital-related costs (Ilne 74 minus Ilne 77)  70.00 Program capital-related costs (Ilne 74 minus Ilne 77)  70.00 Program capital-related costs (Ilne 74 minus Ilne 77)  70.00 Program capital-related cos		9 ,	ing cost and to	argot amount (	lino 56 minus	lino 52)		
market basket  0.00 (both of the cost of lines 53/54 or 55 from prior year cost report, updated by the market basket  0.00 (60.00 (lines of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relider payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) et instructions (it le xVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (till e XVIII only)  65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAM (See instructions) (till e XVIII only)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (till e XVIII only)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING RACILLY, OTHER NURSING RACILLY, OTHER NUSSING RACILLY, OTHER NUSSI	58. 00 Bor		ing cost and to	arget amount (	Title 50 iii lius	1111e 33)	-	l
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 fol.00 line 53/54 is less than the lower of lines 55/5 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.62.00 Relief payment (see instructions) 0.63.00 Relief payment (see instructions) 0.64.00 Relief payment (see instructions) 0.65.00 Relief payment (see instructions) 0.65.			porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  8cl ief payment (see instructions)  8cl ief payment (see instructions)  9cl 30.00  All owable Inpatient cost plus incentive payment (see instructions)  9cl 30.00  All owable Inpatient cost plus incentive payment (see instructions)  9cl 40.00  9cl 40.	60.00 Les	sser of lines 53/54 or 55 from prior year					0. 00	
amount (IIne 56), otherwise enter zero (see instructions)   0 62.00							0	61.00
63.00   Allowable Inpatient cost plus incentive payment (see instructions)   PROGRAM INPATIENT ROUTINE SWING BED COST	amo							
PROGRAM INPATIENT ROUTINE SWING BED COST								
instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)  60.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Total itile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total itile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/lcf/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Total Program general inpatient routine service costs (line 72 + line 73)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  74.00 Total Program capital-related costs (line 75 + line 2)  75.00 Coptala-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)  79.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiarles for excess costs (from provider records)  79.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Reasonable inpatient matilary service costs (see instructions)  80.00 Total Program inpatient ancillary service costs (see instructions)  81.00 Reasonable inpatient proutine service costs (see instructions)  82.00 Utilization review - physician compensation (see instructions)  83.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  10 Total Observation bed days	PRO	GRAM INPATIENT ROUTINE SWING BED COST	·	,				
65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   CAH (see instructio		·	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICC/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICC/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 75 + line 2)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Inpatient routine service cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost (see instructions)  81.00 Inpatient routine service cost (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient operating costs (sum of lines 83 through 85)  85.00 Utilization review - physician compensation (see instructions)  75.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87	65.00 Med	dicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital-related costs (line 75 + line 2)  76.00 Program capital-related costs (line 75 + line 2)  77.00 Aggregate charges to beneficiaries for excess costs (from provider records)  78.00 Inpatient routine service cost [line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost per dlem limitation  81.00 Inpatient routine service cost per dlem limitation  82.00 Inpatient routine service cost (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Program inpatient noutine service costs (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of line 83 through 85)  87.00 Total Program inpatient operating costs (sum of line 83 through 85)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted		, ,	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
Cline 12 x line 19)   Cline 12 x line 19)   Cline 12 x line 20)   Cline 13 x line 20)   Cline 14 x line 20   Cline 15 x line 20   Cline 27 x line 27   Cline 27 x line 28   Cline 37   Cline 38	1	· · · · · · · · · · · · · · · · · · ·	a costs through	n December 31	of the cost r	enorting period	0	67.00
Cline 13 x line 20)   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY   Program routine service cost (line 37)   Program routine service cost per diem (line 70 + line 2)   Program routine service cost (line 9 x line 71)   Program routine service cost (line 9 x line 71)   Program routine service cost (line 9 x line 71)   Program routine service cost (line 9 x line 71)   Program routine service cost (line 72 + line 73)   Program general inpatient routine service costs (line 72 + line 73)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program cost applicable to Program (line 14 x line 35)   Program (line 45)   Program cost applicable to Program (line 14 x line 35)			e costs till ougi	i becember 31	or the cost in	eporting perrou		
69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0   69.00			e costs after [	December 31 of	the cost rep	orting period	0	68.00
70.00 71.00	69. 00 Tot	tal title V or XIX swing-bed NF inpatient					0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)						)		70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	71. 00 Adj	usted general inpatient routine service co	ost per diem (I		•			71.00
74.00 75.00 75.00 76.00 76.00 76.00 76.00 77.00 78.00 78.00 78.00 79.00 70 70 70 70 70 70 70 70 70 70 70 70 7	1	•	•	m (line 14 x l	ine 35)			
20, line 45)  76.00  Per diem capital -related costs (line 75 ÷ line 2)  77.00  Program capital -related costs (line 9 x line 76)  Regregate charges to beneficiaries for excess costs (from provider records)  79.00  Aggregate charges to beneficiaries for excess costs (from provider records)  79.00  Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  81.00  82.00  Reasonable inpatient routine service costs (see instructions)  84.00  Program inpatient ancillary services (see instructions)  85.00  Willization review - physician compensation (see instructions)  86.00  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  76.00  76.00  76.00  77.00  77.00  78.00	74. 00 Tot	tal Program general inpatient routine serv	ice costs (line	e 72 + line 73	)	David II		
77. 00 Program capital-related costs (line 9 x line 76) 77. 00 Inpatient routine service cost (line 74 minus line 77) 78. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00		•	routine service	e costs (Trom	worksneet B,	Part II, column		/5.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1							1
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  80.00  80.00 Inpatient routine service costs (imitation (line 78 minus line 79) 81.00 Exp. 82.00 Sec. 83.00 Sec. 83.00 Program inpatient routine service cost limitation (line 78 minus line 79) 81.00 Exp. 82.00 Sec. 83.00 Sec. 83.00 Sec. 84.00 Sec. 85.00 Sec. 86.00 Sec. 87.00 Sec. 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Observation Sec. 89.00 Sec. 80.00 Sec. 80.	1	•						
81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient routine service costs (see instruct	50		, ,			aus Lino 70)		ł
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Reasonable inpatient routine service costs (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  88.00 89.00	1			Jose Timi latio	(IIIIC /O IIIII	INSTITE /7)		ł
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		* .						ł
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions) 0 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	1			13)				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  0.00 88.00	1		•					
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00				n ough 60)				00.00
		, ·		: line 2)				ı
	, ,							

Health Financial Systems	THE OTIS R. B	OWEN CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2019		
				To 06/30/2020		pared:
					11/18/2020 3:	44 pm
		Ti tl	e XIX	Hospi tal	Cost	
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	188, 932	5, 044, 411	0. 03745	0	0	90.00
91.00 Nursing School cost	0	5, 044, 411	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 044, 411	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 044, 411	0. 00000	0 0	0	93.00

Health Financial Systems	THE OTIS R. BOWEN CENTER		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			rom 07/01/2019 o 06/30/2020		
	Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		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			813, 980		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00  06000 LABORATORY		1. 020958	2, 604	2, 659	60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		1. 017951	15, 525	15, 804	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00  09000  CLI NI C		0. 475933	0	0	90.00
90. 01  09001 PARTIAL HOSPITALIZATION		0.000000	0	0	90. 01
200.00 Total (sum of lines 50 through 94 and 9	96 through 98)		18, 129	18, 463	200.00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			18, 129		202.00

Health Financial Systems	THE OTIS R. BOWEN CENTER		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	1
			From 07/01/2019 Fo 06/30/2020		
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		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			948, 283		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00   06000   LABORATORY		1. 020958	3 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 017951	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00  09000  CLI NI C		0. 472646	6 0	0	90.00
90. 01   09001   PARTI AL HOSPI TALI ZATI ON		0.000000	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-Pro	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	-		0		202.00

Health Financial Systems	THE OTIS R. BOWE	EN CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-4014	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/18/2020 3:44 pm

			Title XVIII	Hospi tal	11/18/2020 3: PPS	44 pm
MRT B - MEDICAL AND OTHER HEALTH SENVICES   0   1.00   Medical and other services (see instructions)   5.00, 4.00   2.0				noop: ta:		
Medical and other services (See instructions)		DADT D. MEDICAL AND OTHER HEALTH CERVICORS			1. 00	
Medical and other services relinoursed under DPVS (see Instructions)   560, 668   2.00   00   00   00   00   00   00	1 00				0	1 00
OPES payments						
0.011   cr   coometitation   second   case   instructions    0.000		·				
Instant the hospit hal specific payment fo cost ratio (see instructions)	4.00	Outlier payment (see instructions)			0	4.00
Line 2 times   line 5		, , , , , , , , , , , , , , , , , , , ,			_	
2.00   Sam of lines 3, 4, and 4.01, divided by line 6   0.00   7.00			.)			
2.00   Content					_	
9.00   Ancillary service other pass through costs from Wkst. D. Pt. IV. col. 13, line 200   0   9.00						
1.00   Total cost (sum of lines 1 and 10) (see instructions)   0   1.00		1	ol. 13, line 200			
COMPUTATION OF LESSER OF COST OR CHÂRCES	10.00	Organ acqui si ti ons			0	
Reasonable charges	11. 00				0	11.00
12.00						-
3.00   Organ acquisition charges (Erron Wist, D4, Pt. III, col. 4, line 69)	12 00				0	12 00
14.00   Total reasonable charges (sum of lines 12 and 13)			))			
15.00   Aggregate amount actually collected from patients   Table for payment for services on a charge basis   0   15.00			,		0	
16.00   Amounts that would have been realized from patients   Isible for payment for services on a chargebasl s had assuch payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.000   0.000000   17.000   0.000000   17.000   0.000000   17.000   0.000000   17.000   0.000000   17.000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000						
had such payment been made in accordance with 42 CFR \$413.13(e)						
17.00	16.00		ent for services o	on a chargebasis	0	16.00
18.00   Total customery charges (see instructions)   0   18.00   19.	17 00				0 000000	17 00
19, 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   19, 00   1						
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00   1   1   1   1   1   1   1   1   1			line 18 exceeds li	ne 11) (see	0	19. 00
Instructions		1				
1.00   Lesser of cost or charges (see instructions)   0 21.00	20. 00		line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0 22.00   0 23.00   0 2	21 00	,			0	21 00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   871,670   24.00					_	
COMPUTATION OF REINBURSEMENT SETTLEMENT   25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   25.00   Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   211,655   26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   27.00   Instructions   27.00   Instructions   27.00   Instructions   28.00   Instructions   28.00   Instructions   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0.28.00   29.00   28.00   Direct graduate medical education costs (from Wkst. E-4, line 36)   0.29.00   29.00   29.00   28.00   28.0	23.00		ins)		0	23. 00
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0.0   25.00	24.00				871, 670	24.00
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   211,655   26.00   27	05.00					05.00
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see   660.015   27.00   1   1   1   1   1   1   1   1   1			for CAH see instr	ructions)		
Instructions   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0.29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0.29.00   29						1
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   30.00   31.00   Primary payer payments   0   31.00   31.00   32.00   31.00   ALUMABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   33.00   33.00   33.00   34.00   Allowable bad debts (see instructions)   979   34.00   35.00   34.00   Allowable bad debts (see instructions)   979   36.00   3		I		(		
30.00   Subtotal (sum of lines 27 through 29)   660,015   30.00   31.00   Primary payer payments   0   31.00   31.00   32.00   Subtotal (line 30 minus line 31)   660,015   32.00   33.00   Composite rate ESRD (From West I5, line 11)   0   33.00   33.00   Allowable bad debts (see instructions)   636   55.00   Adjusted relimbursable bad debts (see instructions)   636   55.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   679   36.00   37.00   Subtotal (see instructions)   679   36.00   37.00   Subtotal (see instructions)   660,651   37.00   38.00   MP-LCC reconciliation amount from PS&R   0   38.00   MP-LCC reconciliation amount from PS&R   0   38.00   MP-LCC reconciliation amount from PS&R   0   39.00   39.50   Poincer ACO demonstration payment adjustment (see instructions)   0   39.00   39.50   Poincer ACO demonstration payment adjustment (see instructions)   0   39.97   99			))		0	
31.00					_	
32.00   Subtorial (line 30 minus line 31)   660,015   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   979   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   979   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   979   36.00   37.00   Subtotal (see instructions)   660,651   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC demonstration payment adjustment (see instructions)   93.90   07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Poneer ACO demonstration payment adjustment (see instructions)   93.97   93.98   97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   93.99   94.00   Subtotal (see instructions)   0   39.99   94.00   Subtotal (see instructions)   0   39.99   94.00   Subtotal (see instructions)   0   39.99   94.00   Subtotal (see instructions)   0   40.00   40.01   Sequestration adjustment (see instructions)   0   40.02   40.03   40.0		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, I ine 11)   0   33.00   33.00   Adjusted reimbursable bad debts (see instructions)   0   34.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   0   37.00   37.00   Subtotal (see instructions)   0   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39						
34.00   Allowable bad debts (see instructions)   979   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   636   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   979   36.00   37.00   Subtotal (see instructions)   660, 651   37.00   38.00   MSP-LCC reconciliation amount from PS&R   660, 651   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   660, 651   40.00   40.01   Sequestration adjustment (see instructions)   660, 651   40.00   40.02   Demonstration payment adjustment amount after sequestration   11,033   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.02   40.03   Sequestration adjustment-PARHM pass-throughs   40.03   41.00   Interim payments   649, 017   41.00   42.00   Tentative settlement (for contractors use only)   42.01   Tentative settlement (for contractor use only)   42.01   43.00   Balance due provider/program (see instructions)   601   43.00   43.01   8alance due provider/program-PARHM (see instructions)   43.01   44.00   Forested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2   70   8E COMPLETED BY CONTRACTOR   79.00   79.						
35.00					-	
36. 00		,				
37.00   Subtotal (see instructions)   660,651   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   30.00   39.00   30		1 7	nne)			
38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment amount before sequestration       0       39. 90         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         40. 00       Subtotal (see instructions)       660, 651       40. 00         40. 01       Sequestration adjustment (see instructions)       11, 033       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 02         41. 00       Interim payments       649, 017       41. 00         41. 01       Interim payments-PARHM       649, 017       41. 01         42. 00       Tentative settlement (for contractors use only)       42. 00         43. 01       Bal ance due provider/program (see instructions)       601       43. 00         44. 00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00		, ,	113)			
39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50	38.00					
39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 660, 651 40. 00 40. 01 Sequestration adjustment (see instructions) 11, 033 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 649, 017 41. 00 Interim payments 1 Interim payments 649, 017 42. 01 Tentative settlement (for contractors use only) 41. 01 42. 00 Tentative settlement (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 601 43. 01 Balance due provider/program (see instructions) 601 43. 01 Balance due provider/program (see instructions) 601 43. 01 OPTO BE COMPLETED BY CONTRACTOR 701 90. 00 Original outlier amount (see instructions) 90. 00 91. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00 93. 00 Time Value of Money (see instructions) 0 93. 00		, , , , ,			0	
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       660, 651       40. 00         40. 01       Sequestration adjustment (see instructions)       11, 033       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 00       Interim payments       649, 017       41. 00         41. 01       Interim payments-PARHM       11, 01       41. 01         42. 01       Tentative settlement (for contractors use only)       0       42. 01         43. 00       Bal ance due provider/program (see instructions)       601       43. 00         43. 01       Bal ance due provider/program-PARHM (see instructions)       43. 01         44. 00       Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         415. 2       TO BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         92. 00       The rate used to c		, , , , , , , , , , , , , , , , , , , ,				
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 660, 651 40. 00 40. 01 Sequestration adj ustment (see instructions) 11, 033 40. 01 40. 02 Demonstration payment adj ustment amount after sequestration 0 40. 02 40. 03 Sequestration adj ustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 649, 017 41. 00 41. 01 Interim payments-PARHM (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 601 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 601 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00  90. 00 Original outlier amount (see instructions) 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 92. 00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 0 93. 00			wices (see instru	ctions)		
40.00       Subtotal (see instructions)       660, 651       40.00         40.01       Sequestration adjustment (see instructions)       11, 033       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       649, 017       41.03         41.01       Interim payments       649, 017       41.01         42.00       Interim payments-PARHM       41.01       41.01         42.01       Tentative settlement (for contractors use only)       42.00       42.01         43.00       Balance due provider/program (see instructions)       601       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00       44.00         90.00       Original outlier amount (see instructions)       0       90.00         90.00       Original outlier amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         71 me Value of Money (see instructions)       0       93.00		·	vices (see ilistiud	eti olis)	_	
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 5 Sequestration adjustment-PARHM pass-throughs 6 40.03 Interim payments 11,033 40.01 10,03 Sequestration adjustment-PARHM pass-throughs 11,00 Interim payments 11,033 40.01 40.02 Sequestration adjustment amount after sequestration 11,033 40.01 40.02 Sequestration adjustment amount after sequestration 11,033 40.01 40.02 Sequestration adjustment amount after sequestration 11,033 40.01 40.02 40.03 11terim payments 649,017 41.00 41.00 11terim payments-PARHM 11,000 (for contractor use only) 11,000 (for contractor use only) 12,001 Tentative settlement-PARHM (for contractor use only) 12,001 Tentative settlement-PARHM (see instructions) 13,001 Balance due provider/program (see instructions) 14,001 Balance due provider/program-PARHM (see instructions) 14,001 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 00 44.00 11,001 Sequestration adjustment amount (see instructions) 11,003 40.01 11,003 40.01 11,003 41.00 12,001 42.00 12,001 43.00 13,001 43.00 14,001 52,001 60.00 15,001 60.00						1
40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   Interim payments   649, 017   41. 00   41. 01   42. 00   42. 00   42. 01   Tentative settlement (for contractor use only)   42. 01   43. 00   8al ance due provider/program (see instructions)   43. 01   44. 00   8al ance due provider/program-PARHM (see instructions)   43. 01   44. 00   44. 00   44. 00   45. 20   45.					11, 033	40. 01
41.00   Interim payments   649,017   41.00   41.01   Interim payments-PARHM   41.01   42.00   Tentative settlement (for contractors use only)   42.00   42.01   Tentative settlement-PARHM (for contractor use only)   42.01   43.00   Bal ance due provider/program (see instructions)   601   43.01   43.01   Bal ance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   Filts   601   43.01   44.00   Forested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   Filts   601   43.01   44.00					0	1
41.01		, ,			/40 047	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 42.01 43.00 43.01 44.00 90.00 91.00 91.00 92.00 93.00		1			649, 017	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions)		· · · · · · · · · · · · · · · · · · ·			n	
43.00 Balance due provider/program (see instructions)  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 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.01 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{10 BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		Balance due provider/program (see instructions)			601	43.00
\$115.2  TO BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00 Time Value of Money (see instructions)  \$115.2  10 BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00						
TO BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions)  To BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00	44. 00		th CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00 0.00 92.00 0.00 93.00	90. 00				n	90.00
93.00 Time Value of Money (see instructions) 0 93.00					_	1
						1
94.00   Total (Sum of Tines 91 and 93)   0   94.00						
	<del>7</del> 4. UU	ן וטגמו (טווו טו וווופט או מווע אט)			0	J 74. UU

| Peri od: | Worksheet E-1 | From 07/01/2019 | Part | To 06/30/2020 | Date/Time Prepared: Provi der CCN: 15-4014

				10 00/30/2020	11/18/2020 3:4	
		Ti tl e	e XVIII	Hospi tal	PPS	'
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		308, 42	7	649, 017	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			)	0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER					3. 01
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
0.00	Provider to Program			<u> </u>	Ŭ.	0.00
3. 50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51			1	0	l ol	3. 51
3. 52		•		o O	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		308, 42	7	649, 017	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T	T		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5. 02	TENTATIVE TO TROVIDER		1			5. 02
5. 03				Ö	ő	5. 03
0.00	Provider to Program			<u> </u>	J	0.00
5.50	TENTATI VE TO PROGRAM			o	0	5. 50
5. 51				O	o	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			D	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		1, 97	1	601	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	o	0	6. 02
7. 00	Total Medicare program liability (see instructions)		310, 39	8	649, 618	7. 00
	, and the second			Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8.00	Name of Contractor					8. 00

Health Financial Systems	THE OTIS R. BOWE	N CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-4014		Worksheet E-3 Part II Date/Time Prepared: 11/18/2020 3:44 pm
		Ti +1 o VV/I I I	Hospi tal	DDC

		Title XVIII	Hospi tal	PPS	44 рш	
	PART II - MEDICARE PART A SERVICES - IPF PPS					
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	ical education payments)		408, 421	1.00	
2.00	Net IPF PPS Outlier Payments			0	2.00	
3.00	Net IPF PPS ECT Payments			0	3.00	
4.00	Unweighted intern and resident FTE count in the most recent c	ost report filed on or b	efore November	0. 00	4. 00	
	15, 2004. (see instructions)			0.00		
4. 01	Cap increases for the unweighted intern and resident FTE coun			0. 00	4. 01	
	program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temporary cap adjust	ment under 42			
5. 00	New Teaching program adjustment. (see instructions)			0. 00	5.00	
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth r	eriod of a "new	0.00	6.00	
0.00	teaching program" (see instuctions)	the new program growth p	ici i cu ci cu ci cu	0.00	0.00	
7.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	7.00	
	teaching program" (see instuctions)					
8.00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)		0.00	8. 00	
9.00	Average Daily Census (see instructions)			8. 877049		
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.000000		
11. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.00	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			408, 421	12.00	
13.00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.00	
14. 00 15. 00	Organ acquisition (DO NOT USE THIS LINE)	rusti spol		0	14. 00 15. 00	
16. 00	Cost of physicians' services in a teaching hospital (see inst Subtotal (see instructions)	ructions)		408, 421		
17. 00	Primary payer payments			400, 421	17.00	
18. 00	Subtotal (line 16 less line 17).			408, 421		
19. 00	Deducti bl es			71, 984		
20. 00	Subtotal (line 18 minus line 19)			336, 437		
21. 00	Coinsurance			23, 188		
22.00	Subtotal (line 20 minus line 21)			313, 249	22. 00	
23.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		3, 724	23. 00	
24.00	Adjusted reimbursable bad debts (see instructions)			2, 421		
25. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		3, 724		
26. 00	Subtotal (sum of lines 22 and 24)			315, 670		
27. 00	Direct graduate medical education payments (see instructions)			0		
28. 00	Other pass through costs (see instructions)			0	28. 00 29. 00	
29. 00 30. 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	e)		0	30.50	
30. 99	Demonstration payment adjustment amount before sequestration	3)		0		
31. 00	Total amount payable to the provider (see instructions)			315, 670		
31. 01	Seguestration adjustment (see instructions)			5, 272		
31. 02	Demonstration payment adjustment amount after sequestration			0	31. 02	
32.00	Interim payments			308, 427	32.00	
33.00	Tentative settlement (for contractor use only)			0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.0	2, 32 and 33)		1, 971	34.00	
35.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	35.00	
	§115. 2					
FO 00	TO BE COMPLETED BY CONTRACTOR				F0 00	
	Original outlier amount from Worksheet E-3, Part II, line 2			0		
51. 00 52. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	51. 00 52. 00	
	Time Value of Money (see instructions)				53.00	
55. 50	The factor of money (300 that dottons)		'	٥١	30.00	

Health Financial Systems	THE OTIS R. BOWEN CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4014	Period: Worksheet E-3 From 07/01/2019 Part VII To 06/30/2020 Date/Time Prepared: 11/18/2020 3:44 pm

		7	o 06/30/2020	Date/Time Pre 11/18/2020 3:	
		Title XIX	Hospi tal	Cost	· · · p
		<u> </u>	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		802, 694		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		802, 694	0	4.00
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		802, 694	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		0.40,000		0.00
8.00	Routine service charges		948, 283	0	8.00
9.00	Ancillary service charges		0	0	9.00
10. 00 11. 00	Organ acquisition charges, net of revenue		0		10. 00 11. 00
12.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		948, 283	0	
12.00	CUSTOMARY CHARGES		740, 203	0	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
10.00	basis	ser vi des en a enarge	Ŭ	O	10.00
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		948, 283	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	145, 589	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	•	802, 694	0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22. 00	Other than outlier payments	55p. 51.54 1.5. 1.1.5 p. 51.1.4	0	0	22.00
23. 00	Outlier payments		O	0	23. 00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		802, 694	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		802, 694	0	31.00
	Deducti bl es		0	0	32.00
33. 00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review	22)	000 (04	0	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	802, 694	0	36. 00 37. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		802, 694	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		002, 094	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		802, 694	0	40.00
41. 00	Interim payments		380, 190	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		422, 504	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2.	0	0	43.00
	chapter 1, §115. 2				

Health Financial Systems THE OTIS R.
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-4014

Peri od: From 07/01/2019 To 06/30/2020 Date/Time Prepared: 11/18/2020 3: 44 pm

OH y)					11/18/2020 3:	44 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	11.00	
1.00	Cash on hand in banks	25, 836, 845	0	0	0	
2.00	Temporary investments	0	0	0		1
3. 00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts receivable	19, 154, 572		0	0	1
5.00	Other receivable	230, 295		0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable	-7, 097, 388		0	0	6. 00 7. 00
8. 00	Inventory Prepai d expenses	997, 103		0	0	
9. 00	Other current assets	777, 103		0	0	
10.00	Due from other funds			0	Ö	
11. 00	Total current assets (sum of lines 1-10)	39, 121, 427	Ö	0	l	11.00
	FIXED ASSETS					
12.00	Land	3, 989, 547	0	0	0	12.00
13.00	Land improvements	0	0	0	1	13.00
14. 00	Accumulated depreciation	-723, 883		0	1	14.00
15. 00	Bui I di ngs	33, 618, 988		0	0	15.00
16.00	Accumulated depreciation	-11, 478, 701		0	0	1
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0		0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation		0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks			0	0	21.00
22. 00	Accumulated depreciation			0	0	22.00
23. 00	Major movable equipment	11, 778, 868	-	0	Ö	23.00
24. 00	Accumulated depreciation	-7, 711, 063		0	0	24.00
25. 00	Mi nor equipment depreciable	0	Ö	0	Ō	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	29, 473, 756	0	0	0	30.00
04 00	OTHER ASSETS	7 000 01/				
31.00	Investments	7, 322, 216		0	1	31.00
32. 00 33. 00	Deposits on leases	0	0	0	0	32. 00 33. 00
34. 00	Due from owners/officers Other assets	1, 599, 564	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	8, 921, 780		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	77, 516, 963		0	o o	36.00
	CURRENT LIABILITIES	, , , , , , , , , , , , , , , , , , , ,	, - <u>-</u> 1			
37.00	Accounts payable	1, 089, 750	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0		38. 00
39. 00	Payroll taxes payable	215, 097	0	0	0	
40.00	Notes and Loans payable (short term)	0	0	0	0	1
41.00	Deferred income	21, 000	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	( 010 022	0	0	0	43.00
44. 00 45. 00	Other current liabilities	6, 810, 933		0	0	1
43.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	8, 136, 780	0	0	0	45.00
46. 00	Mortgage payable	1	ol	0	0	46.00
47. 00	Notes payable	325, 000		0	·	
48. 00	Unsecured Loans	020,000		0	l	
49. 00	Other long term liabilities	10, 935, 564		0	l	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	11, 260, 564		0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	19, 397, 344	. 0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	58, 119, 619	)			52.00
53.00	Specific purpose fund		0			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	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	E0 110 /10		^	_	E0 00
59.00	Total fund balances (sum of lines 52 thru 58)	58, 119, 619		0	0	59. 00 60. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	77, 516, 963	ή	Ü		00.00
	1/	I	1		I	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES THE OTIS R. BOWEN CENTER In Lieu of Form CMS-2552-10 Provider CCN: 15-4014 Period: From 07/01/2019 To 06/30/2020 Worksheet G-1 Date/Time Prepared: 11/18/2020 3:44 pm General Fund Special Purpose Fund Endowment Fund 3.00 1.00 2.00 4.00 5. 00 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 49, 429, 409 8, 690, 210 1.00 0 2.00

2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0 0 0 0	8, 690, 210 58, 119, 619 0 58, 119, 619	0 0 0 0 0	0	0 0 0 0 0	5.00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0	0 58, 119, 619	0 0 0 0 0	0	0 0 0 0 0	13. 00 14. 00 15. 00
	Sheet (The II milius The Io)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	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 0	0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	000000000000000000000000000000000000000	0			8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			18. 00 19. 00

| Peri od: | Worksheet G-2 | From 07/01/2019 | Parts | & II | To 06/30/2020 | Date/Time Prepared: Health Financial Systems TATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-4014

			То	06/30/2020	Date/Time Pre 11/18/2020 3:	
	Cost Center Description	Inpatient		Outpati ent	Total	p
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	·				
	General Inpatient Routine Services					
1.00	Hospi tal	6, 195, 9	29		6, 195, 929	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7. 00	SKILLED NURSING FACILITY					7. 00
8.00	NURSI NG FACILITY					8.00
9.00	OTHER LONG TERM CARE				, 405 000	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	6, 195, 9	29		6, 195, 929	10.00
11 00	Intensive Care Type Inpatient Hospital Services					11 00
11. 00 12. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT					11. 00 12. 00
12.00	BURN INTENSIVE CARE UNIT					12.00
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 lin	95	0		0	16. 00
10.00	11-15)	es	٥		U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	6, 195, 9	29		6, 195, 929	17.00
18. 00	Ancillary services	151, 2		0	151, 297	18. 00
19. 00	Outpatient services	,-	0	24, 414, 409	24, 414, 409	19.00
20. 00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	O	0	21.00
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.)					25.00
26.00	HOSPI CE					26.00
27.00	C/C 5 REV		0	3, 150	3, 150	27.00
27. 01	PHYSI CI ANS' PRI VATE OFFI CES		0	94, 010, 162	94, 010, 162	27.01
27. 02	RESI DENTI AL		0	0	0	27.02
27. 03	CSP		0	0	0	27.03
27. 04	MRO		0	25, 118, 716	25, 118, 716	27.04
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 6,347,2	26	143, 546, 437	149, 893, 663	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			82, 855, 142		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 36. 00	Total additions (our of lines 20 25)		U	o		35. 00 36. 00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0	۷		36. 00 37. 00
38.00	DEDUCT (SPECIFT)		0			38.00
39. 00			0			39. 00
40. 00			0			40.00
41.00			0			41.00
42. 00	Total deductions (sum of lines 37-41)		٦	n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		82, 855, 142		43. 00
	to Wkst. G-3, line 4)			, 500, . 12		
		•	'	,	'	

STATEMENT	OF REVENUES AND EXPENSES	Provi der CCN: 15-4014	Peri od: From 07/01/2019	Worksheet G-3	
			To 06/30/2020	Date/Time Pre 11/18/2020 3:	
				1.00	
1 00 Tota	ıl patient revenues (from Wkst. G-2, Part I, colu	mp 2   Line 20)		1.00	1 (
				149, 893, 663	1. 0 2. 0
	s contractual allowances and discounts on patients	s accounts		76, 239, 932	
	patient revenues (line 1 minus line 2)	II line 42)		73, 653, 731	3.0
	s total operating expenses (from Wkst. G-2, Part			82, 855, 142	
	income from service to patients (line 3 minus li R INCOME	ne 4)		-9, 201, 411	5.0
	ributions, donations, bequests, etc			9, 241	
1	ome from investments			9, 241	6. ( 7. (
4	enues from telephone and other miscellaneous comm	unication card cas		0	8.0
	enue from television and radio service	unication services		0	
	chase di scounts			0	
	ites and refunds of expenses			0	11.0
	ting lot receipts			0	
	enue from laundry and linen service			0	13.
	enue from meals sold to employees and guests			0	14.
	enue from rental of living quarters			0	
	enue from sale of medical and surgical supplies to	o other than nationts		0	16.
	enue from sale of drugs to other than patients	o other than patrents		0	17.
	enue from sale of medical records and abstracts			0	18.
	ion (fees, sale of textbooks, uniforms, etc.)			0	19.
	enue from gifts, flowers, coffee shops, and cante	on		0	20.
	al of vending machines	en		0	21.
	al of hospital space			0	22.
	ernmental appropriations			0	23.
1	ESTMENT INCOME			171, 648	
	ATIONS			171,040	24. (
4	E, FEDERAL, AND LOCAL FUNDS			8, 365, 484	
1	I (LOSS) ON DISPOSAL OF PROPERTY			-41, 345	
	RIBUTION OF PROPERTY AND EQUIPME			456, 538	
	CAID FUNDS			5, 300, 000	
24. 07 OTHE				350, 662	
1	EALIZED GAIN ON INVESTMENTS			0	24.
	ER INCOME			225, 018	
	D-19 PHE Funding			3, 054, 375	
	other income (sum of lines 6-24)			17, 891, 621	
	Il (line 5 plus line 25)			8, 690, 210	
	R EXPENSES (SPECIFY)				27.

0 27.00 0 28.00 8,690,210 29.00

24.09 OTHER INCOME
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)