3 Signatory Title

6.00 Swing Bed - NF

200. 00 Total

4 Date

CFO

(Dated when report is electronica

GRANT BLACKFORD MENTAL HEALTH, INC.

In Lieu of Form CMS-2552-10

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-38, 893 200. 00

6.00

	eport is required by law (42 USC 1395g; 42 CFR 413.20(b ts made since the beginning of the cost reporting perio				FORM APPROVED OMB NO. 0938-00 EXPIRES 03-31-2	
AND SE	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFI	CATION Pr	ovider CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepa 11/29/2022 7:30	
	- COST REPORT STATUS					
Provi de use onl	y 2. [] Manually prepared cost report 3. [0] If this is an amended report enter the 4. [F] Medicare Utilization. Enter "F" for ful	number of or "L" f	or low.			30 am
Contrad use on	the first design the state of t	port for t rt for thi	his Provider CCN12.	NPR Date: Contractor's Vendo [0]If line 5, cc number of tin	or Code: Jumn 1 is 4: En Nes reopened = 0	4 iter)-9.
PART I	- CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN	ILSTRATOR (R PROVIDER(S)			
ADMI NI S PROVI DI	RESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAIN STRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL ED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECT STRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FUR	THERMORE, IF SERVICE	ES IDENTIFIED IN T	HIS REPORT WERE	
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTR	ATOR OF PR	ROVI DER(S)			
	I HEREBY CERTIFY that I have read the above certifical electronically filed or manually submitted cost repor Statement of Revenue and Expenses prepared by GRANT E reporting period beginning 07/01/2021 and ending 06/3 report and statement are true, correct, complete and accordance with applicable instructions, except as no regulations regarding the provision of health care se report were provided in compliance with such laws and	t and subm LACKFORD M 0/2022 and prepared f ted. I fur ervices, ar	hitted cost report an MENTAL HEALTH, INC. (I to the best of my H From the books and re- ther certify that I id that the services	nd the Balance She (15-4021) for th knowledge and beli ecords of the prov am familiar with	eet and ne cost ef, this vider in the laws and	
S	IGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	1	2	SI GI	NATURE STATEMENT		
1	Jonda Manwell	Y	I have read and agr statement. I certif signature on this c binding equivalent	y that I intend m ertification be t	y electronic he legally	1
2 3	Signatory Printed Name Jonda Manwell					2

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	ΗΙΤ	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	510	-25	0	-38, 893	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00

0

0

510

-25

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

	AL AND HOSPITAL HEALTH CARE COMPLEX					From 07/01/ To 06/30/		Part I Date/Ti	eet S-2	
						10 00/30/	2022	11/29/2		
	1.00	2.00		3.00			4.00			
00	Hospital and Hospital Health Care Co Street: 505 WABASH AVENUE	PO Box:								1.
00	City: MARION	State: IN	Zip Code	e: 46952	Count	v:				2.
		Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified	Т,	0, or	N)	
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componer Hospital	GRANT BLACKFORD MENTAL	154021	99915	4	08/12/1982	N	Р	0	3.
50		HEALTH, INC.	154021	77713	4	00/12/1902				3.
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7
00	Swing Beds - NF									8
00	Hospital-Based SNF									9
00	Hospital-Based NF									10.
00 00	Hospital-Based OLTC Hospital-Based HHA									12
	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce									14.
00	Hospital -Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
00	Other						L			19
						From: 1.00		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)					07/01/2		06/30/		20
	Type of Control (see instructions)					2			-	21
										-
	Inpatient PPS Information				1.00	2.00		3. (00	
00	Does this facility qualify and is it	currently receiving pa	vments for	-	N	N				22.
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fc	r yes or "N" for no. Is	this							
	facility subject to 42 CFR Section §		endment							
~ 4	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim un				Ν	N				22.
	cost reporting period? Enter in colu the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft									
. 02	Is this a newly merged hospital that	requires final uncompe	nsated car	-e	N	N				22
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th October 1.	e cost reporting period	on or art	ter						
03	Did this hospital receive a geograph	ic reclassification fro	m urban to		Ν	N		Ν		22
00	rural as a result of the OMB standar				N					22.
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin	g period prior to Octob	er 1. Ente	er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 yes or "N" for no.	z. ius): Enter in column	່ວ, r FC	א						
04	5	ic reclassification fro	m urban to	,	Ν	N		Ν		22
U 1	rural as a result of the revised OME	delineations for stati	stical are	eas						
	adopted by CMS in FY 2021? Enter in	column 1, "Y" for yes c	r "N" for	no						
	for the portion of the cost reportin	g period prior to Octob	er 1. Ente							
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	2.105)? Enter in colum	in 3, "Y" f	or						
00	yes or "N" for no. Which method is used to determine Me	dicaid days on Linos 24	and/or 20	.		3 N				23
00	below? In column 1, enter 1 if date					3 IV				23
	Derew: In Corumn 1, Children I I Uale	or aum ssron, ∠ rr u⊂ns	uaya, t			1				1
		of identifying the days	in this o	cost						
	if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	method used in the pric	r cost	cost						

	nancial Systems GRANT BLACKF AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION D.		Provider CC		Peri od:			eet S-2	
						0/2022	11/29/	ime Pre 2022 7:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	nys Me)ther di cai d days	
1 00 1 0		1.00	2.00	3.00	4.00	5.00		6.00	
in- Mecout out 4, col 5.00 If Mecout Mecout	this provider is an IPPS hospital, enter the -state Medicaid paid days in column 1, in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid paid days in column 3, t-of-state Medicaid eligible unpaid days in column Medicaid HMO paid and eligible but unpaid days in lumn 5, and other Medicaid days in column 6. this provider is an IRF, enter the in-state dicaid paid days in column 1, the in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid days in column 3, out-of-state dicaid eligible unpaid days in column 4, Medicaid 0 paid and eligible but unpaid days in column 5.	0			0		0	Ĺ	24.(
I IIIIC	o para ana errgrore bat anpara days rir corann o.	1		<u> </u>	Urban/R	ural S	Date o	f Geogr	
6.00 Ent	ter your standard geographic classification (not w	ane) status	at the be	ainning of	1.C	2		00	26.0
COS	st reporting period. Enter "1" for urban or "2" fo	r rural.		0 0		2			
rep ent	ter your standard geographic classification (not w porting period. Enter in column 1, "1" for urban o ter the effective date of the geographic reclassif this is a sole community hospital (SCH), enter th	r"2" for r ication in	rural. If a column 2.	pplicable,		2			35.0
	fect in the cost reporting period.		perrous 3			0			35.0
					Beginn 1. C		End 2	i ng: 00	-
	ter applicable beginning and ending dates of SCH s		script line	36 for num			2.		36.0
7.00 f is	periods in excess of one and enter subsequent dat this is a Medicare dependent hospital (MDH), ente in effect in the cost reporting period. this hospital a former MDH that is eligible for t	r the numbe			us	0			37.0
aco ins 8.00 lf	cordance with FY 2016 OPPS final rule? Enter "Y" f structions) line 37 is 1, enter the beginning and ending date	for yes or " es of MDH st	N" for no.	(see ine 37 is					38.0
	eater than 1, subscript this line for the number o ter subsequent dates.	of periods i	n excess o	f one and					
1-	· · · · · · · · · · · · · · · · · · ·				Y/I			/N	-
9.00 Doe	es this facility qualify for the inpatient hospita	l payment a	adjustment	for low vol	1.C ume N			00 V	39.0
1 ' acc or 0.00 [s	spitals in accordance with 42 CFR §412.101(b)(2)(i "Y" for yes or "N" for no. Does the facility meet cordance with 42 CFR 412.101(b)(2)(i), (ii), or (i "N" for no. (see instructions) this hospital subject to the HAC program reductio " for no in column 1, for discharges prior to Octo	the mileage ii)? Enter n adjustmer	e requireme in column nt? Enter "	nts in 2 "Y" for y Y" for yes y	es or N			N	40.
	in column 2, for discharges on or after October 1								
						V 1.00	XVIII 2.00		-
	ospective Payment System (PPS)-Capital es this facility qualify and receive Capital payme	nt for dia	roportiona	to share in	accordance			N	45.0
wit 5.00 Is	th 42 CFR Section §412.320? (see instructions) this facility eligible for additional payment exc rsuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordi n	ary circums	tances	N N	N N	N	45.0
Pt.	. 111. this a new hospital under 42 CFR §412.300(b) PPS				-	N	N	N	47.
Теа	the facility electing full federal capital paymen aching Hospitals					<u>N</u>	<u>N</u>	<u>N</u>	48.
" N' was yea En1	this a hospital involved in training residents in " for no in column 1. For column 2, if the respons s involved in training residents in approved GME p ar, and are you are impacted by CR 11642 (or appli ter "Y" for yes; otherwise, enter "N" for no in co line 56 is yes, is this the first cost reporting	e to columr programs in cable CRs) lumn 2.	n 1 is "Y", the prior MA direct	or if this year or pen GME payment	hospital ultimate reduction?				56.
CM	E programs trained at this facility? Enter "Y" fo "Y" did residents start training in the first mon	th of this	cost repor	ting period	? Enter "Y				
is for "N'	r yes or "N" for no in column 2. If column 2 is " ", complete Wkst. D, Parts III & IV and D-2, Pt. I	I, if appli	cabl e.						50
is for "N' 8.00 f		l, if appli bursement f	cable. ⁼or physici						58.

Health Financial Systems GRANT BLACKF(HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ITAL HEALTH, IN Provider C		In Lie Period:	u of Form CMS-2 Worksheet S-2	
HUSEFTAL AND HUSEFTAL HEALTH CARE COMPLEX EDUNTIFICATION DA		Frovider co	F	rom 07/01/2021 o 06/30/2022	Part I	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in col	85? (umn 1. CR) NAH	see lf column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
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)						61.01
61.02 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)						61.02
 61.03 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) 						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		N				61.06
	Pro	ogram Name	Program Code	IME FTE Count	FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	4.00	61. 10
 FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0. 00	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser					1	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting per	iod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	a Teach gram. (<u>see instructio</u>		o your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00

alth Financial Systems)SPITAL AND HOSPITAL HEA	LTH CARE COMPLE		ORD MENTAL HEALTH, IN ATA Provider CO	CN: 15-4021 P	In Lieu Veriod:	Worksheet S-2	
					rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre 11/29/2022 7:	pared: 30 am
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
			lonprovider Settings	This base year	r is your cost	reporti ng	
in the base year pe resident FTEs attri settings. Enter in	if line 63 is period, the numb butable to rota column 2 the trained in you	yes, or your facili er of unweighted no ations occurring in number of unweighte r hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. OC
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
	-	1.00	2.00	Si te 3.00	4.00	5.00	-
5.00 Enter in column 1, is yes, or your fac trained residents i year period, the pr associated with pri FTEs for each prima program in which you residents. Enter in the program code. E column 3, the numbe unweighted primary residents attributa rotations occurring non-provider settir column 4, the numbe unweighted primary resident FTEs that your hospital. Ente 5, the ratio of (co divided by (column 4)). (see instructi	sility n the base ogram name mary care ou trained n column 2, enter in er of care FTE bble to jin all gs. Enter in er of care trained in er in column olumn 3 3 + column			0.00 Unwei ghted FTEs Nonprovi der			65.00
				Site	0.00		-
Section 5504 of the	ACA Current V	ear FTE Posidonte i	n Nonprovider Setting	1.00	2.00	<u>3.00</u>	
beginning on or aft				JS Effective		ring periods	
b.00 Enter in column 1 t FTEs attributable t Enter in column 2 t FTEs that trained i	he number of un o rotations oc he number of un n your hospita	nweighted non-prima curring in all nonp	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, name associated wit your primary care p which you trained r Enter in column 2, code. Enter in colu number of unweighte care FTE residents to rotations occurr non-provider settir column 4, the numbe unweighted primary resident FTEs that your hospital. Ente 5, the ratio of (ccc divided by (column	th each of programs in residents. the program umn 3, the ed primary attributable ring in all ngs. Enter in er of care trained in er in column olumn 3			0.00	0.00	0. 000000) 67.00

Heal th	Financial Systems GRANT BLACKFORD MENTAL HEALTH, INC.	l r	n Lieu	of Form	n CMS-2	2552-10
HOSPI T		eriod: rom 07/01/ p 06/30/	/2021 /2022	Workshe Part I Date/Ti	me Pre	pared:
				11/29/2		30 am
	Inpatient Psychiatric Facility PPS		1.00	2.00	3.00	
70.00	ls this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub Enter "Y" for yes or "N" for no.	provi der?	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.	N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes c	r "N" for	N	N	0	76.00
	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)					
			-	1.0	0	-
00.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		00.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? I	Enter	N N		80.00 81.00
	"Y" for yes and "N" for no. TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectic §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85.00 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI) 2. 0		-
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	IF line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 0 N		95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y		0. 0 Y	0	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03
98. 04	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		98.04
98. 05	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 column 2 for title XIX.	Y		Y		98.05
98.06	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.	Y		Y		98.06
105 00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					105.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an	N				107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

IDENTIAL AND INCENTIAL IFACTION CONTROL OF OWNERS (INFORTING NATA) Provider COL: 15: 422	Health Financial Systems GRANT BLACKFORD MEN	NTAL HEALTH, I	NC.	In Lieu	u of Form CMS-	-2552-10
108 001s 1.00 2.00 107 <td>HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA</td> <td>Provider C</td> <td>Fr</td> <td>rom 07/01/2021 0 06/30/2022</td> <td>Part I Date/Time Pr 11/29/2022 7</td> <td>epared:</td>	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	Fr	rom 07/01/2021 0 06/30/2022	Part I Date/Time Pr 11/29/2022 7	epared:
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100. 001 f his hospital qualifies as a CAH or a cost provider, and therapy services provide by outside services. N N N N 100. 001 d his hospital participation in the Rard Comunity Hospital Demonstration project (6410A 1.00 1.00 110. 001 d this hospital participation in the Rard Comunity Hospital Demonstration project (6410A N 100. 001 d his hospital participation in the Rard Comunity Hospital Demonstration project (6410A N 100. 001 d his hospital participation in the Rard Comunity Hospital Demonstration project (6410A N 100. 000 d his hospital participation in the Rard Comunity Participation in the Scott reporting period Participation Project (6410P demonstration for this cost reporting period Participation Project (6410P demonstration for this cost reporting period Participation Project (6410P demonstration for the correct reporting period Participation Project (6410P demonstration for the correct reporting period Participation in the Radd Lip period Participation Participatin Participatin Partend Participation Participation Participatin Pa						-
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111.00[F this facility qualifies as a CAR, did it participate in the Frontine Community N 111.00 Weal th Integration Proof of the FCH P demostration for this cost reporting period? Enter N 111.00 Y for yes or "W" for no in colum 1. If the response to colum 1 is Y, enter the integration proof of the FCH P demostration CAR is participating in colum 2. N 111.00 Integration proof of the FCH P demostration in which this CAR is participating in colum 2. N 112.00 100 2.00 3.00 112.00[Jif this hospifal participate in the Pennsylvania Rural Health Model demostration. In colum 3. enter the date the hospital began participating in the demostration. In colum 3. enter the date the hospital began participating in the demostration. In colum 3. enter the root was percent for short term hospital or "9" percent for long term core "1" for yes or "N" for no. N 115.00 115.00 In colum 1. If colum 1 is yes, enter the neutron usel ther "9" percent for short term hospital or "9" percent for long term core (Includes providers) field as a colum short term in colum and et ther "9" for set or "1" for no. N 116.00 117.00 Y for no. 115.00 115.00 116.00 116.00 117.00 2.00 3.00 115.00 115.00 117.00 1.00 2.00 3.00 116.00 117.00 10.00 2.00 3.00				1.00	2.00	-
112.00Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? N 112.00 Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2. the date the hospital began participating in the demonstration. In column 3. enter the date the hospital ceased participating information N 112.00 Ibscell aneous Cost Reporting Information N N N 0115.00 Ibscell aneous Cost Reporting Information N N N 0115.00 In column 2. If column 2 is 'E', enter in colum 3 either '93' percent for short term hospital or '99' percent for long term care (Includes peschinztic, crhabitist tration and long term hospital s provider? Enter 'Y' for yes or 'N' for no. If '90' pesco'' N' for no. If '90' pesco''' N' for no. If '90' pesco''' N' for no. If '90' pesco''''''''''''''''''''''''''''''''''''	Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	cost reporting column 1 is Y, articipating i	period? Enter enter the n column 2.			111.00
112.00Did this hospital participate in the Pennsylvania Rural Heal th Model demonstration for any portion of the current cost reporting period? N 112.00 Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased aerticipation in the demonstration. N 112.00 Its coll pation in the demonstration if social aneous Cost Reporting Information N N N 115.00Lis this an all-inclusive rate provider? Inter 'Y' for yes or 'N' for no in column 2. If colum 2 is 'E', enter in colum 3 either '93' percent for short term hospital or '96' percent for long term care (includes psychial sproviders) based on the definition in CUS PUD.15-1. Chapter 22, \$2208.1. N 116.00 116.00Lis this facility legally-required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no. N 116.00 117.00Lis this facility legally-required addition and paid losses: 73,446 0 0 0118.00 118.01List anounts of malpractice premiums and paid losses: 73,446 0 0 0 118.00 118.02/Are malpractice premiums and paid losses: 73,446 0 0 0 118.02 119.00Di Not USE THIS LIN ME N N 12.00 118.02 118.02/Are malpractice premiums and paid losses: 74.46 0 0 0 <			1.00	2.00	3.00	-
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"N" for no. "N" for no. "Y" for yes or "N" for no. 117.00 s the mal practice insurance a claims-made or occurrence policy? Enter 1 2 118.00 s the mal practice insurance. Insurance 118.00 s the mal practice insurance. Premi ums Losses 118.01 List amounts of mal practice premi ums and paid losses: 73,446 0 118.02 Are mal practice premi ums and paid losses: 73,446 0 118.02 Are mal practice premi ums and paid losses: 73,446 0 118.02 Are mal practice premi ums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 119.00 D00 NOT USE THIS LINE INE 119.00 N 112.00 120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Si21 and applicable amendments? (see instructions) N 112.00 121.00 Did Harmless provision in ACA §3121 and applicable amendments? (see instructions) N 121.00 122.00 Des the cost report contain heal these taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no. N 122.00 121.00 Did Mis facility operate a transplant center? Enter "Y" for yes and "N" for no. If masplant Center Information 125.00 N 122	115.00 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, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	B, or E only) '93" percent (includes				0115.00
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118.00 s the maipractice insurance a claims-made or occurrence policy? Enter 1 2 118.00 if the policy is claim-made. Enter 2 if the policy is occurrence. Premiums Losses Insurance 118.01_List amounts of maipractice premiums and paid losses: 73,446 0 0118.01 118.02_Are malpractice premiums and paid losses: 73,446 0 0118.01 118.02_Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 119.000 NOT USE THIS LINE N 119.000 119.000 119.000 120.000 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. N N 120.00 121.000 Jid this facility incur and report costs for high cost implantable devices charged to N act?Enter "Y" for yes or "N" for no. 121.00 121.00 122.00 125.000 Dees the cost report contain heal thcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no. N 122.00 126.000 Jif this is a Medicare certified kidney transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date (s) (mm/dd/yyyy) below. N 125.00 126.001 Jif th		urance? Enter	Y			117.00
Premiums Losses Insurance 118.01 List amounts of mal practice premiums and paid losses: 73,446 0 0 0118.01 118.02 Are mal practice premiums and paid losses: 73,446 0 0 0 0 0 118.01 118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 118.02 119.000D NOT USE THIS LINE Safat applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Harmless provision in ACA Saf212 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for yes or "N" for no.	118.00 Is the mal practice insurance a claims-made or occurrence po		2			118.00
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118. 02 Are mal practice premiums and paid Losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule Listing cost centers and amounts contained therein. N 118. 02 119. 00 D0 NOT USE THIS LINE 119. 00 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. N N 121. 00 121. 00 Does the cost report contain heal thcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 N 122. 00 122. 00 Does the cost report contain heal thcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 N 122. 00 125. 00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 125. 00 N 125. 00 126. 00 If this is a Medicare certified kidney transplant center, enter the certification date 126. 00 126. 00 127. 00 If this is a Medicare certified kidney transplant center, enter t			, , , , , ,			
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	in column 1 and termination date, if applicable, in column	2.				
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.	in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent	2.				

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	GRANT BLACKFORD			Peri od	:	u of Form CMS Worksheet S	
					7/01/2021 6/30/2022	Part I Date/Time Pi 11/29/2022	repared 7:30 am
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0.00 f this is a Medicare certified pa	ancreas transplant cen	ter, enter the cer	ti fi cati on		1.00	2.00	130.0
date in column 1 and termination of 1.00 If this is a Medicare certified in			ertificatio	n			131.0
date in column 1 and termination of	date, if applicable, i	n column 2.					
2.00 If this is a Medicare certified is in column 1 and termination date,			ication dat	te			132.0
3.00 Removed and reserved							133. (
4.00 If this is an organ procurement or and termination date, if applicabl All Providers		er the OPO number	in column 1	1			134.0
0.00 Are there any related organization chapter 10? Enter "Y" for yes or '					N		140. 0
are claimed, enter in column 2 the		mber. (see instruc		513			
<u> </u>	in organization enter	2.00	uah 143 th	e name ar	3.00 address	of the home	
office and enter the home office	contractor name and co	ntractor number.					
1.00 Name: 2.00 Street:	Contractor's Name PO Box:	ə:	Contra	ctor's Nu	ımber:		141.0
3. 00 Ci ty:	State:		Zip Coo	de:			142.0
						1.00	_
4.00 Are provider based physicians' cos	sts included in Worksh	eet A?				N	144. (
					1.00	2.00	_
5.00 If costs for renal services are cl	aimed on Wkst. A, lin	e 74, are the cost	s for		1.00	2.00	145.0
inpatient services only? Enter "Y no, does the dialysis facility ind	clude Medicare utiliza			5			
period? Enter "Y" for yes or "N" 6.00Has the cost allocation methodolog		oviously filed cos	t roport2		N		146.
					IN IN		140.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	-	ub. 15-2, chapter	40, §4020)	lf			
3	-	ub. 15-2, chapter	40, §4020)	lf		1.00	_
3	dd/yyyy) in column 2.	•		lf		1.00 N	147.0
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Health Financial Systems	AL HEALTH, INC.	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DATA		Period:	Worksheet S-2	
				Part I	
			To 06/30/2022	Date/Time Pre	pared:
				11/29/2022 7:	<u>30 am</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)		ate for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this pr	ovider have any days for ind	ividuals enrolled in	N	0	171.00
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 co	lumn 1 lf column 1 is ves (enter the number of sectio	n		
1876 Medicare days in column 2.					
prozo meurcare udys fil corumni z.			1		

	Financial Systems GRANT BLACKFORD MEI	Provi der C		Peri od:	u of Form CMS- Worksheet S-	
0111				From 07/01/2021 To 06/30/2022	Part II Date/Time Pr	epare
					11/29/2022 7	<u>: 30 a</u>
				Y/N	Date	_
	General Instruction: Enter Y for all YES responses. Enter M	V for all NO r	osponsos Ent	1.00	2.00	-
	mm/dd/yyyy format.		esponses. Lint	er all uates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1 1.
	reporting period? If yes, enter the date of the change in ()		
			Y/N	Date	V/I	
			1.00	2.00	3.00	
)0	Has the provider terminated participation in the Medicare		N			2.
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includi		N			3.
	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 directors through ownership, control, or family and oth	er similar				
	relationships? (see instructions)		V /N	T	Dete	
			Y/N 1.00	<u>Type</u> 2.00	Date 3.00	_
	Einancial Data and Departs		1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A	[4.
0	Accountant? Column 2: If yes, enter "A" for Audited, "C"			A		4.
	or "R" for Reviewed. Submit complete copy or enter date av					
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit re-					
			1	Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities	·	-			
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	r N		6.
	is the legal operator of the program?	5	•			
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.
00	Were nursing programs and/or allied health programs approve	ed and/or rene	wed during the	e N		8.
	cost reporting period? If yes, see instructions.					
00	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	N		9.
	program in the current cost report? If yes, see instruction					
00	Was an approved Intern and Resident GME program initiated	or renewed in	the current	N		10.
	cost reporting period? If yes, see instructions.					
00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	_
			-		1.00	_
00	Bad Debts	!+	41		N N	1 12
	Is the provider seeking reimbursement for bad debts? If yes			oot ronarting	Y N	12.
00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	porrey change	during this c	ost reporting	IN IN	13.
00	If line 12 is yes, were patient deductibles and/or co-paym	onte waivod? L	f vos soo in	structions	N	14
00	Bed Complement	ents warveu? I	i yes, see in	STIUCTIONS.	IN	- 14
00	Did total beds available change from the prior cost report	ing period? If	ves see ins	tructions	N	15
00			rt A	Par	t B	10
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only?	Y	09/06/2022	Y	09/06/2022	16.
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
00	Was the cost report prepared using the PS&R Report for	N		Ν		17.
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		18.
00	Report data for additional claims that have been billed					
00		1				
00	but are not included on the PS&R Report used to file this					
00						
	but are not included on the PS&R Report used to file this	N		N		19.
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		Ν		19.

Health Financial Systems

GRANT BLACKFORD MENTAL HEALTH, IN	IC.
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In Lieu of Form CMS-2552-10

Health Financial Systems GRANT BLACKFORD MEN	NTAL HEALTH, IN	u of Form CMS	of Form CMS-2552-10					
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 07/01/2021 Fo 06/30/2022		repared:			
	Descri	ption	Y/N	Y/N	7:30 alli			
)	1.00	3.00				
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00			
	Y/N	Date	Y/N	Date				
	1.00	2.00	3.00	4.00				
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00			
				1.00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	HOSPI TALS)		•				
Capital Related Cost								
22.00 Have assets been relifed for Medicare purposes? If yes, see					22.00 23.00			
reporting period? If yes, see instructions.	reporting period? If yes, see instructions.							
4.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions								
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see								
26.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.								
7.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.								
Interest Expense 0.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting								
period? If yes, see instructions. D0 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)								
	treated as a funded depreciation account? If yes, see instructions 00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
instructions. 1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see								
instructions. Purchased Services								
2.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.								
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competit	ive bidding? If		33.00			
Provider-Based Physicians 34.00 Are services furnished at the provider facility under an a	rrangomont with	n providor bas	od physicians?		34.00			
If yes, see instructions.	i angement with				54.00			
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the p	rovi der-based		35.00			
			Y/N 1.00	Date 2.00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?37.00 If line 36 is yes, has a home office cost statement been put	repared by the	home office?			36.00 37.00			
If yes, see instructions. 38.00 fline 36 is yes, was the fiscal year end of the home of					38.00			
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe	d of the home of	offi ce.			39.00			
see instructions. 40.00 If line 36 is yes, did the provider render services to the		5	N		40.00			
i nstructi ons.								
	1.	00	2.	00				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.00			
	BLUE AND CO LL	с			42.00			
 43.00 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. 	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43.00			

Health Financial Systems	GRANT BLACKFORD MENT	TAL HEALTH,	INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der		Period:	Worksheet S-2	
				From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	narod
				10 00/ 30/ 2022	11/29/2022 7:	30 am
			3.00			
Cost Report Preparer Contact Information	1					
41.00 Enter the first name, last name and the	title/position M	IANAGER				41.00
held by the cost report preparer in col	umns 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 ad	dress of the cost					43.00
report preparer in columns 1 and 2, res	becti vel y.					

	_Financial Systems GRANT AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-4021	Period: From 07/01/2021 To 06/30/2022		pared:
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	30. 00	16	5, 8	40 0.00	0	1.00 2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		16	5, 8	40 0.00	0 0	6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ \end{array}$	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE		16	5, 8	40 0.00	0	$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ \end{array}$
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	16 0		0	0	26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33.00							

HOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 07/01/2021 To 06/30/2022		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	279	172	2, 29	6		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	0 0	360 0				2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0 0	0		0		4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	279	172	2, 29	6		7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						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 (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	279 0	172 0	2, 29	6 0.00 0	158. 19	
20.00 21.00 22.00 23.00 24.00 24.10 25.00	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC				0		20.00 21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0 0	0		0 0.00 0.00		27.00 28.00 29.00
30.00 31.00 32.00 32.01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	0		0 0 0 0		30.00 31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0					33.00 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-4021	Period: From 07/01/2021 To 06/30/2022		pared:
	Full Time		Di s	charges		
Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) MM0 and other (see instructions) MM0 IPF Subprovider Mo HN0 IRF Subprovider Mo Hospital Adults & Peds. Swing Bed SNF Mo INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT O GORONARY CARE UNIT O GURDIARY CARE UNIT O GURDIARY CARE UNIT O GURDIARY CARE UNIT O GURDIARY CARE UNIT O GURGICAL INTENSIVE CARE UNIT O Total (see instructions) MURSERY O Total (see instructions) O SUBPROVIDER - IPF O SUBPROVIDER - IRF O SUBPROVIDER O SKILLED NURSING FACILITY O MURSING FACILITY O MABULATORY SURGICAL CENTER (D. P.) AMBULATORY SURGICAL CENTER (D. P.) O MURC (See instruction) O SUBPROVIDE (DALLINE (SECONT ADVALUE) O ON CMRAL HEALTH CLINIC C SECONT ADVALUE (See instruction) O DSERVATION BED DAYS O OSERVATION BED DAYS O OSERVATION BED ADYS O OSERVATION BED ADYS O OSERVATION BED ADYS O DERDIALY OVALIFIED HEALTH CENTER O DERDIALY OVALIFIED HEALTH CENTER	0. 00 0. 00 0. 00	0		38 48 0 108 0 38 48		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 32.\ 00\\ 31.\ 00\\ 31.\ $
 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 				0 0		32.01 33.00 33.01

Health Financial Systems GRAN	T BLACKFORD MEN	TAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 07/01/2021 Fo 06/30/2022	Date/Time Pre 11/29/2022 7:	
Cost Center Description	Sal ari es	Other		Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		308, 396			308, 396	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	199, 809	158, 486			358, 295	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 225, 612	2, 617, 853			3, 843, 465	
7.00 00700 OPERATION OF PLANT	442, 350	232, 637			674, 987	7.00
16.00 01600 MEDICAL RECORDS & LIBRARY	387, 462	11, 135	398, 597	7 0	398, 597	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDIATRICS	2, 727, 638	364, 180	3, 091, 818	3 0	3, 091, 818	30.00
ANCILLARY SERVICE COST CENTERS				1	i	
60. 00 06000 LABORATORY	0	28, 796			28, 796	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	80, 673	80, 673	3 0	80, 673	73.00
OUTPATIENT SERVICE COST CENTERS				1	1	
90. 00 09000 CLINIC	2, 143, 706	1, 074, 689	3, 218, 395	-318, 007	2, 900, 388	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 126, 577	4, 876, 845	12, 003, 422	2 -318, 007	11, 685, 415	118.00
NONREI MBURSABLE COST CENTERS				1	1	
194. 00 07950 RESI DENTI AL	2, 705, 121	340, 687				
200.00 TOTAL (SUM OF LINES 118 through 199)	9, 831, 698	5, 217, 532	15, 049, 230	0 0	15, 049, 230	200.00

Health Financial Systems GRAN	T BLACKFORD MEI	NTAL HEALTH, INC	2.	In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CC	N: 15-4021	Peri od:	Worksheet A	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 7:	epared:
	A.1				11/29/2022 7:	30 am
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
	6.00	Allocation				
GENERAL SERVICE COST CENTERS	6.00	7.00				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	0	308, 396				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	358, 295				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-494, 134					5.00
7. 00 00700 OPERATION OF PLANT	-494, 134	674, 987				7.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	398, 597				16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	370, 377				10.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 091, 818				30.00
ANCI LLARY SERVICE COST CENTERS	0	3,071,010				30.00
60. 00 06000 LABORATORY	0	28, 796				60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	80, 673				73.00
OUTPATIENT SERVICE COST CENTERS	0	00,075				/ 5.00
90. 00 09000 CLINIC	-72, 991	2, 827, 397				90.00
SPECIAL PURPOSE COST CENTERS	12,771	2,027,077				70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-567, 125	11, 118, 290				118.00
NONREI MBURSABLE COST CENTERS		,				
194. 00 07950 RESI DENTI AL	0	3, 363, 815				194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-567, 125					200.00
······		, ., . <u></u> ,				

Heal th	Financial Systems	GRAM	NT BLACKFORD M	ENTAL HEALTH, I	NC.	In Lieu	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 15-4021	Period:	Worksheet A-6	5
						From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 7:	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – MRO EXPENSE							
1.00	RESIDENTIAL	194.00	21 <u>5, 7</u> 26	102, 281				1.00
	TOTALS		215, 726	102, 281				
500.00	Grand Total: Increases		215, 726	102, 281				500.00

RECLASSIFICATIONS Provider CCN: 15-4021 Period: Worksheet A From 07/01/2021 To 06/30/2022 Date/Time F	
	repared:
11/29/2022	7:30 am
Decreases	
Cost Center Line # Salary Other Wkst. A-7 Ref.	
6.00 7.00 8.00 9.00 10.00	
A - MRO EXPENSE	
1.00 CLINIC 90.00 215,726 102,281 0	1.00
TOTALS 215, 726 102, 281	
500.00 Grand Total: Decreases 215,726 102,281	500.00

Hoal th	Financial Systems GRAN	T BLACKFORD MEN			In Li	eu of Form CMS-:	2552_10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-4021	Period: From 07/01/202 To 06/30/202	Worksheet A-7 1 Part I	pared:
				Acquisition	IS		
		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					_	
1.00	Land	406, 017	11, 930		0 11, 93	0 0	1.00
2.00	Land Improvements	0	0		0	0 0	2.00
3.00	Buildings and Fixtures	6, 297, 898	403, 362		0 403, 36	2 0	3.00
4.00	Building Improvements	0	0		0	0 0	4.00
5.00	Fixed Equipment	2,087,425	349, 287		0 349, 28	7 0	5.00
6.00	Movable Equipment	520, 829	214, 902		0 214, 90	2 0	6.00
7.00	HIT designated Assets	0	0		0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	9, 312, 169	979, 481		0 979, 48	1 0	8.00
9.00	Reconciling Items	0	0		0	o l	9.00
10.00	Total (line 8 minus line 9)	9, 312, 169	979, 481		0 979, 48	1 0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	417, 947	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	6, 701, 260	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2, 436, 712	0				5.00
6,00	Movable Equipment	735, 731	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	10, 291, 650	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	10, 291, 650	0				10.00
			0	I			1 . 0. 00

Health Financial Systems GRAN	T BLACKFORD MEN	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-4021	Period: From 07/01/2021	Worksheet A-7 Part II	
				To 06/30/2022	Date/Time Pre	pared:
					11/29/2022 7:	<u>30 am</u>
		SL	JMMARY OF CAP			
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	308, 396	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	308, 396	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
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	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	308, 396				1.00
3.00 Total (sum of lines 1-2)	0	308, 396				3.00

Health Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, II	NC.	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022		pared:
	COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			_		
1.00 NEW CAP REL COSTS-BLDG & FIXT	10, 291, 650	0	10, 291, 65			1.00
3.00 Total (sum of lines 1-2)	10, 291, 650		10, 291, 65			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 308, 396		1.00
3.00 Total (sum of lines 1-2)	0	0		0 308, 396	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			_		_
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	308, 396	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	308, 396	3.00

Health Financial Systems ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10 Worksheet A-8

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-4021	Period: From 07/01/2021	Worksheet A-8	
					To 06/30/2022	Date/Time Pre 11/29/2022 7:	
			T	Expense Classification of		1172772022 7.	
				o/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		<u>(2)</u> 1.00	2.00	3.00	4.00	Ref. 5.00	
	Investment income - NEW CAP		ONE	W CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)		FI	XT			
	Investment income - CAP REL		0**	** Cost Center Deleted **	* 2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time				0.00	0	4.00
	di scounts (chapter 8)		0		0.00	0	4.00
	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter				0.00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	21) Television and radio service		0		0.00	0	8.00
	(chapter 21)						
	Parking lot (chapter 21) Provider-based physician	A-8-2	0		0.00	0	
	adjustment				0.00		11 00
	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	
	and others						
	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients				0.00		17.00
	Sale of drugs to other than patients		0		0.00	0	17.00
	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00	0	
	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to		0		0.00	0	22.00
23 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0**	** Cost Center Deleted **	* 65.00		23.00
	therapy costs in excess of	K 0 3		oust center bereted	00.00		23.00
	limitation (chapter 14) Adjustment for physical	A-8-3	0**	** Cost Center Deleted **	* 66.00		24.00
	therapy costs in excess of						
	limitation (chapter 14) Utilization review –		0**	** Cost Center Deleted **	* 114.00		25.00
	physicians' compensation						
	(chapter 21) Depreciation - NEW CAP REL			EW CAP REL COSTS-BLDG &	1.00	0	26.00
	COSTS-BLDG & FIXT Depreciation - CAP REL			XT ** Cost Center Deleted **	* 2.00	0	27.00
	COSTS-MVBLE EQUIP					0	
	Non-physician Anesthetist Physicians'assistant		0 **	** Cost Center Deleted **	* 19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational	A-8-3	0 **	** Cost Center Deleted **			30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OAD	OULTS & PEDIATRICS	30.00		30. 99
	instructions)		I I		I I		I

Heal th	Financial Systems	GRAN	F BLACKFORD MEI	NTAL HEALTH, INC.	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	;
					From 07/01/2021		
					To 06/30/2022	Date/Time Pre 11/29/2022 7:	pared:
				Expense Classification o	n Worksheet A	11/29/2022 7.	
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest		0/0 704		5 00		
	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
	STORE REVENUE	В			90.00		00101
	PAYEE I NCOME	В	-41, 914		90.00		00.02
33.03	CAFETERIA REVENUE	В			90.00		00.00
	CASUALTY LOSSES (REVENUE)	В		ADMI NI STRATI VE & GENERAL	5.00		00101
	MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
	MI SCELLANEOUS I NCOME	В		MEDICAL RECORDS & LIBRARY	16.00		
	MI SCELLANEOUS I NCOME	В	-30, 977		90.00		00101
33.08	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.08
33.09	(3) SPONSORSHI P	А	2 005	ADMINISTRATIVE & GENERAL	5.00	0	33.09
	SPONSORSHI P	A		CLINIC	90.00		
	INTEREST INCOME	B		ADMINISTRATIVE & GENERAL	5.00		
	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5.00		
33.12	ADVERTI SI NG	A		CLINIC	90.00		
	NURSE PRACTITIONER	A		CLINIC	90.00		
	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5.00		
	TOTAL (sum of lines 1 thru 49)		-567, 125		5.00		50.00
50.00	(Transfer to Worksheet A,		-507, 125				30.00
	column 6, line 200.)						
	Corumn 0, TTHE 200. J						L

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

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

	Financial Syste		NT BLACKFORD ME	ENTAL HEALTH, I	NC.	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI			Provider (CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		0 0 0 0 0 0 0	0			0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00
9.00 9.00 10.00 200.00	0.00 0.00 0.00		0 0 0 0				0 0 0 0	9.00 10.00
	Wkst. A Line #	Cost Center/Physician Identifier		Unadjusted RCE Limit	Conti nui ng Educati on	Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 200.00	0.00 0.00	Cost Center/Physician	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0	0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
		Identifier	Component Share of col. 14	Limit	Di sal I owance			
1 00	1.00	2.00	15.00	16.00	17.00	18.00 0 0		1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 200.00	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 200.\ 00\\ \end{array}$

Heal th	Financial Systems GRAN	T BLACKFORD MEN	NTAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 7:	pared: 30 am
	Cost Center Description	Net Expenses	CAPI TAL RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost Allocation (from Wkst A	FLXT	BENEFI TS DEPARTMENT	Subtotal	E & GENERAL	
		col. 7)					
	GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	308, 396	308, 396				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	358, 295		358, 29	5		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 349, 331		45, 59		3, 438, 389	5.00
7.00	00700 OPERATION OF PLANT	674, 987		16, 45			7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	398, 597		14, 41	3 413,010	128, 588	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 091, 818	23, 688	101, 46	5 3, 216, 971	1, 001, 581	30.00
	ANCILLARY SERVICE COST CENTERS						
	06000 LABORATORY	28, 796			28, 796		
73.00	07300 DRUGS CHARGED TO PATIENTS	80, 673	0		0 80, 673	25, 117	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00		2, 827, 397	162, 588	71, 71	9 3, 061, 704	953, 240	90.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	11 110 200	227 424	249, 64	10 030 ((0	2 225 150	110.00
118.00	NONREIMBURSABLE COST CENTERS	11, 118, 290	237, 426	249, 04	4 10, 938, 669	2, 335, 159	118.00
10/ 00	07950 RESIDENTIAL	3, 363, 815	70, 970	108, 65	1 3, 543, 436	1, 103, 230	101 00
200.00		5, 505, 015	70, 970	100, 05	0, 343, 430	1, 105, 250	200.00
200.00			0		0 0	0	200.00
202.00		14, 482, 105	308, 396	358, 29			

Heal th	Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 7:	pared: <u>30 am</u>
	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						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	916, 794					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	541, 598				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	84, 422	230, 541	4, 533, 51	5 0	4, 533, 515	30.00
	ANCILLARY SERVICE COST CENTERS]
60.00	06000 LABORATORY	0	0	37, 76	1 0	37, 761	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	105, 79	0 0	105, 790	73.00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	579, 442	311, 057	4, 905, 44	3 0	4, 905, 443	90.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	663, 864	541, 598	9, 582, 50	9 0	9, 582, 509	118.00
	NONREIMBURSABLE COST CENTERS						1
194.00	07950 RESI DENTI AL	252, 930	0	4, 899, 59	6 0	4, 899, 596	194.00
200.00	Cross Foot Adjustments				0 0	0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	916, 794	541, 598	14, 482, 10	05 0	14, 482, 105	202.00

Heal th	Financial Systems GR	ANT BLACKFORD ME	NTAL HEALTH, I	NC.	In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider (Period: From 07/01/2021 To 06/30/2022		
			CAPI TAL				
	Cost Center Description	Directly	RELATED COSTS	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	cost center bescription	Assigned New	FIXT	Subtotal	BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS		-		_	-	
1.00	OO1OO NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	(-	0 0		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	43, 466			43, 466	
7.00	00700 OPERATION OF PLANT	0	7, 684			2, 752	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	()	0 0	1, 626	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	0	23, 688	3 23, 68	8 0	12, 662	30.00
	ANCI LLARY SERVICE COST CENTERS	-		-1	-		
	06000 LABORATORY	0			0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	318	73.00
00.00	OUTPATIENT SERVICE COST CENTERS		1(2,50)			10.051	00.00
90.00	09000 CLINIC SPECIAL PURPOSE COST CENTERS	0	162, 588	3 162, 58	8 0	12, 051	90.00
118.00		7) 0	237, 426	5 237, 42	6 0	20 522	118.00
116.00	NONREIMBURSABLE COST CENTERS	0	237,420	237,42	.0 0	29, 322	1110.00
194 00	07950 RESI DENTI AL	0	70, 970	70, 97	0 0	13 944	194.00
200.00			, , , , , , , , , , , , , , , , , , , ,	, , , , , ,	õ	.0, /44	200.00
200.00	· · · · · · · · · · · · · · · · · · ·		0	0	0 0	0	201.00
202.00		0	308, 396	308, 39	6 0		202.00

Heal th	Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2021 Fo 06/30/2022	Worksheet B Part II Date/Time Pre 11/29/2022 7:	pared: 30 am
	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						
1.00	OO1OO NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	10, 436					7.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 626				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	961	693	38, 004	4 0	38, 004	30.00
	ANCILLARY SERVICE COST CENTERS						1
60.00	06000 LABORATORY	0	0	113	3 0	113	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	318	3 0	318	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	6, 596	933	182, 168	3 0	182, 168	90.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7, 557	1, 626	220, 603	3 0	220, 603	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	07950 RESI DENTI AL	2, 879	0	87, 793	3 0	87, 793	194.00
200.00	Cross Foot Adjustments			(0 0	0	200.00
201.00	Negative Cost Centers	0	0	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	10, 436	1, 626	308, 396	5 0	308, 396	202.00

Health Financial Systems	GRANT BLACKFORD MEN	TAL HEALTH, II	NC.	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	1	Period: From 07/01/2021 Fo 06/30/2022		pared:
					11/29/2022 7:	<u>30 am</u>
Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG &	EMPLOYEE		ADMI NI STRATI V	OPERATION OF	
	FI XT (SQUARE FEET)	BENEFI TS DEPARTMENT (GROSS SALARI ES)	n	E & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	130, 997					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 631, 889				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	18, 463	1, 225, 612	-3, 438, 389	9 11, 043, 716		5.00
7.00 00700 OPERATION OF PLANT	3, 264	442, 350	(699, 126	109, 270	7.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	387, 462	(413, 010	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·		·			1
30. 00 03000 ADULTS & PEDI ATRI CS	10, 062	2, 727, 638	(3, 216, 971	10, 062	30.00
ANCILLARY SERVICE COST CENTERS]
60. 00 06000 LABORATORY	0	0)	28, 796	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0) (80, 673	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	69, 062	1, 927, 980	(3, 061, 704	69, 062	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 1	117) 100, 851	6, 711, 042	-3, 438, 389	7, 500, 280	79, 124	118.00
NONREI MBURSABLE COST CENTERS						
194. 00 07950 RESI DENTI AL	30, 146	2, 920, 847	(3, 543, 436	30, 146	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	308, 396	358, 295		3, 438, 389	916, 794	202.00
203.00 Unit cost multiplier (Wkst. B, Part	t I) 2.354222	0. 037199		0. 311343	8. 390171	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		0		43, 466	10, 436	204.00
205.00 Unit cost multiplier (Wkst. B, Part	t	0. 000000		0. 003936	0. 095507	205.00
206.00 NAHE adjustment amount to be alloca (per Wkst. B-2)	ated					206.00
207.00 NÄHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th	Fi nanci al	Systems	
COCT A			

In Lieu of Form CMS-2552-10

Health Financial Systems GRAN	I BLACKFORD MEN	NIAL HEALTH, INC.	In Lieu of Form CMS	5-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-4021	Period: Worksheet B	-1
			From 07/01/2021	
			To 06/30/2022 Date/Time P	repared:
Cost Center Description	MEDI CAL		11/29/2022	7:30 am
cost center Description	RECORDS &			
	LIBRARY			
	(GROSS			
	SALARIES)			
	16.00			
GENERAL SERVICE COST CENTERS	1			1
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	7, 362, 774			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	3, 134, 091			30.00
ANCILLARY SERVICE COST CENTERS				
60. 00 06000 LABORATORY	0			60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · ·			
90. 00 09000 CLINIC	4, 228, 683			90.00
SPECIAL PURPOSE COST CENTERS	·			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 362, 774			118.00
NONREI MBURSABLE COST CENTERS				
194. 00 07950 RESI DENTI AL	0			194.00
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B,	541, 598			202.00
Part I)				
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 073559			203.00
204.00 Cost to be allocated (per Wkst. B,	1, 626			204.00
Part II)	., 020			201100
205.00 Unit cost multiplier (Wkst. B, Part	0, 000221			205.00
	0.000221			200.00
206.00 NAHE adjustment amount to be allocated				206.00
(per Wkst. B-2)				
207.00 NAHE unit cost multiplier (Wkst. D,				207.00
Parts III and IV)				
	1 1			I

Health Financial Systems 0	GRANT BLACKFORD MEN	ITAL HEALTH, IN	VC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 7:	pared: 30 am
		Title	XVIII	Hospi tal	PPS	
				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 & PEDIATRICS	4, 533, 515		4, 533, 51	5 0	4, 533, 515	30.00
ANCILLARY SERVICE COST CENTERS			-			
60. 00 06000 LABORATORY	37, 761		37, 76	1 0	37, 761	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	105, 790		105, 79	0 0	105, 790	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	4, 905, 443		4, 905, 44	3 0	4, 905, 443	90.00
200.00 Subtotal (see instructions)	9, 582, 509	0	9, 582, 50	9 0	9, 582, 509	200.00
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	9, 582, 509	0	9, 582, 50	0	9, 582, 509	202.00

Health Financial Systems	GRANT BLACKFORD MEN	TAL HEALTH, IN	IC.	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 7:	
		Title	XVIII	Hospi tal	PPS	<u>30 alli</u>
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			r	r		
30. 00 03000 ADULTS & PEDI ATRI CS	3, 023, 125		3, 023, 125	b l l l l l l l l l l l l l l l l l l l		30.00
ANCILLARY SERVICE COST CENTERS				т. — т		
60. 00 06000 LABORATORY	29, 190	0	29, 190	1. 293628	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 776	0	81, 776	1. 293656	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	2, 709, 761	2, 709, 761	1. 810286	0.000000	90.00
200.00 Subtotal (see instructions)	3, 134, 091	2, 709, 761	5, 843, 852	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 134, 091	2, 709, 761	5, 843, 852	2		202.00

Health Financial Systems	GRANT BLACKFORD MENT	AL HEALTH, INC.	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 7:	
		Title XVIII	Hospi tal	PPS	30 alli
Cost Center Description	PPS Inpatient Ratio 11.00			113	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	1. 293628				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 293656				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	1. 810286				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	GRANT BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021 To 06/30/2022		pared: 30 am
		Titl	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 & PEDIATRICS	4, 533, 515		4, 533, 51	5 0	4, 533, 515	30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	37, 761		37, 76	1 0	37, 761	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	105, 790		105, 79	0 0	105, 790	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	4, 905, 443		4, 905, 44	3 0	4, 905, 443	90.00
200.00 Subtotal (see instructions)	9, 582, 509	0	9, 582, 50	9 0	9, 582, 509	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	9, 582, 509	0	9, 582, 50	9 0	9, 582, 509	202.00

Health Financial Systems	GRANT BLACKFORD MEN	TAL HEALTH, IN	IC.	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 7:	epared: 30 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 023, 125		3, 023, 125	5		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	29, 190	0	29, 190	1. 293628	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 776	0	81, 776	1. 293656	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	2, 709, 761	2, 709, 761	1. 810286	0.000000	90.00
200.00 Subtotal (see instructions)	3, 134, 091	2, 709, 761	5, 843, 852	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	3, 134, 091	2, 709, 761	5, 843, 852	2		202.00

Health Financial Systems	GRANT BLACKFORD MENT	AL HEALTH, INC.	In Lieu	u of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepa 11/29/2022 7:30	ared:) am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				:	30.00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY	0. 000000			6	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000			(90.00
200.00 Subtotal (see instructions)				20	00.00
201.00 Less Observation Beds				20	01.00
202.00 Total (see instructions)				20	02.00

Health Financial Systems GRA	NT BLACKFORD MEI	NTAL HEALTH, II	NC.	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2021	Worksheet D Part I	
				To 06/30/2022		pared: 30 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	-	Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	38, 004	0	38, 00	4 2, 296	16. 55	30.00
200.00 Total (lines 30 through 199)	38, 004		38, 004	4 2, 296		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	279	4, 617				30.00
200.00 Total (lines 30 through 199)	279	4, 617	1			200.00

Health Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2021	Worksheet D Part II	
				To 06/30/2022		pared: 30 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description		Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	-		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY	113	29, 190	0.00387	/1 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	318	81, 776	0. 00388	39 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	182, 168	2, 709, 761	0. 06722	27 0	0	90.00
200.00 Total (lines 50 through 199)	182, 599	2, 820, 727		0	0	200.00
						-

Health Financial Systems GRAN	IT BLACKFORD ME	NTAL HEALTH, II	NC.	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period:	Worksheet D	
				From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/29/2022 7:	
		Title	XVIII	Hospi tal	PPS	30 811
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
	Program	Program	Post-Stepdowr		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 & PEDI ATRI CS	0	0		0 0	0	30.00
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)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-	-				
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 29			
200.00 Total (lines 30 through 199)		0	2, 29	6	279	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00
	1	1				

Health Financial Systems GRANT BLACKFORD MENTAL HEALTH, INC. In Lieu of Form						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-4021	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022		pared:
					11/29/2022 7:	30 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems GRAN	T BLACKFORD MEI	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre	paradi
				10 00/30/2022	11/29/2022 7:	
		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)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0 29, 190	0.00000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 81, 776	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 2, 709, 761	0. 000000	90.00
200.00 Total (lines 50 through 199)	0	0		0 2, 820, 727		200. 00

Health Financial Systems GRAN	T BLACKFORD MENT	AL HEALTH, II	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-4021	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022		pared:
					11/29/2022 7:	30 am
			<u>XVIII</u>	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	r				-	
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 141, 350	0	90.00
200.00 Total (lines 50 through 199)		0		0 141, 350	0	200.00

Health Financial Systems GRAN	IT BLACKFORD ME	NTAL HEALTH, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 07/01/2021 To 06/30/2022		
		Title	XVIII	Hospi tal	PPS	
			Charges	_	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	1. 293628	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 293656	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	1. 810286	141, 350		0 0	255, 884	90.00
200.00 Subtotal (see instructions)		141, 350		0 0	255, 884	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		141, 350	1	0 0	255, 884	202.00

Health Financial Systems GRAN	IT BLACKFORD MEN	TAL HEALTH, IN	NC.	In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-4021	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/29/2022 7:	
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00	-			
ANCILLARY SERVICE COST CENTERS	L L		•			
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 CLINIC	0	0				90.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	0				202.00

GRANT BLACKFORD MENTAL HEALTH, INC.

In Lieu of Form CMS-2552-10

Heal th	Financial Systems GRANT BLACKFOR	RD MENTAL HEALTH, INC.	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022		pared:
		Title XVIII	Hospi tal	11/29/2022 7: PPS	
	Cost Center Description		поѕргта	PP3	
	· · · · · · · · · · · · · · · · · · ·			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	Inpatient days (including private room days and swing-	bed days, excluding newborn)		2, 296	1.00
2.00	Inpatient days (including private room days, excluding	g swing-bed and newborn days)		2, 296	
3.00	Private room days (excluding swing-bed and observation	n bed days). If you have only	private room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observ	(ation had days)		2, 296	4.00
5.00	Total swing-bed SNF type inpatient days (including pri		ber 31 of the cost		5.00
	reporting period	<i>, , , , , , , , , ,</i>		-	
6.00	Total swing-bed SNF type inpatient days (including pri		r 31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this li Total swing-bed NF type inpatient days (including priv		er 31 of the cost	0	7.00
7.00	reporting period	ate room days) through becen	ier 51 01 the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including priv		31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this li				
9.00	Total inpatient days including private room days appli newborn days) (see instructions)	cable to the Program (excludi	ng swing-bed and	279	9.00
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				
11.00	Swing-bed SNF type inpatient days applicable to title December 31 of the cost reporting period (if calendar		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles		ate room days)	0	12.00
	through December 31 of the cost reporting period	<u> </u>	5 1		
13.00	Swing-bed NF type inpatient days applicable to titles			0	13.00
14.00	after December 31 of the cost reporting period (if cal Medically necessary private room days applicable to th			0	14.00
	Total nursery days (title V or XIX only)	le Frogram (excruding swrng-be	u uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to reporting period	o services through December 31	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to	o services after December 31 c	of the cost	0, 00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to	services through December 31	of the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to	services after December 31 of	the cost	0.00	20.00
20.00	reporting period			0.00	20.00
	Total general inpatient routine service cost (see inst			4, 533, 515	
22.00	Swing-bed cost applicable to SNF type services through 5×10^{-10} x line 17)	n December 31 of the cost repo	rting period (line	• 0	22.00
23.00	Swing-bed cost applicable to SNF type services after [December 31 of the cost report	ing period (line 6	0	23.00
	x line 18)			-	
24.00	Swing-bed cost applicable to NF type services through	December 31 of the cost report	ting period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after De	cember 31 of the cost reporti	ng period (line 8	0	25.00
23.00	x line 20)	seember of the cost report	ng period (rine o	0	20.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-be	ed cost (line 21 minus line 26)	4, 533, 515	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding s	swing-bed and observation bed	charges)	0	28.00
	Private room charges (excluding swing-bed charges)	swing bed and observation bed	chur ges)	0	
30.00	Semi -private room charges (excluding swing-bed charges			0	30.00
	General inpatient routine service cost/charge ratio (I			0.00000	
	Average private room per diem charge (line 29 ÷ line 3 Average semi-private room per diem charge (line 30 ÷ l			0. 00 0. 00	32.00 33.00
	Average per diem private room charge differential (lir		uctions)	0.00	
35.00	Average per diem private room cost differential (line	34 x line 31)	-	0.00	35.00
	Private room cost differential adjustment (line 3 x li		differentiat (1)	0	
37.00	General inpatient routine service cost net of swing-be 27 minus line 36)	ed cost and private room cost	aitterential (line	4, 533, 515	37.00
ł	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH C				
				1, 974. 53	38.00
38.00	Adjusted general inpatient routine service cost per di	, ,			
38.00 39.00	Adjusted general inpatient routine service cost per di Program general inpatient routine service cost (line 9 Medically necessary private room cost applicable to th	9 x line 38)		550, 894	39.00

PUTATION OF INPATIENT OPERATING COST		Provider (F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet D-1 Date/Time Pre		
					11/29/2022 7:		
Cost Center Description	Total Inpatient Cost 1.00	Total Inpatient Days 2.00	<pre>xVIII Average Per Diem (col. 1 ÷ col. 2) 3.00</pre>	Hospital Program Days 4.00	PPS Program Cost (col. 3 x col. 4) 5.00		
00 NURSERY (title V & XIX only)		2.00	3.00	4.00	5.00	42	
Intensive Care Type Inpatient Hospital Units	1	I	1	1			
						43	
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT						44	
00 SURGI CAL I NTENSI VE CARE UNI T						46	
00 OTHER SPECIAL CARE (SPECIFY)						47	
Cost Center Description					1.00	-	
00 Program inpatient ancillary service cost (Wk	st D-3 col	3 Line 200)			1.00 C) 48	
00 Total Program inpatient costs (sum of lines			ons)		550, 894		
PASS THROUGH COST ADJUSTMENTS	v ,	•	,				
00 Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	4, 617	/ 50	
<pre>00 Pass through costs applicable to Program inp</pre>	ationt ancilla	ry corvicos (f	From Wkst D s	um of Parts II	C	51	
and IV)		ry services (i	TOIL WKSt. D, S		C	/ 51	
00 Total Program excludable cost (sum of lines					4, 617		
00 Total Program inpatient operating cost exclu		elated, non-ph	iysi ci an anesth	etist, and	546, 277	53	
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1	
00 Program di scharges					C	54	
00 Target amount per discharge					0.00	55	
00 Target amount (line 54 x line 55)				50)	C		
00 Difference between adjusted inpatient operat 00 Bonus payment (see instructions)	C						
market basket		0	•				
00 Lesser of lines 53/54 or 55 from prior year					0.00		
00 If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					C	61	
amount (line 56), otherwise enter zero (see				the target			
00 Relief payment (see instructions)					C		
00 Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			C	0 63	
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	na neriod (See	C	64	
instructions) (title XVIII only)	tis through bee					/	
00 Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	period (See	C	65	
instructions)(title XVIII only) 00 Total Medicare swing-bed SNF inpatient routi	na anata (lina	(1 plug ling	(E) (+; + o V)/		C	66	
CAH (see instructions)	ne costs (inne	64 prus rine	os)(title xvii	i oniy). Foi	L L		
00 Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost re	porting period	C	67	
(line 12 x line 19)					-		
00 Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after	December 31 of	the cost repo	rting period	C	68	
00 Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	ie 68)		C	69	
PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILIT	Y, AND ICF/IID	ONLY				
00 Skilled nursing facility/other nursing facil	J					70	
00 Adjusted general inpatient routine service c 00 Program routine service cost (line 9 x line		ine /U ÷ IINe	: ∠)			71	
00 Medically necessary private room cost applic		m (line 14 x l	ine 35)			73	
00 Total Program general inpatient routine serv						74	
00 Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B, P	art II, column		75	
26, line 45) 00 Per diem capital-related costs (line 75 ÷ li	ne 2)					76	
00 Program capital -related costs (line 9 x line						77	
00 Inpatient routine service cost (line 74 minu						78	
00 Aggregate charges to beneficiaries for exces		•				79	
00 Total Program routine service costs for comp 00 Inpatient routine service cost per diem limi			nı (irne /8 min	us iine 79)		80	
00 Inpatient routine service cost per diem rimit 00 Inpatient routine service cost limitation (I		1)				82	
00 Reasonable inpatient routine service costs (83	
00 Program inpatient ancillary services (see in		,				84	
00 Utilization review - physician compensation						85	
00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		mouyn 85)				86	
00 Total observation bed days (see instructions					C	87	
00 Adjusted general inpatient routine cost per	diem (line 27				0.00		
00 Observation bed cost (line 87 x line 88) (se							

Health Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022		pared: 30 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	38, 004	4, 533, 515	0. 00838	3 0	0	90.00
91.00 Nursing Program cost	0	4, 533, 515	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 533, 515	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 533, 515	0.00000	0 0	0	93.00

GRANT BLACKFORD MENTAL HEALTH, INC.

In Lieu of Form CMS-2552-10

		LACKFORD MENTAL HEALTH, INC.	In Lieu of Form CMS	-2552-1
COMPUTAT	ION OF INPATIENT OPERATING COST	Provi der CCN: 15-4021 Peri od:	Worksheet D-	-1
		From 07/01 To 06/30)/2022 Date/Time Pr	repared
			11/29/2022 7	
		Title XIX Hospita	al Cost	
	Cost Center Description			
			1.00	_
	ART I – ALL PROVIDER COMPONENTS			_
	npatient days (including private room days and	swing-bed days excluding newborn)	2, 29	6 1.0
	npatient days (including private room days and		2, 29	
		rvation bed days). If you have only private room		0 3.0
	o not complete this line.		aayo	0.0
	emi-private room days (excluding swing-bed and	observation bed days)	2, 29	6 4.0
		ing private room days) through December 31 of the	e cost	0 5.0
	eporting period			
		ing private room days) after December 31 of the	cost	0 6.0
	eporting period (if calendar year, enter 0 on			
		ng private room days) through December 31 of the	cost	0 7.0
	eporting period	na maiurta name dava) after December 31 of the a	+	
		ng private room days) after December 31 of the co	ost	0 8.0
	eporting period (if calendar year, enter 0 on otal inpatient days including private room day	s applicable to the Program (excluding swing-bed	and 17	2 9.0
	ewborn days) (see instructions)	S appricable to the riggian (excluding swifty-bed		2 7.0
		title XVIII only (including private room days)		0 10.0
	hrough December 31 of the cost reporting perio			
11.00 Sv	wing-bed SNF type inpatient days applicable to	title XVIII only (including private room days)	after	0 11.0
	ecember 31 of the cost reporting period (if ca			
		titles V or XIX only (including private room day	s)	0 12.0
	hrough December 31 of the cost reporting perio			
		titles V or XIX only (including private room days	S)	0 13.0
	fter December 31 of the cost reporting period edically necessary private room days applicabl			0 14.0
	otal nursery days (title V or XIX only)	e to the Program (excluding swing-bed days)		0 14.0
	ursery days (title V or XIX only)			0 16.0
	WING BED ADJUSTMENT			0 10.0
		able to services through December 31 of the cost	0.0	0 17.0
re	eporting period	U U		
		able to services after December 31 of the cost	0.0	0 18.0
	eporting period			
	0	ble to services through December 31 of the cost	0.0	0 19.0
	eporting period edicaid rate for swing-bed NF services applica	ble to services after December 21 of the cost	0.0	0 20.0
	eporting period	ble to services after becember 31 of the cost	0.0	20.0
	otal general inpatient routine service cost (s	ee instructions)	4, 533, 51	5 21.0
		through December 31 of the cost reporting period		0 22.0
	x line 17)			
		after December 31 of the cost reporting period (line 6	0 23.0
	line 18)			
	5 11 51	hrough December 31 of the cost reporting period	(line	0 24.0
	x line 19) wing had agat appliable to NE type convices a	fter December 21 of the east reporting period ()	ing 0	0 25 0
	line 20)	fter December 31 of the cost reporting period (I		0 25.0
	otal swing-bed cost (see instructions)			0 26.0
	eneral inpatient routine service cost net of s	wina-bed cost (line 21 minus line 26)	4, 533, 51	
	RIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00 Ge	eneral inpatient routine service charges (excl	uding swing-bed and observation bed charges)		0 28.0
29.00 Pr	rivate room charges (excluding swing-bed charg	es)		0 29.0
	emi-private room charges (excluding swing-bed	3		0 30.0
1	eneral inpatient routine service cost/charge r	, ,	0.00000	
	verage private room per diem charge (line 29 ÷		0.0	
	verage semi-private room per diem charge (line		0.0	
	verage per diem private room charge differenti verage per diem private room cost differential		0.0	
	rivate room cost differential adjustment (line		0.0	0 35.0
		wing-bed cost and private room cost differential		
	7 minus line 36)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5/5/.0
	ART II - HOSPITAL AND SUBPROVIDERS ONLY		I	
	ROGRAM INPATIENT OPERATING COST BEFORE PASS TH	ROUGH COST ADJUSTMENTS		
38.00 Ac	djusted general inpatient routine service cost	per diem (see instructions)	1, 974. 5	
	rogram general inpatient routine service cost	. ,	339, 61	
	edically necessary private room cost applicabl		339, 61	0 40.0
41.00 To	otal Program general inpatient routine service	cost (1100 20 + 1100 (0)		

IPUTATION OF INPATIENT OPERATING COST		Provider (Period: From 07/01/2021	Worksheet D-1	1
				To 06/30/2022		
		Ti †	le XIX	Hospi tal	11/29/2022 7: Cost	30
Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	40
00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
00 INTENSIVE CARE UNIT						43
00 CORONARY CARE UNIT						44
00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT						45
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1 00	
00 Program inpatient ancillary service cost (Wk	st. D-3. col.	3. Line 200)			1.00 C) 48
00 Total Program inpatient costs (sum of lines /			ons)		339, 619	
PASS THROUGH COST ADJUSTMENTS				E Daveta I		
00 Pass through costs applicable to Program inpa	atient routine	services (rrd	OM WKST. D, SUN	n or Parts I and	l C	50
00 Pass through costs applicable to Program inpa	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	C	51
and IV)	E0 and $E1$				C	
00 Total Program excludable cost (sum of lines 9 00 Total Program inpatient operating cost exclud		elated, non-ph	nysician anesth	netist, and		
medical education costs (line 49 minus line !	5 1		,			
TARGET AMOUNT AND LIMIT COMPUTATION 00 Program di scharges					C	54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					C	
00 Difference between adjusted inpatient operation	ing cost and t	arget amount (line 56 minus	line 53)	C	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost re	oorting period	ending 1006	undated and co	mounded by the	0. 00	
market basket	sol tring period	endring 1990,	upuateu anu co	inpounded by the	0.00	
00 Lesser of lines 53/54 or 55 from prior year of					0.00	
00 If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	61
amount (line 56), otherwise enter zero (see				the target		
00 Relief payment (see instructions)					C	
00 Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			C) 63
00 Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	ng period (See	C	64
instructions)(title XVIII only)						
00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts atter Decem	ber 31 of the	cost reporting	g period (See	C) 65
00 Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVII	I only). For	C	66
CAH (see instructions)	a acata thrawa	h December 21	of the east re	norting poriod	C	
00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs throug	n December 31	of the cost re	eporting period	Ĺ	67
00 Title V or XIX swing-bed NF inpatient routine	e costs after	December 31 of	the cost repo	orting period	C	68
(line 13 x line 20) 00 Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	a 68)		C) 69
PART III - SKILLED NURSING FACILITY, OTHER NU						, 0,
00 Skilled nursing facility/other nursing facili	2)		70
00 Adjusted general inpatient routine service of 00 Program routine service cost (line 9 x line		line /0 ÷ line	2)			71
00 Medically necessary private room cost application		m (line 14 x l	ine 35)			73
00 Total Program general inpatient routine servi	•					74
00 Capital-related cost allocated to inpatient 1 26, line 45)	routine servic	e costs (from	Worksheet B, F	art II, column		75
00 Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00 Program capital-related costs (line 9 x line						77
00 Inpatient routine service cost (line 74 minus 00 Aggregate charges to beneficiaries for excess		nrovi der recor	(ab			78
00 Total Program routine service costs for compa	•	•		nus line 79)		80
00 Inpatient routine service cost per diem limit	tation		,	<i>,</i>		81
00 Inpatient routine service cost limitation (1)						82
00 Reasonable inpatient routine service costs (00 Program inpatient ancillary services (see ins		115)				83
00 Utilization review - physician compensation		ons)				85
00 Total Program inpatient operating costs (sum	of lines 83 t	hrough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PASS						1 07
00 Total observation bed days (see instructions) 00 Adjusted general inpatient routine cost per o		÷line 2)			0. 00	
						89

Health Financial Systems GRAN	T BLACKFORD MEN	ITAL HEALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022		pared: 30 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	38, 004	4, 533, 515	0.00838	3 0	0	90.00
91.00 Nursing Program cost	0	4, 533, 515	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 533, 515	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 533, 515	0.00000	0 0	0	93.00

Health Financial Systems GRA	NT BLACKFORD MENTAL HEALTH,	INC.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-4021	Peri od:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 7:	pared: 30 am
	Ti t	le XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS			274, 947		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		1. 29362	28 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 2936	56 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		1.81028	36 0	0	90.00
200.00 Total (sum of lines 50 through 94 and	96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)	5 2 5 X		0		202.00

Health Financial Systems	GRANT BLACKFORD MENTAL HE	EALTH, IN	IC.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMEN	T Pro	ovider CC		Period:	Worksheet D-3	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 7:	pared: 30 am
		Title	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				187, 996		30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY			1. 29362	8 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS			1.29365	6 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC			1.81028	6 0	0	90.00
200.00 Total (sum of lines 50 through 94	and 96 through 98)			0	0	200.00
201.00 Less PBP Clinic Laboratory Service	es-Program only charges (I	ine 61)		0		201.00
202.00 Net charges (line 200 minus line :	201)			0		202.00

Fram DP/02/2022 Event in the second and	-	Financial Systems GRANT BLACKFORD MENTAL ATION OF REIMBURSEMENT SETTLEMENT	HEALTH, INC. Provider CCN: 15-4021	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
It the XVIII Hospital PPS 1.00 Teach of the Auto Once WeAt this Services 1.00 1.00 Reducal and other services (see Instructions) 205.84 2.00 1.00 Reducal and other services relationed under QMS (sue instructions) 205.84 2.00 0.00 Outlier recording the payment (see Instructions) 0.00				From 07/01/2021	Part B Date/Time Pre	
Not Fig. WRTICAL AND STREE HEATLIN STRVICTS 1.00 Noted call and other services relimbursed under OVPS (see instructions) 25.888 2.00 Noted call and other services relimbursed under OVPS (see instructions) 2.588 2.00 Duttiner reconcilization ansunt (see instructions) 0.415 0.00 Duttiner reconcilization ansunt (see instructions) 0.00 0.01 Duttiner theopital specific payment (see instructions) 0.000 0.01 Dutiner theopital specific payment (see instructions) 0.0000 1.000 Dutiner theopital specific payment (see instructions) 0.0000 1.000 Dutiner theopital specific payment (see instructions) 0.1000 1.000 Dutiner theopital specific payment (see instructions) 0.10000 1.000			Title XVIII	Hospi tal		
Not Fig. WRTICAL AND STREE HEATLIN STRVICTS 1.00 Noted call and other services relimbursed under OVPS (see instructions) 25.888 2.00 Noted call and other services relimbursed under OVPS (see instructions) 2.588 2.00 Duttiner reconcilization ansunt (see instructions) 0.415 0.00 Duttiner reconcilization ansunt (see instructions) 0.00 0.01 Duttiner theopital specific payment (see instructions) 0.000 0.01 Dutiner theopital specific payment (see instructions) 0.0000 1.000 Dutiner theopital specific payment (see instructions) 0.0000 1.000 Dutiner theopital specific payment (see instructions) 0.1000 1.000 Dutiner theopital specific payment (see instructions) 0.10000 1.000					1 00	
2 00 Medical and other services reinbursed under OPPS (see Instructions) 25,888 2,100 0 00 OPPS payments 0		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3 00 OPPS payments 215.008 3.00 4 00 Outline repared liquing mean (loss instructions) 0 4.01 4 01 Outline repared liquing mean (loss instructions) 0 4.01 4 01 Outline repared liquing mean (loss instructions) 0 4.01 6 01 Outline repared liquing mean (loss instructions) 0 0 4.01 6 01 Outline repared liquing mean (loss instructions) 0 0 0 0 7 00 Rest only specific set instructions) 0					-	
4 cm Datti isr payment (see instructions) 0 4.00 1 Datti isr payment (see instructions) 0.000 4.01 5 cm Primer the hospital specific payment to cast rario (see instructions) 0.000 6 cm Files 3.4. and 4.0.1 divided by line 6 0.000 7 cm Sine of rises 3.4. and 4.0.1 divided by line 6 0.000 8 cm Files 3.4. and 4.0.1 divided by line 6 0.000 9 cm Files 3.4. and 4.0.1 divided by line 6 0.000 9 cm Files 3.4. and 4.0.1 divided by line 6 0.000 9 cm Files 3.4. and 4.0.1 divided by line 6 0.000 9 cm Files 5.4. and 4.0.1 divided by line 6 0.000 9 cm Files 5.4. and 5.0. diverses 0.000 10 cm Cm Files 5.4. and 5.0. diverses 0.1.0.0. files 5.0. diverses 10 cm Cm Cm Cm Cm Cm 11 cm Cm Cm Cm Cm Cm 12 cm Cm Cm Cm Cm Cm Cm 12 cm Cm Cm			i ons)			
4.01 Outling Trebenditiation amount (see instructions) 0.01 0.00 5.00 0.00 Dire 2 times in e 5 0.000 5.00 0.00 Dire 2 times in e 5 0.000 5.00 0.00 Dire 2 times in e 5 0.000 0.000 0.00 Direct instructions) 0.000 0.000 0.00 Direct instructions) 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000		1.5				
6.00 Line 2 times 1 ines 3. 4, and 4.01, divided by line a 0 6.00 7.00 Sam of lines 3. 4, and 4.01, divided by line a 0 0 8.00 Transitional corridor payment (see instructions) 0 0 8.00 Transitional corridor payment (see instructions) 0 0 8.00 Transitional corridor payment (see instructions) 0 10.00 0.00 Cost Cost Cost AcAcciss 0 10.00 0.00 Cost Cost Cost Cost Cost Cost Cost Cost		Outlier reconciliation amount (see instructions)			-	
2.00 Sam of lines 3, 4, and 4.01, divided by line 6 0.00 0.00 8.00 9.00 8.00 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00			tions)			
8.00 Transitional corridor payment (see instructions) 0 8.00 0 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 1.00 0.000000 <					-	
10.00 Organ acquisitions 0 11.00 10.01 Order Cost (sum of lines 1 and 10) (see instructions) 0 11.00 11.00 Total cost (sum of lines 1 and 10) (see instructions) 0 12.00 12.00 Ancl I lary service charges 0 12.00 12.00 Ancl I lary service charges 0 12.00 12.00 Ancl I lary service charges 0 12.00 12.00 Ancred acquisition actual ty collected from patients liable for payment for services on a charge basis 0 16.00 12.00 Anounts that would have been realized from patients liable for payment for services on a charge basis 0 15.00 12.00 Excess of castionary charges over reasonable cost over	8.00				0	8.00
11.00 Total cost (sum of lines Land 10) (see instructions) 0 11.00 Demonstration Dor Lisses for Cost of CMARES 0 12.00 Reasonable charges 0 12.00 12.00 Appliciting service charges 0 12.00 13.00 Appliciting service charges 0 12.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 12.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 17.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 18.00 Total connery charges 0 0.000000 0			V, col. 13, line 200		-	
COMPUTATION OF LISSER OF COST OR CHARGES 12.00 Reasonable charges 0 12.00 Anci liary service charges (rem West. 0-4, PL 111, col. 4, line 69) 0 13.00 Organ acquisition charges (from West. 0-4, PL 111, col. 4, line 69) 0 10.00 Anci liary service charges 0 10.01 Charge consult actually collected Trom patients liable for payment for services on a charge basis 0 10.02 Anounts that would have been realized from patients liable for payment for services on a charge basis 0 10.02 Anounts that would have been realized from patients liable for payment for services on a charge basis 0 10.01 Coll customary charges (see instructions) 0 0 10.01 Coll customary charges (see instructions) 0 21.00 10.02 Exerce of cost or charges (see instructions) 0 21.00 10.02 Exerce of cost or charges (see instructions) 0 21.00 10.02 Exerce of cost or charges (see instructions) 0 21.00 10.02 Exerce of cost or charges (see instructions) 0 21.00 10.02 Exerce of cost or charges (5			-	
12.00 Ancillary service charges 0 12.00 Ancillary service charges 0 12.00 13.00 Drgm acquisition charges (sum of lines 12 and 13) 0 13.00 0 0 14.00 15.00 Aggregate ancunt actually collected from patients liable for payment for services on a charge basis 0 14.00 15.00 Aggregate ancunt actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Addition of line 15 to line 16 (not to exceed 1.000000) 0<						
13.00 Organ acquisition charges (rom Wist, D-4, Pt, H1, ol. 4, line 69) 0 13.00 0.00 Destinary charges (sum of lines 12 and 12) 0 14.00 0.01 Accurts that would have been realized from patients liable for payment for services on a charge basis 0 16.00 16.00 Accurts that would have been realized from patients liable for payment for services on a charge basis 0 16.00 17.00 Resting of lines 15 to line 16 (not to exceed 1.000000) 0 0.0000007 0 17.00 Exceeds of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 0 20.00 18.00 Desceed of charges services in a teaching hospital (see instructions) 0 21.00 22.00 20.00 Excess of reasonable cost (see instructions) 0 21.00 22.00 22.00 21.00 Excess of reasonable cost (see instructions) 0 21.00 22.00 22.00 22.00 Descess of reasonable cost (see instructions) 0 21.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 <td< td=""><td>10.00</td><td></td><td></td><td></td><td>0</td><td>10.00</td></td<>	10.00				0	10.00
14.00 Initial reasonable charges (sum of lines 12 and 13) 0 14.00 15.00 Aggregate ansumt actually collected from patients liable for payment for services on a charge basis 0 15.00 15.00 Aggregate ansumt actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 15.00 17.00 Excess of customary charges (see instructions) 0 0.000000 17.00 18.00 Excess of customary charges (see instructions) 0 21.00 15.00 20.00 Excess of customary charges (see instructions) 0 21.00 21.00 21.00 21.00 Lesser of cost or charges (see instructions) 0 21.00 21.00 21.00 22.00 Deductibles and coinsurance amounts (ref CAH, see instructions) 0 21.00 22.00 23.00 Deductibles and coinsurance amounts (ref CAH, see instructions) 0 22.00 21.00 22.00 21.00 22.00 21.00 22.00 21.00 20.00 21.00 21.00 22.00 21.00 21.00 21.00			ne 69)		-	
15:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0 15:00 10:00 Anothers that would have been reade liad from payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0 16:00 10:00 Total customary charges (see instructions) 0 0.000000 17:00 10:00 Excess of customary charges (see instructions) 0 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>					-	
16.00 Amount's that would have been read in accordance with A2 CFR §413.13(e) 0 16.00 17.00 Ratio of Line 15 to Line 16 (not to exceed 1.000000) 0.000000 17.00 0 18.00 Total customary charges (see instructions) 0 0.000001 17.00 0 19.00 Excess of customary charges (see instructions) 0 19.00 0 0 0 0.000001 17.00 0 <td>45 00</td> <td></td> <td></td> <td></td> <td></td> <td>15 00</td>	45 00					15 00
had such payment been made in accordance with 42 CFR §413.13(e) 0 0 0.000000 17.00 18.00 Total customary charges (see instructions) 0.000000 17.00 0 19.00 Excess of customary charges cyre reasonable cost (complete only if line 11 exceeds line 11) (see instructions) 0 18.00 19.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20.00 21.00 Instructions) 0 22.00 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0 22.00 23.00 Deductibles and coinsurance amounts (For CAH, see instructions) 56.65 25.00 26.00 Deductibles and coinsurance amounts (For CAH, see instructions) 56.65 25.00 26.00 Deductibles and coinsurance amounts (For Mikst. E-4, line 30) 0 29.00 29.00 20.00 20.00 Direct graduate medical education costs (from Wkst. E-4, line 30) 0 29.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>					-	
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40.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs158,55141.0041.00Interim payments158,55141.0041.01Interim payments-PARHM158,55141.0142.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-2543.0043.01Balance due provider/program (see instructions)-2543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		· · · · · · · · · · · · · · · · · · ·				
40.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments158,55141.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)-2543.01Balance due provider/program (see instructions)-2544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,044.00Stills.2070De E COMPLETED BY CONTRACTOR090.00Outlier reconciliation adjustment amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0						
41.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)-2543.01Bal ance due provider/program-PARHM (see instructions)-2544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0					Ũ	
42.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)-2543.01Balance due provider/program-PARHM (see instructions)-2544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0		1 5			158, 551	
42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -25 43.00 43.01 Balance due provider/program-PARHM (see instructions) -25 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 0					0	
43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0	42.01	Tentative settlement-PARHM (for contractor use only)			-	42.01
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 0 44.00 TO BE COMPLETED BY CONTRACTOR 0 90.00 0 90.00 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 91.00 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					-25	
§115.2TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)001.0001.0092.0093.0001.0093.0002.0003.0003.0004.0004.0005.0006.0007.0007.0008.0009.0009.0000.00 <t< td=""><td></td><td></td><td>ce with CMS Pub 15-2</td><td>chapter 1</td><td>Ο</td><td></td></t<>			ce with CMS Pub 15-2	chapter 1	Ο	
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91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	00.00				-	
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		5 · · · · · · · ·			-	
					-	
94. 00 [TOTAL (SUM OF LINES 91 and 93) [0] 94.00						
	94.00	וטנמו (Sum OF FILES או מחם אז)			0	94.00

Health Financial Systems	GRANT BLACKFORD MENTA	L HEALTH, INC.	In Lieu	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4021	Period:	Worksheet E	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	harod
			10 00/30/2022	11/29/2022 7:3	
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Pre 11/29/2022 7:3	pared:
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		209, 53	13 0	158, 551 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVI DER			0	0	3.01
3.02				0	0	3.02
3. 03 3. 04				0	0	3.03 3.04
3.04 3.05				0	0	3.02
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.52 3.53
3.53				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		209, 53	3	158, 551	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider		I	_		
5.01 5.02	TENTATI VE TO PROVIDER			0	0	5.01 5.02
5.02				0	0	5.0
	Provider to Program		L			5.50
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.5
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5 5.9
	5. 50-5. 98)			č	0	5.7
5. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
6.01	SETTLEMENT TO PROVIDER		51		0	6.0
6.02	SETTLEMENT TO PROGRAM		210.04	0	25 159 524	6.0
7.00	Total Medicare program liability (see instructions)		210, 04	Contractor	158,526 NPR Date	7.0
				Number	(Mo/Day/Yr)	

Heal th	Financial Systems GRANT BLACKFORD ME	ENTAL HEALTH, INC.	. In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4021	Period:	Worksheet E-3	
			From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	pared:
				11/29/2022 7:	30 am
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	medical education payments)	262, 735	
2.00 3.00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments			0	
4.00	Unweighted intern and resident FTE count in the most recer	nt cost report filed on or	hefore November	0.00	
1.00	15, 2004. (see instructions)			0.00	1.00
4.01	Cap increases for the unweighted intern and resident FTE or program or hospital closure, that would not be counted with			0.00	4.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	thout a temporary cap aujus	tillerit 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	period of a "new	0.00	6.00
	teaching program" (see instuctions)				
7.00	Current year's unweighted I&R FTE count for residents with teaching program" (see instuctions)	nin the new program growth	period of a "new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education ac	diustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)		, ,	6. 290411	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.000000	10.00
	Teaching Adjustment (line 1 multiplied by line 10).			0	
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 1			262, 735	
	Nursing and Allied Health Managed Care payment (see instru Organ acquisition (DO NOT USE THIS LINE)	uction)		0	13.00 14.00
	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	
	Subtotal (see instructions)			262, 735	
	Primary payer payments			0	
18.00	Subtotal (line 16 less line 17).			262, 735	18.00
	Deducti bl es			37, 326	
	Subtotal (line 18 minus line 19)			225, 409	
	Coinsurance Subtotal (line 20 minus line 21)			14, 840 210, 569	
	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		210, 307	
	Adjusted reimbursable bad debts (see instructions)	,		0	
25.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		0	
	Subtotal (sum of lines 22 and 24)			210, 569	
	Direct graduate medical education payments (see instruction	ons)		0	
	Other pass through costs (see instructions)			0	
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
	Recovery of accelerated depreciation.			0	
30.99	Demonstration payment adjustment amount before sequestrati	on		0	
	Total amount payable to the provider (see instructions)			210, 569	
	Sequestration adjustment (see instructions)			526	
	Demonstration payment adjustment amount after sequestration	on		0 209, 533	
	Interim payments Tentative settlement (for contractor use only)			209, 535	
34.00	Balance due provider/program (line 31 minus lines 31.01, 3	31.02, 32 and 33)		510	
	Protested amounts (nonallowable cost report items) in acco		chapter 1,	0	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line	2		0	50.00
	Outlier reconciliation adjustment amount (see instructions			0	
	The rate used to calculate the Time Value of Money	·		0.00	
	Time Value of Money (see instructions)			0	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020				
	Teaching Adjustment Factor for the cost reporting period i	• • •	ary 29, 2020.	0.000000	
99.01	Calculated Teaching Adjustment Factor for the current year	. (see instructions)		0.000000	99.01

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4021	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Pre 11/29/2022 7:	epare
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR	XIX SERVICES		-
~~	COMPUTATION OF NET COST OF COVERED SERVICES		220 (10		1 1
00	Inpatient hospital/SNF/NF services		339, 619	0	1.
00 00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.
00	Subtotal (sum of lines 1, 2 and 3)		339, 619	0	
00	Inpatient primary payer payments		0	0	5.
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		339, 619	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		007,017		1 ''
	Reasonabl e Charges				1
00	Routine service charges		187, 996		8.
00	Ancillary service charges		0	0	9
0. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		187, 996	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s			_	
1.00	Amounts that would have been realized from patients liable for		on 0	0	14
- 00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0,000000	0,000000	1-
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000 187, 996	0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	ly if line 16 exceeds	187, 996	0	
. 00	line 4) (see instructions)	If y IT ITTLE TO exceeds	0	0	''
2 00	Excess of reasonable cost over customary charges (complete or	ly if line 4 exceeds li	ne 151, 623	0	18
. 00	16) (see instructions)		101,023	0	1 '0
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		187, 996	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
2.00	Other than outlier payments	· · ·	0	0	22
	Outlier payments		0	0	23
1.00	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		187, 996	0	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		151 (00)	0	1 20
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		151, 623 187, 996	0	
2.00	Deductibles	3)	187, 990	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	187, 996	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- /	0	0	
	Subtotal (line 36 ± 1 ine 37)		187, 996	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
	Total amount payable to the provider (sum of lines 38 and 39)	1	187, 996	0	
	Interim payments		226, 889	0	
	Balance due provider/program (line 40 minus line 41)		-38, 893	0	42
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	43
	chapter 1, §115.2				1

	Financial Systems GRANT BLACKFORD MEN E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-4021 Pe	eriod: 	u of Form CMS-2 Worksheet G	
nly)	ype accounting records, comprete the General Fund cordinin		To		Date/Time Pre 11/29/2022 7:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	5, 504, 009	0	0	0	1.0
00	Temporary investments	0	0	0	0	
00	Notes receivable	0	0	0	0	3.0
00 00	Accounts receivable Other receivable	5, 211, 114	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	-1, 819, 047	0	0	0	
00	Inventory	0	0	0	0	
00	Prepaid expenses	177, 131	0	0	0	
00	Other current assets	0	0	0	0	
). 00	Due from other funds Total current assets (sum of lines 1-10)	9, 073, 207	0	0	0	10. 11.
. 00	FIXED ASSETS	7,073,207			0	1
2.00	Land	417, 947	0	0	0	12.
	Land improvements	0	0	0	0	
	Accumulated depreciation		0	0	0	
	Buildings Accumulated depreciation	7, 511, 597 -5, 109, 023	0	0	0	
	Leasehold improvements	382, 271	0	0	0	
	Accumulated depreciation	-195, 018	0	0	0	18.
	Fixed equipment	2, 436, 713		0	0	19.
	Accumulated depreciation	-1, 739, 526		0	0	
	Automobiles and trucks	353, 461		0	0	
	Accumulated depreciation Major movable equipment	-296, 961	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27.
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	3, 761, 461	0	0	0	
. 00	OTHER ASSETS	0,701,101				
. 00	Investments	0	0	0	0	31
. 00	Deposits on Leases	0	0	0	0	
	Due from owners/officers Other assets	0	0	0	0	33
	Total other assets (sum of lines 31-34)		0	0	0	34
	Total assets (sum of lines 11, 30, and 35)	12, 834, 668		0	0	
	CURRENT LI ABI LI TI ES					
	Accounts payable	320, 324		0	0	
. 00	Salaries, wages, and fees payable	3, 707, 249	1	0	0	
. 00	Payroll taxes payable Notes and Loans payable (short term)		0	0	0	
	Deferred income	66, 463	0	0	0	
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	71,070		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	4, 165, 106	0	0	0	45
. 00	Mortgage payable	0	0	0	0	46.
. 00	Notes payable	0	0	0	0	
. 00	Unsecured Loans	C	0	0	0	48.
	Other long term liabilities	687, 093		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	687,093		0	0	
. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	4, 852, 199	0	0	0	51
. 00	General fund balance	7, 982, 469				52
. 00	Specific purpose fund		0			53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ũ	
. 00	Total fund balances (sum of lines 52 thru 58)	7, 982, 469		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	12, 834, 668	0	0	0	60.

	Financial Systems GRAN ENT OF CHANGES IN FUND BALANCES	F BLACKFORD MENT	Provi der CC		Period: From 07/01/2021 To 06/30/2022		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) 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)		5, 449, 039 2, 533, 430 7, 982, 469 0 7, 982, 469 0 7, 982, 469				5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0		19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	L HEALTH, II Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet G-2 Parts I & II	epared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services		0.000.1	25	0.000.405	1
1.00	Hospi tal		3, 023, 1	25	3, 023, 125	
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSI NG FACI LI TY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		3, 023, 1	25	3, 023, 125	10.00
	Intensive Care Type Inpatient Hospital Services		•			
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)	`			0 000 405	1
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 023, 1		3, 023, 125	
18.00 19.00	Ancillary services Outpatient services		110, 9			
20.00	RURAL HEALTH CLINIC			0 4, 328, 453 0 0		
20.00	FEDERALLY QUALIFIED HEALTH CENTER				-	
22.00	HOME HEALTH AGENCY			0	0	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	RESI DENTI AL			0 3, 500, 494	3, 500, 494	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	3, 134, 0	91 7, 828, 947	10, 963, 038	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		r		•	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			15, 049, 230		29.00
30.00	ADD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00	Total additions (sum of lines 20.25)			0		35.00
36.00	Total additions (sum of lines 30-35)			-		36.00
37.00 38.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
40.00				0		40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			~ г		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		15, 049, 230		43.00
	to Wkst. G-3, line 4)	_, (anoi of		,, 200		.5. 50

Health Financial Systems GRANT BLACKFORD STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-4021	Period: From 07/01/2021	Worksheet G-3	
To 06/30				D22 Date/Time Prepar 11/29/2022 7:30	
1 00	Tatal anti-ant any and (from What C 2 Dout L ashima 2	11		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			10, 963, 038	1.00
2.00 3.00	Less contractual allowances and discounts on patients' accounts			3, 229, 094 7, 733, 944	2.00 3.00
	Net patient revenues (line 1 minus line 2)				
4.00	Less total operating expenses (from Wkst. G-2, Part II, Net income from service to patients (line 3 minus line 4)			15,049,230	4.00
5.00	OTHER INCOME)		-7, 315, 286	5.00
6.00				0	6.00
6.00 7.00	Contributions, donations, bequests, etc Income from investments			0	7.00
7.00 8.00	Revenues from telephone and other miscellaneous communication	ation convious		0	8.00
	Revenue from tel evision and radio service	ation services		0	9.00
9.00				-	9.00 10.00
10.00	Purchase discounts Rebates and refunds of expenses			0	
12.00				0	11.00 12.00
12.00	Parking lot receipts Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and quests			0	14.00
14.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to ot	har than nationts		0	16.00
17.00	Revenue from sale of drugs to other than patients	ner than patrents		0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
20.00	Rental of vending machines			0	20.00
21.00	Rental of hospital space			0	21.00
22.00	Governmental appropriations			0	22.00
23.00	OTHER REVENUE			8, 499, 828	
24.00	MI SCELLANEOUS REVENUE			0, 499, 020	24.00
24.01	OTHER INCOME - EXCESS			1, 348, 888	
24.02	COVID-19 PHE Funding			1, 340, 000	24.02
24.50	GAIN ON DEBT FORGIVENESS			0	24.50
24.51	Total other income (sum of lines 6-24)			9, 848, 716	
26.00	Total (line 5 plus line 25)			2, 533, 430	
27.00	OTHER EXPENSES (SPECIFY)			2, 555, 450	27.00
27.00	Total other expenses (sum of line 27 and subscripts)			0	27.00
				01	20.00