REGIONAL MENTAL HEALTH CENTER

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-4020 Worksheet S Peri od. From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: То 11/20/2023 9:33 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/20/2023 Time: 9:33 am Manually prepared cost report use only 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 [1] As Submitted
 7. Contractor No.

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 10. NPR Date:

 (10) In the status
 11. Contractor's Vendor Code:

 (2) Settled without Audit
 9.

 [N] Final Report for this Provider CCN
 12.

 [0] If line 5, column 1 is 4:
 Enter number of times reopened = 0-9.

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REGIONAL MENTAL HEALTH CENTER (15-4020) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR ELECTRONI C CHECKBOX 2 SIGNATURE STATEMENT 1 have read and agree with the above certification 1 certify that I intend my electronic

	Bill	Trowbridge	Ŷ	signature on this certification be the legally binding equivalent of my original signature.	
2	Signatory Printed Name	Bill Trowbridge			2
3	Signatory Title	CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	134, 404	50, 522	0	36, 559	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	134, 404	50, 522	0	36, 559	200.00

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

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

0	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	REGIONAL MENTAL				Period:	2000	Workshe	et S-2	2552· ?
						From 07/01/ To 06/30/	2023	Part I Date/Ti		
	1.00	2.00		3.00		4	1.00	11/20/2	2023 9:	<u>33 a</u>
	Hospital and Hospital Health Care Co									
00	Street: 8555 TAFT STREET	PO Box:	7	- 4/41						1.
00	City: MERRILLVILLE	State: IN Component Name	Zip Code	CBSA		y: LAKE Date	Payme	nt Syst	em (P	2.
			Number	Numbe		Certi fi ed		0, or		
							V	XVIII]
		1.00	2.00	3.00	0 4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componer Hospital	REGIONAL MENTAL HEALTH	154020	2384	4 4	02/16/1981	N	P	0	3
0		CENTER	134020	2304		0271071901		'		
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 Hospital-Based NF									9.
	Hospital - Based OLTC									11
	Hospital -Based HHA									12
	Separately Certified ASC									13
	Hospital-Based Hospice									14
. 00	Hospital-Based Health Clinic - RHC									15
. 00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
00	Other					_				19
						From:		To		-
00	Cost Reporting Period (mm/dd/yyyy)					1.00		2.0		20
	Type of Control (see instructions)					2		50/ 50/	2023	20
					1.00	2.00		3.0	00	
00	Inpatient PPS Information Does this facility qualify and is it	ourrently ready ing re	wmente for	-	N	N				1 22
00	disproportionate share hospital adju				IN	N				22
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
01	Did this hospital receive interim UC	Ps, including supplement	ntal UCPs,	for	Ν	N				22
	this cost reporting period? Enter in	column 1, "Y" for yes	or "N" for	r no						
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or			he						
	cost reporting period occurring on o	r after October 1. (see	9							
00	instructions)	requires a final UCD t	a ha		N	N				1 22
. 02	Is this a newly merged hospital that				N	N				22
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			no.						
	for the portion of the cost reportin			/						
. 03	Did this hospital receive a geograph	ic reclassification fro	om urban to	o	Ν	N		Ν		22
	rural as a result of the OMB standar	ds for delineating stat	istical ar	reas						
	adopted by CMS in FY2015? Enter in c	olumn 1, "Y" for yes or	"N" for r	no						
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft Does this hospital contain at least	-	,	ae						
	counted in accordance with 42 CFR 41									
	yes or "N" for no.		,	-						
04	Did this hospital receive a geograph	ic reclassification fro	om urban to	5						22
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	g period prior to Octob	per 1. Ente	er						
	in column 2, "Y" for yes or "N" for	no for the portion of t	he cost							
	reporting period occurring on or aft									
	Does this hospital contain at least		•							
	icounted in accordance with 12 CED 11	2.105)? Enter in colum	nn 3, "Y" f	ror						
						1				1
00	yes or "N" for no.	dicald dave on line- 2	and/or of	-		2 N				1 22
. 00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24	and/or 25	5		3 N				23
00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	of admission, 2 if cens	sus days, d	or 3		3 N				23
00	yes or "N" for no. Which method is used to determine Me	of admission, 2 if cens of identifying the days	sus days, c s in this c	or 3		3 N				23

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	CN: 15-4020	Peri od:			eet S-2	2
					From 07/0 To 06/3	1/2022 0/2023	11/20/	2023 9:	eparec 33 an
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Me)ther di cai d days	
		1.00	2.00	3.00	4.00	5.00) (6.00	
i M c 4 5. 00 I M 0 0	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, but-of-state Medicaid paid days in column 3, but-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, but-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0			0		0	C	24.
	HMO paid and eligible but unpaid days in column 5.								
			I		Urban/R				•
00	Enter your standard geographic classification (not w	ago) at-t	0++h	al ppl pa -f	1. (00	2.	00	26.
7.00 E r	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	r rural. age) status r "2" for r	s at the en rural. If a	d of the co		1			27.
5. 00 I	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	0			35.
					Begi nr 1. (Endi 2.		-
. OO E	Enter applicable beginning and ending dates of SCH s	tatus. Subs	script line	36 for num		0	۷.	00	36.
. 00 I	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	es.				0			37.
. 01 I a	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37.
. 00 I	If line 37 is 1, enter the beginning and ending date: greater than 1, subscript this line for the number o enter subsequent dates.								38.
					Y/			/N 00	+
1 1 2	Does this facility qualify for the inpatient hospita nospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	(iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	ume N mn es			N	39.
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				1	-	40.
						V 1.00	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital						2.00	0.00	
v	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc		•			e N N	N	N	45.
F	oursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o				-	N	N	N	47.
. 00 T	ls the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48.
r	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	s or "N" fo under 42 "Y", or if prior year	r no in col CFR 413.78(this hospi or penulti yment reduc	umn 1. For b)(2), see tal was mate year,	. Y	N		56.

Health Financial Systems REGIONAL	MENTAL	HEALTH CENTER		In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 07/01/2022	Worksheet S-2 Part I	
				06/30/2023	Date/Time Pre 11/20/2023 9:	pared:
				V	XVIII XIX	55 dili
58.00 If line 56 is yes, did this facility elect cost reim	hurcomo	nt for physici	anc' convious	as N	2.00 3.00	58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans services			56.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye	s, comp	lete Wkst. D-2	, Pt. I. NAHE 413.85	N Worksheet A	Pass-Through	59.00
			Y/N	Line #	Qual i fi cati on	
					Criterion	
			1.00	2.00	Code 3.00	
60.00 Are you claiming nursing and allied health education			N			60.00
any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co						
is "Y", are you impacted by CR 11642 (or subsequent	CR) NAH					
adjustment? Enter "Y" for yes or "N" for no in colu	mn 2. Y/N	IME	Direct GME	IME	Direct GME	
61.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.00
section 5503? Enter "Y" for yes or "N" for no in						
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61.01
FTEs from the hospital's 3 most recent cost reports						0.1.01
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care						61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.03
determining compliance with the 75% test. (see						
instructions) 61.04 Enter the number of unweighted primary care/or						61.04
surgery allopathic and/or osteopathic FTEs in the						01.04
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary						61.05
and/or general surgery FTEs and the current year's						01.00
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
61.06 Enter the amount of ACA §5503 award that is being						61.06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
Care or general sargery. (see mistractrons)	Pro	ogram Name	Program Code	Unweighted	Unwei ghted	
				IME FTE Count	Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0. 00	61.10
for each new program. (see instructions) Enter in						
column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE						
unweighted count. Enter in column 4, the direct GME						
FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61.20
program specialty, if any, and the number of FTE				0.00	0.00	01.20
residents for each expanded program. (see instructions) Enter in column 1, the program name.						
Enter in column 2, the program code. Enter in column						
 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 						
			1			
ACA Provisions Affecting the Health Decourage and Se	rvi coc	Administration			1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital	trai ne	d in this cost	reporting per	iod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru	ctions)				0.00	62 01
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC pro				your nospital	0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovid 63.00 Has your facility trained residents in nonprovider so	er Sett	i ngs		pori od? Entor	N	62 00
"Y" for yes or "N" for no in column 1. If yes, comple					N	63.00

)SPI 1	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		MENTAL HEALTH CENTER ATA Provider C		eri od:	u of Form CMS- Worksheet S-2	
				Fr Tc	com 07/01/2022 06/30/2023	Part I Date/Time Pre 11/20/2023 9:	epared:
				Unweighted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Si te	2.00	2.00	-
	Section 5504 of the ACA Base Yea	r FTF Residents in N	lonnrovider Settings.	1.00 This base year	2.00	3.00	
	period that begins on or after J			ini s buse year		- cpor tring	
1.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		5	, j	FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1.00	2.00	Si te	4.00	F 00	-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000) 65 (
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
5. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
	column 1 divided by (column 1 +	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		g. c Mano	g. am oodo	FTEs	FTEs in	3/ (col . 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1 00	2.00	Si te	4 00	5.00	-
. 00	Enter in column 1, the program	1.00	2.00	3.00	4.00) 67
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						

Health Financial Systems REGIONAL MENTAL HEALTH CEN	FER	In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide		Period: From 07/01/202		
	-	To 06/30/202	3 Date/Time Pr 11/20/2023 9	
			1.00	_
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 4906			N	(0.00
68.00 For a cost reporting period beginning prior to October 1, 2022, did yo MAC to apply the new DGME formula in accordance with the FY 2023 IPPS (August 10, 2022)?			N	68.00
		1.	00 2.00 3.00	•
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it o	ontain an IPF su	bprovider?	(70.00
Enter "Y" for yes or "N" for no.			N Y 1	
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME tea recent cost report filed on or before November 15, 2004? Enter "Y" for	or yes or "N" for	no. (see		71.00
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train reside program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" fo				
Column 3: If column 2 is Y, indicate which program year began during (see instructions)				
Inpatient Rehabilitation Facility PPS		I		
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does i subprovider? Enter "Y" for yes and "N" for no.	t contain an IRF	1	N	75.00
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME tea recent cost reporting period ending on or before November 15, 2004? En			0	76.00
no. Column 2: Did this facility train residents in a new teaching proc	ram in accordanc	e with 42		
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period.				
			1.00	-
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	for no		N	80.00
81.00 Is this a LTCH co-located within another hospital for part or all of		g period? Ente		81.00
"Y" for yes and "N" for no. TEFRA Provi ders				-
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? I 86.00 Did this facility establish a new Other subprovider (excluded unit) un			D. N	85.00 86.00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
87.00 Is this hospital an extended neoplastic disease care hospital classifi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
		Approved for Permanent	r Number of Approved	
		Adjustment (Y/N)	Permanent Adjustments	
		1.00	2.00	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the amount per discharge? Enter "Y" for yes or "N" for no. If yes, comple-		e		0 88.00
89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				
	Wkst. A Line	Effective	Approved Permanent	
	No.	Date	Adjustment	
			Amount Per Discharge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00	3.00	0 89.00
on which the per discharge permanent adjustment approval was based.	0.0			0 89.00
Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amou	nt			
per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	2			
TEFRA target amount per discharge.		V		
		1.00	XI X 2.00	_
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services	? Enter "Y" for	N	N	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost re	port either in	N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable col	umn.	IN I		
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certifiinstructions) Enter "Y" for yes or "N" for no in the applicable column	1.		N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title " "Y" for yes or "N" for no in the applicable column.	/ and XIX? Enter	Ν	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.	or no in the	Ν	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable co		0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		N	N	96.00
97.00 [If line 96 is "Y", enter the reduction percentage in the applicable co	olumn.	0.00	0.00	97.00

	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period:	Worksheet S-	-2
				rom 07/01/2022 o 06/30/2023		repared
					11/20/2023 9	
				V 1.00	XI X 2.00	-
st	bes title V or XIX follow Medicare (title XVIII) for the i tepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" olumn 1 for title V, and in column 2 for title XIX.			Y	Y	98.
3. 01 Dc C,	bes title V or XIX follow Medicare (title XVIII) for the r Pt. I? Enter "Y" for yes or "N" for no in column 1 for t tle XIX.			Y	Y	98.
02 Do	bes title V or XIX follow Medicare (title XVIII) for the c ed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or title V, and in column 2 for title XIX.			Y	Y	98.
. 03 Do re	bes title V or XIX follow Medicare (title XVIII) for a cri beimbursed 101% of inpatient services cost? Enter "Y" for y or title V, and in column 2 for title XIX.			N 1	N	98.
3. 04 Do ou	bes title V or XIX follow Medicare (title XVIII) for a CAP utpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	N	98.
3. 05 Dc Wk	bes title V or XIX follow Medicare (title XVIII) and add b kst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in olumn 2 for title XIX.				Y	98.
3.06 Do Pt	bes title V or XIX follow Medicare (title XVIII) when cost ts. I through IV? Enter "Y" for yes or "N" for no in colum olumn 2 for title XIX.			Y	Y	98.
RL	ural Providers				1	
06. 00 I f	pes this hospital qualify as a CAH? f this facility qualifies as a CAH, has it elected the all pr outpatient services? (see instructions)	-inclusive me [.]	thod of paymen	t		105. 106.
07.00Cc tr Cc	olumn 1: If line 105 is Y, is this facility eligible for craining programs? Enter "Y" for yes or "N" for no in colum olumn 2: If column 1 is Y and line 70 or line 75 is Y, dc opproved medical education program in the CAH's excluded 1	n 1. (see in: you train I&l	structions) Rs in an			107
08. 00 I s	iter "Y" for yes or "N" for no in column 2. (see instruct s this a rural hospital qualifying for an exception to the FR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 42	Ν		108
		Physi cal	Occupati onal	Speech	Respi ratory	<u>, </u>
	f this hospital qualifies as a CAH or a cost provider, are	1.00	2.00	3.00	4.00	
	nerapy services provided by outside supplier? Enter "Y"					109
						109.
fc 10. 00 Di De cc	nerapy services provided by outside supplier? Enter "Y"	al Demonstrati "Y" for yes ol	r "N" for no.	410A If yes,	1.00 N	
fc 10. 00 Di De cc	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrati "Y" for yes ol	r "N" for no.	410A If yes, Jgh 215, as	1.00 N	
10.00 Di De cc ap 11.00 I f He "Y i r Er	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrati "Y" for yes of rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in	r "N" for no. lines 200 throu Community period? Enter enter the n column 2.	410A If yes,	1.00	109.
fc 10. 00 Di De cc ap 11. 00 f He "Y i r Er	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wc oplicable. f this facility qualifies as a CAH, did it participate in each Integration Project (FCHIP) demonstration for this c (" for yes or "N" for no in column 1. If the response to c ntegration prong of the FCHIP demo in which this CAH is pa nter all that apply: "A" for Ambulance services; "B" for a	al Demonstrati "Y" for yes of rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, Jgh 215, as 1.00 N	1.00 N	110
10.00 Di De CC 11.00 I f He "Y i r Fc 12.00 Di (F F Y G e Y G e	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo oplicable. f this facility qualifies as a CAH, did it participate in ealth Integration Project (FCHIP) demonstration for this c (" for yes or "N" for no in column 1. If the response to c thegration prong of the FCHIP demo in which this CAH is pa ther all that apply: "A" for Ambulance services; "B" for a part tele-health services. d this hospital participate in the Pennsylvania Rural Hea PARHM) demonstration for any portion of the current cost r eriod? Enter "Y" for yes or "N" for no in column 1. If column 1. If column 2, the date the hospital began particip emonstration. In column 3, enter the date the hospital ce	al Demonstrati "Y" for yes of rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	410A If yes, Jgh 215, as	1.00 N	110
10.00 Di De CC 20 11.00 f He "Y i r Fc 12.00 Di (F Pe "Y de pe pe	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo oplicable. f this facility qualifies as a CAH, did it participate in ealth Integration Project (FCHIP) demonstration for this c (" for yes or "N" for no in column 1. If the response to c ntegration prong of the FCHIP demo in which this CAH is pa ther all that apply: "A" for Ambulance services; "B" for a parter all that apply: "A" for Ambulance services; "B" for a part tele-health services. d this hospital participate in the Pennsylvania Rural Hea 2ARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "," enter in column 2, the date the hospital began partici emonstration. In column 3, enter the date the hospital ce articipation in the demonstration, if applicable.	al Demonstrati "Y" for yes of rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	410A If yes, Jgh 215, as 1.00 N	1.00 N	110
10.00 Di De CC 11.00 I f He "Y i r Er fc 12.00 Di (F pe "Y de pa pa 15.00 I s i r i r fc	d this hospital participate in the Rural Community Hospit monstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo coplicable. f this facility qualifies as a CAH, did it participate in calth Integration Project (FCHIP) demonstration for this con- tegration prong of the FCHIP demo in which this CAH is partice and the that apply: "A" for Ambulance services; "B" for a contegration prong of the FCHIP demo in which this CAH is partice and this hospital participate in the Pennsylvania Rural Hea ARHM) demonstration for any portion of the current cost re- reriod? Enter "Y" for yes or "N" for no in column 1. If column 1. If contegration in the demonstration, if applicable. scellaneous Cost Reporting Information is this an all-inclusive rate provider? Enter "Y" for yes on column 1. If column 1 is yes, enter the method used (A, no column 2. If column 2 is "E", enter in column 3 either " or short term hospital or "98" percent for long term care sychiatric, rehabilitation and long term hospitals provide	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	410A If yes, Jgh 215, as 1.00 N	1.00 N	1110.
10. 00 Di CC ap 11. 00 I f He "Y i r Er fc 12. 00 Di (F pe "Y de <u>pa</u> 15. 00 I s i r fc 15. 00 I s i r fc 15. 00 I s	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo oplicable. f this facility qualifies as a CAH, did it participate in ealth Integration Project (FCHIP) demonstration for this of "for yes or "N" for no in column 1. If the response to on the gration prong of the FCHIP demo in which this CAH is parter all that apply: "A" for Ambulance services; "B" for a or tele-health services. d this hospital participate in the Pennsylvania Rural Hea PARHM) demonstration for any portion of the current cost r eriod? Enter "Y" for yes or "N" for no in column 1. If c (", enter in column 2, the date the hospital began partici emonstration. In column 3, enter the date the hospital ce articipation in the demonstration, if applicable. scellaneous Cost Reporting Information s this an all-inclusive rate provider? Enter "Y" for yes of n column 1. If column 1 is yes, enter the method used (A, n column 2. If column 2 is "E", enter in column 3 either " or short term hospital or "98" percent for long term care sychiatric, rehabilitation and long term hospitals provide s this facility classified as a referral center? Enter "Y"	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	410A If yes, Jgh 215, as 1.00 N	1.00 N	110.
10. 00 Di De cap 11. 00 I f He "Y ir Er fc 12. 00 Di (F Pe "Y de pa 15. 00 I s ir ir fc 15. 00 I s "N 16. 00 I s	d this hospital participate in the Rural Community Hospit monstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo coplicable. f this facility qualifies as a CAH, did it participate in ealth Integration Project (FCHIP) demonstration for this co (" for yes or "N" for no in column 1. If the response to con- tegration prong of the FCHIP demo in which this CAH is partice and the services. d this hospital participate in the Pennsylvania Rural Hea- parter all that apply: "A" for Ambulance services; "B" for a cor tele-health services. d this hospital participate in the Pennsylvania Rural Hea- PARHM) demonstration for any portion of the current cost r enod? Enter "Y" for yes or "N" for no in column 1. If co (", enter in column 2, the date the hospital began partici emonstration. In column 3, enter the date the hospital ce articipation in the demonstration, if applicable. scellaneous Cost Reporting Information as this an all-inclusive rate provider? Enter "Y" for yes of n column 1. If column 1 is yes, enter the method used (A, n column 2. If column 2 is "E", enter in column 3 either or short term hospital or "98" percent for long term care sychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	r "N" for no. lines 200 throu Community period? Enter enter the n column 2. s; and/or "C" 1.00 N N	410A If yes, Jgh 215, as 1.00 N	1.00 N	1110. 1111. 1112. 01115.
fc 10.00 Di De CC ap 11.00 I f He "Y i r Fc 12.00 Di (F pe "Y de <u>pa</u> Mi 15.00 I s i r fc 11.00 I s 17.00 I s "N 17.00 I s "N 17.00 I s "N 17.00 I s "N 17.00 I s "N 17.00 I s "N 17.00 I s "N "N "N "N "N "N "N "N "N "N	herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospit emonstration) for the current cost reporting period? Enter omplete Worksheet E, Part A, lines 200 through 218, and Wo oplicable. f this facility qualifies as a CAH, did it participate in ealth Integration Project (FCHIP) demonstration for this of "for yes or "N" for no in column 1. If the response to o the gration prong of the FCHIP demo in which this CAH is pa ther all that apply: "A" for Ambulance services; "B" for a or tele-health services. d this hospital participate in the Pennsylvania Rural Hea PARHM) demonstration for any portion of the current cost r eriod? Enter "Y" for yes or "N" for no in column 1. If co (", enter in column 2, the date the hospital began partici emonstration. In column 3, enter the date the hospital ce articipation in the demonstration is this an all-inclusive rate provider? Enter "Y" for yes o n column 1. If column 1 is yes, enter the method used (A, n column 2. If column 2 is "E", enter in column 3 either " or short term hospital or "98" percent for long term care sychiatric, rehabilitation and long term hospitals provide s this facility classified as a referral center? Enter "Y" or for no.	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	r "N" for no. lines 200 through the second	410A If yes, Jgh 215, as 1.00 N	1.00 N	110 111 111 112 0115 116

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE	REGIONAL MENTAL F COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 07/01/2022	u of Form CM Worksheet S Part I Date/Time P 11/20/2023	5-2
			Premi ums	Losses	Insurance	
			1.00	2.00	2.00	
8.01 List amounts of malpractice	premiums and paid losses:		1.00 454,756	2.00	3.00	0118.0
			1			
9 02 Aro mal practi co promiumo ar	d paid losses reported in a cost	contor other	than the	1.00 N	2.00	118.0
	P If yes, submit supporting sched			N		119. 0
0.00 Is this a SCH or EACH that §3121 and applicable amendr "N" for no. Is this a rural	qualifies for the Outpatient Hold eents? (see instructions) Enter in hospital with < 100 beds that qu ACA §3121 and applicable amendmen yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient	Ν	N	120.0
	report costs for high cost impla	ntable device	es charged to	Ν		121.0
2.00 Does the cost report contai Act?Enter "Y" for yes or "N	n healthcare related taxes as def "for no in column 1. If column 1 where these taxes are included.			N		122.0
3.00 Did the facility and/or its services, e.g., legal, acco	subproviders (if applicable) pur unting, tax preparation, bookkeep ces, from an unrelated organizati	ing, payroll,	and/or			123. (
for yes or "N" for no. If column 1 is "Y", were th professional services exper	e majority of the expenses, i.e., ises, for services purchased from of the main hospital CBSA? In colu	greater than unrelated org	n 50% of total janizations			
Certified Transplant Cente						105
and "N" for no. If yes, ent	a Medicare-certified transplant c er certification date(s) (mm/dd/y	yyy) below.	5	N		125. (
	fied kidney transplant program, e date, if applicable, in column 2		ification date			126. (
	fied heart transplant program, er 1 date, if applicable, in column 2		fication date			127.(
8.00 If this is a Medicare-certi	fied liver transplant program, er	ter the certi	fication date			128. (
9.00 f this is a Medicare-certi	n date, if applicable, in column 2 fied lung transplant program, ent	er the certif	ication date			129. (
0.00 f this is a Medicare-certi	n date, if applicable, in column 2 fied pancreas transplant program, mation date, if applicable, in col	enter the ce	erti ficati on			130. (
	fied intestinal transplant progra ation date, if applicable, in col		certi fi cati on			131. (
2.00 If this is a Medicare-certi	fied islet transplant program, er date, if applicable, in column 2	ter the certi	fication date			132. (
3.00 Removed and reserved	date, il applicable, ili column 2					133.
	lorgan procurement organization (date, if applicable, in column 2		he OPO number			134.0
chapter 10? Enter "Y" for y are claimed, enter in colur	nization or home office costs as c res or "N" for no in column 1. If n 2 the home office chain number.	yes, and home (see instruc	e office costs	Y		140.
office and enter the home of	2.00 a chain organization, enter on l office contractor name and contract	ines 141 thro			of the home	
1.00Name: 2.00Street:	Contractor's Name: PO Box:		Contractor	's Number:		141. 142.
3. 00 Ci ty:	State:		Zip Code:			142.
					1 00	_
4.00 Are provider based physicia	ns' costs included in Worksheet A	?			1.00 Y	144.
5 00 lf costs for ronal convision	are claimed on Wkst. A, line 74,	and the east	s for	1.00	2.00	145.
inpatient services only? Er	ter "Y" for yes or "N" for no in ity include Medicare utilization	column 1. If	column 1 is			145.
6.00 Has the cost allocation met	chodology changed from the previou r no in column 1. (See CMS Pub. 1			N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	4	Provider CC	N: 15-4020		eriod:	/01/2022	Worksheet S- Part I	2
					T		/30/2023		
					·			1.00	_
47.00 Was there a change in the statist								N	147.00
48.00Was there a change in the order of					6			N	148.00
49.00Was there a change to the simplif	ed cost finding metho	od? Ent	<u>ter "Y" for y</u> Part A	es or "N" Part			tle V	N Title XIX	149.00
		-	1.00	2.00	5		3.00	4.00	-
Does this facility contain a prov or charges? Enter "Y" for yes or									
55. 00Hospi tal			N	N			N	N	155.0
56.00 Subprovi der – I PF			N	N			Ν	N	156.0
57.00 Subprovi der – IRF			N	Ν			Ν	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF			Ν	N			N	N	158.0 159.0
60.00HOME HEALTH AGENCY			N	N			N	N	160.0
61. OO CMHC				N			N	N	161.0
								1.00	
Mul ti campus									
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in di	ffer	ent CE	ISAs?	Ν	165. C
	Name		County	State		Code	CBSA	FTE/Campus	_
(6 00) f line 1/F is yes far such	0		1.00	2.00	3.	00	4.00	5.00	0166.0
66.00 If line 165 is yes, for each campus enter the name in column								0.0	0 100.0
0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									_
	F)							1.00	_
Health Information Technology (HI 67.00 Is this provider a meaningful use	i) incentive in the Ar	mericar tor "V"	n Recovery an " for ves or	"N" for n	tmen	LACT		N	167.0
68.00 If this provider is a CAH (line 10						enter	the		168.0
reasonable cost incurred for the I									
68.01 If this provider is a CAH and is i						a harc	lshi p		168.0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y")					N"), ε	enter the	0. C	00169.0
transition factor. (see instruction	ons)					Rog	i nni ng	Endi ng	
							1. 00	2.00	-
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ding da	ate for the r	eporting					170.0
							1 00	0.00	
71.00 fline 167 is "Y", does this prov	ider have any dave fr	ar indi	i vi dual si opro	lledin			1.00 N	2.00	0171.0
section 1876 Medicare cost plans " "Y" for yes and "N" for no in colu	reported on Wkst. S-3,	Pt. I	I, line 2, co	l. 6? Ente			IN		

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-4020	Peri od:	Worksheet S-	2
				From 07/01/2022 To 06/30/2023	Date/Time Pr	
	· · · · · · · · · · · · · · · · · · ·			V /N	11/20/2023 9	:33 am
				Y/N 1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTION	VALRE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N			er all dates in	the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			1	1	
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	corumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includir		N			3.
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of dispersions through expension control on family and other					
	of directors through ownership, control, or family and other relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert		Y	A		4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
	column 3. (see instructions) If no, see instructions.					_
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Logal Oper	_
				1.00	Legal Oper. 2.00	-
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provide	er N		6.
	the legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see ir	nstructions.		N		7.
00	Were nursing programs and/or allied health programs approve	ed and/or rene	wed during th	ne N		8.0
	cost reporting period? If yes, see instructions.					
00	Are costs claimed for Interns and Residents in an approved		cal education	Y Y		9.
	program in the current cost report? If yes, see instruction		the ourrent	Y		10.
0.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.	n renewed in	the current	I		10.
1.00	Are GME cost directly assigned to cost centers other than I	& R in an An	nroved	Ν		11.
1.00	Teaching Program on Worksheet A? If yes, see instructions.	a it in an Ap	or oved			
					Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				N	12.
. 00	If line 12 is yes, did the provider's bad debt collection p	oolicy change	during this c	ost reporting	N	13.
	period? If yes, submit copy.				N	14
. 00	If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts w	aived? IT yes	s, see	N	14.
	Bed Complement					-
00	Did total beds available change from the prior cost reporti	na period? [f	ves see ins	tructions	N	15.
		V	t A		rt B	101
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data			-		
5.00	Was the cost report prepared using the PS&R Report only?	Y	09/26/2023	Y	09/26/2023	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					
. 00	instructions)	Ν		Ν		17.
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	IN		IN		17.
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		Ν		18.
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.
9.00						
. 00	Report data for corrections of other PS&R Report information? If yes, see instructions.					

	Heal th	Fi nanci al	Systems
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REGIONAL MENTAL HEALTH CENTER

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period:	Worksheet S-2	2
				From 07/01/2022		norod.
				To 06/30/2023	Date/Time Pre 11/20/2023 9:	
		Descri	ption	Y/N	Y/N	
)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N	Date	Y/N	Date	
0.1 0.0		1.00	2.00	3.00	4.00	01.00
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPLTALS)		1.00	
	Capital Related Cost					1
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense		sals made duri	ng the cost	N	23.00
	reporting period? If yes, see instructions.			0		
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	orting period?	N	24.00
	lf yes, see instructions					
25.00	Have there been new capitalized leases entered into during	, the cost repo	rting period?	lf yes, see	N	25.00
24 00	instructions.				N	24 00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	ne cost reporti	ng period? I	yes, see	N	26.00
27.00	Has the provider's capitalization policy changed during th	ne cost renorti.	na period? If	ves submit	N	27.00
27.00	COPV.		ig period: II	yes, subin t		27.00
	Interest Expense				I	
28.00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporting	N	28.00
	period? If yes, see instructions.		0			
29.00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service Re	eserve Fund)	N	29.00
	treated as a funded depreciation account? If yes, see inst					
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes,	see	N	30.00
21 00	instructions.				N	21 00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? IT yes,	See	N	31.00
	Purchased Services				I	
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni she	ed through cor	tractual	N	32.00
	arrangements with suppliers of services? If yes, see instr					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	N	33.00
	no, see instructions.					
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-ba	ised physi ci ans?	Y	34.00
25 00	If yes, see instructions.	loting ogroomo	ata with the r	rouldor bood	Y	25 00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		its with the p	or ovi der -based	ř	35.00
	physicians during the cost reporting period: in yes, see i			Y/N	Date	-
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	N		37.00
	lf yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of			N		38.00
00.00	the provider? If yes, enter in column 2 the fiscal year er					
39.00	If line 36 is yes, did the provider render services to oth see instructions.	ier chai'n compoi	hents? IT yes,	N		39.00
40 00	If line 36 is yes, did the provider render services to the	home office?	lf ves see	Ν		40.00
40.00	instructions.		TT yes, see	IN		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position	KYLE		SMI TH		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively.					
42.00	Enter the employer/company name of the cost report	BLUE & CO LLC				42.00
13 00	preparer. Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO COM	43.00
	report preparer in columns 1 and 2, respectively.	51/-/13-/93/		NO SWITTIEDLUEAN		43.00
	report property in containing rand 2, respectively.	1		1		11

Heal th	Financial Systems REGIONA	L MENTAL	HEALTH CENTER		In Lieu	of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE	Provider CCN: 15-4020		ri od:	Worksheet S-2	
				To		Part II Date/Time Pre 11/20/2023 9:	pared: <u>33 am</u>
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/posi	tion	DI RECTOR				41.00
	held by the cost report preparer in columns 1, 2,	and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of th	e cost					43.00
	report preparer in columns 1 and 2, respectively.						

0SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023		pared
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		Line No.		Avai I abl e			
	PART I – STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	16	5, 8	40 0.00	0	1.0
. 00	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)	50.00		5, 0.	+0 0.00	0	2.0
. 00	HMO IPF Subprovider						3.0
. 00	HMO I RF Subprovi der						4.0
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.0
. 00	Hospital Adults & Peds. Swing Bed NF					0	6.0
. 00	Total Adults and Peds. (exclude observation		16	5,84	40 0.00	0	7.0
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT						8.0
00	CORONARY CARE UNIT						9.1
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
4.00	NURSERY Total (see instructions)		16	5,8	40 0.00	0	14.0
5.00	CAH visits		10	5, 6	+0 0.00	0	14.0
5.10	REH hours and visits					Ū	15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
3. 00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0. 00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00 4.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						23. 24.
4.00 4.10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC	99.00				0	25.
5.00	RURAL HEALTH CLINIC	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Ũ	26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		16				27.
3. 00	Observation Bed Days					0	
9.00	Ambul ance Trips						29.
). 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF		~				31.
2.00	Labor & delivery days (see instructions)		0		0		32. 32.
	Total ancillary labor & delivery room outpatient days (see instructions)						32.
3. 00	LTCH non-covered days						33.
3.01	LTCH site neutral days and discharges						33.
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	F	eriod: rom 07/01/2022 o 06/30/2023		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui 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	
	PART I – STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	199	127	1, 778			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	100	205				
2.00	HMO and other (see instructions)	420	385				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	U	0	0			6.00
7.00	Total Adults and Peds. (exclude observation	199	127	1, 778			7.00
. 00	beds) (see instructions)	177	127	1,770			/.00
3.00	INTENSI VE CARE UNI T						8.00
9.00	CORONARY CARE UNI T						9.00
0.00	BURN INTENSIVE CARE UNIT	o	0	0			10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T	-	-	-			11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.00
14.00	Total (see instructions)	199	127	1, 778	4.00	324.07	14.00
5.00	CAH visits	0	0	0			15.00
5.10	REH hours and visits						15.10
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00				0			24.0
4.10 5.00	HOSPICE (non-distinct part) CMHC - CMHC	0	0	0		0.00	24.1 25.0
5.00 6.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	25.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
7.00	Total (sum of lines 14-26)	U	0	0	4.00	324.07	
8.00	Observation Bed Days		0	0		524.07	28.0
9.00	Ambul ance Trips	0	0	0			29.0
0.00	Employee discount days (see instruction)	0		0			30.0
1.00	Employee discount days - IRF			0			31.0
2.00	Labor & delivery days (see instructions)	0	0	0			32.0
2.01	Total ancillary labor & delivery room		-	0			32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33.0
33.01	LTCH site neutral days and discharges	0					33.0
24 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023		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	
	PART I – STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0		24 12	237	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)				44 58		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL INTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	0		24 12	237	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00 19.00							19.00
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)						24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days	0.00					28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						0
33.00	LTCH non-covered days				0		33.00
33.01	LTCH site neutral days and discharges				0		33.0
	Temporary Expansion COVID-19 PHE Acute Care			1			34.00

	EGIONAL MENTAL H				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CO	CN: 15-4020	Period: From 07/01/2022	Worksheet A	
				o 06/30/2023	Date/Time Pre 11/20/2023 9:	pared: 33 am
Cost Center Description	Sal ari es	Other		Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT		1, 140, 415	1, 140, 415	121, 597	1, 262, 012	1.00
3. 00 00300 OTHER CAP REL COSTS		0			1, 202, 012	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 976, 463	-	-	4, 976, 463	
5. 00 00500 ADMINI STRATI VE & GENERAL	1, 634, 908	5, 990, 607			7, 617, 956	
6. 00 00600 MAI NTENANCE & REPAI RS	707, 980	98, 455			797, 406	
10. 00 01000 DI ETARY	301, 900	309, 510			610, 933	•
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	351, 253			351, 253	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	133, 342	166, 548			584, 908	•
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·			· · · · ·		1
30. 00 03000 ADULTS & PEDI ATRI CS	1, 685, 567	1, 460, 477	3, 146, 044	584, 171	3, 730, 215	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	33.00
ANCILLARY SERVICE COST CENTERS			•			1
60. 00 06000 LABORATORY	0	0			4, 946	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	167, 585	167, 585	0	167, 585	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	r			T		
90. 00 09000 CLINIC	7, 452, 868	1,084,661	8, 537, 529	-4, 269, 339	4, 268, 190	90.00
OTHER REIMBURSABLE COST CENTERS			1			
99.00 09900 CMHC	0	0			0	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	(0 0	0	102.00
SPECIAL PURPOSE COST CENTERS	11 01/ 5/5	15 745 074		2 200 (72)	24 271 0/7	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	11, 916, 565	15, 745, 974	27, 662, 539	-3, 290, 672	24, 371, 867	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(0	192.00
192. 01 19200 FITIST CLANS FREVATE OFFICES	2, 702, 886	2, 895, 498		-	5, 557, 084	
192. 02 19202 FORENSI C	2,702,000	2,075,470	3, 370, 30-	-41, 300		192.02
192. 03 19203 C&E	1, 326, 826	888, 226	2, 215, 052	, vi	2, 213, 447	
192. 04 19204 HUD	103, 348	21, 071	124, 419		120, 901	
192. 05 19205 OTHER	764, 080	720, 031	1, 484, 111		1, 452, 949	
192. 06 19206 MRO	004,000	, 20, 031	(3, 429, 329	
194. 00 07950 FQHC CLINIC HOHAM	1, 617, 549	1, 117, 711	-		2, 725, 539	
194. 01 07951 FQHC CLINIC	793, 932	627, 183			1, 374, 807	
194. 02 07952 FQHC HOMELESS SHELTER	0	25, 375				194.02
194. 03 07953 REGIONAL HEALTH CARE AT STARK	347, 904	73, 234			421, 138	
194. 04 07954 REGIONAL HEALTH CARE AT STRAWHUN	369, 535	115, 943			485, 478	
194. 05 07955 FQHC_PURDUE	34, 845	19, 630				194.05
	19, 977, 470				42, 227, 346	
200.00 TOTAL (SUM OF LINES 118 through 199)	19, 977, 470	22, 249, 876			42, 227, 346	20

Heal th	Financial Systems RI	EGIONAL MENTAL	HEALTH CENTER		Inlie	u of Form CMS	-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der CCN:	15-4020	Peri od:	Worksheet A	2002 10
					From 07/01/2022		
					To 06/30/2023	Date/Time Pr 11/20/2023 9	epared:
	Cost Center Description	Adjustments	Net Expenses			11/20/2023 9	1:33 alli
	cost center bescription	(See A-8)	For				
		(300 A 0)	Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	0,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-33, 639	1, 228, 373				1.00
3.00	00300 OTHER CAP REL COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 976, 463				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	994, 491	8, 612, 447				5.00
6.00	00600 MAINTENANCE & REPAIRS	-18, 689	778, 717				6.00
10.00	01000 DI ETARY	-561, 965	48, 968				10.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	351, 253				21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0					22.00
	INPATIENT ROUTINE SERVICE COST CENTERS		· · · ·				
	03000 ADULTS & PEDIATRICS	-1, 570, 859	2, 159, 356				30.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0				33.00
	ANCILLARY SERVICE COST CENTERS						
	06000 LABORATORY	0	4, 946				60.00
	07300 DRUGS CHARGED TO PATIENTS	0					73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	-2, 560, 291	1, 707, 899				90.00
	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC	0					99.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0				102.00
	SPECIAL PURPOSE COST CENTERS	0.750.050					
118.00		-3, 750, 952	20, 620, 915				118.00
100.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFI CES	0					102.00
		0					192.00
	19201 RESI DENTI AL 19202 FORENSI C	0	5, 557, 084				192. 01 192. 02
	19202 FORENSI C 19203 C&E	0	0				
	19203 C&E 19204 HUD	0	2, 213, 447				192. 03 192. 04
	19205 OTHER	0	120, 901				192.04
	19205 OTHER 19206 MRO	0	1, 452, 949 3, 429, 329				192.05
	07950 FQHC CLINIC HOHAM	0					192.00
	07951 FQHC CLINIC HOHAM		2, 725, 539 1, 374, 807				194.00
	07951 FORC CETING 07952 FORC HOMELESS SHELTER		21, 857				194.01
	07952 FUNC NOMELESS SHELLER 07953 REGIONAL HEALTH CARE AT STARK	0	421, 138				194.02
	07954 REGIONAL HEALTH CARE AT STARK	0	421, 138				194.03
	07955 FQHC PURDUE	0	52, 950				194.04
200.00		-3, 750, 952					200.00
200.00		J 3, 730, 732	00, 470, 374				1200.00

Health Financial Systems RECLASSIFICATIONS

REGIONAL MENTAL HEALTH CENTER Provider CCN: 15-4020 Period: Erom 07/0

In Lieu of Form CMS-2552-10 Worksheet A-6

RECERC				in ovider e	JON: 13 4020	From 07/01/2022	Nor Kaneet A o	
						To 06/30/2023	Date/Time Prepar 11/20/2023 9:33	red:
		Increases					11/20/2023 9.33	
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - PROPERTY INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71, 344				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0			3	3.00
4.00		0.00	0	0			4	4.00
5.00		0.00	0	0			Ę	5.00
6.00		0.00	0	0			6	6.00
7.00		0.00	0	0			-	7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0			Q	9.00
10.00		0.00	0	0			1(0.00
	0		0	71, 344				
	B - AUTO INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50, 253				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0			8	8.00
	0		0	50, 253				
	D - PBP CLINIC							
1.00	ADULTS & PEDIATRICS		<u>544, 5</u> 16	3 <u>9, 6</u> 55				1.00
	0		544, 516	39, 655				
	E – MRO EXPENSE							
1.00	MRO	192.06	<u>3, 316, 8</u> 44	<u>112, 4</u> 85				1.00
	0		3, 316, 844	112, 485				
	F - LAB RECLASS							
1.00	LABORATORY	60.00	0	4,946				1.00
	TOTALS		0	4, 946				
	G – I &R RECLASS							
1.00	I &R SERVICES-OTHER PRGM.	22.00	285, 018	0				1.00
	COSTS APPRVD							
2.00	<u> </u>	0.00	0	0				2.00
	TOTALS		285, 018	0				
500.00	Grand Total: Increases		4, 146, 378	278, 683			500	0.00
			·					

Health Financial Systems RECLASSIFICATIONS

REGIONAL MENTAL HEALTH CENTER

Provider CCN: 15-4020 Period: From 07/01/2022 Worksheet A-6

In Lieu of Form CMS-2552-10

						From 07/01/2022 To 06/30/2023	Date/Time Prepared: 11/20/2023 9:33 am
		Decreases					1172072023 9.33 alli
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9,00	10,00	-	
	A - PROPERTY INSURANCE						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	5, 123	3 1:	2	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	153	3 (b	2.00
3.00	CLINIC	90.00	0	10, 553	3 (b	3.00
4.00	RESI DENTI AL	192. 01	0	36, 168	3 (b	4.00
5.00	C&E	192.03	0	1, 605	5 (b	5.00
6.00	HUD	192.04	0	3, 518	3 (b	6.00
7.00	FQHC CLINIC HOHAM	194.00	O	7,035	5 (b	7.00
8.00	FQHC CLINIC	194. 01	O	3, 518	3 (b	8.00
9.00	FQHC HOMELESS SHELTER	194.02	0	3, 518	3 (C	9.00
10.00	FQHC PURDUE	194.05	0	153	3 (C	10.00
	0		0	71, 344	1		
	B - AUTO INSURANCE						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 436			1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	8, 876		D	2.00
3.00	DI ETARY	10.00	0	477		D	3.00
4.00	CLI NI C	90.00	0	3, 058		D	4.00
5.00	RESI DENTI AL	192. 01	0	186		D	5.00
6.00	OTHER	192.05	0	31, 162		D	6.00
7.00	FQHC CLINIC HOHAM	194.00	0	2, 686		D	7.00
8.00	FQHC_PURDUE	1 <u>94.</u> 05	0	<u> </u>		2	8.00
	0		0	50, 253	3		
	D - PBP CLINIC					1	
1.00	<u>CLINIC</u>		<u>544, 5</u> 16	3 <u>9, 6</u> 55		2	1.00
	0		544, 516	39, 655	5		
	E - MRO EXPENSE				1	1	
1.00	<u>CLINIC</u>	90.00	<u>3, 316, 8</u> 44	11 <u>2, 4</u> 85		2	1.00
	0		3, 316, 844	112, 485	5		
	F - LAB RECLASS	100.01			.1		
1.00	RESIDENTIAL	1 <u>92.</u> 01		<u>4, 946</u>		2	1.00
	TOTALS		0	4, 946			
1 00	G - I&R RECLASS	00.00	0.40, 000				
1.00		90.00	242, 228	0	-		1.00
2.00	FOHC CLINIC	<u> </u>	42, 790	0		<u></u>	2.00
			285,018	278, 683	,	-	F00.00
500.00	Grand Total: Decreases	l I	4, 146, 378	278,683	5	1	500.00

Heal th	Financial Systems RI	EGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2022 To 06/30/2023		pared:
				Acquisition	S		
		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	F BALANCES					
1.00	Land	671, 905	0		0 0	0	1.00
2.00	Land Improvements	635, 390	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	30, 264, 527	568, 431		0 568, 431	11, 591	4.00
5.00	Fixed Equipment	7, 108, 418	515, 667		0 515, 667	68, 011	5.00
6.00	Movable Equipment	657,642	38, 455		0 38, 455	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39, 337, 882	1, 122, 553		0 1, 122, 553	79, 602	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	39, 337, 882	1, 122, 553		0 1, 122, 553	79, 602	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	671, 905	0				1.00
2.00	Land Improvements	635, 390	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	30, 821, 367	0	1			4.00
5.00	Fixed Equipment	7, 556, 074	0				5.00
6.00	Movable Equipment	696, 097	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	40, 380, 833	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40, 380, 833	0				10.00

Health Financial Systems R	EGIONAL MENTAL	EGIONAL MENTAL HEALTH CENTER			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-4020		Period: From 07/01/2022	Worksheet A-7 Part II			
				To 06/30/2023		pared: 33 am		
		SL	JMMARY OF CAPI	TAL				
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	KSHEET A, COLUM	<u>MN 2, LINES 1 a</u>	and 2					
1.00 CAP REL COSTS-BLDG & FIXT	1, 059, 050	0	81, 36	5 0	0	1.00		
3.00 Total (sum of lines 1-2)	1, 059, 050	0	81, 36	5 0	0	3.00		
	SUMMARY O	F CAPITAL						
Cost Center Description	Other	Total (1)	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, COLUM	MN 2, LINES 1 a	and 2					
1.00 CAP REL COSTS-BLDG & FIXT	0	1, 140, 415				1.00		
3.00 Total (sum of lines 1-2)	0	1, 140, 415				3.00		

Health Financial Systems R	EGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2022 To 06/30/2023		pared:
	COMF	PUTATION OF RAT	TI OS	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 CAP REL COSTS-BLDG & FIXT	40, 380, 833	0	40, 380, 83			1.00
3.00 Total (sum of lines 1-2)	40, 380, 833		40, 380, 83			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1		0.4.000	
1.00 CAP REL COSTS-BLDG & FIXT	0			0 1, 140, 976		1.00
3.00 Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	0 <u>1, 140, 976</u>	-34, 200	3.00
		SL	JMMARY OF CAPT			
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 CAP REL COSTS-BLDG & FIXT	0	121, 597		0 C	1, 228, 373	1.00
3.00 Total (sum of lines 1-2)	0	121, 597	I	0 0	1, 228, 373	3.00

In Lieu of Form CMS-2552-10 Worksheet A-8

Health Financial Systems ADJUSTMENTS TO EXPENSES	R	EGIONAL MENTAL		In Lie Period:	u of Form CMS-2 Worksheet A-8	
ADSOSTIMENTS TO EAFENSES				From 07/01/2022 To 06/30/2023		pared:
			Expense Classification on To/From Which the Amount is			
Cost Contor Description	Pacis (Codo	Amount	Cost Center	lino #	Wkst. A-7	
Cost Center Descriptior	(2)	Amount	Cost center	Line #	Ref.	
1.00 Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
COSTS-BLDG & FIXT (chapter 2						
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time		0		0.00	0	4.00
discounts (chapter 8) 5.00 Refunds and rebates of		0		0.00	0	5.00
6.00 Rental of provider space by		0		0.00	0	6.00
suppliers (chapter 8)		0		0.00		
stations excluded) (chapter		0		0.00	0	7.00
21) 8.00 Television and radio service		0)	0.00	0	8.00
(chapter 21) 9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provi der-based physi ci an	A-8-2	-2, 582, 338	3	0.00	0	
adjustment 11.00 Sale of scrap, waste, etc.		0		0.00	0	11.00
(chapter 23) 12.00 Related organization	A-8-1	1, 391, 314			0	12.00
transactions (chapter 10)		1,0,1,011				
13.00 Laundry and linen service 14.00 Cafeteria-employees and gues	ts B	-29, 685	DI ETARY	0. 00 10. 00		
15.00 Rental of quarters to employ and others	ee	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17.00 Sale of drugs to other than		0		0.00	0	17.00
patients 18.00 Sale of medical records and		0		0.00	0	18.00
abstracts 19.00 Nursing and allied health		0		0.00	0	19.00
education (tuition, fees, books, etc.)						
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 01
19.02 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 02
20.00 Vending machines	В		DI ETARY	10.00		
21.00 Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00 charges (chapter 21) Interest expense on Medicare overpayments and borrowings		0		0.00	0	22.00
repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization (chapter 14) physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
(chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00 Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant	I	0)	0.00	0	29.00

ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2022 To 06/30/2023		
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
	Deel e (Cerle	Americant	Cost Costor	1:	WI + A 7	
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4,00	5.00	
30.00 Adjustment for occupational	A-8-3		*** Cost Center Deleted ***			30.00
therapy costs in excess of						
limitation (chapter 14)						
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
instructions)			*** 0+ 0+ 0++ ***	(0.00		21 00
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00		
33.01 MEAL CHARGED TO OTHER	В	-532, 107	DI ETARY	10.00	0	33.01
DEPARTMENTS		00.005		5 00		
33. 02 MISC INCOME - UNASSIGNED 33. 03 MISC INCOME - UNASSIGNED	B		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	5.00 6.00		33.02 33.03
33. 04 MISC INCOME - UNASSIGNED	B	-172, 530		90.00		33.03
33. 05 MI SC I NCOME - OTHER	B		ADMINISTRATIVE & GENERAL	5.00		33.05
33.06 MISC INCOME - OTHER	B	-24,000		90.00		33.06
33. 07 ADVERTI SI NG	A	-257, 327	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33. 08 ADVERTI SI NG	A		CLINIC	90.00	0	33.08
33. 09 RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00		33.09
33. 10 RECRUI TMENT	A	-16, 801		90.00		33.10
33. 11 RECRUITMENT	A		ADULTS & PEDIATRICS	30.00		33.11
33. 12 PSYCHOLOGI ST OFFSET 33. 13 PHYSI CI AN OFFSET	A		ADULTS & PEDIATRICS ADULTS & PEDIATRICS	30.00 30.00		33. 12 33. 13
33. 13 PHYSICIAN OFFSET 33. 14 HAF PAYMENT	A		ADULTS & PEDIATRICS	30.00		33.13
50.00 TOTAL (sum of lines 1 thru 49)		-3, 750, 952		50.00	0	50.00
(Transfer to Worksheet A,		0,700,702				50.00
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	REGIONAL MENTA	L HEALTH CENTER	In Li€	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-4020	Period: From 07/01/2022	Worksheet A-8	-1
OFFICE				To 06/30/2023		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANIZATIONS OF	R CLAIMED HOME	
	OFFICE COSTS:		-			
1.00	5.00	ADMINISTRATIVE & GENERAL	A&G	5, 266, 739	3, 957, 351	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPI TAL	82, 427	501	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	5, 349, 166	3, 957, 852	5.00

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

			Related Organization(s) and	/or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	А	REGIONAL MHC	100.00 GEMI NUS CORP	100.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00 G.	Other (financial or				100.00
nc	on-financial) specify:				

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

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

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

Health Financial Systems	REGIONAL MENTAL HE	ALTH CENTER	In Lieu of Form		
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-4020	Period: From 07/01/2022		
				Date/Time Prepared:	

								11/20/20	<u>23 9:</u>	<u>33 am</u>
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS	OR CLAIMED H	HOME	
	OFFICE COSTS:									
1.00	1, 309, 388	0								1.00
2.00	81, 926	9								2.00
3.00	0	0								3.00
4.00	0	0							1	4.00
5.00	1, 391, 314									5.00

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

nas no	L DEEL POSTED TO MOLKSHEET A,	COLUMNIS I ANU/O	Ζ, Ι	ne allount	arrowabre	should be	Thui cateu	TH COLUMN 4 OF	this part.	
	Related Organization(s)									
	and/or Home Office									
		-								
	Type of Business									
	6.00	1								
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION	(S) AN	D/OR HOME	OFFLCE:					

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

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

rei mou	rsement under title XVIII.	
6.00	MGMT COMPANY	6.00
7.00		7.00
8.00 9.00		8.00
		9.00
10.00		10.00
100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

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

Heal th	Financial Syste	ems	REGIONAL MENTAI	L HEALTH CENTER	2	In Li	eu of Form CMS-	2552-10
	ER BASED PHYSIC				CCN: 15-4020	Period:	Worksheet A-8	
						From 07/01/2022		
						To 06/30/2023	3 Date/Time Pre 11/20/2023 9:	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	WRSt. A LINE #	I denti fi er	Remuneration	Component	Component		ider Component	
		i denti i i ei	Remarker at rom	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	436, 944	88, 926	348, 018			1.00
2.00		CLINIC	920, 711	404,073	516, 638			
3.00		CLINIC	2, 560, 992	1, 251, 416	1, 309, 576			1
4.00	90.00 0.00	CEINIC	2, 300, 392	1, 251, 410	1, 307, 370			1
4.00 5.00	0.00			0	(-	
							-	1
6.00	0.00		0		l			
7.00	0.00		0	0	l		-	
8.00	0.00		0	0	(0	8.00
9.00	0.00		0	0	(
10.00	0.00		0	0	(C	0	10.00
200.00			3, 918, 647	1, 744, 415			15, 084	
	Wkst. A Line #	Cost Center/Physician	Unadj usted RCE		Cost of	Provi der	Physi ci an Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	192, 718					
2.00		CLINIC	317, 449	15, 872		-	-	
3.00		CLINIC	804, 606	40, 230	(
4.00	0.00		0	0	() C	0	4.00
5.00	0.00		0	0	() C	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0	7.00
8.00	0.00		0	0	(C C	0	8.00
9.00	0.00		0	0	(c c	0	9.00
10.00	0.00		0	0	(ol c	0	10.00
200.00			1, 314, 773	65, 738	(ol c	39, 169	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	30.00	ADULTS & PEDIATRICS	4, 208	196, 926	151, 092			1.00
2.00		CLINIC	0	317, 449				2.00
3.00		CLINIC	17, 328	821, 934	487, 642			3.00
4.00	0,00		0	0	(0,,0,1		1	4.00
5.00	0.00		0	0	(-		5.00
6.00	0.00			0	(6.00
7.00	0.00			0	(7.00
8.00	0.00			0	((8.00
9.00	0.00			0	(9.00
9.00 10.00	0.00			0	(10.00
200.00	0.00		21, 536	Ű	837, 923			200.00
200.00	I I		21, 530	1, 336, 309	037,923	p 2,002,338	1	∠00. 00

Heal th Financial Systems REGIONAL MENTAL HEALTH CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-4020 Period: From 07/01/2022 Worksheet B Part I Date/Time Prepared: 11/20/2023 9: 33 am Cost Center Description Net Expenses for Cost Allocation (from Wkst A col. 7) CAPITAL RELATED COSTS BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT Subtotal ADMINISTRATIV E & GENERAL GENERAL SERVICE COST CENTERS 0 1.00 4.00 4A 5.00
Cost Center DescriptionNet Expenses for Cost Allocation (from Wkst A col. 7)CAPITAL RELATED COSTS BLDG & FIXTEMPLOYEE BENEFITS DEPARTMENTSubtotal EMPLOYEE BUDG 44 5.00ADMINISTRATIV E & GENERAL
Cost Center Description Net Expenses for Cost Allocation (from Wkst A col. 7) CAPITAL RELATED COSTS BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT Subtotal ADMINISTRATIV E & GENERAL 0 1.00 4.00 4A 5.00
Cost Center Description Net Expenses for Cost Allocation (from Wkst A col. 7) CAPITAL RELATED COSTS BLDG & FIXT BENEFITS DEPARTMENT Subtotal ADMINISTRATIV E & GENERAL 0 1.00 4.00 4A 5.00
Related cost Related costs Related costs Subtotal ADMINISTRATIV Cost Center Description Net Expenses for Cost Allocation (from Wksta col. 7) BLDG & FIXT BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT Subtotal ADMINISTRATIV E & GENERAL 0 1.00 4.00 4A 5.00
Cost Center Description Net Expenses for Cost Allocation (from Wkst A col. 7) BLDG & FIXT BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT Subtotal E & GENERAL ADMINISTRATIV E & GENERAL 0 1.00 4.00 4A 5.00
for Cost BENEFITS E & GENERAL Allocation DEPARTMENT E (from Wkst A col. 7) 0 0 1.00 4.00 4A 5.00
Allocation (from Wkst A col. 7) DEPARTMENT 0 1.00 4.00 4A 5.00
(from Wkst A col. 7)
col. 7) 4.00 4A 5.00
0 1.00 4.00 4A 5.00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 1, 228, 373 1, 228, 373 1, 228, 373 1, 200 100 CAP REL COSTS-BLDG & FIXT 1, 228, 373 1, 200 100 CAP REL COSTS-BLDG & FIXT
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4,976,463 0 4,976,463 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 8, 612, 447 166, 330 407, 262 9, 186, 039 9, 186, 039 5. 00
6. 00 00600 MAINTENANCE & REPAIRS 778, 717 37, 488 176, 361 992, 566 311, 289 6. 00
10.00 O1000 DI ETARY 48, 968 7, 524 75, 204 131, 696 41, 302 10.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 351, 253 0 0 351, 253 110, 160 21.00
22. 00 02200 1&R SERVICES-OTHER PRGM. COSTS APPRVD 584, 908 15, 550 104, 215 704, 673 221, 000 22. 00
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRI CS 2, 159, 356 19, 829 555, 523 2, 734, 708 857, 659 30. 00
33.00 O3300 BURN I NTENSI VE CARE UNI T O O O O 33.00
ANCILLARY SERVICE COST CENTERS
60.00 06000 LABORATORY 4,946 0 0 4,946 1,551 60.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 167, 585 0 0 167, 585 52, 558 73.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77. 00
0UTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 1,707,899 53,304 834,315 2,595,518 814,006 90,00
90. 00 09000 CLINIC 1, 707, 899 53, 304 834, 315 2, 595, 518 814, 006 90. 00 OTHER REIMBURSABLE COST CENTERS
99.00 09900 CMHC 0 0 0 0 99.00
99.00 09900 01 <
SPECIAL PURPOSE COST CENTERS
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 20,620,915 300,025 2,152,880 16,868,984 2,409,525 118.00
NONREI MBURSABLE COST CENTERS
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192.00
192. 01 19201 RESIDENTIAL 5, 557, 084 390, 218 673, 300 6, 620, 602 2, 076, 352 192. 01
192.0219202 FORENSIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
192. 03 19203 C&E 2, 213, 447 194, 917 330, 518 2, 738, 882 858, 968 192. 03
192. 0419204 HUD 120, 901 171, 095 25, 744 317, 740 99, 650 192. 04
192. 05 19205 OTHER 1, 452, 949 2, 036 190, 335 1, 645, 320 516, 005 192. 05
192. 06 19206 MRO 3, 429, 329 112, 254 826, 239 4, 367, 822 1, 369, 836 192. 06
192. 00 19200 millo 19200 millo 19200 millo 19200 millo 19200 1920 1920 1920 1920 1920 1920 192
194. 00 07950 FORC CLINIC HORAW 22, 723, 337 30, 050 402, 930 3, 159, 127 990, 703 194. 00 194. 01 07951 FORC CLINIC
194. 01079511 010 CET NTC 17, 374, 807 11, 311 107, 112 1, 373, 230 475, 370 174. 01 194. 02 07952 FOHC HOMELESS SHELTER 21, 857 0 21, 857 6, 855 194. 02
194. 03 07953 REGIONAL HEALTH CARE AT STARK 421, 138 2, 164 86, 664 509, 966 159, 936 194. 03 194. 04 07954 REGIONAL HEALTH CARE AT STRAWHUN 485, 478 5, 835 92, 053 583, 366 182, 955 194. 04
194. 05 07955 FQHC PURDUE 52, 950 7, 868 8, 680 69, 498 21, 796 194. 05 200. 00 Cross Foot Adjustments 52, 950 7, 868 8, 680 69, 498 21, 796 194. 05
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00
201.00 Negative cost centers 0 0201.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
202.00 [107AL (Sum tries to through 201) [$30,470,374$ [$1,220,373$] $4,770,403$] $30,470,374$] 7,100,037[202.00]

Health Financial Systems R	EGIONAL MENTAL F	HEALTH CENTER		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2022 o 06/30/2023	Worksheet B Part I Date/Time Pre 11/20/2023 9:	
			INTERNS &	RESI DENTS		
Cost Center Description	MAINTENANCE &	DI ETARY	SERVI CES-SALA	SERVI CES-OTHE	Subtotal	
	REPAI RS			R PRGM. COSTS		
	6.00	10. 00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 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
6.00 00600 MAI NTENANCE & REPAI RS	1, 303, 855					6.00
10. 00 01000 DI ETARY	9, 575	182, 573				10.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	461, 413			21.00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	19, 789	0		945, 462		22.00
INPATIENT ROUTINE SERVICE COST CENTERS	I			· · · · · · · · · · · · · · · · · · ·		
30. 00 03000 ADULTS & PEDIATRICS	25, 234	39, 332	230, 707	472, 731	4, 360, 371	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33.00
ANCILLARY SERVICE COST CENTERS	i i			· · · · ·		
60. 00 06000 LABORATORY	0	0	C		6, 497	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C		220, 143	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	I I			,		
90. 00 09000 CLINIC	67, 835	0	230, 706	472, 731	4, 180, 796	90.00
OTHER REIMBURSABLE COST CENTERS	1 I			,		
99. 00 09900 CMHC	0	0	C		0	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	122, 433	39, 332	461, 413	945, 462	8, 767, 807	118.00
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C			192.00
192. 01 19201 RESI DENTI AL	496, 593	143, 241	C		9, 336, 788	
192. 02 19202 FORENSI C	0	0	0	0		192.02
192. 03 19203 C&E	248, 053	0	C	0	3, 845, 903	
192. 04 19204 HUD	217, 737	0	C	0	635, 127	
192. 05 19205 OTHER	2, 591	0	C	0	2, 163, 916	
192. 06 19206 MRO	142, 855	0	C	0	5, 880, 513	
194.0007950 FQHC CLINIC HOHAM	39, 006	0	C	0	4, 188, 898	
194. 01 07951 FQHC CLINIC	14, 394	0	0	0	2,081,020	
194.0207952 FOHC HOMELESS SHELTER	0	0	C	0		194.02
194. 03 07953 REGIONAL HEALTH CARE AT STARK	2, 754	0	0	0	672, 656	
194.04 07954 REGIONAL HEALTH CARE AT STRAWHUN	7, 426	0	C	0	773, 747	
194. 05 07955 FQHC PURDUE	10, 013	0	0	0	101, 307	
200.00 Cross Foot Adjustments			0	0		200.00
201.00 Negative Cost Centers	1 202 055	100 570	0	0	-	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 303, 855	182, 573	461, 413	945, 462	38, 476, 394	J202. 00

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				CED

неагтп н	FINANCIAI SYSTEMS RI	EGIONAL MENIAL	HEALTH CENTER	In Lieu of Form	CMS-2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-	From 07/01/2022 Part I To 06/30/2023 Date/Tin	
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS	[]			
4.00 C 5.00 C	DO100 CAP REL COSTS-BLDG & FIXT DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO600 MAINTENANCE & REPAIRS				1.00 4.00 5.00 6.00
21.00	D1000 DI ETARY D2100 I &R SERVI CES-SALARY & FRI NGES APPRVD D2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD				10.00 21.00 22.00
	NPATIENT ROUTINE SERVICE COST CENTERS		1		
	D3000 ADULTS & PEDIATRICS	-703, 438	3, 656, 933		30.00
33.00 0	D3300 BURN INTENSIVE CARE UNIT	0	0		33.00
A	ANCILLARY SERVICE COST CENTERS		· ·		
	D6000 LABORATORY	0	6, 497		60.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0	220, 143		73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
	DUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	-703, 437	3, 477, 359		90.00
	OTHER REIMBURSABLE COST CENTERS	I			
	09900 CMHC	0	0		99.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
	SPECIAL PURPOSE COST CENTERS	1 10/ 075	7 0 (0 000		110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 406, 875	7, 360, 932		118.00
	NONRELMBURSABLE COST CENTERS		0		102.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RESIDENTIAL	0	0 224 700		192.00 192.01
	19201 RESIDENTIAL 19202 FORENSI C	0	9, 336, 788		192.01
	19202 FORENSI C 19203 C&E	0	3, 845, 903		192.02
	19203 G&L	0	635, 127		192.03
	19205 OTHER	0	2, 163, 916		192.04
	19206 MRO	0	5, 880, 513		192.06
	D7950 FQHC CLINIC HOHAM	0	4, 188, 898		194.00
	07951 FQHC CLINIC	0	2,081,020		194.01
	07952 FQHC HOMELESS SHELTER	0	28, 712		194.02
	07953 REGIONAL HEALTH CARE AT STARK	o	672, 656		194.03
	07954 REGIONAL HEALTH CARE AT STRAWHUN	0	773, 747		194.04
	07955 FQHC PURDUE	o	101, 307		194.05
200.00	Cross Foot Adjustments	0	0		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	-1, 406, 875	37, 069, 519		202.00
					·

Health Financial Systems	REGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				From 07/01/2022	Part II	
				To 06/30/2023	Date/Time Pre 11/20/2023 9:	pared:
		CAPI TAL			1172072023 7.	
		RELATED COSTS				
Cost Center Description	Directly	BLDG & FIXT	Subtotal	EMPLOYEE	ADMI NI STRATI V	
·	Assigned New			BENEFI TS	E & GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0			0 0		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	166, 330	166, 33	0 0	166, 330	5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	37, 488	37, 48	8 0	5, 637	6.00
10. 00 01000 DI ETARY	0	7, 524	7, 52		748	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0			0 0		
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	15, 550	15, 55	0 0	4,002	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	1	•		-		
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
ANCILLARY SERVICE COST CENTERS		1	1			
60. 00 06000 LABORATORY	0		1	0 0	28	
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	952	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	1	50.001	50.00		44.740	
90.00 09000 CLINIC	0	53, 304	53, 30	4 0	14, 740	90.00
OTHER REI MBURSABLE COST CENTERS			1		0	00.00
99.00 09900 CMHC 102.00 10200 0PI 0I D TREATMENT PROGRAM	0			0 0 0 0		
SPECIAL PURPOSE COST CENTERS	0	ί <u></u> 0	1	0 0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	300, 025	300, 02	5 0	43, 632	110 00
NONREIMBURSABLE COST CENTERS	0	y 300, 025	300, 02	<u> </u>	43,032	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 RESIDENTIAL	0	-				
192. 02 19202 FORENSI C		0 0		0 0		192.02
192. 03 19203 C&E	0	194, 917			15, 554	
192. 04 19204 HUD	0					192.04
192. 05 19205 OTHER	0	2, 036				192.05
192. 06 19206 MRO	0	112, 254			24, 805	
194. 00 07950 FQHC CLINIC HOHAM	0	30, 650			17,941	
194. 01 07951 FQHC CLINIC	0	11, 311				194.01
194. 02 07952 FQHC HOMELESS SHELTER	0	0		0 0		194.02
194.0307953 REGIONAL HEALTH CARE AT STARK	0	2, 164	2, 16	4 0		194.03
194.0407954 REGIONAL HEALTH CARE AT STRAWHUN	0	5,835	5,83	5 0	3, 313	194.04
194. 05 07955 FQHC PURDUE	0	7, 868				194.05
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 228, 373	1, 228, 37	3 0	166, 330	202.00

Health Financial Systems REGIONAL MENTAL HEALTH CENTER In Lieu of Form ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-4020 Period: From 07/01/2022 Workshee Date/Tim 11/20/20	
	t в e Prepared: <u>23 9:33 am</u>
I NTERNS & RESI DENTS	
Cost Center Description MAINTENANCE & DIETARY SERVICES-SALA SERVICES-OTHE Subtota	al
REPAIRS RY & FRINGES R PRGM. COSTS	
<u>6.00</u> <u>10.00</u> <u>21.00</u> <u>22.00</u> <u>24.00</u>	
GENERAL SERVICE COST CENTERS	
1.00 00100 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
6. 00 00600 MAI NTENANCE & REPAI RS 43, 125	6.00
10. 00 01000 DI ETARY 317 8, 589	10.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 1, 995	21.00
22. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 655 0 20, 207	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 835 1,850 38	3,044 30.00
33.00 03300 BURN I NTENSI VE CARE UNI T 0 0	0 33.00
ANCI LLARY SERVICE COST CENTERS	
60.00 06000 LABORATORY 0 0 0	28 60.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0	952 73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0	0 77.00
OUTPATI ENT SERVI CE COST CENTERS	
	0, 288 90.00
OTHER REIMBURSABLE COST CENTERS	
99.00 09900 CMHC 0 0 0	0 99.00
102. 0010200 OPI 0I D TREATMENT PROGRAM 0 0	0 102.00
SPECIAL PURPOSE COST CENTERS	
	9, 312 118.00
NONREL MBURSABLE COST CENTERS	1012
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0	0 192.00
	, 968 192.01
192.0219202 FORENSI C 0 0	0 192.02
	3, 675 192. 03
	0, 101 192.04
	, 466 192.05
	, 784 192.06
	9, 881 194. 00
), 721 194. 01
194. 02 07952 FOHC HOMELESS SHELTER 0 0 0	124 194.02
	5, 151 194. 02
	9, 394 194. 04
	3, 594 194. 05
	2, 202 200. 00
201.00 Negative Cost Centers 0 </td <td>0 201.00</td>	0 201.00
202.00 TOTAL (sum lines 118 through 201) 43,125 8,589 1,995 20,207 1,228	3, 373 202. 00

LOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-4020	Peri od:	Worksheet B
				From 07/01/2022 To 06/30/2023	Part II Date/Time Prepa 11/20/2023 9:33
Cost Center Description	Intern &	Total			11/20/2023 9:33
	Residents				
	Cost & Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
GENERAL SERVICE COST CENTERS					
00 00100 CAP REL COSTS-BLDG & FIXT					
00 00400 EMPLOYEE BENEFITS DEPARTMENT					
00 00500 ADMINISTRATIVE & GENERAL					
00 00600 MAI NTENANCE & REPAI RS					
0. 00 01000 DI ETARY					1
. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD					2
2. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD					2
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS	0	38, 044			3
. 00 03300 BURN INTENSIVE CARE UNIT	0	0			3
ANCILLARY SERVICE COST CENTERS					
0. 00 06000 LABORATORY	0	28			6
. 00 07300 DRUGS CHARGED TO PATIENTS	0	952			7
. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			7
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC	0	70, 288			9
OTHER REIMBURSABLE COST CENTERS	1 .1				
0. 00 09900 CMHC	0	0			9
2.00 10200 OPI OI D TREATMENT PROGRAM	0	0			10
SPECIAL PURPOSE COST CENTERS	1 .1				
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	109, 312			11
NONREI MBURSABLE COST CENTERS					
22.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			19
2. 01 19201 RESI DENTI AL	0	450, 968			19
22. 02 19202 FORENSI C	0	0			19
2. 03 19203 C&E	0	218, 675			19
2. 04 19204 HUD	0	180, 101			19
2. 05 19205 OTHER	0	11, 466			19
2. 06 19206 MRO	0	141, 784			19
4. 00 07950 FQHC CLINIC HOHAM	0	49, 881			19
	0	20, 721			19
4. 02 07952 FOHC HOMELESS SHELTER	0	124			19
4. 03 07953 REGIONAL HEALTH CARE AT STARK	0	5, 151			19
4. 04 07954 REGIONAL HEALTH CARE AT STRAWHUN	0	9, 394			19
4. 05 07955 FQHC PURDUE	0	8, 594			19
0.00 Cross Foot Adjustments	0	22, 202			20
1.00 Negative Cost Centers	0	0			20

	nancial Systems R OCATION - STATISTICAL BASIS		HEALTH CENTER	CN: 15-4020 F	Peri od:	u of Form CMS-2 Worksheet B-1	
0001 /122					rom 07/01/2022		
				T	o 06/30/2023	Date/Time Pre 11/20/2023 9:	
		CAPI TAL				11/20/2023 9.	
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	MAINTENANCE &	
	·	(SQUARE FEET)	BENEFI TS	n	E & GENERAL	REPAI RS	
		`````	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS				
			SALARI ES)				
		1.00	4.00	5A	5.00	6.00	
	NERAL SERVICE COST CENTERS	400 542					1 1 00
	100 CAP REL COSTS-BLDG & FIXT 1400 EMPLOYEE BENEFITS DEPARTMENT	499, 562	10 077 470				1.00
		0	19, 977, 470				4.00
	0500 ADMINI STRATI VE & GENERAL	67,644	1, 634, 908			41/ / 70	5.00
	600 MAINTENANCE & REPAIRS	15, 246	707, 980			416, 672	
		3, 060	301, 900			3, 060	
	100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0		0	
	200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	6, 324	418, 360	0	704, 673	6, 324	22.00
	PATIENT ROUTINE SERVICE COST CENTERS	0.044			0 704 700	0.0(1	
	000 ADULTS & PEDIATRICS	8, 064	2, 230, 083	C		8, 064	
	300 BURN INTENSIVE CARE UNIT	0	0	0	0 0	0	33.00
	CILLARY SERVICE COST CENTERS	-1				-	
	000 LABORATORY	0	0			0	
	300 DRUGS CHARGED TO PATIENTS	0	0			0	
	700 ALLOGENEIC HSCT ACQUISITION	0	0	(	0 0	0	77.00
	TPATIENT SERVICE COST CENTERS						
	2000 CLINIC	21, 678	3, 349, 280	(	2, 595, 518	21, 678	90.00
	HER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
99.00 09		0	0			0	1
	200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
	ECIAL PURPOSE COST CENTERS				1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	122, 016	8, 642, 511	-9, 186, 039	7, 682, 945	39, 126	_118. OC
	NREI MBURSABLE COST CENTERS			1			
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0	-			192.00
	201 RESI DENTI AL	158, 696	2, 702, 886			158, 696	
	202 FORENSI C	0	0	0			192.02
192.03 19		79, 270	1, 326, 826	0	2, 738, 882	79, 270	192.03
192.04 19		69, 582	103, 348	0		69, 582	
	205 OTHER	828	764, 080	( C	1, 645, 320	828	192.05
192.06 19	206 MR0	45, 652	3, 316, 844	0	4, 367, 822	45, 652	192.06
	950 FQHC CLINIC HOHAM	12, 465	1, 617, 549	( C	3, 159, 127	12, 465	
	951 FQHC CLINIC	4, 600	751, 142	0	1, 573, 230	4,600	194.0
194.0207	952 FQHC HOMELESS SHELTER	0	0	C	21, 857	0	194.02
194.0307	953 REGIONAL HEALTH CARE AT STARK	880	347, 904	0	509, 966	880	194.03
194.0407	954 REGIONAL HEALTH CARE AT STRAWHUN	2, 373	369, 535	0	583, 366	2, 373	194.04
194.0507	955 FQHC PURDUE	3, 200	34, 845	0	69, 498	3, 200	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 228, 373	4, 976, 463		9, 186, 039		
	Part I)		,				
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 458900	0, 249104		0. 313620	3. 129212	203.00
204.00	Cost to be allocated (per Wkst. B,		0		166, 330		
	Part II)		0			.5, 120	[
205.00	Unit cost multiplier (Wkst. B, Part		0. 000000		0.005679	0. 103499	205 00
			2. 000000		0.000077	0.100177	
206.00	NAHE adjustment amount to be allocated						206.00
							[
	(per Wkst, B-2)						
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00

alth Financial Systems RE NST ALLOCATION - STATISTICAL BASIS		HEALTH CENTER Provi der C	°N· 15_4020	Peri od:	u of Form CMS-255 Worksheet B-1
ST ALLOCATION - STATISTICAL DASIS		Provider C	GN. 15-4020	From 07/01/2022	
				To 06/30/2023	Date/Time Prepar 11/20/2023 9:33
		INTERNS &	RESI DENTS		
Cost Conton Description				IF.	
Cost Center Description	DI ETARY (MEALS	SERVI CES-SALA RY & FRI NGES	R PRGM. COST		
	SERVED)	(ASSI GNED	(ASSI GNED	5	
		TIME)	TIME)		
	10.00	21.00	22.00		
GENERAL SERVICE COST CENTERS			1		
00 00100 CAP REL COSTS-BLDG & FLXT					
00 00400 EMPLOYEE BENEFITS DEPARTMENT					
00 00500 ADMI NI STRATI VE & GENERAL 00 00600 MAI NTENANCE & REPAI RS					
. 00 01000 DI ETARY	25, 303				1
. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	25, 303	1, 460			2
. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	1, 100	1, 40	60	2
INPATIENT ROUTINE SERVICE COST CENTERS			.,		
. 00 03000 ADULTS & PEDIATRICS	5, 451	730	7:	30	3
. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0	3
ANCILLARY SERVICE COST CENTERS					
. 00 06000 LABORATORY	0	0		0	6
. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	7
. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	7
OUTPATIENT SERVICE COST CENTERS	0	730		30	
. 00 09000 CLINIC OTHER REIMBURSABLE COST CENTERS	U	/30	1.	30	9
. 00 09900 CMHC	0	0		0	9
2.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0	10
SPECIAL PURPOSE COST CENTERS	-		1	-1	
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 451	1, 460	1, 4	60	11:
NONREI MBURSABLE COST CENTERS			-		
2.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	19
2. 01 19201 RESI DENTI AL	19, 852	0		0	19
2. 02 19202 FORENSI C	0	0		0	19
2. 03 19203 C&E	0	0		0	19.
2. 04 19204 HUD	0	0		0	19
2. 05 19205 OTHER	0	0		0	19
2. 06 19206 MR0	0	0		0	19
4. 00 07950  FQHC CLINIC HOHAM 4. 01 07951  FQHC CLINIC	0	0		0	19- 19-
4. 02 07952 FQHC HOMELESS SHELTER	0	0		0	19
4. 03 07953 REGIONAL HEALTH CARE AT STARK	0	0		0	19
4. 04 07954 REGIONAL HEALTH CARE AT STRAN	0	0		0	19
4. 05 07955 FQHC PURDUE	0	0		0	19
0.00 Cross Foot Adjustments	Ŭ	, i i i i i i i i i i i i i i i i i i i			20
1.00 Negative Cost Centers					20
2.00 Cost to be allocated (per Wkst. B,	182, 573	461, 413	945, 40	62	20
Part I)					
3.00 Unit cost multiplier (Wkst. B, Part I)	7. 215469				20
4.00 Cost to be allocated (per Wkst. B,	8, 589	1, 995	20, 20	07	20
Part II)					
5.00 Unit cost multiplier (Wkst. B, Part	0. 339446	1. 366438	13. 8404	11	20
16.00 NAHE adjustment amount to be allocated					20
(per Wkst. B-2)					20
					20
07.00 NAHE unit cost multiplier (Wkst. D,					

Health Financial Systems	REGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023		pared: 33 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	3, 656, 933		3, 656, 93	3 151, 092	3, 808, 025	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
ANCILLARY SERVICE COST CENTERS			_			
60.00 06000 LABORATORY	6, 497		6, 49	0	6, 497	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	220, 143		220, 14	3 0	220, 143	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	3, 477, 359		3, 477, 35	686, 831	4, 164, 190	90.00
OTHER REIMBURSABLE COST CENTERS			_			
99.00 09900 CMHC	0			0	0	99.00
102.00 10200 OPI OLD TREATMENT PROGRAM	0			0	0	102.00
200.00 Subtotal (see instructions)	7, 360, 932	0	7, 360, 93	2 837, 923	8, 198, 855	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	7, 360, 932	0	7, 360, 93	837, 923	8, 198, 855	202.00

Health Financial Systems	REGIONAL MENTAL	HEALTH CENTER		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 07/01/2022	Worksheet C	
				To 06/30/2023	Date/Time Pre	pared:
		T: +1 a		Hospi tal	11/20/2023 9: PPS	<u>33 am</u>
Cost Center Description	Inpatient	Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
				Ratio	Ratio	
	6,00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 920, 423		2, 920, 42	3		30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		_,,.	0		33.00
ANCILLARY SERVICE COST CENTERS	-					1
60. 00 06000 LABORATORY	2, 475	0	2,47	2. 625051	0.00000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	179, 732	3, 738	183, 47	0 1.199886	0.000000	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0. 000000	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLINIC	0	6, 598, 402	6, 598, 40	0. 527000	0. 000000	90.00
OTHER REIMBURSABLE COST CENTERS						]
99.00 09900 CMHC	0	0		0		99.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200.00 Subtotal (see instructions)	3, 102, 630	6, 602, 140	9, 704, 77	0		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	3, 102, 630	6, 602, 140	9, 704, 77	0		202.00

Health Financial Systems	REGIONAL MENTAL	HEALTH CENTER	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4020	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/20/2023 9:	epared: 33 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	2. 625051				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 199886				73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 631091				90.00
OTHER REIMBURSABLE COST CENTERS					
99. 00 09900 CMHC					99.00
102.00 10200 OPI OLD TREATMENT PROGRAM					102.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

Health Financial Systems	REGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023		
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 656, 933		3, 656, 93	151, 092	3, 808, 025	30.00
33.00 03300 BURN I NTENSI VE CARE UNI T	0			0 0	0	33.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	6, 497		6, 49	07 0	6, 497	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	220, 143		220, 14	3 0	220, 143	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3, 477, 359		3, 477, 35	686, 831	4, 164, 190	90.00
OTHER REIMBURSABLE COST CENTERS	· · ·		•			1
99.00 09900 CMHC	0			0	0	99.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0		1	0	0	102.00
200.00 Subtotal (see instructions)	7, 360, 932	0	7, 360, 93	837, 923	8, 198, 855	200.00
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	7, 360, 932	0	7, 360, 93	837, 923	8, 198, 855	202.00

Heal th	Financial Systems	REGIONAL MENTAL	HEALTH CENTER		In Lieu of Form CMS-2552-10			
COMPUT	ATION OF RATIO OF COSTS TO CHARGES				Period: From 07/01/2022	Worksheet C Part I		
					To 06/30/2023		pared: 33 am	
		Title XIX Hospital						
		Charges						
	Cost Center Description	I npati ent	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		
	INPATIENT ROUTINE SERVICE COST CENTERS			_				
30.00	03000 ADULTS & PEDIATRICS	2, 920, 423		2, 920, 42	23		30.00	
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00	
	ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	2, 475	0	2,4	2. 625051	0. 000000	60.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	179, 732	3, 738	183, 4	1. 199886	0. 000000	73.00	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0.00000	77.00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	6, 598, 402	6, 598, 40	0. 527000	0. 000000	90.00	
	OTHER REIMBURSABLE COST CENTERS						1	
99.00	09900 CMHC	0	0		0		99.00	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00	
200.00	Subtotal (see instructions)	3, 102, 630	6, 602, 140	9, 704, 7	0		200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	3, 102, 630	6, 602, 140	9, 704, 7	0		202.00	

Health Financial Systems	REGIONAL MENTAL I	HEALTH CENTER	In Lieu	J of Form CMS-2552-	-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4020	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared 11/20/2023 9:33 an	 d: m
		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
33.00 03300 BURN INTENSIVE CARE UNIT				33.	00
ANCILLARY SERVICE COST CENTERS					
60.00 06000 LABORATORY	0. 000000			60.	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.	00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000			90.	00
OTHER REIMBURSABLE COST CENTERS					
99.00 09900 CMHC				99.	00
102.00 10200 OPI OI D TREATMENT PROGRAM				102.	00
200.00 Subtotal (see instructions)				200.	00
201.00 Less Observation Beds				201.	00
202.00 Total (see instructions)				202.	00

Health Financial Systems R	EGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-4020	Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023	Part I Date/Time Pre	narod
				10 06/30/2023	11/20/2023 9:	33 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, 044	0	38, 04	4 1, 778	21.40	1
33.00 BURN I NTENSI VE CARE UNI T	0			0 0	0.00	1
200.00 Total (lines 30 through 199)	38,044		38, 04	4 1, 778		200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x				
		col. 6)				
	6,00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	199	4, 259				30.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
200.00 Total (lines 30 through 199)	199	4, 259				200.00

Health Financial Systems REGIONAL MENTAL HEALTH CENTER In Lieu of Form C						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-4020		Worksheet D Part II Date/Time Pre 11/20/2023 9:	
	Title	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	28	2, 475	0. 01131	3 89	1	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	952	183, 470	0.00518	9 17, 642	92	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	70, 288	6, 598, 402	0. 01065	2 0	0	90.00
200.00   Total (lines 50 through 199)	71, 268	6, 784, 347		17, 731	93	200. 00

Health Financial Systems	REGIONAL MENTAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C		Period: From 07/01/2022 To 06/30/2023		epared: 33 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
· ·	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
200.00 Total (lines 30 through 199)	0			0 0		200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	Inpatient	200.00
oust conter bescription	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	buys	col. 6)	l l l ogi am bays	
		minus col. 4)		001.0)		
	4,00	5.00	6,00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 77	8 0.00	199	30.00
33. 00 03300 BURN I NTENSI VE CARE UNI T	0		.,,,,	0 0.00		
200.00 Total (lines 30 through 199)			1, 77			200.00
Cost Center Description	I npati ent	0	1,77	0	177	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	<u>x col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
	0					
200.00  Total (lines 30 through 199)	0					200.00

Health Financial Systems REGIONAL MENTAL HEALTH CENTER In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023			
		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	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00	
OUTPATIENT SERVICE COST CENTERS	· ·		•				
90. 00 09000 CLI NI C	0	0		0 0	0	90.00	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00	

Health Financial Systems R	EGIONAL MENTAL	HEALTH CENTER	In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	Provider CCN: 15-4020		Worksheet D	
THROUGH COSTS				From 07/01/2022 To 06/30/2023		nared
				10 00/00/2020	11/20/2023 9:	
		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 2, 475	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 183, 470	0.00000	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 6, 598, 402	0.00000	90.00
200.00  Total (lines 50 through 199)	0	0		0 6, 784, 347	-	200. 00

Health Financial Systems R	u of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C	Provider CCN: 15-4020		Worksheet D Part IV	
				To 06/30/2023	Date/Time Pre 11/20/2023 9:	pared: 33 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0. 000000	89		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	17, 642		0 0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 588, 925	0	90.00
200.00 Total (lines 50 through 199)		17, 731		0 588, 925	0	200.00

Health Financial Systems REGIONAL MENTAL HEALTH CENTER In Lieu of Form CMS-2552-7								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider C	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023			
			Title	XVIII	Hospi tal	PPS		
				Charges		Costs		
Cost Center Description	Cost to		PPS	Cost	Cost	PPS Services		
	Charge Ratio	Re	eimbursed	Reimbursed	Reimbursed	(see inst.)		
	From	Ser	vices (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	2. 625051		0		0 0	0	60.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 199886		0		0 0	0	73.00	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000		0		0 0	0	77.00	
OUTPATIENT SERVICE COST CENTERS							1	
90. 00 09000 CLINIC	0. 527000	)	588, 925		0 0	310, 363	90.00	
200.00 Subtotal (see instructions)			588, 925		0 0	310, 363	200.00	
201.00 Less PBP Clinic Lab. Services-Program					0 0		201.00	
Only Charges								
202.00 Net Charges (line 200 - line 201)			588, 925		0 0	310, 363	202.00	

Health Financial Systems R	REGIONAL MENTAL	HEALTH CENTER		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/20/2023 9:	epared: 33 am
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
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	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

## REGIONAL MENTAL HEALTH CENTER

In Lieu of Form CMS-2552-10

<u>Heal th</u>	Financial Systems REGIONAL MENTAL H	EALTH CENTER	In Lie	u of Form CMS-2	<u>2552-10</u>
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4020	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Pre 11/20/2023 9:	pared:
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed day			1, 778	
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d do not complete this line.		orivate room days,	1, 778 0	
4.00 5.00	Semi-private room days (excluding swing-bed and observation   Total swing-bed SNF type inpatient days (including private r		per 31 of the cost	1, 778 0	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable in newborn days) (see instructions)	to the Program (excludir	ng swing-bed and	199	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instru-		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	only (including private	room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period		ite room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13.00
14.00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	l days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service reporting applied	es through December 31 c	of the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem 5 x line 17)		ting period (line	3, 808, 025 0	
23.00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reporti	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost report	ing period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December x line 20) $$	31 of the cost reportin	ng period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 808, 025	
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and abcomunition by L	horaco	0	20.00
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	eu anu opservation bed c	marges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00 35.00	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l		ictions)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost c	lifferential (line		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			0 4 4 4 75	20.00
38.00 39.00	Adjusted general inpatient routine service cost per diem (ser Program general inpatient routine service cost (line 9 x line			2, 141. 75 426, 208	
40.00	Medically necessary private room cost applicable to the Prog			420, 208	
	Total Program general inpatient routine service cost (line 3			426, 208	

OMPUTATION O	A Systems R F INPATIENT OPERATING COST		Provider CC	N: 15-4020	Period: From 07/01/2022	Worksheet D-1	
					To 06/30/2023	Date/Time Pre 11/20/2023 9:	
				XVIII	Hospi tal	PPS	
C	ost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
2.00 NURSER	Y (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	ve Care Type Inpatient Hospital Units	5					1 42
	I VE CARE UNI T RY CARE UNI T						43.
	NTENSI VE CARE UNI T	0	0	0.0	0 00	0	
	AL INTENSIVE CARE UNIT						46
	SPECIAL CARE (SPECIFY) ost Center Description						47
						1.00	10
	m inpatient ancillary service cost (₩k m inpatient cellular therapy acquisiti			III line 10	) column 1)	21, 402 0	
	Program inpatient costs (sum of lines					447, 610	
	IROUGH COST ADJUSTMENTS			· · · ·			
	nrough costs applicable to Program inp	patient routine	services (from	ı Wkst. D, su	m of Parts I and	4, 259	50
.00 Pass tl	nrough costs applicable to Program ing	oatient ancillar	y services (fr	om Wkst. D,	sum of Parts II	93	51
and IV	)		<b>J</b>				
	Program excludable cost (sum of lines		lated		hatiot '	4, 352	
	Program inpatient operating cost exclu education costs (line 49 minus line		erated, non-phy	sician anest	netist, and	443, 258	53
	AMOUNT AND LIMIT COMPUTATION	02)					
	n di scharges					0	
	amount per discharge ent adjustment amount per discharge					0. 00 0. 00	
	nent amount per discharge (contractor	use only)				0.00	
-	amount (line 54 x sum of lines 55, 55	5.	1			0	
	ence between adjusted inpatient operat	ting cost and ta	arget amount (I	ine 56 minus	iline 53)	0	
	bayment (see instructions) d costs (lesser of line 53 ÷ line 54,	or line EE from	the cost room	sting portod	l onding 1004	0 0.00	
	d and compounded by the market basket)		i the cost rept	n tring period	i enuring 1990,	0.00	09
). 00 Expecte	ed costs (lesser of line 53 ÷ line 54,		om prior year o	ost report,	updated by the	0.00	60
. 00 Continu 55. 01,	basket) Jous improvement bonus payment (if lir or line 59, or line 60, enter the les e less than expected costs (lines 54 >	sser of 50% of t	he amount by w	which operati	ng costs (line	0	61
	zero. (see instructions)		0				
	payment (see instructions) ple Inpatient cost plus incentive paym	ment (see instru	uctions)			0	
	I INPATIENT ROUTINE SWING BED COST					0	03
	re swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	cost report	ing period (See	0	64
	ctions)(title XVIII only)	ata aftar Daaamk	on 21 of the	aat ranartin	a partial (Caa	0	65
	re swing-bed SNF inpatient routine cos ctions)(title XVIII only)	sts after Decemi		ost reportin	ig period (see	0	00
6.00 Total I	Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66
	ee instructions	a costs through	Decombor 21	of the cost r	concreting partiad	0	67
	/ or XIX swing-bed NF inpatient routir 12 x line 19)	ne costs through	1 December 31 C	in the cost i	eporting period	0	
3.00 Title V	/ or XIX swing-bed NF inpatient routir	ne costs after [	December 31 of	the cost rep	orting period	0	68
	13 x line 20) title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	• 68)		0	69
	I - SKILLED NURSING FACILITY, OTHER N						
	d nursing facility/other nursing facil				")		70
	ed general inpatient routine service o m routine service cost (line 9 x line		ine 70 ÷ line	2)			71
5	ly necessary private room cost applic	,	n (line 14 x li	ne 35)			73
.00 Total I	Program general inpatient routine serv	vice costs (line	e 72 + line 73)				74
	-related cost allocated to inpatient	routine service	e costs (from V	lorksheet B,	Part II, column		75
26, liı .00 Per die	ne 45) em capital-related costs (line 75 ÷ li	ne 2)					76
	m capital-related costs (line 9 x line						77
	ent routine service cost (line 74 minu			1-2			78
	ate charges to beneficiaries for exces Program routine service costs for comp				nus line 70)		79 80
	ent routine service costs for comp ent routine service cost per diem limi				nas i ne 77)		81
2.00 Inpatio	ent routine service cost limitation (I	line 9 x line 81					82
	able inpatient routine service costs (	•	ıs)				83
	m inpatient ancillary services (see ir ation review - physician compensation		ns)				84
	Program inpatient operating costs (sun						86
PART IV	/ - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST	~ <i>'</i>				
.00  Total (	observation bed days (see instructions	= )				0	87

Health Financial Systems R	EGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-4020	Period:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		pared: 33 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	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, 044	3, 808, 025	0.00999	0 0	0	90.00
91.00 Nursing Program cost	0	3, 808, 025	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3, 808, 025	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 808, 025	0.0000	0 0	0	93.00

## REGIONAL MENTAL HEALTH CENTER

In Lieu of Form CMS-2552-10

	Financial Systems REGIONAL MENTAL HE	ALTH CENTER	In Lie	u of Form CMS-2	<u>2552-10</u>
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4020	Period: From 07/01/2022 To 06/30/2023		pared:
		Title XIX	Hospi tal	Cost	SS dill
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		1, 778	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 778	
3.00	Private room days (excluding swing-bed and observation bed da		orivate room days,	0	3.00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation k			1, 778	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	per 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	7.00
0.00	reporting period		21 - 5 + +	0	0.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t	to the Program (excludin	na swina-bed and	127	9.00
	newborn days) (see instructions)	3	5 5		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of	ctions)	room days) after		11.00
11.00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		ate room days)	0	12.00
	through December 31 of the cost reporting period		5 .		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	year, enter 0 on this li	ne)		14.00
14.00	Total nursery days (title V or XIX only)	all (excluding swing-bec	i uays)		15.00
16.00	Nursery days (title V or XIX only)				16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.00
18.00	reporting period	ac ofter December 21 of	the cost	0.00	18.00
16.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	Les al tel December 31 01	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 d	of the cost	0.00	19.00
	reporting period	-			
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	ns)		3, 656, 933	21 00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
	5 x line 17)		0 1 1		
23.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	ar 31 of the cost report	ing period (line		24.00
24.00	7 x line 19)	is a of the cost report	ing period (inc	U U	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportir	ng period (line 8	0	25.00
o (   o o	x line 20)				04.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		0 3, 656, 933	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(THE ZT MITUS TITLE 20)		3, 030, 933	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed o	charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	1
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	uctions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x li			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and and the set of the	li commente de la la	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost o	airterential (line	3, 656, 933	37.00
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see	e instructions)		2, 056. 77	
39.00	Program general inpatient routine service cost (line 9 x line	-		261, 210	
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	• • •		0 261, 210	40.00
+1.00	Total Frogram general ripatrent routine service cost (TINE 3)	7 T T HE 407	I	201, 210	1 41.00

MPUTATION OF INPATIENT OPERATING COST		Period: From 07/01/2022	u of Form CMS-2 Worksheet D-1	
		To 06/30/2023	Date/Time Pre 11/20/2023 9:	parec
	Title XIX	Hospi tal	Cost	
Cost Center Description Total Inpatient Cost	Total Average Per Inpatient Diem (col. 1 Days ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	2.00 3.00	4.00	5.00	42.0
Intensive Care Type Inpatient Hospital Units				
B. OO   INTENSIVE CARE UNIT 1. OO   CORONARY CARE UNIT				43.0
5. 00 BURN INTENSIVE CARE UNIT	0 0.00	0 0	0	
5. 00 SURGI CAL I NTENSI VE CARE UNI T			-	46.0
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description	L			47.
			1.00	
B. 00 Program inpatient ancillary service cost (Wkst. D-3, col. B. 01 Program inpatient cellular therapy acquisition cost (Works)		colump 1)	0	
9.00 Total Program inpatient costs (sum of lines 41 through 48.		corumit ()	261, 210	
PASS THROUGH COST ADJUSTMENTS				
0.00 Pass through costs applicable to Program inpatient routine	services (from Wkst. D, sum	of Parts I and	0	50.
) 00 Pass through costs applicable to Program inpatient ancilla	rv services (from Wkst. D. s	um of Parts II	0	51.0
and IV)				
2.00 Total Program excludable cost (sum of lines 50 and 51) 3.00 Total Program inpatient operating cost excluding capital r	alatad non physician anoth	otict and	0	
medical education costs (line 49 minus line 52)	stateu, non-physician anesth	erist, and	0	53.
TARGET AMOUNT AND LIMIT COMPUTATION				1
I.OO Program discharges 5.00 Target amount per discharge			0 0.00	
5.00   Target amount per discharge 5.01   Permanent adjustment amount per discharge			0.00	
5.02 Adjustment amount per discharge (contractor use only)			0.00	
0.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02	-		0	
7.00  Difference between adjusted inpatient operating cost and t 3.00  Bonus payment (see instructions)	arget amount (line 56 minus	line 53)	0	
0.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 fro	m the cost reporting period	endi na 1996.	0.00	
updated and compounded by the market basket)		J I		
0.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from market basket)	om prior year cost report, u	pdated by the	0.00	60.
1.00 Continuous improvement bonus payment (if line 53 ÷ line 54 55.01, or line 59, or line 60, enter the lesser of 50% of 53) are less than expected costs (lines 54 x 60), or 1 % o	the amount by which operatin	ng costs (line	0	61.
enter zero. (see instructions) 2.00 Relief payment (see instructions)			0	62.
3.00 Allowable Inpatient cost plus incentive payment (see instru-	uctions)		0	
PROGRAM INPATIENT ROUTINE SWING BED COST				
I.OO Medicare swing-bed SNF inpatient routine costs through Dec instructions)(title XVIII only)	ember 31 of the cost reporti	ng period (See	0	64.
5.00 Medicare swing-bed SNF inpatient routine costs after Decem	per 31 of the cost reporting	period (See	0	65.
instructions)(title XVIII only)				
D. 00 Total Medicare swing-bed SNF inpatient routine costs (line CAH, see instructions	64 plus line 65)(title XVII	I only); for	0	66.
7.00 Title V or XIX swing-bed NF inpatient routine costs throug	n December 31 of the cost re	porting period	0	67.
(line 12 x line 19)				
B. 00 Title V or XIX swing-bed NF inpatient routine costs after (line 13 x line 20)	Jecember 31 of the cost repo	riting period	0	68.
0.00 Total title V or XIX swing-bed NF inpatient routine costs			0	69.
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILIT 0.00 Skilled nursing facility/other nursing facility/ICF/IID ro				70.
0.00  Skilled nursing facility/other nursing facility/ICF/IID ro 1.00  Adjusted general inpatient routine service cost per diem (				71.
2.00 Program routine service cost (line 9 x line 71)	,			72.
8.00 Medically necessary private room cost applicable to Progra				73.
I.OO Total Program general inpatient routine service costs (lin 5.00 Capital-related cost allocated to inpatient routine servic	<i>,</i>	art II. column		74.
26, line 45)				
b. 00 Per diem capital-related costs (line 75 ÷ line 2)				76.
7.00  Program capital-related costs (line 9 x line 76) 8.00  Inpatient routine service cost (line 74 minus line 77)				77.
Aggregate charges to beneficiaries for excess costs (from	provider records)			79.
0.00 Total Program routine service costs for comparison to the	· · · · · · · · · · · · · · · · · · ·	us line 79)		80.
1.00 Inpatient routine service cost per diem limitation	1)			81.
<ol> <li>2.00  Inpatient routine service cost limitation (line 9 x line 8</li> <li>3.00  Reasonable inpatient routine service costs (see instructio</li> </ol>				82. 83.
I. 00Program inpatient ancillary services (see instructions)				84.
5.00 Utilization review - physician compensation (see instruction				85.
D. 00 Total Program inpatient operating costs (sum of lines 83 t PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	nrough 85)			86.
7.00 Total observation bed days (see instructions)			0	
	÷line 2)		0.00	88.

Health Financial Systems R	EGIONAL MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		pared: 33 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	1			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	38, 044	3, 656, 933	0. 01040	03 0	0	90.00
91.00 Nursing Program cost	0	3, 656, 933	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 656, 933	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 656, 933	0.00000	0 0	0	93.00

Health Financial Systems	REGIONAL MENTAL HEALTH CENTER	2	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-4020	Period: From 07/01/2022	Worksheet D-3	
			To 06/30/2023	Date/Time Pre 11/20/2023 9:	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			Ũ	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			288, 750		30.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
ANCI LLARY SERVI CE COST CENTERS					
60. 00 06000 LABORATORY		2. 6250	51 89	234	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 1998	36 17, 642	21, 168	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C		0.6310	91 0	0	90.00
200.00 Total (sum of lines 50 through 94 an	d 96 through 98)		17, 731	21, 402	200.00
201.00 Less PBP Clinic Laboratory Services-			0		201.00
202.00 Net charges (line 200 minus line 201			17, 731		202.00

Health Financial Systems	REGIONAL MENTAL HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 07/01/2022	Worksheet D-3	
			To 06/30/2023	Date/Time Pre 11/20/2023 9:	
	Titl	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			212, 137		30.00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		2. 62505	51 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 19988	6 0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 52700	0 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			0		201.00
202.00 Net charges (line 200 minus line 201)			0		202.00

2.00         Medical and other services in structions)         310.833         2.00           0.00         DOPE or SetH payment (see instructions)         0.10         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00			NTER er CCN: 15-4020 Title XVIII	In Lie Period: From 07/01/2022 To 06/30/2023 Hospital		pared:
Dest 6         HUTICAL AND OTHER HEALT SERVICES         0           10         Needed and other services reinflaxmand under OPE (see instructions)         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300         300					1 00	
2.00         Well call and other services rel blursed under GivPs (see Instructions)         310.862         2.00           0.00         OPES or REH payment (carl instructions)         4.00         6.00           0.00         Dill ter payment (carl instructions)         6.00         6.00           0.00         Dill ter the heapt all specific payment to cost ratio (see instructions)         0.00         0.00           0.00         Sin dell tires 3. 4. and 4.01 divide by line 6         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00 </td <td></td> <td>PART B - MEDICAL AND OTHER HEALTH SERVICES</td> <td></td> <td></td> <td>1.00</td> <td></td>		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.00     OPS or REH payment (see instructions)     421,881     3.00       4.01     Outline recordinization amount (see instructions)     0     4.01       4.01     Outline recordinization amount (see instructions)     0     4.00       4.01     Outline recordinization amount (see instructions)     0     4.00       4.01     Outline recordinization amount (see instructions)     0     4.00       6.00     Trans times innes     0.00     0       7.00     San of lines 3, 4, and 4.01, divided by line 6     0.00     0       8.00     Trans times innes     0.00     0     0       9.00     Ancell lary service other pays through costs from Rest, D. Pt, IV, col. 13, line 200     0     0       1.00     Cost (san of lines 1 and 10; son instructions)     0     10     0       1.00     Cost (san of lines 1 and 15; on instructions)     0     10     10       1.00     Cost (san of lines 1 and 15; on instructions)     0     10     10       1.00     Cost (san of lines 1 and 15; on instructions)     0     10     10       1.00     Cost (san of lines 1 and 15; on instructions)     0     10     10       1.00     Cost (san of lines 1 and 15; on instructions)     0     10     0       1.00     Cost (san of lines 1 and 16; on instruction					-	1.00
0.00     Outlier payment (see instructions)     0     4.00       0.01     Dettier resonciliation amount (see instructions)     0.000     0.000       0.00     Enter the hospital specific payment to cost ratio (see instructions)     0.000     0.000       0.00     Transitional corridor payment (see instructions)     0.000     0.000       0.00     Accilianes 3.4, and 4.01, divided by line 6     0.000     0.000       0.00     Accilianes 3.4, and 4.01, divided by line 6     0.000     0.000       0.00     Accilianes 3.4, and 4.01, divided by line 6     0.000     0.000       0.00     Accilianes 3.4, and 4.01, divided by line 6     0.000     0.000       0.000     Accilianes 3.4, and 4.01, divided by line 6     0.000     0.0000       0.0000     Accilianes 1.000     11.000     11.000     0.0000       0.00000     Total cost (com pi lines 1.2 and 13)     0.1000     11.000       11.00     Total costmary charges (see instructions)     0.000000     11.000       12.00     Actio of line 15 to line 16 (not to exceed 1.000000)     0.000000     11.000       12.00     Excess of castomary charges (com pi tak 2.4, 4.11, 4.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.11, 1.						
4.01       Outlier reconsisticition arount (see instructions)       0       4.01         0.01       Definition the shall all specific payment to cost ratio (see instructions)       0       6.00         0.00       Finition control regions (to cost ratio (see instructions)       0       6.00         0.00       Arcil Lary service other pass through costs from Rest. D. PL. IV. col. 13. Line 200       0       0         0.00       Arcil Lary service other pass through costs from Rest. D. PL. IV. col. 13. Line 200       0       10.00         0.00       Arcil Lary service charges       0       11.00         0.00       Arcil Lary service charges       0       11.00         0.00       Arcil Lary service charges (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       12.00         1.00       Arcil Lary service charges (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       16.00         1.00       Arcil Lary services charges (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       16.00         1.00       Arcil Lary services charges (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       16.00         1.00       Arcid Lary services charges (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       16.00         1.00       Arcid Lary services (from Rest. D.4. Pt. 111, col. 4. Line 69)       0       16.00         1.0						
6.00       Line 2 times 1 ines 3, 4, and 4.01, divided by line 6       0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0					-	
1.00     Sum of Titnes 3, 4, and 4, 01, divided by line 6     D.00     F.000       0.00     Transitional corridon payment (see instructions)     0     0       0.00     Ancil lary service athrough costs from Ket. 0, Pt, IV, cul. 13, line 200     0     0       0.00     Ancil lary service athrough costs from Ket. 0, Pt, IV, cul. 13, line 200     0     0       0.01     Comparison of the service athrough costs from Ket. 0, Pt, IV, cul. 13, line 200     0     0       0.01     Comparison of the service athrough costs from Ket. 0, Pt, IV, cul. 13, line 200     0     0       0.01     Comparison of the service athrough costs from Ket. 0, Pt, IV, cul. 13, line 200     0     0       0.01     Comparison of the service athrough costs from potential services on a charge basis     0     1       0.01     Comparison of the service athrough costs from potential liable for payment for services on a charge basis     0     1       0.01     Comparison of costs from program (see resconds)     0     1     0     1       0.01     Costs for program (see resconds)     0     1     0     1     0       0.01     Instructions)     0     0     0     0     0       0.01     Costs for program (see resconds)     0     1     0     1     0       0.02     Costs for program (see resconds)     0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
8.00       Transitional corridor pagement (see instructions)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0					-	
9.00       Anciliary service other pass through costs from WKSL D. Pt. IV. col. 13, line 200       0       9.00         11.00       Organ acquisitions       0       10.00         12.00       Anciliary service charges       0       10.00         13.00       Train acet (sum of lines 1 and 10) (see instructions)       0       10.00         13.00       Anciliary service charges       0       10.00         13.00       Train acet (sum of lines 12 and 13)       0       0         14.00       Inter restonatic charges (fram (kst. D.4, Pt. 111, col. 4, line 60)       0       13.00         14.00       Train acet (sum of lines 12 and 13)       0       0       14.00         15.00       Delease (see instructions)       0       15.00       0       0       0.00000       17.00         16.00       Delease of cost or charges (see instructions)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>8.00</td>						8.00
11:00       Total cost (cum of lines 1 and 10) (see instructions)       0       11:00         Commutation Or Lisses OF OST OR CHARGES       Massonable charges       12:00         Massonable charges       0       12:00         11:00       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 charge basis       0       16:00         16:00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16:00         16:00       Rest of 11:ne 15:00 for to exceed 1:000000       0       0       0       0         17:00       Excess of restonable cost over customary charges (complete only if line 11 exceeds line 10) (see instructions)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	9.00		. 13, line 200		0	9.00
DUMBURTATION OF LESSER OF COST OR CHARGES           Reasonable charges           12.00         Ancillary service charges           13.00         Organ acquisition charges (rem Bickt. 0-4, Pt. 111, col. 4, Line 69)         0           14.00         Total reasonable charges (rem Bickt. 0-4, Pt. 111, col. 4, Line 69)         0           15.00         Ancillary service charges         0           16.00         Amounts that would have been realized from patients liable for payment for services on a charge basis         0           16.00         Amounts that would have been realized from patients liable for payment for services on a charge basis         0           17.00         Bailto of line 15 to line 16 (not to exceed 1.000000)         18.00           10.00         Total contency charges (see instructions)         0         18.00           10.01         Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions)         21.00           11.00         Excess of reasonable cost over customary charges (see instructions)         21.00         22.00           20.00         Excess of reasonable cost over customary charges (see instructions)         21.00         21.00           21.00         Exset of reasonable cost over customary charges (see instructions)         21.00         21.00           22.00         Dintert seavid can marke amount sev					-	
Reasonable charges         Reasonable charges         12.00           13.00         Organ acquisition charges (from Wist: D-4, Pt. 11), col. 4, Line 69)         0         12.00           13.00         Organ acquisition charges (sum of lines 12 and 13)         0         14.00           15.00         Aggregate smooth actually collected from patients liable for payment for services on a charge basis         0         15.00           16.00         Amount actual structure on a charge basis         0         16.00           17.00         Ratio of line 15 to into to exceed 1.000000         0         0         0           18.00         Istal castnamery charges (see instructions)         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	11.00				0	11.00
13.00       Organ acquisition charges (rom Wkst. D-4, PL 111, col. 4, line 69)       0       13.00         14.00       Total reasonable charges (sum of lines 12 and 13)       0       14.00         15.04       Aggregate amount actually collected from patients flable for payment for services on a charge basis of the constraints and thare due neccedincem patients (12) (FT 1000000)       15.00         16.00       Administry charges (sum of lines 12 or for administry (12) (FT 1000000)       16.00         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       16.00         18.00       Instructions)       0       0.000000         18.00       Detactomary charges (sum of lines 12, and lines 11) (see instructions)       0       10.00         19.00       Excess of reasonable cost over customary charges (see instructions)       0       21.00         20.01       Interne and readiatis (see instructions)       0       23.00       23.00         20.01       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00       23.00         20.02       Deductibles and coinsurance amounts (for CAH, see instructions)       0       24.01       25.00         20.03       Deductibles and coinsurance amounts (for CAH, see instructions)       0       76.41       26.00         20.00       Distruct probulate medical educatio		Reasonabl e charges				
14:00       Total reasonable charges (sum of lines 12 and 13)       0       14:00         00       Aggregate amount actually collected from patients Liable for payment for services on a charge basis       0       15:00         15:00       Aggregate amount actually collected from patients Liable for payment for services on a charge basis       0       15:00         10:00       Laster payment been made in accordance with 42 CFR \$113.13(e)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <					-	
Customary charges         Customary charges         Customary charges         15.00           15.00         Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00					-	
16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis have been made in accordance with A2 CFR §41.3 (2000)       0       16.00         17.00       Ratis of Line 15 to Line 16 (not to exceed 1.000000)       0.000001       0.000001       0.000001         18.00       Total customary charges (see instructions)       0.000001       0.000001       0.000001       0.000001         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions)       0.000001       0.0000000         20.00       Instructions)       0.000001       0.000000000       0.00000000000000000000000000000000000	14.00				0	14.00
had such payment been made in accordance with 42 CFR \$413.13(e)       0         10.00 Ratio of line 15 to line 16 (not to exceed 1.000000)       0         18.00 Total customary charges (see instructions)       0.000000         19.00 Excess of customary charges (see instructions)       0         20.00 Excess of customary charges (see instructions)       0         21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0         21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0         21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0         21.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0         22.00 Defunctions and residuents (see instructions)       0       22.00         23.00 Defunctible sean do onsurance amounts (for CAH, see instructions)       76, 413 26.00         26.00 Defunctible sean do onsurance amounts (from Wkst. E-4, line 50)       51, 554 28.00         28.00 Direct medical education payments (from Wkst. E-4, line 50)       33, 71, 73, 30         20.00 Direct medical education costs (from Wkst. E-4, line 36)       0       34, 00         20.00 Direct medical education payment see instructions)       33, 00       33, 00         20.00 Direct medical education payment see instructions)					-	
17.00       Ratio of line 1s to line 16 (not to exceed 1.00000)       0.000000       17.00         18.00       Total customary charges (see instructions)       0.000000       17.00         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0       0         20.00       Excess of customary charges (see instructions)       0       21.00         21.00       Lesser of cost or charges (see instructions)       0       23.00         22.00       Interns and residents (see instructions)       0       23.00         23.00       Computitions (see instructions)       0       23.00         25.00       Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)       30.017       25.00         26.00       Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)       30.621       27.00         27.00       Subtotal (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see instructions)       30.56.71       70.00         28.00       Direct graduate medical education costs (from Wst. E-4, line 36)       0       29.00       29.00         20.00       Subtotal (lun ins 21 nes 21.82.80 and 29)       35.71.75       30.00       35.71.75       30.00         31.00       D	16.00		nt for services of	on a chargebasis	0	16.00
18:00       Total customary charges (see instructions)       0       18:00       Total customary charges (see instructions)       0       19:00         19:00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0       19:00         10:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0       20:00         10:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0       21:00         10:00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0       21:00         10:00       Instructions)       0       21:00       22:00       22:00         10:00       Instructions)       0       74:11:85       25:00       26:00         10:00       Instructions)       76:413       25:00       27:00       30:65:21       27:00         11:00:01       Instructions)       0       30:65:21       27:00       30:65:22       27:00         10:00       Comports       1:00:25:30:42       20:00       20:00       20:00       20:00       20:00       20:00       20:00       20:00       20:00       20:00       20:00       20:0	17.00				0.000000	17.00
Instructions)         Constructions)         Constructions)           20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)         Cost           21.00 Lesses of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)         Cost           22.00 Interns and residents (see instructions)         Cost         Cost           23.00 Cost of physicians' services in a teaching hospital (see instructions)         Cost         Cost           25.00 Deductible sand coinsurance amounts (for CAH, see instructions)         Total prospective payment (sum of lines 25 and 26) plus the sum of lines 22 and 23] (see         Total for sum of the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see           26.00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         Total for payments           27.00 Subtotal (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see         Stots 11 to payment amount no cost (from Wkst. E-4, line 30)           28.00 Subtotal (sum of lines 27, 28, 28, 50 and 29)         Stots 11 to payment amount no cost (from Wkst. E-4, line 36)         Stots 11 to payment amount no cost (from Wkst. E-4, line 36)           33.00 Composite rate ESR0 (from Wkst. 1-5, line 11)         Stots 11 to payment 30 minus line 31)         Stots 11 to payment 30 minus line 31)           34.00 Composite rate ESR0 (from Wkst. 1-5, line 11)         Stots 11 to payment 30 ustment case instructions)					0	18.00
20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	19.00		ne 18 exceeds li	ne 11) (see	0	19.00
Instructions)       0       21.00         10.00       Lesser of cost or charges (see instructions)       0       21.00         22.00       Interns and residents (see instructions)       0       22.00         23.00       Cost of physic laws' services in a teaching hospital (see instructions)       0       22.00         23.00       Cost of physic laws' services in a teaching hospital (see instructions)       0       22.00         25.00       Deductibles and coinsurance amounts (for CAH, see instructions)       76.413       25.00         26.00       Deductibles and coinsurance amounts (for CAH, see instructions)       76.413       26.00         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 20) plus the sum of lines 22 and 23] (see       137.153       28.00         28.00       Direct graduate medical education costs (from Wkst. E-4, line 30)       28.00       28.00       27.00         29.00       Subtotal (crime medical education costs (from Wkst. E-4, line 30)       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00	20 00		ine 11 exceeds li	ne 18) (see	0	20 00
22.00         Interns and residents (see instructions)         0         22.00           23.00         Cost of physic law is services in a teaching hospital (see instructions)         0         23.00           23.00         Total prospective payment (sum of lines 3, 4, 401, 8 and 9)         421.851         24.00           25.00         Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         76.04         76.04           26.00         Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         76.413         26.00           27.00         Subtotal [(1) res 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         70.02         27.00           28.00         Direct graduate medical education costs (from Wkst. E-4, line 50)         28.50         28.00         29.00         305.71.75         30.00           20.00         Direct graduate medical education costs (from Wkst. E-4, line 36)         0         29.00         31.00         29.00         31.00         29.00         31.00         28.05         31.00         35.71.75         30.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         32.00         35.00         35.00         35.00         35.00 <t< td=""><td>20100</td><td></td><td></td><td></td><td>Ũ</td><td>20100</td></t<>	20100				Ũ	20100
22.00       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00         24.00       Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)       24.06         25.00       Deductibles and coinsurance amounts (for CAH, see instructions)       76, 413       26.00         26.00       Deductibles and Coinsurance amounts (for CAH, see instructions)       76, 413       26.00         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       305, 621       27.00         28.00       Direct graduate medical education costs (from Wkst. E-4, line 50)       51, 554       28.00       29.00         29.00       Subtotal ((lines 27, 28, 28.50 and 29)       357, 175       30.00       0       29.00         30.00       Subtotal (sum of lines 27, 128, 28.50 and 29)       357, 175       32.00         30.00       Subtotal (sum of lines 27, 128, 28.50 and 29)       357, 175       32.00         30.00       Composite rate ESPD (from Wst. 1-5, line 11)       0       34.00       357, 175       32.00         30.00       Composite rate SPS (br(lines 10, See Instructions)       0       357, 175       37.00       350.00       357, 175       37.00       350.00       357, 175       37.00       350.00       357, 175       37.00 <td></td> <td><b>3</b></td> <td></td> <td></td> <td>-</td> <td>21.00</td>		<b>3</b>			-	21.00
24.00         Total prospective payment (sum of lines 3, 4, 4, 0, 6, 8 and 9)         421,851         24.00           0         CoMPUTION OF REINBURSEMENT SETTLEMENT         39,817         55,00           0.00         Conductibles and coinsurance amounts (for CAH, see instructions)         76,413         26,00           0.00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions)         305,621         27,00           0.20         Deductible and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         51,554         28,00           28,00         Direct graduate medical education payments (from Wkst. E-4, line 50)         51,555         28,00           28,00         Subtotal [(um of lines 27, 28, 28, 28, 0 and 29)         357,175         30,00           30,00         Subtotal (um of lines 31)         31,00         31,00           31,00         Subtotal (um of lines 3)         0         31,00           32,00         Composi te rate ESRD (from Wkst. I-5, line 11)         0         33,00           33,00         Composi te rate ESRD (from Wkst. I-5, line 11)         0         34,00           34,00         Adjusted te aduets (see instructions)         0         34,00           35,01         Adjusted reinbursable bad debts (see instructions)         0		, , ,	e)		-	
25.00       Deductibles and coinsurance amounts (for CAH, see instructions)       39,817       25.00         26.00       Deductibles and coinsurance amounts (from XH, see instructions)       76,413       26.00         27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       305,621       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       51,554       28.00         28.00       ESRD direct medical education payments (from Wkst. E-4, line 36)       0       29.00         30.00       Subtotal (sum of lines 27, 28, 28.50 and 29)       357,175       30.00         31.00       Subtotal (line 30 minus line 31)       31.00       357,175       33.00         32.00       Composite rate ESR0 (from Wst. 1-5, line 11)       0       33.00       34.00         33.00       Composite rate ESR0 (from Wst. 1-5, line 11)       0       34.00       36.00         33.00       Allowable bad debts (see instructions)       0       35.00       35.717       37.00         30.00       Allowable bad debts (see instructions)       0       35.00       35.717       37.00         30.00       Allowable bad debts (see instructions)       0       36.00       38.00       36.00       38.00       35.00			3)		-	
26.00       Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)       76.413       26.00         27.00       Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       305.621       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       51,554       28.00         29.00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0       28.00         20.00       Primary payer payments       0       357.175       30.00         20.00       Primary payer payments       37.017       32.00         20.00       ALLOWABLE BAD DEBTS (EXCLUDE RAD DEBTS FOR PROFESSIONAL SERVICES)       33.00       33.00         20.00       Allowable bad debts (see instructions)       0       34.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       35.00       <						
27.00       Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       305, 621       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       51, 554       28.00         28.00       ESSD direct medical education costs (from Wkst. E-4, line 36)       0       29.00         30.00       Subtotal (line 30 minus line 31)       357, 175       30.00         31.00       Subtotal (line 30 minus line 31)       357, 175       32.00         32.00       Composite rate ESR0 (from Wkst. I-5, line 11)       0       33.00         33.00       ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       33.00         33.00       Adjusted reinbursable bad debts (see instructions)       0       34.00         30.00       Aluvable bad debts (see instructions)       0       35.00         30.00       Aluvable bad debts (see instructions)       0       36.00         30.00       Mischard debts for dual eligible beneficiaries (see instructions)       0       36.00         30.00       Mischard debts for dual eligible stemet (see instructions)       0       36.00         30.00       Mischard debts for dual eligible stemet (see instructions)       0       39.00         30.00       Mischard debts for dual eligible stemet (s		• • • • •	or CAH soo inst	cuctions)		
28.00Direct graduate medical education payments (from Wkst. E-4, line 50)51,55428.0028.00ESRD direct medical education costs (from Wkst. E-4, line 36)028.5029.00Subtotal (sum of lines 27, 28, 28.50 and 29)357,17530.0031.00Subtotal (sum of lines 27, 28, 28.50 and 29)357,17530.0032.00Subtotal (sum of lines 27, 28, 28.50 and 29)357,17532.0031.00Subtotal (sum of lines 27, 28, 28.50 and 29)357,17532.0032.00Subtotal (sum of lines 27, 28, 28.50 and 29)357,17532.0033.00Composite rate ESRD (from Wkst. I-5, line 11)033.0030.00Adjusted reimbursable bad debts (see instructions)034.0030.00Adjusted reimbursable bad debts (see instructions)036.0030.00Mitowable bad debts (see instructions)036.0030.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.0030.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0037.75Demonstration payment adjustment sequestration039.7539.75Demonstration payment adjustment amount before sequestrations)039.9739.97Demonstration adjustment amount fore requestration039.9739.98RECOVERV OF ACCELERATED DEPRECIATION35.7,17540.0040.01Sequestration adjustment (see instructions)039.9739.99RECOVERV OF ACCELERATED DEPRECIATION039.97 <trr<td>39.9929.900<t< td=""><td></td><td></td><td></td><td></td><td></td><td>27.00</td></t<></trr<td>						27.00
28.50       REH Facility payment amount       28.50         29.00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0         30.00       Subtral (sum of lines 27, 28, 28.50 and 29)       357,175         31.00       Primary payer payments       357,175         30.00       Subtral (Sum of Line 30 minus Line 31)       357,175         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       357,175         31.00       Composite rate ESRD (from Wst. 1-5, line 11)       0         31.00       Allowable bad debts (see instructions)       0         35.00       Allowable bad debts (see instructions)       0         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       36.00         36.00       Subtral (see instructions)       0       38.00       38.00         37.00       Subtral (see instructions)       0       38.00       39.90       39.90         38.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.90       39.95       99       99       Partial or full credits received from manufacturers for replaced devices (see instructions)       39.95       39.95       39.75       39.75       39.75       39.75       39.75       39.77       40.00       39.96       39.97						
29.00         ESRD direct medical education costs (from West. E-4, line 36)         0         29.00           30.00         Subtotal (sum of lines 27, 28, 28.50 and 29)         357,175         30.00           31.00         Primary payer payments         357,175         30.00           32.00         Subtotal (sum of lines 27, 28, 28.50 and 29)         357,175         32.00           32.00         Subtotal (sum of lines 21)         357,175         32.00           33.00         Composite rate ESRD (from West. I-5, line 11)         0         33.00           30.00         Allowable Ead debts (see instructions)         0         34.00           30.00         Adjusted relmbursable bad debts (see instructions)         0         35.00           30.00         Subtotal (see instructions)         0         36.00           30.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         38.00           30.05         Pioneer ACO demonstration payment adjustment amount before sequestration         39.90         39.95           30.05         Pioneer ACO demonstration payment adjustment nound after sequestration         0         39.95           30.05         Pioneer ACO demonstration payment adjustment for replaced devices (see instructions)         0         39.95           30.05         Pioneer ACO demon					51, 554	
30.00         Subtotal (sum of lines 27, 28, 28.50 and 29)         357,175         30.00           31.00         Primary payer payments         31.00           32.00         Subtotal (line 30 minus line 31)         357,175         32.00           ALLOMABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         357,175         32.00           30.00         Composite rate ESRD (from West. 1-5, line 11)         0         33.00           31.00         Allowable bad debts (see instructions)         0         34.00           35.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         0         35.00           36.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         0         36.00           30.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         38.00           39.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39.50           39.57         N95 respirator payment adjustment amount (see instructions)         0         39.97           39.99         RECOVERY OF ACCELERATED DEPRECIATION         0         39.97           39.99         RECOVERY OF ACCELERATED DEPRECIATION         0         39.97           40.01         Sequestration adjustment sequestration         0         39.97					0	29.00
32. 00       Subtotal (line 30 minus line 31)       357,175       32.00         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       33.00       33.00         33.00       Composite rate ESRD (from Wkst. 1-5, line 11)       0       33.00         33.00       Allowable bad debts (see instructions)       0       34.00         35.00       Adjusted reinbursable bad debts (see instructions)       0       34.00         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       35.00         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       36.00         38.00       MSP-LCC reconciliation amount from PS&R       0       39.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Phoneer ACO demostration payment adjustment (see instructions)       0       39.75         39.75       N95 respirator payment adjustment amount (see instructions)       0       39.97         39.99       RECOVERV OF ACCELERATED DEPRECIATION       0       39.75         40.00       Sequestration adjustment amount after sequestration       0       39.97         40.01       Sequestration adjustment Amounds       299.509       41.00         41.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       33.00         33.00       Composite rate ESRD (from Wkst. I-5, line 11)       03.00         34.00       Allowable bad debts (see instructions)       034.00         35.00       Adjusted reimbursable bad debts (see instructions)       036.00         36.00       Adjusted reimbursable bad debts (see instructions)       036.00         37.00       Subtotal (see instructions)       036.00         38.00       MSP-LCC reconciliation amount from PS&R       037.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       039.00         39.01       Strespirator payment adjustment amount (see instructions)       39.75         39.7       Pomonstration payment adjustment amount (see instructions)       039.97         39.99       RECOVERY OF ACCELERATED DEPRECIATION       039.99         91.00       Subtotal (see instructions)       037.174         00.01       Sequestration adjustment second for for sequestration       037.714         00.02       Demonstration payment adjustment amount (see instructions)       71.44         01.03       Sequestration adjustment sequestration       040.02         02.01       Sequestration adjustment (for contractors use only)       042.00         02.01       Sequestration adjustment (for co					-	
33.00       Composite rate ESR0 (from Wkst. I-5, line 11)       0       33.00       Allowable bad debts (see instructions)       0       34.00         34.00       Allowable bad debts (see instructions)       0       34.00       34.00         35.00       Allowable bad debts (see instructions)       0       36.00       36.00       36.00         36.00       Allowable bad debts (see instructions)       0       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       36.00       37.05       37.05       37.05       37.05       37.05       37.05       37.05       38.00       39.00       39.00       39.00       39.00       39.00       39.00       39.97       Demonstration payment adjustment (see instructions)       39.97       39.97       Demonstration payment adjustment amount (see instructions)       0       39.97       39.97       39.97       Demonstration adjustment amount sequestration       0       39.97       39.98       39.98       39.97       35.71.75       40.00       39.98       39.99       35.71.75       40.00       39.98       35.71.75       40.00       39.98       35.91.75       40.00       35.9	52.00					52.00
35.00Adjusted reimbursable bad debts (see instructions)035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)357,17537.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.0039.50Ploneer ACO demonstration payment adjustment (see instructions)39.7539.7539.75N95 respirator payment adjustment amount before sequestration039.7539.97Demonstration payment adjustment amount before sequestration039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECI ATION040.0140.00Sequestration adjustment (see instructions)040.0240.01Sequestration adjustment amount after sequestration040.0341.00Interim payments299,50941.0041.01Interim payments299,50941.0042.00Tentative settlement (for contractors use only)42.0143.01Bal ance due provider/program (see instructions)50,52243.0044.00Protested amount (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0070.00Original outlier amount (see instructions)091.0090.00Original outlier amount (see instructions)091.00 <tr< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td></tr<>					-	
36.00Al lowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)036.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer AC0 demonstration payment adjustment amount (see instructions)039.7539.75N95 respirator payment adjustment amount (see instructions)039.7539.97Demonstration payment adjustment amount before sequestration039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.999.97RECOVERY OF ACCELERATED DEPRECIATION039.990.00Subtotal (see instructions)0357.17540.000.01Sequestration adjustment (see instructions)7,14440.0140.02Demonstration payment adjustment amount after sequestration040.020.02Sequestration adjustment (for contractor use only)41.0140.0241.01Interim payments -PARHM299,50941.0042.0043.00Balance due provider/program (see instructions)50,52243.0043.00Balance due provider/program (see instructions)50,52243.0043.01Balance due provider/program (see instructions)50,52243.0043.01Balance due provider/program (see instructions)042.0143.01Balance due provider/program (see instructions)0 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>					-	
37.00Subtotal (see instructions)357,17537.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACO demonstration payment adjustment (see instructions)039.5039.75N95 respirator payment adjustment amount (see instructions)039.7039.97Demonstration payment adjustment amount before sequestration039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9800.00Subtotal (see instructions)039.9701.01Sequestration adjustment (see instructions)039.9802.02Demonstration payment adjustment free sequestration039.9703.03Sequestration adjustment (see instructions)040.0202Demonstration payment djustment amount after sequestration040.0203.03Interim payments299,50941.0041.00Interim payments299,50941.0042.00Tentative settlement-PARHM (for contractor use only)042.0143.00Balance due provider/program (see instructions)043.0143.00Balance due provider/program (see instructions)043.0144.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 043.0144.00Stifis.2090			s)		-	36.00
39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACO demonstration payment adjustment (see instructions)39.0039.75N95 respirator payment adjustment amount (see instructions)039.97Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION039.99Recovery of ACCELERATED DEPRECIATION357,17540.00Subtotal (see instructions)357,17540.00Sequestration adjustment (see instructions)040.01Sequestration adjustment Ament amount after sequestration040.02Demonstration payments40.0341.00Interim payments299,50941.00Interim payments299,50941.01Interim payments-PARHM29042.00Tentative settlement (for contractors use only)043.00Balance due provi der/program (see instructions)43.0044.00Protested amounts (nonaliowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.00Original outlier amount (see instructions)090.00Original 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 Money0.0092.00The rat		Subtotal (see instructions)			357, 175	37.00
39.50Pioneer AC0 demonstration payment adjustment (see instructions)39.5039.75N95 respirator payment adjustment amount (see instructions)039.75N95 respirator payment adjustment amount (see instructions)039.97Demonstration payment adjustment amount before sequestration039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION000Subtotal (see instructions)357,17500Sequestration adjustment (see instructions)7,14400Sequestration adjustment (see instructions)001Interim payments002Demonstration payment adjustment amount after sequestration003Sequestration adjustment (for contractors use only)0040.01Interim payments299,50905010Interim payments299,509041.01Interim payments299,50905111112011Tentative settlement (for contractors use only)042.0042.01Tentative settlement (for contractor use only)42.0143.01Balance due provider/program (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, stils.244.0090.00Original outlier amount (see instructions)090.0091.00Dutlier reconciliation adjustment amount (see instructions)090.0092.00The					-	
39.75N95 respirator payment adjustment amount (see instructions)039.7539.75Demonstration payment adjustment amount before sequestration039.7539.97Demonstration payment adjustment amount before sequestration039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9830.01Sequestration adjustment (see instructions)039.9940.01Sequestration adjustment (see instructions)7,14440.0140.02Demonstration payment adjustment amount after sequestration004.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments299,50941.0042.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement (for contractor use only)43.0143.00Balance due provider/program (see instructions)50,52243.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0090.0090.00Original outlier amount (see instructions)091.0092.00The raceociliation adjustment amount (see instructions)091.0092.00Time Value of Money (see instructions)091.0093.00Time Value of Money (see instructions)093.00					0	
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)0357,17540.01Sequestration adjustment (see instructions)7,14440.0140.03Sequestration adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments299,50941.0041.01Interim payments-PARHM42.0042.01Tentative settlement (for contractors use only)042.0143.00Bal ance due provider/program (see instructions)50,52243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier 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					0	39.75
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40.00Subtotal (see instructions)357,17540.0040.01Sequestration adjustment (see instructions)7,14440.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs040.0341.00Interim payments299,50941.0041.01Interim payments-PARHM299,50941.0142.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)50,52243.0043.01Balance due provider/program-PARHM (see instructions)50,52243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2040.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The ate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			ces (see instruc	ctions)	0	
40.01Sequestration adjustment (see instructions)7,14440.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments299,50941.01Interim payments-PARHM299,50942.00Tentative settlement (for contractors use only)042.00Tentative settlement (for contractor use only)043.00Balance due provider/program (see instructions)50,52243.01Balance due provider/program (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0093.0093.00Time Value of Money (see instructions)093.00					357, 175	
40.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments299,50941.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)41.0142.01Tentative settlement-PARHM (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)50,52243.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to cal culate the Time Value of Money093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0		Sequestration adjustment (see instructions)			7, 144	
41.00Interim payments299, 50941.0041.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)50, 52243.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070BE COMPLETED BY CONTRACTOR090.00Original 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)093.00					0	
41.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)50,52243.01Balance due provider/program-PARHM (see instructions)50,52244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2070BE COMPLETED BY CONTRACTOR090.00Original 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)093.00093.00					299.509	
42.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)50,52243.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, ST 0 BE COMPLETED BY CONTRACTOR44.0090.00Original outlier amount (see instructions)90.0091.00Outlier 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					,	
43.00Balance due provider/program (see instructions)50,52243.0043.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, STI5.2070BE COMPLETED BY CONTRACTOR090.00Original 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)093.00Omega and the tail of tail of tail of the tail of tail of tail of the tail of tail					0	42.00
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       43.01         44.00 <u>§115.2</u> TO BE COMPLETED BY CONTRACTOR       0         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       Time Value of Money (see instructions)       0       93.00					50 522	
44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0       44.00         70       BE COMPLETED BY CONTRACTOR       0       90.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00					50, 522	43.00 43.01
TO BE COMPLETED BY CONTRACTOR90.00Original 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	44.00	Protested amounts (nonallowable cost report items) in accordance with	n CMS Pub. 15-2,	chapter 1,	0	44.00
90.00Original 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						
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	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00		Outlier reconciliation adjustment amount (see instructions)			-	91.00
		5				
		Total (sum of lines 91 and 93)			-	

Health Financial Systems	REGIONAL MENTAL HE	ALTH CENTER	In Lieu	ı of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-4020		Worksheet E	
			From 07/01/2022 To 06/30/2023	Part B Dato/Timo Pro	narod
			10 00/30/2023	Date/Time Pre 11/20/2023 9:	33 am
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

	I Financial Systems REGIONAL MENTAL SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-4020	Period: From 07/01/2022 To 06/30/2023		pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider 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		161, 5	33 0	299, 509 0	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3.02
3.03 3.04				0	0	3. 03 3. 04
3.04				0	0	3.04
5.05	Provider to Program			0	0	5.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.54 3.99
5. 77	3, 50-3, 98)			0	Ű	5.77
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)		161, 5	33	299, 509	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER		1	0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		134, 4		50, 522	6.01
6.02	SETTLEMENT TO PROGRAM		20E 0	0	0 250_021	6.02
7.00	Total Medicare program liability (see instructions)		295, 9	37 Contractor	350,031 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	C	1.00	2.00	
8.00	Name of Contractor					8.00

1.00         Net Federal           2.00         Net I PF PPS           3.00         Net I PF PPS           4.00         Unweighted i           15, 2004. (s           4.01         Cap i ncrease           program or h           CFR §412.424	DICARE PART A SERVICES - IPF PPS IPF PPS Payments (excluding outlier, ECT, and me Outlier Payments ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted withd (d)(1)(iii)(F)(1) or (2) (see instructions) program adjustment. (see instructions)	cost report filed on or unt for residents that we		Part II Date/Time Pre 11/20/2023 9: PPS 1.00 173,613 16,722 0 0.00	
1.00         Net Federal           2.00         Net I PF PPS           3.00         Net I PF PPS           4.00         Unweighted i           15, 2004. (s           4.01         Cap i ncrease           program or h           CFR §412.424	IPF PPS Payments (excluding outlier, ECT, and me Outlier Payments ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	edical education payments cost report filed on or unt for residents that we	5)	PPS 1.00 173,613 16,722 0	1.00
1.00         Net Federal           2.00         Net I PF PPS           3.00         Net I PF PPS           4.00         Unweighted i           15, 2004. (s           4.01         Cap i ncrease           program or h           CFR §412.424	IPF PPS Payments (excluding outlier, ECT, and me Outlier Payments ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	edical education payments cost report filed on or unt for residents that we	5)	1. 00 173, 613 16, 722 0	
1.00         Net Federal           2.00         Net I PF PPS           3.00         Net I PF PPS           4.00         Unweighted i           15, 2004. (s           4.01         Cap i ncrease           program or h           CFR §412.424	IPF PPS Payments (excluding outlier, ECT, and me Outlier Payments ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	cost report filed on or unt for residents that we		173, 613 16, 722 0	
1.00         Net Federal           2.00         Net I PF PPS           3.00         Net I PF PPS           4.00         Unweighted i           15, 2004. (s           4.01         Cap i ncrease           program or h           CFR §412.424	IPF PPS Payments (excluding outlier, ECT, and me Outlier Payments ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	cost report filed on or unt for residents that we		16, 722 0	
3.00         Net I PF PPS           4.00         Unwei ghted i           15, 2004.         (s           4.01         Cap i ncrease           program or h         CFR §412.424	ECT Payments ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	unt for residents that we	before November	0	2.00
<ul> <li>4.00 Unweighted i 15, 2004. (s</li> <li>4.01 Cap i ncrease program or h CFR §412.424</li> </ul>	ntern and resident FTE count in the most recent ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	unt for residents that we	before November		
4.01 (s 4.01 Cap increase program or h CFR §412.424	ee instructions) s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)	unt for residents that we	before November		
4.01 Cap increase program or h CFR §412.424	s for the unweighted intern and resident FTE cou ospital closure, that would not be counted witho (d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.00
				0.00	4. 01
5.00 New Teaching	OF OUT AND A OF US FINELLY IS SEE TO STELLCTLODS)			0.00	5.00
	's unweighted FTE count of I&R excluding FTEs in	n the new program growth	period of a "new	0.00	
	gram" (see instuctions)				
	's unweighted I&R FTE count for residents withir	n the new program growth	period of a "new	4.00	7.00
	gram" (see instuctions) esident count for IPF PPS medical education adju	ustment (see instructions	;)	4.00	8.00
	y Census (see instructions)		,	4.871233	
	ustment Factor {((1 + (line 8/line 9)) raised to	o the power of .5150 -1}.		0. 361688	
	ustment (line 1 multiplied by line 10).	<b>N</b>		62, 794	
	t IPF PPS Payments (sum of lines 1, 2, 3 and 11) Allied Health Managed Care payment (see instruct			253, 129 0	
5	ition (DO NOT USE THIS LINE)			0	14.00
	icians' services in a teaching hospital (see ins	structions)		0	15.00
	e instructions)			253, 129	
17.00 Primary paye				252 120	
18.00 Subtotal (li 19.00 Deductibles	ne 16 less line 17).			253, 129 20, 448	
	ne 18 minus line 19)			232, 681	
21.00 Coi nsurance	·			5, 057	21.00
	ne 20 minus line 21)			227, 624	
	d debts (exclude bad debts for professional serv mbursable bad debts (see instructions)	vices) (see instructions)		0	
3	d debts for dual eligible beneficiaries (see ins	structions)		0	
	m of lines 22 and 24)			227, 624	
0	ate medical education payments (see instructions	s)		74, 353	
1 .	hrough costs (see instructions)			0	
	ents reconciliation MENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	demonstration payment adjustment (see instruction	ons)		0	
30.98 Recovery of	accel erated depreciation.			0	
	n payment adjustment amount before sequestration	n		0	
	payable to the provider (see instructions) n adjustment (see instructions)			301, 977 6, 040	
	n payment adjustment amount after sequestration			8, 040 0	
32.00 Interim paym				161, 533	
	ttlement (for contractor use only)			0	
	provider/program (line 31 minus lines 31.01, 31.		abortor 1	134, 404	
35.00 Protested am §115.2	ounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	cnapter I,	0	35.00
	TED BY CONTRACTOR				
5	lier amount from Worksheet E-3, Part II, line 2			16, 722	
	nciliation adjustment amount (see instructions)			0	51.00
	d to calculate the Time Value of Money f Money (see instructions)			0. 00 0	
	DRTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN	ND BEGINNING ON OR BEFORE	MAY 11, 2023 (TH		55.00
COVID-19 PHE					l
0,1	ustment Factor for the cost reporting period imm eaching Adjustment Factor for the current year.	31	iary 29, 2020.	0. 000000 0. 361688	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-4020	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Pre 11/20/2023 9:	pare
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FUR TITLES V UR	XIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		261, 210		1 1.
00	Medical and other services		201, 210	0	2.
00	Organ acquisition (certified transplant programs only)		0	0	3.
00	Subtotal (sum of lines 1, 2 and 3)		261, 210	0	
00	Inpatient primary payer payments		201, 210	0	5.
00	Outpatient primary payer payments			0	6.
00	Subtotal (line 4 less sum of lines 5 and 6)		261, 210	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				1
00	Routi ne servi ce charges		212, 137		8.
00	Ancillary service charges		0	0	9.
0. 00	Organ acquisition charges, net of revenue		0		10.
1.00	Incentive from target amount computation		0		11.
2.00	Total reasonable charges (sum of lines 8 through 11)		212, 137	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	0,00000	15
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	ly if line 14 exceeds	212, 137 0	0	
7.00	line 4) (see instructions)	if y ff fffle to exceeds	0	0	
3 00	Excess of reasonable cost over customary charges (complete or	ly if line 4 exceeds li	ne 49, 073	0	18
5.00	16) (see instructions)		47,075	0	'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		212, 137	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
2.00	Other than outlier payments	· · ·	0	0	22
3.00	Outlier payments		0	0	23
1.00	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		212, 137	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		49,073	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	)	212, 137	0	
2.00	Deducti bl es Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	34
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	ad 22)	212, 137	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	iu 33)	212, 137	0	
	Subtotal (line 36 $\pm$ line 37)		212, 137	0	
	Direct graduate medical education payments (from Wkst. E-4)		212, 137	0	39
	Total amount payable to the provider (sum of lines 38 and 39)		212, 137	0	
	Interim payments		175, 578	0	41
	Balance due provider/program (line 40 minus line 41)		36, 559	0	
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2.	0	0	
	chapter 1, §115.2		Ű		``

	Financial Systems REGIONAL MENTAL HE	ALTH CENTER		In Lie	u of Form CMS-2	2552-10	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider CC	N: 15-4020	Period: From 07/01/2022	Worksheet E-4		
MEDICA	L EDUCATION COSTS			To 06/30/2023			
		Title	XVIII	Hospi tal	11/20/2023 9: PPS	33 am	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00		
1.00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost report	ing periods	0.00	1.00	
	ending on or before December 31, 1996.			•			
1.01 2.00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see inst	ructions)	0.00 0.00	1.01 2.00	
2.26	Rural track program FTE cap limitation adjustment after the c				0.00	2.00	
	the CAA 2021 (see instructions)			-			
3.00 3.01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance	(500	0.00 0.00	3.00 3.01			
3.01	instructions for cost reporting periods straddling 7/1/2011)	. (See	0.00	3.01			
3.02	Adjustment (increase or decrease) to the hospital's rural tra	ack FTE limit	ation(s) for	rural track	0.00	3.02	
	programs with a rural track Medicare GME affiliation agreemen	nt in accorda	nce with 413	.75(b) and 87 FF			
4.00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and	osteonathi c	programs due	to a Medicare	0.00	4.00	
4.00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)				0.00	4.00	
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst	ructions for	cost report	ing periods	0.00	4.01	
4.02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (soo inst	ructions for	cost roporting	0.00	4.02	
4.02	periods straddling 7/1/2011)	.s (see mst		cost reporting	0.00	4.02	
4.21	The amount of increase if the hospital was awarded FTE cap sl	ots under §1	26 of the CA	A 2021 (see	0.00	4. 21	
F 00	instructions)	0.00	F 00				
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin 3.01, plus or minus line 3.02, plus or minus line 4, plus lin	0.00	5.00				
6.00	Unweighted resident FTE count for allopathic and osteopathic	year from your	0.00	6.00			
	records (see instructions)						
7.00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7.00	
		-	1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	0.0	0.00	0.00	8.00	
9.00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	ui so	0. (	0.00	0.00	9.00	
9.00	multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0.00	9.00	
	6. For cost reporting periods beginning on or after October 1						
10.00	if Worksheet S-2, Part I, line 68, is "Y", see instructions.			0.00		10.00	
	Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu	2		0.00		10.00 10.01	
11.00	Total weighted FTE count	intent year	0. (			11.00	
12.00	Total weighted resident FTE count for the prior cost reportin	ng year (see	0. (			12.00	
40.00	instructions)					10.00	
13.00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporting	0.0	0.00		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	0. 0	0.00		14.00	
15.00	Adjustment for residents in initial years of new programs	5	0.0	4.00		15.00	
	Unweighted adjustment for residents in initial years of new p		0. (			15.01	
	Adjustment for residents displaced by program or hospital clo	1	0.0			16.00	
16.01	Unweighted adjustment for residents displaced by program or h closure	iospi tai	0.0	0.00		16.01	
17.00	Adjusted rolling average FTE count		0. 0	4.00		17.00	
	Per resident amount		0.0	100, 000. 00		18.00	
18.01	Per resident amount under §131 of the CAA 2021		0.0		400 000	18.01	
19.00	Approved amount for resident costs			0 400,000	400, 000	19.00	
					1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots re	ceived under 42	0.00	20.00	
21.00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	(ctions)			0.00	21.00	
	Allowable additional direct GME FTE Resident Count (see instru	,				21.00	
	Enter the locality adjustment national average per resident a		nstructions)		0.00		
24.00	Multiply line 22 time line 23				0	24.00	
	0     Total direct GME amount (sum of lines 19 and 24)     400,000     25						

Heal th	Financial Systems REGIONAL MENTAL HE	ALTH CENTER		In Lie	u of Form CMS-2	2552-10
DI REC	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15-4020	Period:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 07/01/2022 To 06/30/2023		nared
				10 00/ 30/ 2023	11/20/2023 9:	
		Title	XVIII	Hospi tal	PPS	
			I npati ent	Managed Care	Total	
			Part A			
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X line	10	9 420		26.00
20.00	3. 02, column 2)	X, THIC		420		20.00
27.00	Total Inpatient Days (see instructions)		1, 7	78 1, 778		27.00
28.00	Ratio of inpatient days to total inpatient days		0. 11192	0. 236220		28.00
29.00	Program direct GME amount		44, 7	94, 488	139, 258	29.00
29.01	Percent reduction for MA DGME					29.01
30.00	Reduction for direct GME payments for Medicare Advantage			13, 351	13, 351	30.00
31.00	Net Program direct GME amount				125, 907	31.00
	DUDGAT NEDLAN, EDUALTIAN AAATA SAD SADD AANDAALTE DATE TIT	-	(10000000000000000000000000000000000000		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	LE XVIII ONL	Y (NURSING PR	OGRAM AND PARAME	DICAL	
32.00						32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8,	sum of lines	74 and 94)	0	33.00
34.00	00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33)					34.00
35.00	Medicare outpatient ESRD charges (see instructions)				0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line		35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				447, 610	
38.00	Organ acquisition and HSCT acquisition costs (see instruction				0	38.00
39.00	Cost of physicians' services in a teaching hospital (see inst	tructions)			0	39.00
40.00	Primary payer payments (see instructions)				0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu Part B Reasonable Cost	us line 40)			447, 610	41.00
42.00	Reasonable cost (see instructions)				310, 363	42.00
42.00	Primary payer payments (see instructions)				310, 303	
43.00	Total Part B reasonable cost (line 42 minus line 43)				310, 363	
44.00	Total reasonable cost (sum of lines 41 and 44)				757, 973	
46.00	Ratio of Part A reasonable cost to total reasonable cost (lir	oo /1 ÷ lino	45)		0. 590536	
47.00	Ratio of Part B reasonable cost to total reasonable cost (III				0. 409464	
+7.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA		10)		0.407404	, T. 00
48.00	Total program GME payment (line 31)				125, 907	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	) (see instr	uctions)		74, 353	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)				51, 554	
		(			,	

	E SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 07/01/2022	Worksheet G	
ina-t il y)	ype accounting records, complete the General Fund column			o 06/30/2023	Date/Time Pre 11/20/2023 9:	pare
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS	0 000 ((4	(	0	0	1 1
00 00	Cash on hand in banks	9, 888, 664		-	0	1
00	Temporary investments Notes receivable	5, 780, 502		-	0	
00	Accounts receivable	2 044 452		-	0	
00	Other receivable	2,066,653			0	
00	Allowances for uncollectible notes and accounts receivable			-	0	6
00	Inventory				0	
00	Prepai d expenses	858, 586		-	0	
00	Other current assets	3, 151, 933		0	0	9
. 00	Due from other funds	2, 245, 981		0	0	10
. 00	Total current assets (sum of lines 1-10)	23, 992, 319		0	0	
	FI XED ASSETS					
. 00	Land	1, 307, 295	(	) 0	0	12
. 00	Land improvements	0	0	0 0	0	13
. 00	Accumulated depreciation	0	0	0 0	0	14
	Bui I di ngs	30, 821, 366	(	0 0	0	15
	Accumulated depreciation	-26, 718, 933		0 0	0	16
	Leasehold improvements	696, 097		-	0	17
	Accumulated depreciation	0	(	-	0	18
	Fixed equipment	0	0		0	19
	Accumulated depreciation	0	(	-	0	20
	Automobiles and trucks	0	(	-	0	21
	Accumulated depreciation		(	-	0	22
	Major movable equipment	7, 556, 073			0	23
	Accumulated depreciation	0		-	0	24
	Minor equipment depreciable			0	0	25
	Accumulated depreciation HIT designated Assets			0	0	26
	8			-	0	27
	Accumulated depreciation Minor equipment-nondepreciable				0	
	Total fixed assets (sum of lines 12-29)	13, 661, 898			0	
. 00	OTHER ASSETS	13,001,070		0	0	1 30
00	Investments	18, 399, 060	(	0	0	31
	Deposits on Leases			-	0	32
. 00	Due from owners/officers			-	0	33
	Other assets	175, 790		0	0	
. 00	Total other assets (sum of lines 31-34)	18, 574, 850	0	0	0	
	Total assets (sum of lines 11, 30, and 35)	56, 229, 067		0 0	0	36
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	1, 520, 492	(	) 0	0	37
. 00	Salaries, wages, and fees payable	2, 939, 843	0	0 0	0	38
	Payroll taxes payable	0	(	0 0	0	39
	Notes and loans payable (short term)	0	0	0 0	0	
	Deferred income	0	0	0 0	0	
	Accel erated payments	0				42
	Due to other funds	0		-	0	
	Other current liabilities	1, 140, 914			0	
. 00	Total current liabilities (sum of lines 37 thru 44)	5, 601, 249	(	0 0	0	45
00	LONG TERM LI ABI LI TI ES	~				1.
	Mortgage payable				0	
. 00	Notes payable Unsecured Loans				0	47
	Other long term liabilities	1, 458, 466		-	0	
	Total long term liabilities (sum of lines 46 thru 49)	1, 458, 466	1	-	0	
	Total liabilities (sum of lines 45 and 50)	7, 059, 715		-	0	
20	CAPITAL ACCOUNTS	.,,			0	1
. 00	General fund balance	49, 169, 352				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
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	49, 169, 352	0	0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	56, 229, 067	( (	0	0	60

Health Financial Systems RE STATEMENT OF CHANGES IN FUND BALANCES	EGIONAL MENTAL H		N. 1E 4000		u of Form CMS-	
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 07/01/2022 To 06/30/2023	11/20/2023 9:	epared:
	General	Fund	Special I	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00.006.00.009.00.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.00.0017.00.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44, 956, 851 4, 212, 501 49, 169, 352 0 49, 169, 352				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
18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	0 49, 169, 352 PI ant	Fund	0		18.00 19.00
	6.00	7.00	8,00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	0	0 0 0 0 0 0 0 0	0.00	0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
<ul> <li>10.00</li> <li>Total additions (sum of line 4-9)</li> <li>11.00</li> <li>Subtotal (line 3 plus line 10)</li> <li>Deductions (debit adjustments) (specify)</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00</li> <li>Total deductions (sum of lines 12-17)</li> <li>19.00</li> <li>Fund balance at end of period per balance</li> </ul>	0 0 0	0 0 0 0 0 0		000000000000000000000000000000000000000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Cost Center Description PART I - PATIENT REVENUES	Provider CC	N: 15-4020	Period: From 07/		Worksheet (	3-2	
				01/2022 30/2023	Parts I & I Date/Time F 11/20/2023	repa	
PART I - PATIENT REVENUES		Inpati ent		tient	Total		
PART I - PATTENT REVENUES		1.00	2.	00	3.00	_	
Conservation the Doubling Completions							
General Inpatient Routine Services 1.00 Hospital		2, 920, 42	2		2, 920, 4	23	1.00
2. 00 SUBPROVIDER - IPF		2, 720, 42	5		2, 720, 4		2.00
3. 00 SUBPROVIDER - IRF							3.00
4. 00 SUBPROVI DER							4.00
5.00 Swing bed - SNF			0			0	5.00
6.00 Swing bed - NF			0			0	6.00
7.00 SKILLED NURSING FACILITY							7.00
8.00 NURSING FACILITY							8.00
9.00 OTHER LONG TERM CARE							9.00
10.00 Total general inpatient care services (sum of lines 1-9)		2, 920, 42	23		2, 920, 4	23 1	10.00
Intensive Care Type Inpatient Hospital Services	F						
11.00 INTENSIVE CARE UNIT							11.00
12.00 CORONARY CARE UNIT							12.00
13.00 BURN INTENSIVE CARE UNIT			0				13.00
14.00 SURGI CAL I NTENSI VE CARE UNI T							14.00
15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of	Lines		0				15.00 16.00
16.00 Total intensive care type inpatient hospital services (sum of 11-15)	TTHES		0				10.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)		2, 920, 42	2		2, 920, 4	23 1	17.00
18.00 Ancillary services	,	182, 20		3, 738	185, 9		18.00
19.00 Outpatient services		,		598, 402	6, 598, 4		19.00
20.00 RURAL HEALTH CLINIC			0	0			20.00
21.00 FEDERALLY QUALI FI ED HEALTH CENTER			0	0		0 2	21.00
22.00 HOME HEALTH AGENCY						2	22.00
23. 00 AMBULANCE SERVICES						2	23.00
24. 00 CMHC				0		0 2	24.00
25.00 AMBULATORY SURGICAL CENTER (D. P. )							25.00
26. 00 HOSPI CE							26.00
27.00 PROFESSIONAL FEES		33, 09		459, 202	36, 492, 3		27.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3	to Wkst.	3, 135, 72	43,	061, 342	46, 197, 0	71 2	28.00
G-3, line 1)						_	
PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200)			12	227, 346		<u> </u>	29.00
30. 00 ADD (SPECIFY)			42,	227, 340			30.00
31.00			0				31.00
32.00			0				32.00
33.00			0				33.00
34.00			0				34.00
35.00			0			3	35.00
36.00 Total additions (sum of lines 30-35)				0		3	36.00
37.00 DEDUCT (SPECIFY)			0			3	37.00
38.00			0				38.00
39.00			0				39.00
40. 00			0				40.00
41.00			0				41.00
42.00 Total deductions (sum of lines 37-41)				0			42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		42,	227, 346		4	43.00
to Wkst. G-3, line 4)	I		l.				

	Financial Systems REGIONAL MENTAL HE			u of Form CMS-2	
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-4020	Period: From 07/01/2022	Worksheet G-3	
			To 06/30/2023	Date/Time Pre	pared:
				11/20/2023 9:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			46, 197, 071	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		22, 419, 900	
3.00	Net patient revenues (line 1 minus line 2)			23, 777, 171	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		42, 227, 346	
5.00	Net income from service to patients (line 3 minus line 4)			-18, 450, 175	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			2, 344, 260	
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	
	Revenue from meals sold to employees and guests			-	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other t	than patients			16.00
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
22.00	Rental of hospital space			0	
23.00	Governmental appropriations			0	
	OTHER INCOME			22, 364, 746	
24.50	COVI D-19 PHE Fundi ng			0	
25.00	Total other income (sum of lines 6-24)			24, 709, 006	25.00
26.00	Total (line 5 plus line 25)			6, 258, 831	
27.00	MRO MATCH			1, 364, 330	
27.01	I MPLIED PRICE CONCESSION			682,000	
28.00				2,046,330	
29.00	Net income (or loss) for the period (line 26 minus line 28)			4, 212, 501	29.00