Health Financial Systems COMMUNITY MENTAL HEALTH CENTER In Lieu of Form CMS-2552-10

	s required by law (42 USC 1395g; 42 CFR 413.20(b)).			
payments made	since the beginning of the cost reporting period be	eing deemed overpayments	s (42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATI	ON Provider CCN: 15-401		Worksheet S
AND SETTLEMENT	Γ SUMMARY		From 07/01/2020	
			To 06/30/2021	
				11/22/2021 10:31 am
PART I - COST	REPORT STATUS			
Provi der	<ol> <li>[ X ] Electronically prepared cost report</li> </ol>		Date: 11/22/2	:021 Time: 10:31 am
use only	2. [ ] Manually prepared cost report			
	3. [ 0 ] If this is an amended report enter the number		er resubmitted this o	cost report
	4. [ F ] Medicare Utilization. Enter "F" for full or	"L" for low.		
Contractor	5. [ 1 ]Cost Report Status 6. Date Received:	1	10. NPR Date:	
use only	(1) As Submitted 7. Contractor No.	1	<ol> <li>Contractor's Vende</li> </ol>	or Code: 4
, , , ,	(2) Settled without Audit 8. [ N ] Initial Report	for this Provider CCN1	12.[ 0 ]If line 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9. [ N ] Final Report f	for this Provider CCN	number of tim	mes reopened = 0-9.
	(4) Reopened			•
	(5) Amended			
	(3) America			

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY MENTAL HEALTH CENTER (15-4011) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) ERIC BUSCH
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	0	1	0	33, 690	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	0	1	0	33, 690	200.00

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

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX	COMMUNITY MENTAL IDENTIFICATION DATA				<u>Ir</u> Period: From 07/01/ To 06/30/	′2020 ′2021	Workshe Part I Date/Ti	eet S-2 ime Pre	
	1.00	2. 00		3. 00		4	4. 00			
1. 00	Hospital and Hospital Health Care Co Street: 285 BIELBY ROAD	PO Box:								1.00
2. 00	Ci ty: LAWRENCEBURG	State: IN	Zip Cod			y: DEARBORN				2.00
		Component Name	CCN Number	CBSA Number		Date Certified		nt Syst O, or		
							V	XVIII	XIX	
	Hospital and Hospital-Based Componer	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7.00	8.00	
3.00	Hospi tal	COMMUNITY MENTAL HEALTH	154011	17140	) 4	11/09/1997	N	Р	0	3.00
4. 00	  Subprovi der - IPF	CENTER								4.00
5. 00	Subprovi der - IRF									5.00
6.00	Subprovi der - (Other)									6.00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF									7. 00 8. 00
9. 00	Hospital -Based SNF									9.00
10.00	Hospi tal -Based NF Hospi tal -Based OLTC									10.00
11. 00 12. 00	Hospital -Based HHA									12.00
	Separately Certified ASC									13.00
14. 00 15. 00	Hospi tal -Based Hospi ce Hospi tal -Based Heal th Clinic - RHC									14. 00 15. 00
16. 00	Hospital -Based Health Clinic - FQHC									16.00
17. 00	Hospital-Based (CMHC) I									17. 00
18.00	Renal Dialysis Other									18. 00 19. 00
17.00	other					From:		To	):	17.00
20, 00						1.00		2. (		20.00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					07/01/2	020	06/30	/2021	20.00
	Inpatient PPS Information				1. 00	2. 00		3. (	00	
22. 00	Does this facility qualify and is it	t currently receiving pay	yments fo	r	N	N				22.00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			R						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
22. 01	Did this hospital receive interim ur cost reporting period? Enter in colu				N	N				22. 01
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
22. 02	reporting period occurring on or aft Is this a newly merged hospital that				N	N				22. 02
	payments to be determined at cost re	eport settlement? (see in	nstructio	ns)						
	Enter in column 1, "Y" for yes or "N	N" for no, for the portion	on of the							
	cost reporting period prior to Octob or "N" for no, for the portion of th									
	October 1.	, , ,								
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N	l	22. 03
	adopted by CMS in FY2015? Enter in o									
	for the portion of the cost reporting			er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least	100 but not more than 49	99 beds (	as						
	counted in accordance with 42 CFR 41 yes or "N" for no.	12.105)? Enter in column	3, "Y" f	or						
22. 04	Did this hospital receive a geograph	nic reclassification from	n urban t	0						22. 04
	rural as a result of the revised OME									
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportir									
	in column 2, "Y" for yes or "N" for			·						
	reporting period occurring on or aft									
	Does this hospital contain at least counted in accordance with 42 CFR 41									
	yes or "N" for no.	,								
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date					3 Y				23. 00
	if date of discharge. Is the method	of identifying the days	in this							
	reporting period different from the									
	reporting period? In column 2, ente	er rouges or N For	HO.	I		1	1			I

	Medical d paid days in column 1, the in-state					
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state					
	Medicaid eligible unpaid days in column 4, Medicaid					
	HMO paid and eligible but unpaid days in column 5.					
		Urban/Ru	ıral S	Date of	Geogr	
		1. 00	)	2.	00	
26. 00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1			26.00
27. 00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,		1			27. 00
35. 00	enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Begi nni 1. 00		Endi 2.	ng: 00	
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37. 00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see					37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and					38. 00
	enter subsequent dates.	Y/N		Υ/	′N	
		1.00	)	2.	00	
39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes	N		N	I	39.00
0. 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N	I	40.00
			V 1.00	XVI I I		
	Prospective Payment System (PPS)-Capital		1 00	1 2.00	1 0.00	
5. 00	Does this facility qualify and receive Capital payment for disproportionate share in account with 42 CFR Section §412.320? (see instructions)	cordance	N	N	N	45.00
16. 00	Is this facility eligible for additional payment exception for extraordinary circumstand pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. IPt. III.		N	N	N	46.00
7 00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" fo	or no	N	N	N	47. 00
8. 00			N	N	N	48.00
	Teaching Hospitals		•	•	•	1
56. 00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this howas involved in training residents in approved GME programs in the prior year or penultiyear, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment recenter "Y" for yes; otherwise, enter "N" for no in column 2.	spital mate	- N			56.00
7. 00	If line 56 is yes, is this the first cost reporting period during which residents in app GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If is "Y" did residents start training in the first month of this cost reporting period? If or yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "Y", complete Worksheet E-4.	column 1 Enter "Y"				57.00
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services a defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	as				58. 00
			1	1	1	59.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der Co		Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/22/2021 10	pared:
			NAHE 413. 85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	. 31 alli
			1. 00	2. 00	3. 00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in colu	.85? ( lumn 1. CR) NAH	see If column 1	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2.00	3. 00	4. 00	5. 00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0. 00	0.00	61.00
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
21.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61.10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	
of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61. 20
the direct GME FTE unweighted count.						
ACA Provisions Affecting the Health Resources and Se	rvi ces	Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ne cti ons)	d in this cost	reporting pe			62.00
2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression and the second reaching Hospitals that Claim Residents in Nonprovid	gram. (	<u>see instructio</u>		to your hospital	0.00	62.01
			ost reporting			4

Heal th	n Financial Systems	COMMUNITY	MENTAL HEA	LTH CENTER		In Lie	eu of Form CMS-:	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			Provi der C		Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I	enared.
					Unwei ghted FTEs Nonprovi dei Si te	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	7. 31 aiii
	Section 5504 of the ACA Base Yea	ar ETE Residents in N	lonprovi der	Settings-	1.00 This base ve	2.00	3.00	
64. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to re settings. Enter in column 2 the resident FTEs that trained in year	July 1, 2009 and before yes, or your faciling the state of unweighted no brations occurring in the number of unweighte our hospital. Enter it	ty trained on-primary on all nonproduced non-primary no column 3	2010. residents care ovider ary care the ratio		00 0.00		64.00
	of (column 1 divided by (column	1 + column 2)). (see Program Name		ns) m Code	Unweighted	I Unweighted	Ratio (col.	
		og. a Halle		0000	FTEs Nonprovi dei Si te	FTEs in	3/ (col. 3 + col. 4))	
<b>45.00</b>	Enter in column 1, if line 63	1. 00	2.	00	3.00	4.00	5. 00 0. 000000	15.00
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							00.00
					Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
					Nonprovi dei Si te	r Hospi tal	col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovi	der Setting	1.00 gsEffecti ve	2.00 e for cost repor	3.00 ting periods	
44 00	beginning on or after July 1, 20 Enter in column 1 the number of		ru cara ra	i dont		00 0.00	0.000000	44 00
66.00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospiticolumn 1 divided by (column 1 divide	occurring in all nonp unweighted non-prima tal. Enter in column	provider set ary care res 3 the ratio	tings. sident o of	0.	0.0	J. 0. 00000C	0 88.00
	•	Program Name	Progra	m Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
67 00	Enter in column 1, the program	1. 00	2.	00	3.00	4. 00 00 0. 00	5. 00 0. 000000	67 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							

Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/22/2021 10:31 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν N 0 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 75 00 N subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00  $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 Ν 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems COMMUNITY MENTAL				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO	F	Period: From 07/01/2020 To 06/30/2021	Worksheet S-   Part     Date/Time Pr	
				11/22/2021 1	
			V 1. 00	2. 00	_
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sche	edul e? See 42	N N	2.00	108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2. 00 N	3. 00 N	4. 00 N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1 14	IV IV	IV.	IN .	109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	lf yes,	N	110.00
			1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this converge of the FCHIP demonstration for this converge of the FCHIP demonstration properties and the FCHIP demonstration properties of the FCHIP demonstration properties and the FCHIP demonstration properties of the FCHIP demonstration of the FCHIP	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3. 00	-
112.00 Did this hospital participate in the Pennsylvania Rural Head demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable.	g period? s "Y", enter the	N	2.00	57.00	112.00
Miscellaneous Cost Reporting Information  115.00 s this an all-inclusive rate provider? Enter "Y" for yes or	or "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) '93" percent (includes				
116.00 s this facility classified as a referral center? Enter "Y" "N" for no.	,	N			116.00
117.00 s this facility legally-required to carry malpractice insu	urance? Enter	Y			117. 00
118.00 Is the mal practice insurance a claims-made or occurrence point the policy is claim-made. Enter 2 if the policy is occur		;	2		118.00
		Premi ums	Losses	Insurance	
		1.00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		118, 11	3 0		0118.01
			1.00	2. 00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1, "Y qualifies for t	/" for yes or the Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	N		121. 00
122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.  Transplant Center Information	N		122.00		
125.00 Does this facility operate a transplant center? Enter "Y" f	for yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, each in column 1 and termination date, if applicable, in column		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, er	nter the certif	ication date			127. 00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, er	nter the certif	cation date			128. 00
in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified lung transplant center, ent		cation date in	n		129. 00
column 1 and termination date, if applicable, in column 2.			I		I

Health Financial Systems	COMMUNITY MENTAL	HEALTH CENTER			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC		Period:	//01/2020	Worksheet S-	
					/30/2021	Date/Time Pr	
						11/22/2021 1	0:31 am
					1. 00	2. 00	
130.00 If this is a Medicare certified p			ti fi cati on				130. 00
131.00 If this is a Medicare certified i	ntestinal transplant cente	er, enter the c	erti fi cati on				131. 00
date in column 1 and termination 132.00 If this is a Medicare certified i			ication date				132. 00
in column 1 and termination date,							
133.00 Removed and reserved 134.00 If this is an organ procurement o	rganization (OPO) enter t	the OPO number i	in column 1				133. 00 134. 00
and termination date, if applicab							
All Providers  140.00 Are there any related organizatio	n or home office costs as	defined in CMS	Pub 15-1		N		140. 00
chapter 10? Enter "Y" for yes or	"N" for no in column 1. If	f yes, and home	office costs	5			
are claimed, enter in column 2 th	e home office chain number 2.0		tions)		3. 00		
If this facility is part of a cha	in organization, enter on	lines 141 thro	ugh 143 the	name and		of the home	
office and enter the home office 141.00 Name:	contractor name and contra Contractor's Name:	actor number.	Contracto	or's Mur	mhar:		141. 00
142. 00 Street:	PO Box:		Contracti	31 3 Nui	iibei .		142. 00
143. 00 Ci ty:	State:		Zi p Code:	:			143. 00
						1.00	-
144.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144. 00
					1. 00	2. 00	_
145.00 If costs for renal services are c							145. 00
inpatient services only? Enter "Y no, does the dialysis facility in							
period? Enter "Y" for yes or "N"	for no in column 2.						
146.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i				-	N		146. 00
yes, enter the approval date (mm/		15 Z, Gliapter					
						1. 00	-
147.00 Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			N N	147. 00
148.00 Was there a change in the order o						N	148.00
149.00 Was there a change to the simplif	rea cost finding method? E	Part A	es or "N" for Part B		tle V	N Title XIX	149. 00
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF		N N	N N		N N	N N	156. 00 157. 00
158. OO SUBPROVI DER			14		14		158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N	N		N	N	159.00
161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
						1.00	
Mul ti campus						1. 00	
165.00 Is this hospital part of a Multic	ampus hospital that has or	ne or more camp	uses in diffe	erent CE	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code	CBSA	FTE/Campus	
	0	1.00		3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column						0.0	0 166. 00
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)							
						1. 00	
Health Information Technology (HI	T) incentive in the Americ	can Recovery an	d Reinvestme	nt Act		1.00	
167.00 Is this provider a meaningful use	r under §1886(n)? Enter '	'Y" for yes or '	"N" for no.			N	167. 00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the			e 16/ (s "Y")	, enter	the		168. 00
168.01 If this provider is a CAH and is	not a meaningful user, doe	es this provide			dshi p		168. 01
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful					enter the	0.0	0169.00
transition factor. (see instruction			,	//			

Health Financial Systems	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 15-4011	Peri od:	Worksheet S-2	
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre	
				11/22/2021 10	: 31 am
			Begi nni ng	Endi ng	
	1.00	2.00			
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)			170. 00		
			1.00	2. 00	
171.00 If line 167 is "Y", does this pro-	vider have any days for ind	ividuals enrolled in	N	0	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes, o	enter the number of secti	on		
1876 Medicare days in column 2. (	see instructions)				

HOSPI T	Financial Systems COMMUNITY MENTAL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-4011	Peri od:	eu of Form CMS- Worksheet S-2	
103111	AL AND HOST THE HEALTH CARE RETWOORDSEMENT QUESTIONNALIRE	Trovider	,civ. 13-4011	From 07/01/2020 To 06/30/202	0 Part II	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter I	l for all NO r	esnonses Ent	1.00	2.00	
	mm/dd/yyyy format.		esponses. Em			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in		instructions			
			1. 00	<u>Date</u> 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare	Program? If	N 1.00	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colu	nn 3, "V" for				
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi	na management	l N			3.0
	contracts, with individuals or entities (e.g., chain home	offices, drug				
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prepared by a Cer		Υ	A		4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C"					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	arrabre in				
. 00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit re	conciliation.		V /N	Logal Open	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider i	is N		6.0
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.0
. 00	Were nursing school and/or allied health programs approved		ed during the	N		8.0
00	cost reporting period? If yes, see instructions.			- N		
0. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		car education	n N		9.0
0. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.0
1 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than	l & Din an Λn	provod	N		11.0
1.00	Teaching Program on Worksheet A? If yes, see instructions.	i a k ili ali Ap	proved	IN IN		11.0
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If ye	s, see instruc	tions.		Y	12.0
3. 00	If line 12 is yes, did the provider's bad debt collection	oolicy change	during this d	cost reporting	N	13. 0
4 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym	ants waived? I	fyes see in	netructi one	N	14.0
4.00	Bed Complement	ents warveu: I	1 yes, see 11	istructions.	IV.	14.0
5. 00	Did total beds available change from the prior cost report				N	15.0
		Y/N	rt A Date	Y/N	rt B 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? If either column 1 or 3 is yes, enter the paid-through	Y	08/03/2021	Υ	08/03/2021	16.0
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					1
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17.0
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)	N.I		8.7		10
0.00	l	N		N		18.0
3. 00	lReport data for additional claims that have been billed		1			1
8. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N.		<b>N</b> /		10.0
<ul><li>8. 00</li><li>9. 00</li></ul>	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		19.0

Heal th	Financial Systems COMMUNITY MENTAL	L HEALTH CENTER	₹	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Pre 11/22/2021 10	epared:
		Descr	iption	Y/N	Y/N	
00	16114447		0	1.00	3.00	00.77
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	100-00-00-00-00-00-00-00-00-00-00-00-00-	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	5		N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost r	eporting period?	N	24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost reno	ortina neriod	2 If was see	N	25. 00
23.00	instructions.	, the cost rept	, triig perrou	. 11 yes, see	IN	23.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost report	ing period?	If yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into du	ıring the cos	t reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If ye	s, see	N	30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ye	s, see	N	31.00
	instructions. Purchased Services			·		
32. 00	Have changes or new agreements occurred in patient care se	ervi ces furni sh	ned through c	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to compet	itive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34.00	1	arrangement wit	h provider-b	ased physicians?	N	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		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	prepared by the	home office	? N		37.00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			f N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If ves see	N		40.00
	instructions.	311100:	303, 366	14		10.00
		1.	. 00	2.	00	-
	Cost Report Preparer Contact Information			2.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	LC			42.00
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems COMMUNITY M	IENTAL	HEALTH CENTI	ΕR	In Lieu of Form CMS-2552-10				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	!E	Provi der	CCN: 15-4011	Fro	iod: om 07/01/2020			
					То	06/30/2021	Date/Time Pre 11/22/2021 10		
			;	3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position	n [	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	ĺ						42.00	
	preparer.								
43.00	Enter the telephone number and email address of the co	ost						43.00	
	report preparer in columns 1 and 2, respectively.								

 
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 07/01/2020 | Part I | Date/Time Prepared: | Provider CCN: 15-4011

					Т	o 06/30/2021	Date/Time Pre 11/22/2021 10	
							I/P Days /	01 011
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number		0.00	Available	4.00	F 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00		2. 00	3. 00 5, 840	4.00	5. 00	1, 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		10	3, 640	0.00	U	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			16	5, 840	0.00	0	7. 00
	beds) (see instructions)							
8.00	I NTENSI VE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							10.00 11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)			16	5, 840	0. 00	0	14.00
15. 00	CAH visits			10	0,010	0.00	0	15.00
16. 00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00 24. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	30.00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27.00	Total (sum of lines 14-26)			16				27. 00
28.00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF			_	_			31.00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32. 01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1		1	1 1	ı	

Health Financial Systems COMMUNITY!
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-4011

Peri od: Worksheet S-3 From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared: 11/22/2021 10:31 am

		_				11/22/2021 10	:31 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time Equivalents		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	248	285	2, 293			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	754				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	248	285	2, 293			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	248	285	2, 293	0.00	250.00	14.00
15.00	CAH vi si ts	ol	o	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	0. 00	0.00	ı
	Total (sum of lines 14-26)		Ĭ	· ·	0.00	250.00	l
	Observation Bed Days		0	0		200.00	28.00
29. 00	Ambul ance Trips	0	Ĭ	O			29.00
30.00	Employee discount days (see instruction)			0		•	30.00
31. 00	Employee discount days (see Fristraetron)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room		٩	0			32.00
32.01	outpatient days (see instructions)			0			32.01
33. 00	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	o					33.00
55.51	12.5 5. to hout at days and at sonal ges	١	I		1	ı	1 30.01

 
 Health Financial
 Systems
 COMMUNITY

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA
 | Peri od: | Worksheet S-3 | From 07/01/2020 | Part I | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-4011

				10	06/30/2021	Date/IIme Pre   11/22/2021 10	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
1 00	Tu	11. 00	12. 00	13. 00	14. 00	15. 00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	40	52	504	1. 00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			0	185		2.00
3. 00	HMO IPF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0 00	beds) (see instructions)						0 00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	40	52	504	14.00
15. 00	CAH visits	0.00	O	40	52	304	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						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. 01
33. 00	outpatient days (see instructions)			0			33. 00
	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
33. UI	TETOT SI LE HEULT AT MAYS AND UT SCHALGES			ı V			33.01

Heal th	Financial Systems CO	MMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10			
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CO		eri od:	Worksheet A				
					rom 07/01/2020					
				1	o 06/30/2021	Date/Time Pre 11/22/2021 10				
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cat	Reclassi fi ed	. ST alli			
	cost center bescription	Sararres	Other	+ col . 2)	i ons (See	Trial Balance				
				+ (01. 2)	A-6)	(col. 3 +-				
					h-0)	col . 4)				
		1. 00	2. 00	3. 00	4. 00	5. 00				
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00				
1.00	00100 CAP REL COSTS-BLDG & FLXT		0	0	0	0	1.00			
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00			
3. 00	00300 OTHER CAP REL COSTS		0	0	0	0	3.00			
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00			
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 145, 695	1, 068, 649	3, 214, 344	0	3, 214, 344	5.00			
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0, = 1.1, 0.1	0	0, _ 1, 1, 1	6.00			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	o	0	0	0	0	16.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-							
30.00	03000 ADULTS & PEDIATRICS	1, 928, 453	1, 485, 221	3, 413, 674	-175, 034	3, 238, 640	30.00			
	ANCILLARY SERVICE COST CENTERS									
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	20, 772	20, 772	54.00			
60.00	06000 LABORATORY	O	0	0	56, 377	56, 377	60.00			
66.00	06600 PHYSI CAL THERAPY	0	0	0	536	536	66.00			
69.00	06900 ELECTROCARDI OLOGY	0	0	0	1, 513	1, 513	69.00			
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	95, 836	95, 836	73.00			
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLI NI C	3, 784, 185	1, 992, 742	5, 776, 927	-1, 976, 356	3, 800, 571	90.00			
	SPECIAL PURPOSE COST CENTERS									
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	7, 858, 333	4, 546, 612	12, 404, 945	-1, 976, 356	10, 428, 589	118. 00			
	NONREI MBURSABLE COST CENTERS									
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	2, 642, 929	2, 642, 929				
	19300 NONPALD WORKERS	0	0	0	0		193. 00			
	19301 COMMUNI TY SERVI CE	0	0	0	0		193. 01			
100 00	10202 DECLDENTIAL	1 11/ 001	4 044 777	2 224 750	20/ 225	2 045 422	1100 00			

1, 116, 981 2, 241, 803

2, 185, 944

13, 403, 061

1, 214, 777 1, 302, 215

1, 371, 358

8, 434, 962

2, 331, 758 3, 544, 018

3, 557, 302

21, 838, 023

-286, 335 -314, 701

-65, 537

2, 045, 423 193. 02 3, 229, 317 193. 03 3, 491, 765 193. 04 21, 838, 023 200. 00

193.02 19302 RESI DENTI AL
193.03 19303 COMMUNI TY SUPPORT SERVI CES
193.04 19304 I NTENSI VE YOUTH SERVI CES

TOTAL (SUM OF LINES 118 through 199)

200.00

 
 Health Financial
 Systems
 COMMUNITY MEN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Peri od: Worksheet A From 07/01/2020 Provider CCN: 15-4011

				To 06/30/20	Date/Time Prepared: 11/22/2021 10:31 am
	Cost Center Description	Adjustments	Net Expenses	<u> </u>	
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FLXT	0	0		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	1	1		2. 00
3. 00	00300 OTHER CAP REL COSTS	0	0		3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-189, 379	3, 024, 965		5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	0		6. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-1, 263, 330	1, 975, 310		30.00
E 4 00	ANCILLARY SERVICE COST CENTERS	0	20 770		54.00
	05400 RADI OLOGY-DI AGNOSTI C	0	20, 772		54.00
	06000 LABORATORY	0	56, 377		60.00
	06600 PHYSI CAL THERAPY	0	536		66.00
69.00	06900 ELECTROCARDI OLOGY	0	1, 513		69.00
/3.00	07300 DRUGS CHARGED TO PATIENTS	U	95, 836		73.00
00 00	OUTPATIENT SERVICE COST CENTERS	04/ 414	2.054.157		00.00
90.00	09000 CLINIC SPECIAL PURPOSE COST CENTERS	-846, 414	2, 954, 157		90.00
118.00		-2, 299, 122	0 120 447		118. 00
118.00	NONREIMBURSABLE COST CENTERS	-2, 299, 122	8, 129, 467		118.00
102.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 642, 929		192. 00
	19200 PHTSICIANS PRIVATE OFFICES	0	2, 042, 929		192.00
	19301 COMMUNITY SERVICE	0	0		193.00
	19301 COMMONT I SERVICE	0	2, 045, 423		193.01
	19303 COMMUNITY SUPPORT SERVICES	0	3, 229, 317		193. 02
	19304   NTENSI VE YOUTH SERVI CES	0	3, 491, 765		193. 04
200. 00		-2, 299, 122			200. 00
200.00	TOTAL (SOM OF LINES THE UNIOUGH 199)	-2,277,122	17, 330, 701		1200.00

Heal th Financial Systems COMMUNITY MENTAL HEALTH CENTER In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-4011 Period: From 07/01/2020 To 06/30/2021 Date/Time Prepared:

					То	06/30/2021	Date/Time Pro	epared: 0:31 am
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - ANCILLARY SERVICES							
1.00	RADI OLOGY-DI AGNOSTI C	54.00		20, 772	2			1.00
2.00	LABORATORY	60.00		56, 377	7			2.00
3.00	PHYSI CAL THERAPY	66. 00		536	6			3.00
4.00	ELECTROCARDI OLOGY	69. 00		1, 513	3			4.00
5. 00	DRUGS CHARGED TO PATIENTS	7300		9 <u>5, 8</u> 36	<u>6</u>			5.00
	TOTALS		0	175, 034	1			
	B - NON-HOSPITAL RECLASS							
1. 00	PHYSICIANS' PRIVATE OFFICES	<u> </u>		91 <u>1, 6</u> 74				1.00
	TOTALS		1, 731, 255	911, 674	1			
	C - FACILITY FEE RECLASS							
1. 00	CLINIC	90. 00	376, 502	290, 071	1			1.00
2.00		0. 00	0	0				2. 00
3.00			0	0	<u> </u>			3. 00
	TOTALS		376, 502	290, 071				
500.00	Grand Total: Increases		2, 107, 757	1, 376, 779	9			500.00

Health Financial Systems RECLASSIFICATIONS COMMUNITY MENTAL HEALTH CENTER
Provider CCN: 15-4011 In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/22/2021 10:31 am Decreases

	Deer educes			1		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7.00	8. 00	9. 00	10.00	
	A - ANCILLARY SERVICES					
1.00	ADULTS & PEDIATRICS	30. 00	0	175, 034	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		0	175, 034		
	B - NON-HOSPITAL RECLASS					
1.00	CLI NI C	90.00	1, 731, 255	911, 674	0	1.00
	TOTALS		1, 731, 255	911, 674		
	C - FACILITY FEE RECLASS					
1.00	RESI DENTI AL	193. 02	137, 163	149, 172	0	1.00
2.00	COMMUNITY SUPPORT SERVICES	193. 03	199, 067	115, 634	0	2.00
3.00	INTENSIVE YOUTH SERVICES	193. 04	40, 272	25, 265	0	3.00
	TOTALS		376, 502	290, 071		
500.00	Grand Total: Decreases		2, 107, 757	1, 376, 779		500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-4011 Peri od: Worksheet A-7 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/22/2021 10:31 am Acqui si ti ons Begi nni ng Purchases Total Disposals and Donati on Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 315, 098 1.00 Land 0 0 2.00 Land Improvements 0 2.00 3.00 3.00 Buildings and Fixtures 12, 310, 564 726, 044 726, 044 232, 671 0 4.00 Building Improvements 0 4.00 Fi xed Equi pment 0 5.00 6, 164, 853 267, 357 267, 357 0 5.00 0 6.00 Movable Equipment 6.00 0 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 18, 790, 515 993, 401 0 993, 401 232, 671 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 18, 790, 515 993, 401 232, 671 993, 401 10.00 0 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 315, 098 1.00 2.00 0 2.00 Land Improvements 3.00 Buildings and Fixtures 12, 803, 937 0 3.00 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 6, 432, 210 0 5.00 Movable Equipment 0 6.00 6.00 HIT designated Assets 0 7.00 7.00

19, 551, 245

19, 551, 245

0

0

0

Heal th	Financial Systems CO	DMMUNITY MENTAL HEALTH CENTER			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-4011	Peri od: From 07/01/2020			
					To 06/30/2021	Date/Time Pre 11/22/2021 10		
			Sl	JMMARY OF CAP	I 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, COLUI	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Relat						
			9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	0				3.00	

Heal th	Financial Systems CC	MMUNITY MENTAL	. HEALTH CENTER	!	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	· · · · · · · · ·   F		Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/22/2021 10		
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Louses	(col. 1 -	Thistractrons)		
				col . 2)			
	DART III DECONOLILIATION OF CARLTAL COCTO O	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	12, 803, 937		12, 803, 93	0. 665619	0	1.00
2.00	CAP REL COSTS-BLDG & FIXI	6, 432, 210	l .	6, 432, 210		0	2.00
3.00	Total (sum of lines 1-2)	19, 236, 147		19, 236, 14		-	3.00
3.00	Total (Suil of Titles 1-2)		I∪ TION OF OTHER (			DF CAPITAL	3.00
		ALLUCA	ITON OF OTHER (	DAFITAL	JUNIMAKT C	I CAFITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0	0	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		1	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 1	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DART III DECONCILIATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	

0 0 0

0 0 0

0 0 0

0 0 0

1. 00 2. 00 3. 00

0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

1.00 CAP REL COSTS-BLDG & FIXT
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

	MENTS TO EXPENSES	CO	MMUNITY MENTAL		eriod:	u of Form CMS-2 Worksheet A-8	
				F	rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/22/2021 10	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3.00
	(chapter 2)					_	
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4.00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5.00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	Tel evision and radio service		0		0.00	0	8.00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-1, 566, 026			0	l
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
13. 00	transactions (chapter 10)	-	0		0. 00	0	
14. 00	Cafeteria-employees and guests		0		0.00	0	l .
15. 00	Rental of quarters to employee and others		0		0. 00	0	15.00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	1.	В	-2, 449	ADMINISTRATIVE & GENERAL	5. 00	0	18.00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.)				0.00	0	20.00
21. 00			0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	О	*** Cost Center Deleted ***	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
25 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		O	cost center bereted	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26.00
27. 00	COSTS-BLDG & FLXT	А		CAP REL COSTS-MVBLE EQUIP	2. 00	9	
	COSTS-MVBLE EQUIP	А				9	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0 0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67. 00	_	30.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		l				l

	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31.00	1 2	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00			0		0. 00	0	32.00
	Depreciation and Interest	_					
	FCC FUNDS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02		В	-6, 375	CLINIC	90.00	0	33. 02
33. 03	-	В	0		0. 00	0	33. 03
33. 04		В	-1, 447	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05		В	0		0. 00	0	33. 05
33. 06	APN OFFSET	Α	0		0. 00	0	33. 06
33. 07	APN OFFSET	Α	0		0. 00	0	33. 07
33. 08		Α		ADULTS & PEDIATRICS	30. 00	0	33. 08
33. 09	DONATION REVENUE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	FCC FUNDS	В	-15, 356		90. 00	0	33. 10
33. 11	FCC FUNDS	В	-2, 642	ADULTS & PEDIATRICS	30. 00	0	33. 11
33. 12		В	0		0. 00	0	33. 12
33. 14	DEARBORN COMMUNITY FOUNDATION	В	0		0.00	0	33. 14
33. 15	ADVERTI SI NG/PROMOTI ON	Α	-8, 341	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	ADVERTI SI NG/PROMOTI ON	Α	-737	ADULTS & PEDIATRICS	30.00	0	33. 16
33. 17	ADVERTI SI NG/PROMOTI ON	Α	-1, 650	CLINIC	90. 00	0	33. 17
50.00	TOTAL (sum of lines 1 thru 49)		-2, 299, 122				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	escription - all chapter referen	ces in this co	lumn nertain t	o CMS Pub 15-1			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-4011

					-	To 06/30/2021	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				· ·			Hours	
	1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	1, 075, 347	379, 922	695, 425	181, 300	3, 813	1.00
2.00	90. 00	CLINIC	1, 286, 917	611, 431	675, 486	181, 300	5, 322	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			2, 362, 264		1, 370, 911			200.00
	Wkst. A Line #	<b>3</b>	Unadjusted RCE		Cost of		Physician Cost	
		ldenti 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	332, 354			1		1.00
2.00		CLINIC	463, 884			0	0	2.00
3.00	0.00		0	1	_	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	
6.00	0.00		0	0	0	0	0	6.00
7.00	0. 00 0. 00		0	0	0	0	0	7.00
8.00			0	0	0	0	0	8.00
9. 00 10. 00	0. 00 0. 00		0	0	0	0	0	9. 00 10. 00
200.00	0.00		796, 238	39, 812	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSL. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		racittirei	Share of col.	Li iiii t	Di Sai i Owanec			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	30. 00	ADULTS & PEDIATRICS	0			742, 993		1.00
2.00	90.00	CLINIC	0	463, 884	211, 602	823, 033		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	796, 238	574, 673	1, 566, 026		200.00

	MMUNITY MENTAL				u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/22/2021 10	pared:
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2, 00	4, 00	4A	
GENERAL SERVICE COST CENTERS						
1. 00	0	0		1		1.00 2.00 4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS	3, 024, 965	0		0 0	3, 024, 965 0	
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0			0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			0  0		10.00
30. 00 03000 ADULTS & PEDIATRICS	1, 975, 310	0		1 0	1, 975, 311	30.00
ANCILLARY SERVICE COST CENTERS	, , , , , , ,					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 772	0		0 0	20, 772	54.00
60. 00   06000   LABORATORY	56, 377	0		0	56, 377	60.00
66. 00 06600 PHYSI CAL THERAPY	536	0		0	536	66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 513	0		0	1, 513	69. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	95, 836	0		0 0	95, 836	73. 00
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLINIC	2, 954, 157	0		0 0	2, 954, 157	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 129, 467	0		1 0	8, 129, 467	J118. 00
NONREI MBURSABLE COST CENTERS	0 (40 000		1		0 (10 000	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 642, 929	0		0	2, 642, 929	192.00

2, 045, 423

3, 229, 317

3, 491, 765

19, 538, 901

0

0

2, 045, 423 193. 02

3, 229, 317 193. 03

3, 491, 765 193. 04 0 200. 00 0 201. 00 19, 538, 901 202. 00

0 193.00

0 193. 01

0 0 0

193. 00 19300 NONPALD WORKERS 193. 01 19301 COMMUNITY SERVICE

193. 03 19303 COMMUNITY SUPPORT SERVICES
193. 04 19304 INTENSIVE YOUTH SERVICES

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

193. 02 19302 RESI DENTI AL

200.00

201.00

202.00

Health Financial Systems C	OMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/22/2021 10	pared: 0:31 am
Cost Center Description	E & GENERAL	MAI NTENANCE & REPAI RS	RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	5. 00	6. 00	16. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FIXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	3, 024, 965					5.00
6. 00 00600 MAINTENANCE & REPAIRS	0	0				6.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0		0		16.00
I NPATIENT ROUTINE SERVICE COST CENTERS				0		1 .0.00
30. 00 03000 ADULTS & PEDIATRICS	361, 832	0		0 2, 337, 143	0	30.00
ANCILLARY SERVICE COST CENTERS	00.7002			2/00//110		1 00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 805	0		0 24, 577	0	54.00
60. 00   06000   LABORATORY	10, 327			0 66, 704		60.00
66. 00 06600 PHYSI CAL THERAPY	98			0 634		66.00
69. 00 06900 ELECTROCARDI OLOGY	277			0 1, 790		69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 555	0		0 113, 391	0	73.00
OUTPATIENT SERVICE COST CENTERS	,			,		1
90. 00 09000 CLINIC	541, 134	0		0 3, 495, 291	0	90.00
SPECIAL PURPOSE COST CENTERS		_		2727 =		1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	935, 028	0		0 6, 039, 530	0	118.00
NONREI MBURSABLE COST CENTERS				.,,		1
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	484, 124	0		0 3, 127, 053	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
103 01 10301 COMMINITY SERVICE		1	l			102 01

374, 674 591, 537

639, 602

3, 024, 965

0 0 0

0 0 0

0

2, 420, 097

3, 820, 854

4, 131, 367

19, 538, 901

0 193. 01

0 193. 02 0 193. 03 0 193. 04

0 200.00 0 201.00 0 202.00

193. 01 19301 COMMUNITY SERVICE

200.00

201. 00 202. 00

193. 02 19302 RESI DENTI AL
193. 03 19303 COMMUNI TY SUPPORT SERVI CES
193. 04 19304 I NTENSI VE YOUTH SERVI CES

Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-4011	Peri od: Worksheet B

CUST	LLUCATION - GENERAL SERVICE COSTS		Provider Con: 15-4011	From 07/01/2020 To 06/30/2021	
	Cost Center Description	Total			
		26. 00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
6.00	00600 MAINTENANCE & REPAIRS				6. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	2, 337, 143			30.00
	ANCILLARY SERVICE COST CENTERS				
	05400   RADI OLOGY-DI AGNOSTI C	24, 577			54.00
60.00	06000 LABORATORY	66, 704			60.00
66.00	06600 PHYSI CAL THERAPY	634			66.00
69. 00	06900 ELECTROCARDI OLOGY	1, 790			69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	113, 391			73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	3, 495, 291			90.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 039, 530			118. 00
	NONREI MBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 127, 053			192. 00
193.00	19300 NONPALD WORKERS	0			193. 00
193. 01	19301 COMMUNITY SERVICE	O			193. 01
193. 02	19302 RESI DENTI AL	2, 420, 097			193. 02
193. 03	19303 COMMUNITY SUPPORT SERVICES	3, 820, 854			193. 03
193. 04	19304 I NTENSI VE YOUTH SERVI CES	4, 131, 367			193. 04
200.00		0			200.00
201.00	J	ol			201. 00
202.00	1 1 3	19, 538, 901			202.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	,			

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021		pared:
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	,					
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	
5.00	00500 ADMINISTRATIVE & GENERAL	0	0		0	0	
6.00	00600 MAINTENANCE & REPAIRS	0	0		0	0	0.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	0	0		1 1	0	30.00
	ANCILLARY SERVICE COST CENTERS			1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
60.00	06000 LABORATORY	0	0		0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			ı		_	
90.00	09000 CLINIC	0	0		0 0	0	90.00
440.00	SPECIAL PURPOSE COST CENTERS	1		ı	-1	_	
118.00		0	0		1 1	0	118.00
100.00	NONREI MBURSABLE COST CENTERS			I			100 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19300 NONPALD WORKERS	0	0		0		193. 00 193. 01
	19301 COMMUNITY SERVICE  19302 RESIDENTIAL	0	0		0		193.01
	19302 RESIDENTIAL 19303 COMMUNITY SUPPORT SERVICES	0	0		0		193. 02
	19304 INTENSIVE YOUTH SERVICES	0	0		0		193. 03
200.00		١	U			U	200.00
200.00	1 1		0			_	200.00
201.00	1 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		0		1 1		201.00
202.00	TOTAL (Suill TITIES TTO LITTOUGH 201)	ı Y	U	I	il i	ı	1202.00

Health Financial Systems C ALLOCATION OF CAPITAL RELATED COSTS	OMMUNITY MENTAL	Provi der Co		Peri od: From 07/01/2020 To 06/30/2021		epared:
Cost Center Description	ADMI NI STRATI V E & GENERAL	MAINTENANCE & REPAIRS	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	5. 00	6. 00	16.00	24. 00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	_					4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0					5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	•	0		6.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		0		16. 00
30. 00 03000 ADULTS & PEDIATRICS	O	0		0 1	0	30.00
ANCI LLARY SERVI CE COST CENTERS	J O			U I	0	30.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	
66. 00 06600 PHYSI CAL THERAPY	o o	0		0 0	0	
69. 00   06900   ELECTROCARDI OLOGY	0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		•			
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 1	0	118. 00
NONREI MBURSABLE COST CENTERS						1
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	•	0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
193. 01 19301 COMMUNI TY SERVI CE	0	0		0		193. 01
193. 02 19302 RESI DENTI AL	0	0		0		193. 02
193. 03 19303  COMMUNI TY SUPPORT SERVI CES 193. 04 19304  I NTENSI VE YOUTH SERVI CES	0	0		0		193. 03 193. 04
	١	0				200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		^				200.00
202.00 TOTAL (sum lines 118 through 201)	0	0	•	0 0		201.00
202.00   TOTAL (Suil FITIES FTO ETH OUGH 201)	١	0	I	١١	0	1202.00

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-4011	Peri od: Worksheet B

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-4011	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepared: 11/22/2021 10:31 am
	Cost Center Description	Total			
	[	26. 00			
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FLXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5. 00
6.00	00600 MAINTENANCE & REPAIRS				6. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	1			30.00
	ANCILLARY SERVICE COST CENTERS				
	05400 RADI OLOGY-DI AGNOSTI C	0			54.00
	06000 LABORATORY	0			60.00
	06600 PHYSI CAL THERAPY	0			66.00
	06900 ELECTROCARDI OLOGY	0			69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0			90.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1			118. 00
	NONREI MBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
193.00	19300 NONPALD WORKERS	0			193. 00
193. 01	19301 COMMUNITY SERVICE	0			193. 01
193. 02	19302 RESI DENTI AL	0			193. 02
193. 03	19303 COMMUNITY SUPPORT SERVICES	O			193. 03
193. 04	19304 I NTENSI VE YOUTH SERVI CES	o			193. 04
200.00	Cross Foot Adjustments	o			200. 00
201.00		l			201.00
202.00	1 1 3	1			202. 00
		'			,

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-4011	Peri od: Worksheet B-1 From 07/01/2020

COST ALLOCATION - STATISTICAL BASIS			Provi der C		eri od:	Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre	nared:
				'	0 00/30/2021	11/22/2021 10	
		CAPI TAL REL	ATED COSTS			117 227 2021 10	
Cost Center Description		BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
,		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
		,	,	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(	
				SALARI ES)			
		1. 00	2.00	4.00	5A	5. 00	
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FLXT		15, 920					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	·	·	15, 920				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTM	ENT	424	424	13, 403, 061			4.00
5.00 00500 ADMINISTRATIVE & GENERAL		3, 764	3, 764	2, 145, 695	-3, 024, 965	16, 513, 936	5.00
6.00 00600 MAINTENANCE & REPAIRS		891	891	O	0	0	6.00
16.00 01600 MEDICAL RECORDS & LIBRARY	'	1, 149	1, 149	O	0	0	16.00
INPATIENT ROUTINE SERVICE COST		·	·		•		1
30. 00 03000 ADULTS & PEDIATRICS		8, 741	8, 741	1, 928, 453	0	1, 975, 311	30.00
ANCILLARY SERVICE COST CENTERS							1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0	C	0	20, 772	54.00
60. 00 06000 LABORATORY		0	0	O	0	56, 377	60.00
66. 00 06600 PHYSI CAL THERAPY		0	0	O	0	536	66.00
69. 00 06900 ELECTROCARDI OLOGY		0	0	O	0	1, 513	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0	0	O	0	95, 836	73.00
OUTPATIENT SERVICE COST CENTERS	5						1
90. 00 09000 CLINIC		736	736	2, 429, 432	. 0	2, 954, 157	90.00
SPECIAL PURPOSE COST CENTERS							1
118.00 SUBTOTALS (SUM OF LINES 1	through 117)	15, 705	15, 705	6, 503, 580	-3, 024, 965	5, 104, 502	118. 00
NONREI MBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFIC	ES	0	0	1, 731, 255	0	2, 642, 929	192.00
193.00 19300 NONPALD WORKERS		0	0	0		0	193.00
193. 01 19301 COMMUNITY SERVICE		0	0	0	0	0	193. 01
193. 02 19302 RESI DENTI AL		0	0	979, 818	0	2, 045, 423	193. 02
193. 03 19303 COMMUNITY SUPPORT SERVICE	S	215	215	2, 042, 736	0	3, 229, 317	193. 03
193. 04 19304 I NTENSI VE YOUTH SERVI CES		0	0	2, 145, 672	0	3, 491, 765	193. 04
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00   Cost to be allocated (per	Wkst. B,	0	1	О		3, 024, 965	202. 00
Part I) 203.00 Unit cost multiplier (Wks	+ D Dort I	0. 000000	0. 000063	0. 000000		0. 183177	202 00
, ,		0. 000000	0.000063	0.00000		<b>l</b>	1
204.00   Cost to be allocated (per Part II)	WKSL B,					"	204. 00
205.00 Unit cost multiplier (Wks	t. B. Part			0. 000000	ı	0. 000000	205.00
11)	,						
206.00 NAHE adjustment amount to	be allocated						206.00
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier	(Wkst. D,						207.00
Parts III and IV)							

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY MENTAL HEALTH CENTER COST ALLOCATION - STATISTICAL BASIS Peri od: Provider CCN: 15-4011 Worksheet B-1 From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/22/2021 10:31 am Cost Center Description MAINTENANCE & MEDI CAL REPAI RS RECORDS & (SQUARE FEET) LI BRARY (TIME SPENT) 16. 00 6. 00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 2.00 2.00 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 10, 841 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 149 16.00

10	. 00  01000	INICOLOGICAL RECORDS & ELDRARI	1, 147	O)	10	. 00
	I NPAT	TIENT ROUTINE SERVICE COST CENTERS				
30	. 00 03000	ADULTS & PEDIATRICS	8, 741	0	30	. 00
	ANCI L	LARY SERVICE COST CENTERS				
54	. 00 05400	RADI OLOGY-DI AGNOSTI C	0	0	54	. 00
60	. 00 06000	LABORATORY	0	0	60	. 00
66	. 00 06600	PHYSI CAL THERAPY	0	0	66	. 00
69	. 00 06900	ELECTROCARDI OLOGY	0	0	69	. 00
73	. 00 07300	DRUGS CHARGED TO PATIENTS	0	0	73	. 00
	OUTPA	TIENT SERVICE COST CENTERS				
90	. 00 09000	CLINIC	736	0	90	. 00
	SPECI	AL PURPOSE COST CENTERS				
11	8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 626	0	118	. 00
	NONRE	IMBURSABLE COST CENTERS				
19	2.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192	. 00
19	3.00 19300	NONPALD WORKERS	0	0	193	. 00
19	3. 01 19301	COMMUNITY SERVICE	0	0	193	. 01
19	3. 02 19302	RESI DENTI AL	0	0	193	. 02
19	3. 03 19303	COMMUNITY SUPPORT SERVICES	215	0	193	. 03
19	3. 04 19304	INTENSIVE YOUTH SERVICES	0	0	193	. 04
20	0. 00	Cross Foot Adjustments			200	. 00
20	1. 00	Negative Cost Centers			201	. 00
20	2. 00	Cost to be allocated (per Wkst. B,	0	0	202	. 00
		Part I)				
20	3. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	203	. 00
20	4. 00	Cost to be allocated (per Wkst. B,	0	0	204	. 00
		Part II)				
20	5. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	205	. 00
		[11]				
20	6. 00	NAHE adjustment amount to be allocated			206	. 00
		(per Wkst. B-2)				
20	7. 00	NAHE unit cost multiplier (Wkst. D,			207	. 00
	[	Parts III and IV)				

Health Financial Systems	COMMUNITY MENTAL	MMUNITY MENTAL HEALTH CENTER			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 07/01/2020	Worksheet C Part I			
				To 06/30/2021		pared:		
		Title	XVIII	Hospi tal	PPS			
				Costs				
Cost Center Description	(from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs			
	B, Part I, col. 26)							
	1. 00	2.00	3.00	4. 00	5. 00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDIATRICS	2, 337, 143		2, 337, 14	363, 071	2, 700, 214	30.00		
ANCILLARY SERVICE COST CENTERS								
54. 00   05400   RADI OLOGY-DI AGNOSTI C	24, 577		24, 57	7 0	24, 577	54.00		
60. 00   06000   LABORATORY	66, 704		66, 70	4 0	66, 704	60.00		
66. 00   06600 PHYSI CAL THERAPY	634	0	63	4 0	634	66.00		
69. 00  06900   ELECTROCARDI OLOGY	1, 790		1, 79		1, 790			
73. 00 O7300 DRUGS CHARGED TO PATIENTS	113, 391		113, 39	1 0	113, 391	73.00		
OUTPATIENT SERVICE COST CENTERS								
90. 00  09000  CLI NI C	3, 495, 291		3, 495, 29	1 211, 602	3, 706, 893	90.00		
200.00 Subtotal (see instructions)	6, 039, 530	0	6, 039, 53	0 574, 673				
201.00 Less Observation Beds	0			0	l .	201. 00		
202.00   Total (see instructions)	6, 039, 530	0	6, 039, 53	0 574, 673	6, 614, 203	202.00		

Health Financial Systems		COMMUNITY MENTAL	COMMUNITY MENTAL HEALTH CENTER			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der Co		Peri od:	Worksheet C			
					From 07/01/2020	Part I			
				1	To 06/30/2021	Date/Time Pre	pared:		
			T1 . 1	20111		11/22/2021 10	:31 am		
			Title XVIII		Hospi tal	PPS			
			Charges						
	Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA			
				+ col. 7)	Ratio	I npati ent			
						Ratio			
		6. 00	7.00	8. 00	9. 00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000 ADULTS & PEDIATRICS	2, 737, 645		2, 737, 64	5		30.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 286	0	16, 28	1. 509088	0.000000	54.00		
60.00	06000 LABORATORY	38, 870	450	39, 32	1. 696439	0.000000	60.00		
66.00	06600 PHYSI CAL THERAPY	0	0	(	0.000000	0.000000	66.00		
69.00	06900 ELECTROCARDI OLOGY	552	0	55	2 3. 242754	0.000000	69. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	125, 231	0	125, 23	0. 905455	0.000000	73.00		
OUTPATIENT SERVICE COST CENTERS							ĺ		
90.00	09000 CLI NI C	0	5, 098, 910	5, 098, 91	0. 685498	0.000000	90.00		
200. 00	Subtotal (see instructions)	2, 918, 584	5, 099, 360	8, 017, 94	4		200.00		
201.00 Less Observation Beds			,				201.00		
202.00	Total (see instructions)	2, 918, 584	5, 099, 360	8, 017, 94	4		202.00		
	,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	., ,	-,,	1	ı			

Health Financial Systems		COMMUNITY MENTAL H	HEALTH CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/22/2021 10:31 an	:  :
			Title XVIII	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient Ratio 11.00				
I NPAT	TIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS				30.0	)()
ANCI L	LARY SERVICE COST CENTERS					
54.00 05400	RADI OLOGY-DI AGNOSTI C	1. 509088			54.0	)()
60.00 06000	LABORATORY	1. 696439			60.0	)()
66.00 06600	PHYSI CAL THERAPY	0. 000000			66.0	)()
69.00 06900	ELECTROCARDI OLOGY	3. 242754			69.0	)()
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 905455			73.0	)()
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0. 726997			90.0	)()
200.00 Subtotal (see instructions)					200. 0	)()
201.00	Less Observation Beds				201. 0	)()
202. 00	Total (see instructions)				202. 0	)()

Health Financial Systems	COMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/22/2021 10	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 337, 143		2, 337, 14	363, 071	2, 700, 214	30.00
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	24, 577		24, 57	7 0	24, 577	54.00
60. 00  06000 LABORATORY	66, 704		66, 70	4 0	66, 704	60.00
66. 00  06600 PHYSI CAL THERAPY	634	0	63	4 0	634	66.00
69. 00  06900  ELECTROCARDI OLOGY	1, 790		1, 79	0	1, 790	69.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	113, 391		113, 39	1 0	113, 391	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	3, 495, 291		3, 495, 29	1 211, 602	3, 706, 893	90.00
200.00 Subtotal (see instructions)	6, 039, 530	0	6, 039, 53	0 574, 673	6, 614, 203	200. 00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	6, 039, 530	0	6, 039, 53	0 574, 673	6, 614, 203	202. 00

Heal th Fi	nancial Systems	COMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre	pared:
			<b></b>	V/1.V/		11/22/2021 10	:31 am
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
INF	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	000 ADULTS & PEDIATRICS	2, 737, 645		2, 737, 64	5		30.00
ANG	CILLARY SERVICE COST CENTERS						
54.00 054	400 RADI OLOGY-DI AGNOSTI C	16, 286	0	16, 28	6 1. 509088	0.000000	54.00
60.00 060	000 LABORATORY	38, 870	450	39, 32	1. 696439	0.000000	60.00
66. 00 066	600 PHYSI CAL THERAPY	o	0		0. 000000	0.000000	66.00
69. 00 069	900 ELECTROCARDI OLOGY	552	0	55	2 3. 242754	0.000000	69.00
73. 00 07:	300 DRUGS CHARGED TO PATIENTS	125, 231	0	125, 23	0. 905455	0. 000000	73.00
OU	TPATIENT SERVICE COST CENTERS						
90.00 090	DOO CLINIC	0	5, 098, 910	5, 098, 91	0. 685498	0.000000	90.00
200.00	Subtotal (see instructions)	2, 918, 584	5, 099, 360	8, 017, 94	4		200.00
201.00	Less Observation Beds	, , , , , , ,	., ,				201.00
202.00	Total (see instructions)	2, 918, 584	5, 099, 360	8, 017, 94	4		202.00
202.00	Total (See Thisti detroils)	2, 710, 304	3, 377, 300	0,017,74	7	l	1202.00

Health Financial Systems	COMMUNITY MENTAL H	EALTH CENTER	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepar 11/22/2021 10:3	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				3	30. 00
ANCILLARY SERVICE COST CENTERS					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			5	4.00
60. 00   06000   LABORATORY	0. 000000			6	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			6	6.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			6	9.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00  09000   CLI NI C	0. 000000			9	90.00
200.00 Subtotal (see instructions)				20	00.00
201.00 Less Observation Beds				20	01.00
202.00 Total (see instructions)				20	02.00

Health Financial Systems CO	OMMUNITY MENTAL	HEALTH CENTER	2	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2020 Fo 06/30/2021		pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col. 1 - col. 2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1	0		1 2, 293	0. 00	30.00
200.00 Total (lines 30 through 199)	1			1 2, 293		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
LANDATI ENT. DOUTLANE, OFFICE OF COOT, OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.40					00.00
30. 00 ADULTS & PEDIATRICS	248	l .				30.00
200.00 Total (lines 30 through 199)	248	0	1			200.00

Health Financial Systems CC	MMUNITY MENTAL	HEALTH CENTER	!	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co	CN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/22/2021 10	
			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						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	16, 286	0. 00000	2, 820	0	54.00
60. 00   06000   LABORATORY	0	39, 320	0.00000	00 4, 289	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0.00000	00	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	552	0. 00000	00	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	125, 231	0. 00000	00 13, 436	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	5, 098, 910	0. 00000	00	0	90.00
200.00 Total (lines 50 through 199)	0	5, 280, 299		20, 545	0	200. 00

	OMMUNITY MENTAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co	F	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pro 11/22/2021 10	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education	
	Adj ustments	1.00		0.00	Cost	
INDATIONE DOUTING CERVICE COCT CENTERS	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0			0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	•		
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	2, 293 2, 293		248 248	30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems CC	DMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS	RVICE OTHER PAS	S Provider CO	CN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/22/2021 10	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00   06000   LABORATORY	0	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
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	o		0 0	0	200. 00

Health Financial Systems CC	DMMUNITY MENTAL	HEALTH CENTER	!	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV   Date/Time Pre	pared:
					11/22/2021 10	:31 am
Title XVIII Hospital PPS						
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 286	0.000000	54.00
60. 00   06000   LABORATORY	o	0		0 39, 320	0.000000	60.00
66. 00   06600 PHYSI CAL THERAPY	o	0		0 0	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	o	0		0 552	0.000000	69. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0		0 125, 231	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 5, 098, 910	0.000000	90.00
200.00 Total (lines 50 through 199)	o	0		0 5, 280, 299		200. 00

Health Financial Systems CC	OMMUNITY MENTAL H	EALTH CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-4011	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	narod:
				10 00/30/2021	11/22/2021 10	:31 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	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						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	2, 820		0 0	0	54.00
60. 00   06000   LABORATORY	0. 000000	4, 289		0 450	0	60.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	13, 436		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 590, 888	0	90.00
200.00 Total (lines 50 through 199)		20, 545		0 591, 338	0	200.00
			•	,		•

Health Finar	ncial Systems CO	OMMUNITY MENTAL	. HEALTH CENTE	R	In Lie	u of Form CMS-:	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provi der (	CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021		pared: :31 am
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To			
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	RADI OLOGY-DI AGNOSTI C	1. 509088		0	0 0	0	54.00
60.00 06000	LABORATORY	1. 696439	45	0	0	763	60.00
	PHYSI CAL THERAPY	0. 000000		0	0	0	66. 00
69.00 06900	ELECTROCARDI OLOGY	3. 242754		0	0	0	69. 00
	DRUGS CHARGED TO PATIENTS	0. 905455		0	0 0	0	73.00
	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0. 685498			0	405, 053	90.00
200. 00	Subtotal (see instructions)		591, 33	3	0	405, 816	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		591, 33	3	0 0	405, 816	202. 00

Health Financial Systems	COMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der Co	CN: 15-4011	Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part V   Date/Time Pre	enared:
				10 00/ 30/ 2021	11/22/2021 10	
			XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subj ect To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00   06000   LABORATORY	0	0				60.00
66. 00   06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	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

		ENTAL HEALTH CENTER		u of Form CMS-2			
COMPUT	TION OF INPATIENT OPERATING COST	Provider CCN: 15-4011	Peri od: From 07/01/2020	Worksheet D-1			
			To 06/30/2021				
		Title XVIII	Hospi tal	11/22/2021 10 PPS	:31 am		
	Cost Center Description		110061 101				
	DART I ALL PROVIDED COMPONENTS			1. 00			
	PART I - ALL PROVIDER COMPONENTS  NPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-	-bed days, excluding newborn)		2, 293	1.00		
2.00	Inpatient days (including private room days, excluding			2, 293	2.00		
3. 00	Private room days (excluding swing-bed and observation	n bed days). If you have only p	orivate room days,	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observ		2, 293	4.00			
5. 00	Total swing-bed SNF type inpatient days (including pri		er 31 of the cost	0	5.00		
	reporting period	3 /					
6. 00	Total swing-bed SNF type inpatient days (including pri		31 of the cost	0	6. 00		
7. 00	reporting period (if calendar year, enter 0 on this li Total swing-bed NF type inpatient days (including priv		or 31 of the cost	0	7.00		
7.00	reporting period	rate room days) through becember	si Si di the cost	O	7.00		
8.00	Total swing-bed NF type inpatient days (including priv		31 of the cost	0	8. 00		
0.00	reporting period (if calendar year, enter 0 on this li Total inpatient days including private room days appli	240	0.00				
9. 00	newborn days) (see instructions)	248	9. 00				
10.00							
	through December 31 of the cost reporting period (see instructions)						
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after  December 31 of the cost reporting period (if calendar year, enter 0 on this line)						
12. 00	Swing-bed NF type inpatient days applicable to titles	ite room days)	0	12.00			
.2.00	through December 31 of the cost reporting period	· ·	12.00				
13.00	Swing-bed NF type inpatient days applicable to titles			0	13.00		
14. 00	after December 31 of the cost reporting period (if cal Medically necessary private room days applicable to th			0	14.00		
15. 00	Total nursery days (title V or XIX only)	le Program (excruding swrng-bed	i uays)	0	15.00		
16. 00	Nursery days (title V or XIX only)			0	16.00		
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to reporting period	services through December 31	of the cost	0. 00	17. 00		
18. 00	reporting perrod Medicare rate for swing-bed SNF services applicable to	services after December 31 of	the cost	0.00	18. 00		
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to	services through December 31 c	of the cost	0. 00	19.00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to	sorvices after December 21 of	the cost	0. 00	20.00		
20.00	reporting period	services arter beceinder 31 or	the cost	0.00	20.00		
21.00	Total general inpatient routine service cost (see inst	tructions)		2, 700, 214	21.00		
22. 00	Swing-bed cost applicable to SNF type services through	n December 31 of the cost repor	ting period (line	. 0	22. 00		
22.00	5 x line 17)	December 21 of the cost reporti	ng ported (line (	0	22.00		
23. 00	Swing-bed cost applicable to SNF type services after [ x line 18)	becember 31 of the cost reporti	ng period (Tine o	0	23. 00		
24.00	Swing-bed cost applicable to NF type services through	December 31 of the cost report	ing period (line	0	24.00		
05.00	7 x line 19)				05.00		
25. 00	Swing-bed cost applicable to NF type services after De x line 20)	ecember 31 of the cost reportir	ng period (line 8	0	25. 00		
26. 00	· · · · · · · · · · · · · · · · · · ·						
27. 00	General inpatient routine service cost net of swing-be	ed cost (line 21 minus line 26)		2, 700, 214	27. 00		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
28. 00	General inpatient routine service charges (excluding s	swing-bed and observation bed o	charges)	0	28.00		
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges	5)		0	29. 00 30. 00		

	I NPATI ENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 293	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 293	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 293	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cos∜	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	248	9. 00
40.00	newborn days) (see instructions)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15. 00
	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT	-	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
04 00	reporting period	0 700 014	04 00
	Total general inpatient routine service cost (see instructions)	2, 700, 214	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	while 18)	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	J	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 700, 214	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 700, 214	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routing continue cost per diem (cost instructions)	1 177 50	20 00
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 177. 59 292, 042	
	Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	292, 042	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	292, 042	
71.00	Total Trogram general Tipatront Toutine Service Cost (Time 37 + Time 40)	272, 042	+1.00

Health Financial Syst		OMMUNITY MENTAL	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Title	: XVIII	Hospi tal	11/22/2021 10 PPS	1:31 ar
Cost Cen	ter Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00 NUDCEDY (11.11.	W O WIW and D	1. 00	2. 00	3. 00	4. 00	5. 00	40.0
42.00 NURSERY (title	Type Inpatient Hospital Units						42.0
43.00 INTENSIVE CARE	UNIT						43.0
44.00 CORONARY CARE 45.00 BURN INTENSIVE							44. 0 45. 0
45.00 BURN INTENSIVE 46.00 SURGICAL INTEN							46.0
47.00 OTHER SPECIAL	CARE (SPECIFY)						47.0
Cost Cen	ter Description					1. 00	
48.00 Program inpati	ent ancillary service cost (Wk	st. D-3, col.	3, line 200)			23, 698	48. 0
	inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		315, 740	49.0
	OST ADJUSTMENTS osts applicable to Program inp	atient routine	services (fro	m Wkst D si	m of Parts I and	0	]   50. 0
III)	osts approadre to rrogram rnp	atront routino	301 11 003 (11 0	WKS C. D, 30	iii or rares r and	Ü	00.0
	osts applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.0
and IV) 52.00 Total Program	excludable cost (sum of lines	50 and 51)				0	52.0
53.00 Total Program	inpatient operating cost exclu	ding capital r	elated, non-ph	ysician anest	hetist, and	315, 740	53.0
	ion costs (line 49 minus line AND LIMIT COMPUTATION	52)					-
54. 00 Program di scha						0	54.0
55.00 Target amount							55.0
	(line 54 x line 55) ween adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	1
58.00 Bonus payment	(see instructions)	· ·			ŕ	0	58.0
59.00 Lesser of line market basket	s 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.0
	s 53/54 or 55 from prior year	cost report, u	pdated by the	market basket		0. 00	60.0
	is less than the lower of line				,	0	61.0
	g costs (line 53) are less tha 6), otherwise enter zero (see		ts (lines 54 x	60), or 1% c	f the target		
62.00 Relief payment	•					0	62.0
	tient cost plus incentive paym ENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63.0
	-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64.0
	title XVIII only)						/
	<pre>-bed SNF inpatient routine cos title XVIII only)</pre>	its after Decemb	ber 31 of the	cost reportin	g period (See	0	65.0
66.00 Total Medicare	swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.0
67.00 Title V or XIX	uctions) Sawing-bed NF inpatient routin	o costs through	h Docombor 21	of the cost r	concerting ported	0	67.0
(line 12 x lin		le costs tillough	ii becember 31	or the cost r	epor tring perrou	0	07.0
	swing-bed NF inpatient routin	e costs after l	December 31 of	the cost rep	orting period	0	68.0
(line 13 x lin	e 20) or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	e 68)		0	69.0
PART III - SKI	LLED NURSING FACILITY, OTHER N	URSING FACILIT	Y, AND ICF/IID	ONLY			
1	g facility/other nursing facil al inpatient routine service c	,			)		70.0
, ,	e service cost (line 9 x line		1111C 70 . 1111C	2)			72.0
1	ssary private room cost applic						73.0
, o	general inpatient routine serv d cost allocated to inpatient	•		•	Part II column		74.0
26, line 45)	a cost arrocated to impatreme	roderno servici	0 00313 (110111	worksheet b,	rare rr, coramir		70.0
	al-related costs (line 75 ÷ li I-related costs (line 9 x line						76. 0 77. 0
, ,	ine service cost (line 74 minu	*					78.0
79.00 Aggregate char	ges to beneficiaries for exces	s costs (from	•	*.	>		79.0
	routine service costs for comp ine service cost per diem limi		cost limitatio	n (line 78 mi	nus line 79)		80.0
'	ine service cost limitation (		1)				82.0
	atient routine service costs (		ns)				83.0
	ent ancillary services (see in view - physician compensation		ons)				84. 0 85. 0
4	inpatient operating costs (sum	•	•				86.0
	UTATION OF OBSERVATION BED PASS						
87.00   Total observat	ion bed days (see instructions al inpatient routine cost per	•	· line 2)			0 00	87.0
88.00 Adjusted gener	al libatient routine cost bei		7 IIIIC 21				

Health Financial Systems C	OMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-4011	Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1	2, 700, 214	0.0000	00	0	90.00
91.00 Nursing School cost	0	2, 700, 214	0.0000	00	0	91.00
92.00 Allied health cost	0	2, 700, 214	0.0000	00	0	92.00
93.00 All other Medical Education	0	2, 700, 214	0. 00000	00 0	0	93.00

	Financial Systems	COMMUNITY MENTAL H			of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-4011	Peri od: From 07/01/2020	Worksheet D-1			
				To 06/30/2021	Date/Time Pre 11/22/2021 10			
	Title XIX Hospital							
	Cost Center Description				Cost			
	PART I - ALL PROVIDER COMPONENTS				1. 00			
	INPATIENT DAYS							
1.00	Inpatient days (including private roo	9	,		2, 293	1.00		
2.00	Inpatient days (including private roo				2, 293	2.00		
3. 00	Private room days (excluding swing-bedo not complete this line.	ed and observation bed d	ays). If you have only p	rivate room days,	0	3.00		
4. 00	Semi-private room days (excluding swi	ng-bed and observation	bed davs)		2, 293	4.00		
5.00	Total swing-bed SNF type inpatient da			er 31 of the cost	0	5.00		
,	reporting period							
6. 00	Total swing-bed SNF type inpatient da reporting period (if calendar year, e		oom days) after December	31 of the cost	0	6. 00		
7. 00	Total swing-bed NF type inpatient day		om days) through Decembe	r 31 of the cost	0	7. 00		
	reporting period	3 1	3 , 3					
8. 00	Total swing-bed NF type inpatient day reporting period (if calendar year, e		om days) after December	31 of the cost	0	8. 00		
9. 00	Total inpatient days including privat		to the Program (excludin	g swing-bed and	285	9. 00		
7. 00	newborn days) (see instructions)	te reem days appricable	to the rrogram (exertain)	g swillig bod and	200	7.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)					10. 00		
11. 00	through December 31 of the cost reporting period (see instructions)					11.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					11.00		
12.00	Swing-bed NF type inpatient days appl	icable to titles V or X		te room days)	0	12.00		
12 00	through December 31 of the cost repor Swing-bed NF type inpatient days appl		IV only (including prive	+a maam daya)	0	12 00		
13. 00	after December 31 of the cost reporti				U	13. 00		
14.00	Medically necessary private room days				0	14.00		
15.00	Total nursery days (title V or XIX or	nl y)			0	15. 00		
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16. 00		
17. 00	Medicare rate for swing-bed SNF servi	ces applicable to servi	ces through December 31	of the cost	0.00	17. 00		
	reporting period							
18. 00	Medicare rate for swing-bed SNF servi	ces applicable to servi	ces after December 31 of	the cost	0. 00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF servio	res annlicable to servic	es through December 31 o	f the cost	0.00	19. 00		
17.00	reporting period	ces applicable to service	es through becomber 51 6	the cost	0.00	17.00		
20. 00	Medicaid rate for swing-bed NF servio	ces applicable to servic	es after December 31 of	the cost	0.00	20.00		
21 00	reporting period	as aget (see instruction	no)		2 227 142	21 00		
21. 00 22. 00	Total general inpatient routine servi Swing-bed cost applicable to SNF type			ting period (line	2, 337, 143 0	21. 00 22. 00		
22.00	5 x line 17)	5 30. 11 333 t 34g.: 2333	zer er er er ene deet reper	tring porroa (tring	· ·	22.00		
23. 00	Swing-bed cost applicable to SNF type	e services after Decembe	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	sorvices through Decemb	or 21 of the cost report	ing ported (line	0	24.00		
∠4. 00	7 x line 19)	Services through becellib	ci or the cost report	ing period (Title	U	24.00		
25. 00	Swing-bed cost applicable to NF type	services after December	31 of the cost reportin	g period (line 8	0	25. 00		
0/ 00	x line 20)	>			-	2/ 22		
26. 00 27. 00	Total swing-bed cost (see instruction General inpatient routine service cos		(line 21 minus line 24)		0 2, 337, 143	26. 00 27. 00		
_1.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	or her or swring-bed cost	(TITIC 21 IIITIUS TITIC 20)		2, 337, 143	27.00		
28. 00	General inpatient routine service cha		ed and observation bed c	harges)	0	28. 00		
29 00	Private room charges (excluding swing	n-bed charges)			0	29 00		

PART I - ALL PROVIDER COMPONENTS  INPATIENT DAYS  1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)  1.01 Inpatient days (including private room days, excluding swing-bed and newborn days)  3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8.02 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	2, 293 2, 293 0 2, 293 0 0	2. 00 3. 00 4. 00
<ul> <li>1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)</li> <li>2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)</li> <li>3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</li> <li>4.00 Semi-private room days (excluding swing-bed and observation bed days)</li> <li>5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period</li> <li>6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)</li> <li>7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period</li> <li>8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)</li> <li>9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)</li> <li>10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)</li> </ul>	2, 293 0 2, 293 0	2. 00 3. 00 4. 00
<ul> <li>Inpatient days (including private room days, excluding swing-bed and newborn days)</li> <li>Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</li> <li>Semi-private room days (excluding swing-bed and observation bed days)</li> <li>Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period</li> <li>Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)</li> <li>Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period</li> <li>Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period</li> <li>Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)</li> <li>Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)</li> <li>Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)</li> </ul>	2, 293 0 2, 293 0	2. 00 3. 00 4. 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0 2, 293 0 0	3. 00 4. 00
do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	2, 293 0	4.00
4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost	0	
reporting period  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost		6.00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost	0	0.00
reporting period  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	Ĭ	7.00
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		/
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	8.00
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	285	9.00
through December 31 of the cost reporting period (see instructions)		
through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	10.00
11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after		
2	0	11.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
through December 31 of the cost reporting period		
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15.00 Total nursery days (title V or XIX only)	0	
16.00 Nursery days (title V or XIX only)	0	16.00
SWI NG BED ADJUSTMENT	0.00	17.0
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
reporting period	0.00	10.00
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
reporting period	0.00	17.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
reporting period		
21.00 Total general inpatient routine service cost (see instructions)	337, 143	21.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	1
5 x line 17)		
23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
x line 18)		
24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
7 x line 19)		
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
x line 20)		
26.00   Total swing-bed cost (see instructions)	0	
	337, 143	27.00
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		20.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29.00 Private room charges (excluding swing-bed charges)	0	
30.00 Semi-private room charges (excluding swing-bed charges)		1
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00000	•
		•
33.00   Average semi-private room per diem charge (line 30 ÷ line 4) 34.00   Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	1
35.00 Average per diem private room cost differential (line 34 x line 31)	0.00	•
36.00 Private room cost differential adjustment (line 3 x line 35)	0.00	1
	337, 143	
27 minus line 36)	.57, 143	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		ı
	019. 25	38 0
	290, 486	•
AZ AN TELANTON DEDELOT LINGUEDE DULLINE SELVICE COST UTDE 3 × 110E 301	0	
	J ,	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	290, 486	1 /11 A

	Financial Systems FATION OF INPATIENT OPERATING COST	COMMUNITY MENTAL			In Lie	wof Form CMS-2 Worksheet D-1	
CONICUI	ATTON OF THE ATTENT OF LIVATING COST		i i ovi dei (		From 07/01/2020 To 06/30/2021	Date/Time Pre	
						11/22/2021 10	
	Cost Center Description	Total		le XIX Average Per	Hospital Program Days	Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	2. 00	÷ col . 2) 3.00	4.00	<u>col. 4)</u> 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	1. 00	0.00	42.00
43. 00	Intensive Care Type Inpatient Hospital Uni INTENSIVE CARE UNIT	ts		1			43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
	·					1. 00	
	Program inpatient ancillary service cost ( Total Program inpatient costs (sum of line			one)		17, 636 308, 122	1
47.00	PASS THROUGH COST ADJUSTMENTS	:3 41 till ough 40)	see mstructi	OH3)		300, 122	47.00
50.00	Pass through costs applicable to Program i	npatient routine	services (fro	om Wkst. D, sur	m of Parts I and	0	50.00
51. 00		nnatient ancillar	rv services (1	from Wkst D	sum of Parts II	0	51.00
01.00	and IV)	inpatront anortra	y 301 11 003 (1	Trom mor. b,		o o	01.00
52.00	Total Program excludable cost (sum of line					0	
53. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus lin		erated, non-pr	nysician anesti	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0	54. 00 55. 00
	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient oper	ating cost and ta	arget amount	(line 56 minus	line 53)	0	57.00
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996,	updated and co	ompounaea by the	0.00	59.00
60.00	, ,					0. 00	1
61. 00	If line 53/54 is less than the lower of li which operating costs (line 53) are less t					0	61.00
	amount (line 56), otherwise enter zero (se		.3 (111163 54 7	( 00), OI 1% O	the target		
62.00	, , ,					0	
63.00	Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	iyment (see instru	ictions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine c	osts through Dece	ember 31 of th	ne cost reporti	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine c</pre>	ensts after Decemb	or 21 of the	cost roporting	a ported (See	0	65.00
03.00	instructions)(title XVIII only)	osts after becenik	del 31 di tile	cost reportini	g perrou (see	O	05.00
66. 00	Total Medicare swing-bed SNF inpatient rou	itine costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost re	eporting period	0	67.00
07.00	(line 12 x line 19)	oosts toug.	. 200020. 0.	0	por tring por rou	· ·	07.00
68. 00	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after [	December 31 of	f the cost rep	orting period	0	68. 00
69. 00	1 7	nt routine costs (	(line 67 + lir	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER						1
70. 00 71. 00	Skilled nursing facility/other nursing facili				)		70.00
72.00	Program routine service cost (line 9 x lin	,	7110 70 . 11110	2 2)			72.00
73.00	Medically necessary private room cost appl						73.00
74. 00 75. 00	Total Program general inpatient routine se Capital-related cost allocated to inpatien	,		,	Part II column		74.00
, 0. 00	26, line 45)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		a. c , oo a		70.00
76.00	Per diem capital related costs (line 75 ÷	,					76.00
77. 00 78. 00	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi						77.00
79. 00	Aggregate charges to beneficiaries for exc	, ,		,			79. 00
80. 00 81. 00	Total Program routine service costs for co Inpatient routine service cost per diem li	•	cost limitatio	on (line 78 mii	nus line 79)		80.00
82. 00	Inpatient routine service cost per drem in		1)				82.00
83.00	Reasonable inpatient routine service costs	(see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see Utilization review - physician compensation		nns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (s	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST					07.22
	Total observation bed days (see instruction	ns)				0	87.00
87. 00 88. 00	,		- line 2)				88.00

Health Financial Systems CC	DMMUNITY MENTAL	HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-4011	Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	nared:
				10 00/30/2021	11/22/2021 10	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1	2, 337, 143	0. 00000	0 0	0	90.00
91.00 Nursing School cost	0	2, 337, 143	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 337, 143	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 337, 143	0. 00000	00 0	0	93.00

Health Fina	ncial Systems	COMMUNITY MENTAL HE	ALTH CENTER	!	In Lie	u of Form CMS-2	2552-10
I NPATI ENT A	ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-4011	Peri od:	Worksheet D-3	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
			Ti +Lo	: XVIII	Hospi tal	11/22/2021 10 PPS	. ST alli
	Cost Center Description		11 (10	Ratio of Cos		Inpati ent	
	cost center bescription			To Charges	Program	Program Costs	
				10 Charges			
					Charges	(col . 1 x	
				4.00	0.00	col . 2)	
	THE POLITIME OF DUTY OF ACCUTANTED			1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS				248, 000		30.00
ANCI	LLARY SERVICE COST CENTERS						
54.00 0540	O RADI OLOGY-DI AGNOSTI C			1. 50908	2, 820	4, 256	54.00
60.00 0600	O LABORATORY			1. 69643	4, 289	7, 276	60.00
66.00 0660	O PHYSI CAL THERAPY			0.00000	00	0	66.00
69. 00 0690	O ELECTROCARDI OLOGY			3. 24275	54 0	0	69.00
73.00 0730	O DRUGS CHARGED TO PATIENTS			0. 90545	13, 436	12, 166	73.00
	ATIENT SERVICE COST CENTERS					,	
90. 00 0900	O CLI NI C			0. 72699	97 0	0	90.00
200.00	Total (sum of lines 50 through 94 a	nd 96 through 98)			20, 545	23 698	200.00
201.00	Less PBP Clinic Laboratory Services		(line 61)		20,010	20,070	201.00
202.00	Net charges (line 200 minus line 20		(11110 01)		20, 545		202.00
202.00	The charges (Trine 200 millings Trine 20	1)		I	20, 343	I	1202.00

Health Fina	ancial Systems	COMMUNITY MENTAL HEA	ALTH CENTER	!	In Lie	u of Form CMS-2	2552-10
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-4011	Peri od:	Worksheet D-3	
					From 07/01/2020		
					To 06/30/2021		
			T: +1	e XIX	Hospi tal	11/22/2021 10 Cost	: 31 alli
			11 (1		<del></del>		
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x	
						col. 2)	
				1.00	2.00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	OO ADULTS & PEDIATRICS				285, 000		30.00
ANCI	LLARY SERVICE COST CENTERS						
54.00 0540	OO RADI OLOGY-DI AGNOSTI C			1. 50908	1, 391	2, 099	54.00
60.00 0600	OO LABORATORY			1. 69643	3, 359	5, 698	60.00
66.00 0660	00 PHYSI CAL THERAPY			0. 00000	0 0	0	66.00
69.00 0690	O ELECTROCARDI OLOGY			3. 24275	54 47	152	69.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS			0. 90545	10, 699	9, 687	73.00
OUTP	ATIENT SERVICE COST CENTERS						
90.00 0900	OO CLI NI C			0. 68549	0 8	0	90.00
200.00	Total (sum of lines 50 through 94 a	nd 96 through 98)			15, 496	17, 636	200.00
201.00	Less PBP Clinic Laboratory Services		(line 61)		0		201.00
202. 00	Net charges (line 200 minus line 20				15, 496	ł	202.00
		,		1	1 .27 170	ı	

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/22/2021 10:31 am

RAPE B			Title XVIII	Hospi tal	11/22/2021 10 PPS	:31 am
Mark   S - MEDICAL AND OTHER HEALTH SERVICES			THE XVIII	Hospi tui	'	
Medical and other services (see Instructions)		DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
	1 00				0	1 00
3.00   DPPS payments   53,798   3.00   Autiliar reconcil lation amount (see instructions)   0.40		,				
0.01   For Process   Table in amount (see instructions)   0.000   0.500						
Infract the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			0	4.00
Line 2 times   Line 5   0   0.00		, , , , , , , , , , , , , , , , , , ,				
			)			
Transit floral corridor payment (see Instructions)   0 8.00   0						
Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200						
10.00   Organ acquisitions   0   10.00   11.00   The Control Cost (sum of lines 1 and 10) (see instructions)   0   11.00   1			. 13. Line 200			
Reasonable charges   Reasona			,		0	1
Reasonable charges	11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
12.00   Ancil lary service charges   0   12.00   12.00   12.01   13.00   07gan acquisit ion charges (from Wist. D-4, Pt. 111, col. 4, line 69)   0   14.00   13.00   07gan acquisit ion charges (sum of lines 12 and 13)   0   14.00						
13.00   Organ acquisition chargées (from Wist. D-4, Pt. III. col. 4, line 69)	12 00				0	12.00
14.00			١			
Constraints			)			
16.00   Asount's that would have been real ized from patients liable for payment for services on a chargebasls   0   16.00   had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   17.00   17.00   18.00   17.00   18.00   17.00   18.00   18.00   17.00   18		* '				
had such payment been made in accordance with 42 CFR \$413.13(e)	15.00	Aggregate amount actually collected from patients liable for paymen	t for services on	a charge basis	0	15.00
17.00   Ratio of Line 15 to line 16 (not to exceed 1.000000)   0.000000   17.00   18.00   19.00   Excess of customary charges (see instructions)   0.000000   17.00   18.00   19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0.19.00   1	16. 00		ent for services o	on a chargebasis	0	16. 00
18.00   Total customary charges (see instructions)   0   18.00   18.00   0	17 00				0.000000	17 00
19.00   Excess of customary charges over reasonable cost (complete only if fline 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if fline 11 exceeds line 18) (see   0   20.00   1.5   20.00   1.5   20.00   1.5   20.00   1.5   20.00   1.5   20.00   20.00   1.5   20.00						
Instructions			ine 18 exceeds Li	ne 11) (see		
instructions				, (333		
1.00   Lesser of cost or charges (see Instructions)   0   21.00	20. 00		ine 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0 22.00	04 00					04 00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   513,793   24.00   Collegion prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   513,793   27.00   28.00   29.0						
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   513,793   24.00		·	ns)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   25.00   Deductible sand coinsurance amounts (for CAH, see instructions)   20.811   25.00   Deductible sand coinsurance amounts (for CAH, see instructions)   98,610   26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   394,372   27.00   Instructions   20.811   27.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   394,372   27.00   Democration of the control of the con			13)			
26. 00         Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         394,372         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)         0 28. 00           29. 00         ESRD direct medical education payments (from Wkst. E-4, line 36)         0 29. 00           29. 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         394,372           31. 00         Primary payer payments         0 31.00           32. 00         Subtotal (line 30 minus line 31)         0 31.00           32. 00         Subtotal (line 30 minus line 31)         0 33.00           33. 00         Composite rate ESRD (from Wkst. 1-5, line 11)         0 33.00           34. 00         All usable bad debts (see instructions)         0 35.00           35. 00         Adjusted reimbursable bad debts (see instructions)         394,372           37. 00         Subtotal (see instructions)         394,372           38. 00         OFFIER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIEY)         39. 00           39. 00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIEY)         39. 00           39. 9         Partial or full credits received from manufacturers for replaced devices (see instructions)         39. 90           39. 9         Partial or fu					•	
27. 00   Subtotal   [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   394, 372   27. 00   18   18   18   18   18   18   18					·	
Instructions					·	
28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   28.00   29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   39.30   39.372   30.00   30.0	27. 00	[	ne sum of lines 22	2 and 23] (see	394, 372	27.00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   39.4372   30.00   30.00   Subtotal (sum of lines 27 through 29)   31.00   71.00   31.00   71.00   32.00   71.00   32.00   71.00   32	28 00		)		0	28 00
30. 00   Subtotal (sum of lines 27 through 29)   394,372   30. 00   31. 00   Primary payer payments   30. 30   31. 00   31. 00   31. 00   32. 00   32. 00   32. 00   32. 00   32. 00   33. 00			,			
32.00   Subtotai (i ine 30 minus line 31)   394, 372   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   0   35.00   Allowable bad debts (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   39.00   39.00   39.00   OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   38.00   39.00   OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00		· · · · · · · · · · · · · · · · · · ·			394, 372	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   33.00   Composite rate ESRD (from Wkst. I - 5, Ilne 11)   0   33.00   34.00   All owable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   35.00   35.00   36.00   All owable bad debts (see instructions)   0   35.00   36.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   38.						
33.00	32. 00				394, 372	32.00
34.00	22 00	·			0	22 00
35.00		,				
36.00		· · · · · · · · · · · · · · · · · · ·				
38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.50   39.50   39.50   39.97   39.89   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.90   39.9	36.00	Allowable bad debts for dual eligible beneficiaries (see instruction	ns)		0	36.00
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.00   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.98   39.98   39.99   39.99   8ECOVERY OF ACCELERATED DEPRECIATION   39.99   39.99   8ECOVERY OF ACCELERATED DEPRECIATION   39.99   39.99   39.90   39.00   39.90						
39. 50   39. 97   39. 97   39. 97   39. 97   39. 98   39. 98   39. 98   39. 99   3						
39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   39. 97   Recovery of Accelerated Depreciation   0   39. 98   39. 98   39. 99   Recovery of Accelerated Depreciation   0   39. 99   3		, , , ,			0	
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       394, 372       40. 00         40. 01       Sequestration adjustment (see instructions)       0       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 00       Interim payments       394, 371       41. 00         41. 01       Interim payments-PARHM       41. 01       41. 01         42. 00       Tentative settlement (for contractors use only)       0       42. 01         43. 00       Balance due provider/program (see instructions)       1       43. 00         44. 00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         44. 00       Fils. 2       0       44. 00         70. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00         92. 00       The rate used to calculate		, , , , , , , , , , , , , , , , , , , ,			0	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   5ubtotal (see instructions)   394, 372   40. 00   40. 01   40. 01   40. 01   40. 01   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00   40. 02   40. 03   40. 00			vices (see instru	ctions)		1
40. 01       Sequestration adjustment (see instructions)       0       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 00       Interim payments       394, 371       41. 00         41. 01       Interim payments-PARHM       41. 01       41. 01         42. 00       Tentative settlement (for contractors use only)       0       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Balance due provider/program (see instructions)       1       43. 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       44. 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			•	,	0	39. 99
40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 00       Interim payments       394, 371       41. 00         41. 01       Interim payments-PARHM       41. 01         42. 00       Tentative settlement (for contractors use only)       0       42. 01         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Balance due provider/program (see instructions)       1       43. 00         43. 01       Balance due provider/program-PARHM (see instructions)       43. 01       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         91. 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					394, 372	
40. 03						
41.00					0	
41. 01       Interim payments-PARHM       41. 01         42. 00       Tentative settlement (for contractors use only)       0       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Bal ance due provider/program (see instructions)       1       43. 00         43. 01       Bal ance due provider/program-PARHM (see instructions)       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2       0         70 BE COMPLETED BY CONTRACTOR       0       90. 00         91. 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		, ,			20/ 271	
42.00       Tentative settlement (for contractors use only)       0       42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Bal ance due provider/program (see instructions)       1       43.00         43.01       Bal ance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2       0         70       BE COMPLETED BY CONTRACTOR         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					374, 371	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 10.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{5115.2}{TO BE COMPLETED BY CONTRACTOR}  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00		Tentative settlement-PARHM (for contractor use only)				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\frac{5115.2}{15.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$  90.00 Ordinal outlier amount (see instructions)  0 0010 Outlier reconciliation adjustment amount (see instructions)  1 0 92.00  1 The rate used to calculate the Time Value of Money  1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , ,			1	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 93.00			th CMC Dut 45 C	obonts: 1	_	
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 93.00	44.00		in CMS Pub. 15-2,	cnapter 1,	0	44.00
90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 90.00  91.00  92.00  93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00 0.00 92.00 0.00 93.00	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00					0	91.00
74. 00   10 tai (Suiii 01 11 lies 31 and 33)						
	74. UU	Tiotai (Suiii Oi Tities 71 ailu 73)			Ü	74.00

Health Financial Systems COMMUNI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED COMMUNITY MENTAL HEALTH CENTER In Lieu of Form CMS-2552-10 Peri od: Worksheet E-1
From 07/01/2020 Part I
To 06/30/2021 Date/Time Prepared: 11/22/2021 10:31 am
Hospi tal PPS Provider CCN: 15-4011 Title XVIII Inpatient Part A Part 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		160, 943		394, 371	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		_		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3.04
3. 05			0		0	3. 05
	Provi der to Program		_		_	
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			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98)		140 042		204 271	4 00
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		160, 943		394, 371	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		ol	5. 02
5.03			0		ol	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		1	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		160, 943		394, 372	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
0 00	Name of Contractor	(	)	1. 00	2. 00	0 00
8. 00	Name of Contractor	l				8.00

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4011	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/22/2021 10:31 am
			717 227 2021 10101 4111

PART II - MEDICABE PART A SERVICES - IPP PPS					11/22/2021 10	:31 am_
PART II - MEDICAME PART A SERVICES - IPF PPS			Title XVIII	Hospi tal	PPS	
PART II - MEDICAME PART A SERVICES - IPF PPS						
1.00   Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		F			1. 00	
2.00   Net IPF PPS Outlier Payments   0   2.00   0.00						
3.00   Net IPF PPS ECT Payments			dical education payments)	)	·	
Unweighted Intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (See instructions)		,				
15, 2004, (see instructions)					_	
4.01   Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42   CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4.00		cost report filed on or b	before November	0.00	4.00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRR \$412.424(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)						
CFR \$412.42(d)(1)(iii)(F)(1) or (2) (see instructions)	4.01	]		' '	0.00	4.01
5.00   New Teaching program adjustment. (see instructions)   0.00   5.00			it a temporary cap adjus	tment under 42		
Current year's unwelghted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   Current year's unwelghted 1&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   7.00	E 00				0.00	E 00
teaching program" (see instructions)  7. 00 current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  8. 00 literan and resident count for IPP PPS medical education adjustment (see instructions)  8. 02 literan and resident count for IPP PPS medical education adjustment (see instructions)  8. 03 learning Adjustment (Cline 1 multiplied by line 10).  9. 00 literaning Adjustment factor (Cline 1 multiplied by line 10).  10. 00 Teaching Adjustment (line 1 multiplied by line 10).  10. 01 literaning Adjustment (line 1 multiplied by line 10).  10. 02 literaning Adjustment (line 1 multiplied by line 10).  10. 03 literaning Adjustment (line 1 multiplied by line 10).  10. 04 literaning Adjustment (line 1 multiplied by line 10).  10. 05 literaning Adjustment (line 1 multiplied by line 10).  10. 06 literaning Adjustment (line 1 multiplied by line 10).  10. 07 gen acquisition (00 NOT USE THIS LINE)  10. 08 literaning Adjustment (line 1 multiplied by line 10).  10. 09 literaning and a literaning and literaning hospital (see instructions)  10. 00 literany payer payments			the new program growth .	aniad of a "now		
2.00   Current 'year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (See instructions)   0.00	6.00		the new program growth p	period of a new	0.00	6.00
teaching program" (see instructions)  8. 00  9. 00  Average Daily Census (see instructions)  9. 00  Average Daily Census (see instructions)  10. 00  Teaching Adjustment Factor ((1 + (ine &Hine &Hine &H)) raised to the power of .5150 -1).  10. 00  Teaching Adjustment (I ne 1 multiplied by line 10).  11. 00  Teaching Adjustment (I ne 1 multiplied by line 10).  12. 00  13. 00  Nursing and Allied Health Managed Care payment (see instruction)  14. 00  Teaching Adjusted Net IP FPS Payments (sum of lines 1, 2, 3 and 11)  15. 00  Teaching Adjusted Net IP FPS Payments (sum of lines 1, 2, 3 and 11)  16. 00  Teaching Adjusted Net IP FPS Payments (sum of lines 1, 2, 3 and 11)  17. 00  Teaching Adjusted Net IP FPS Payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 1, 2, 3 and 11)  The seem of payments (sum of lines 2, 2 and 24)  The seem of payments (sum of lines 2, 2 and 24)  The seem of payments (sum of lines 2, 2 and 24)  The seem of payments reconcilitation (see instructions)  The seem of payments (see instructions)  The seem of payments (see instructions)  The seem of payments reconcilitation (see instructions)  The seem of payment adjustment (see instructions)  The seem of payment adjust	7 00		the new program growth r	ported of a "now	0.00	7 00
8. 00	7.00		the new program growth p	period of a new	0.00	7.00
9.00   Average Daily Census (see instructions)   6.282102   9.00	9 00		stmont (soo instructions)	,	0.00	9 00
10.00   Teaching Adj ustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.   0.000000   0.00     10.00   Teaching Adj ustment (line 1 multiplied by line 10).   0   11.00     12.00   Adjusted Net 1PF PPS Payments (sum of lines 1, 2, 3 and 11)   208,011   12.00     13.00   Nursing and Allied Health Managed Care payment (see instruction)   0   13.00     14.00   Organ acquisition (Do Not USE THIS LINE)   14.00     15.00   Cost of physicians' services in a teaching hospital (see instructions)   0   15.00     16.00   Subtotal (see instructions)   208,011   16.00     17.00   Primary payer payments   208,011   16.00     18.00   Subtotal (line 16 less line 17).   208,011   16.00     19.00   Deductibles   47,068   19.00     19.00   Deductibles   47,068   19.00     10.00   Subtotal (line 18 minus line 19)   160,943   20.00     21.00   Colinsurance   22.00     22.00   Subtotal (line 20 minus line 21)   160,943   22.00     23.00   Allowable bad debts (see instructions)   160,943   22.00     24.00   Adjusted reimbursable bad debts (see instructions)   0   24.00     25.00   Allowable bad debts (for dual eligible beneficiaries (see instructions)   160,943   26.00     26.00   Subtotal (sum of lines 22 and 24)   160,943   26.00     27.00   Direct graduate medical education payments (see instructions)   0   27.00     28.00   Outlier payments reconciliation   29.00     29.00   Outlier payments   29.00     29.00   Outlier payments   29.00     29.00   Outlier payments   29.00     29.00   Outlier payment		1	stilletti (see tiisti ucti olis,	'		
11.00			the newer of 5150 1)			
12.00		1 , , , ,	the power of .5150 -13.			
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   13. 00   Organ acquisition (D0 NOT USE THIS LINE)   14. 00   15. 00					-	
14. 00   Organ acquisition (DO NOT USE THIS LINE)   14. 00   15.			on)			
15. 00   Cost of physicians' services in a teaching hospital (see instructions)   208,011   16. 00   17. 00   17. 00   18. 00   19. 00			OH)		U	
16. 00   Subtotal (see instructions)   16. 00   17. 00   Primary payer payments   0   17. 00   17. 00   17. 00   Primary payer payments   0   17. 00   18. 00   Subtotal (line 16 less line 17).   208,011   18. 00   18. 00   Subtotal (line 18 minus line 19)   20. 00   Subtotal (line 18 minus line 19)   160,943   20. 00   21. 00   22. 00   Subtotal (line 20 minus line 21)   160,943   22. 00   23. 00   24. 00   24. 00   25. 00   25. 00   26.			tructions)		0	
17. 00			ir uctrons)		-	
18. 00   Subtotal (line 16 less line 17).   208,011   18. 00   19. 00   Deductibles   47,068   47,068   20. 00   Subtotal (line 18 minus line 19)   160,943   20. 00   21. 00   Coinsurance   0   21. 00   22. 00   Subtotal (line 20 minus line 21)   160,943   22. 00   23. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   23. 00   24. 00   Adjusted reimbursable bad debts (see instructions)   0   24. 00   25. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   25. 00   26. 00   Subtotal (sum of lines 22 and 24)   160,943   26. 00   27. 00   Direct graduate medical education payments (see instructions)   0   27. 00   Direct graduate medical education payments (see instructions)   0   27. 00   28. 00   Other pass through costs (see instructions)   0   27. 00   29. 00   Outlier payments reconciliation   0   29. 00   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   29. 00   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   30. 50   00. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   0   00. 00. 00. 00. 00. 00. 00. 00. 0					·	
19.00   Deductibles					-	
20.00   Subtotal (line 18 minus line 19)   160, 943   20.00   21.00   Coinsurance   0   21.00   21.00   22.00   Subtotal (line 20 minus line 21)   160, 943   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   25.00   26.00   Subtotal (sum of lines 22 and 24)   160, 943   26.00   27.00   Direct graduate medical education payments (see instructions)   0   27.00   Direct graduate medical education payments (see instructions)   0   28.00   29.00   Outlier payments reconciliation   0   29.00   29.00   Outlier payments reconciliation   0   29.00   29.00   Outlier payments reconciliation   0   29.0						
21.00					·	
22. 00       Subtotal (line 20 minus line 21)       160,943       22.00         23. 00       Al lowable bad debts (exclude bad debts for professional services) (see instructions)       0       23.00         24. 00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25. 00       Al lowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26. 00       Subtotal (sum of lines 22 and 24)       160,943       26.00         27. 00       Direct graduate medical education payments (see instructions)       0       27.00         28. 00       Other pass through costs (see instructions)       0       28.00         29. 00       Outlier payments reconciliation       0       29.00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.50         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30. 99       Demonstration payment adjustment amount before sequestration       0       30.99         31. 01       Sequestration adjustment (see instructions)       0       31.00         31. 02       Interim payments       0       31.02         32. 00       Interim payments       0       33.00         32. 00       B					·	
23. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0       23. 00         24. 00       Adjusted reimbursable bad debts (see instructions)       0       24. 00         25. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25. 00         26. 00       Subtotal (sum of lines 22 and 24)       160, 943       26. 00         27. 00       Direct graduate medical education payments (see instructions)       0       27. 00         28. 00       Other pass through costs (see instructions)       0       27. 00         29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 50         30. 90       Pomonstration payment adjustment amount before sequestration       0       30. 99         31. 01       Sequestration adjustment (see instructions)       160, 943       31. 00         31. 02       Demonstration payment adjustment amount after sequestration       0       31. 01         32. 00       Interim payments       0       31. 02         30. 00       Bal ance due provider/program (line 31 minus lines 31. 01, 31. 02, 32 an						
24.00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26.00       Subtotal (sum of lines 22 and 24)       160,943       26.00         27.00       Direct graduate medical education payments (see instructions)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Demonstration payment adjustment amount before sequestration       0       30.99         31.01       Sequestration adjustment (see instructions)       0       31.01         32.00       Interim payments       0       31.02         32.00       Tentative settlement (for contractor use only)       0       33.00         34.00       Bal ance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)       0       34.00         35.00       To BE COMPLETED BY CONTRACTOR       0       50.00         50.00       Tole a			cas) (saa instructions)			
25.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (see instructions)  28.00 Other pass through costs (see instructions)  0 Utilier payments reconciliation  0 Utilier payments reconciliation  0 Utilier payments (SEE INSTRUCTIONS)  0 Utilier payments (SEE INSTRUCTIONS)  0 Utilier payment adjustment (see instructions)  0 Utilier payment adjustment amount before sequestration  0 Utilier payment adjustment amount before sequestration  0 Utilier payment adjustment amount payment adjustment (see instructions)  10 Utilier payment adjustment (see instructions)  10 Utilier payment adjustment amount payment adjustment (see instructions)  10 Utilier payment adjustment amount after sequestration  10 Utilier payment adjustment amount after sequestration  11 Utilier payment adjustment amount after sequestration  12 Utilier payment adjustment amount after sequestration  13 Utilier payment adjustment amount after sequestration  14 Utilier payment adjustment amount after sequestration  15 Utilier payment adjustment amount after sequestration  16 Utilier payment adjustment amount after sequestration  16 Utilier payment adjustment amount after sequestration  17 Utilier payment adjustment amount after sequestration  18 Utilier payment adjustment amount after sequestration  19 Utilier payment adjustment amount (see instructions)  20 Utilier payment adjustment amount (see instructions)  21 Utilier payment adjustment amount (see instructions)  22 Utilier payment adjustment amount (see instructions)  23 Utilier payment adjustment amount (see instructions)  25 Utilier payment adjustment amount (see instructions)  26 Utilier payment adjustment amount (see instructions)  27 Utilier payment adjustment amount (see instructions)  28 Utilier payment adjustment amount (see instructions)  29 Utilier payment adjustment amount (see instructions)  20 Utilier payment adjustment amount (see instructions)  21 Utilier payment adjustmen			ces) (see mistractions)		_	
26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (see instructions)  27.00 Other pass through costs (see instructions)  28.00 Other pass through costs (see instructions)  29.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.50 Pi oneer ACO demonstration payment adjustment (see instructions)  30.99 Demonstration payment adjustment amount before sequestration  30.99 Sequestration adjustment (see instructions)  31.01 Sequestration adjustment (see instructions)  31.02 Demonstration payment adjustment amount after sequestration  31.02 Demonstration payment adjustment amount after sequestration  31.02 Demonstration payment adjustment amount after sequestration  31.02 Demonstration payment (for contractor use only)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Toginal outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  50.00 The rate used to calculate the Time Value of Money  50.00 The rate used to calculate the Time Value of Money		, , , , , , , , , , , , , , , , , , , ,	tructions)		-	
27.00   Direct graduate medical education payments (see instructions)   0   27.00		,	tructrons)		-	
28. 00 Other pass through costs (see instructions) 0 28. 00 29. 00 Outlier payments reconciliation 0 29. 00 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30. 00 30. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30. 50 30. 90 Demonstration payment adjustment amount before sequestration 10 30. 99 31. 00 Total amount payable to the provider (see instructions) 160, 943 31. 00 31. 01 Sequestration adjustment (see instructions) 0 31. 01 31. 02 Demonstration payment adjustment amount after sequestration 0 31. 02 32. 00 Interim payments 160, 943 32. 00 34. 00 Balance due provider/program (line 31 minus lines 31. 01, 31. 02, 32 and 33) 160, 943 32. 00 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00 35. 00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50. 00 50. 00 Untlier reconciliation adjustment amount (see instructions) 0 52. 00 The rate used to calculate the Time Value of Money 0. 00 52. 00			1			
29.00   Outlier payments reconciliation   0   29.00   30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   30.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50   30.99   31.00   Total amount payable to the provider (see instructions)   160,943   31.00   31.01   Sequestration adjustment (see instructions)   0   31.01   31.02   Demonstration payment adjustment amount after sequestration   0   31.02   32.00   Interim payments   160,943   32.00   33.00   34.00   34.00   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   35.00   S115.2   To BE COMPLETED BY CONTRACTOR   0   50.00   50.00   The rate used to calculate the Time Value of Money   0.00   52.00		, , , ,			-	
30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   30.00   30.50   Pi oneer ACO demonstration payment adjustment (see instructions)   0   30.50   30.99   Demonstration payment adjustment amount before sequestration   0   30.99   31.00   Total amount payable to the provider (see instructions)   160,943   31.00   31.01   31.02   Sequestration payment adjustment (see instructions)   0   31.01   32.00   Interim payments   160,943   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   33.00   Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)   0   34.00   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   51.00   Original outlier amount from Worksheet E-3, Part II, line 2   0   50.00   52.00   The rate used to calculate the Time Value of Money   0.00   52.00						
30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 30. 99 Demonstration payment adjustment amount before sequestration 30. 99 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 31. 02 Demonstration payment adjustment amount after sequestration 31. 02 Demonstration payment adjustment amount after sequestration 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31. 01, 31. 02, 32 and 33) 35. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$51. 00 \$11. 02 \$115. 2 \$10. 00 \$11. 00					-	
30. 99 31. 00 31. 00 31. 01 31. 02 32. 00 33. 00 32. 00 33. 00 34. 00 35. 00 36. 99 37. 00 38. 00 39. 99 39. 00 39			าร)		_	
31.00 Total amount payable to the provider (see instructions)  31.01 Sequestration adjustment (see instructions)  31.02 Demonstration payment adjustment amount after sequestration  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  0 Untlier reconciliation adjustment amount (see instructions)  50.00 The rate used to calculate the Time Value of Money  100 160, 943 31.00  31.01 160, 943 32.00  31.02 160, 943 32.00  32.00 160, 943 32.00  33.00 20, 33.00  34.00 35.00 25.00			.5)			
31.01 Sequestration adjustment (see instructions)  31.02 Demonstration payment adjustment amount after sequestration  31.02 Interim payments  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  0 Untlier reconciliation adjustment amount (see instructions)  50.00 The rate used to calculate the Time Value of Money  0 31.01  160, 943  32.00  33.00  34.00  35.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00					-	
31.02 Demonstration payment adjustment amount after sequestration 0 31.02 32.00 Interim payments 160,943 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 0 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00  To BE COMPLETED BY CONTRACTOR  Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00						
32.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35.00 To BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 Utilier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 0 0 0 32.00		, , , , , , , , , , , , , , , , , , , ,			-	
33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 The rate used to calculate the Time Value of Money  0 33.00  34.00  35.00  35.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00  50.00						
34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 Outlier reconciliation adjustment amount (see instructions)  50.00 The rate used to calculate the Time Value of Money  0 34.00 35.00 35.00						
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   35.00   §115.2   TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2   0   50.00   51.00   0   0   0   0   0   0   0   0   0			)2. 32 and 33)		-	
\$115.2 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  50.00 The rate used to calculate the Time Value of Money  51.00 The rate used to calculate the Time Value of Money				chapter 1.	-	
TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money  0.00 52.00	30	,		10	Ü	
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 50.00 50.00 50.00 50.00 50.00 50.00						
51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  0 51.00  0 51.00  0 52.00	50.00				0	50.00
52.00 The rate used to calculate the Time Value of Money 0.00 52.00						
		,			0.00	52.00
					0	53.00

Health Financial Systems	COMMUNITY MENTAL HEALTH CENTER	In Lieu o	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4011	From 07/01/2020 P To 06/30/2021 D	orksheet E-3 art VII ate/Time Prepared: 1/22/2021 10:31 am

			Го 06/30/2021	Date/Time Pre 11/22/2021 10	
		Ti tle XIX	Hospi tal	Cost	. 01 4111
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		308, 122		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		308, 122	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		308, 122	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8. 00	Routine service charges		285, 000		8. 00
9. 00	Ancillary service charges		15, 496	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		300, 496	0	12.00
12 00	CUSTOMARY CHARGES	arril acc on a charge		0	12.00
13. 00	Amount actually collected from patients liable for payment for s basis	services on a charge	0	U	13. 00
14.00	Amounts that would have been realized from patients liable for p	ayment for services or		0	14.00
14.00	a charge basis had such payment been made in accordance with 42		'	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 3413. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		300, 496	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	
	line 4) (see instructions)			_	
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	7, 626	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		300, 496	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provid			
	Other than outlier payments		0	0	
23. 00	1		0	0	
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		300,404	0	
29. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		300, 496	0	29. 00
30. 00	Excess of reasonable cost (from line 18)		7, 626	0	30.00
31. 00			300, 496	0	
32. 00	Deductibles		300, 490	0	
	Coinsurance			0	
	Allowable bad debts (see instructions)			0	34.00
35. 00	Utilization review		0	O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	300, 496	0	1
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	
	Subtotal (line 36 ± line 37)		300, 496	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	ū	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		300, 496	0	40.00
41.00	1 3 1		266, 806	0	41.00
42.00			33, 690	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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

Provider CCN: 15-4011

Peri od: Worksheet G From 07/01/2020 To 06/30/2021 Date/Time Prepared:

onl y)			10	00/30/2021	11/22/2021 10	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS			U. U.	.,	
1.00	Cash on hand in banks	13, 304, 077		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	2, 583, 970	0	0	0	2. 00 3. 00
4. 00	Accounts recei vable	3, 670, 250	- 1	0	0	4.00
5. 00	Other recei vabl e	1, 189, 355		0	Ö	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1, 930, 222		0	0	6.00
7. 00	Inventory	0	0	0	0	7. 00
8.00	Prepai d expenses	128, 464	1	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	82, 507 96, 885		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	19, 125, 286		0	ő	11.00
	FIXED ASSETS					
12.00	Land	315, 098		0	0	12.00
13.00	Land improvements	0		0	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	15, 477, 269	0	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-7, 532, 885	1	0	Ö	16.00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19.00	Fixed equipment	2, 780, 032		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-2, 286, 579 826, 636		0	0	20. 00 21. 00
22. 00	Accumulated depreciation	-619, 854		0	0	22.00
23. 00	Major movable equipment	152, 210		0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation	0		0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	ő	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9, 111, 927	0	0	0	30.00
21 00	OTHER ASSETS	0		0	0	1 21 00
31. 00 32. 00	Investments Deposits on Leases	0	0	0	0	31. 00 32. 00
33. 00	Due from owners/officers	Ö	Ö	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	28, 237, 213	0	0	0	36.00
37. 00	Accounts payable	290, 655	0	0	0	37.00
38. 00	Sal ari es, wages, and fees payable	2, 243, 472		0	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0 407 050	0	0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	2, 427, 958		U	0	41. 00 42. 00
43. 00	Due to other funds	407, 292	o	0	0	43.00
44.00	Other current liabilities	130, 000		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	5, 499, 377	0	0	0	45. 00
46. 00	LONG TERM LIABILITIES  Mortgage payable	65, 288	0	0	0	46.00
47. 00	Notes payable	05, 266		0	0	47.00
48. 00	Unsecured Loans	0	O	0	0	48. 00
49. 00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	65, 288	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS	5, 564, 665	0	0	0	51.00
52. 00	General fund balance	22, 672, 548				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			U	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	22, 672, 548		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	28, 237, 213	0	0	0	60.00
	<i>&gt;')</i>		ı l		l	I

17.00

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-4011 Peri od: Worksheet G-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/22/2021 10:31 am General Fund Special Purpose Fund Endowment Fund 1. 00 2.00 3. 00 4.00 5.00 1.00 Fund balances at beginning of period 14, 768, 986 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 4, 533, 176 2.00 2.00 3.00 Total (sum of line 1 and line 2) 19, 302, 162 ol 3.00 4.00 ROUNDI NG 4.00 0 5.00 0 5.00 0 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 13 19, 302, 175 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 0 1 0 0 0 13.00 ROUNDI NG 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19, 302, 174 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 3.00 Total (sum of line 1 and line 2) 4.00 ROUNDI NG 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 ROUNDI NG 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00

0

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems COMM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-4011

			То	06/30/2021	Date/Time Pre 11/22/2021 10	
	Cost Center Description	Inpati ent		Outpati ent	Total	. JT alli
	3337 3311731 23331 Pt 1311	1, 00		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	2, 737, 6	45		2, 737, 645	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 737, 6	45		2, 737, 645	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0		0	16. 00
	[11-15]					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 737, 6			2, 737, 645	17. 00
18. 00	Ancillary services	180, 9		450	181, 389	18.00
19. 00	Outpati ent servi ces		0	5, 098, 910	5, 098, 910	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25. 00
26.00	HOSPI CE			5 007 0/4	E 007 0/4	26.00
27. 00	PRO FEES		0	5, 087, 061	5, 087, 061	27. 00
27. 01	COMMUNITY SERVICE		0	0 145 101	0	27. 01
27. 02			0	2, 145, 181	2, 145, 181	27. 02
27. 03	COMMUNITY SUPPORT		0	3, 058, 433	3, 058, 433	27. 03
27. 04 27. 05	INTENSIVE YOUTH SERVICE		0	4, 986, 588	4, 986, 588	27. 04 27. 05
28.00	MISCELLANEOUS  Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 2, 918, 5	-	948	948	
26.00	G-3, line 1)	2, 910, 3	04	20, 377, 571	23, 296, 155	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			21, 838, 023		29. 00
30.00	ADD (SPECIFY)		0	21, 030, 023		30.00
31. 00	(SI EGITT)		0			31.00
32. 00			0			32.00
33. 00			0			33.00
34.00			0			34.00
35.00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			ol		36.00
37. 00	DEDUCT (SPECIFY)		0	Ĭ		37. 00
38. 00			0			38. 00
39. 00			0			39.00
40.00			0	ļ		40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			О		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer		21, 838, 023		43.00
	to Wkst. G-3, line 4)					

Health Financial Systems COMMUNITY MENTAL HEALTH CENTER In Lieu of Form CMS-2552-10						
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-4011	Peri od:	Worksheet G-3		
			From 07/01/2020 To 06/30/2021			
1 00	T. I	00)		1.00	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			23, 296, 155	1.00	
2.00	Less contractual allowances and discounts on patients' accounts and discounts on patients' accounts.	ITS		4, 931, 469	2.00	
3.00	Net patient revenues (line 1 minus line 2)	42)		18, 364, 686	3.00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		21, 838, 023	4.00	
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-3, 473, 337	5. 00	
6. 00	Contributions, donations, bequests, etc			0	6. 00	
7. 00	Income from investments			0	7. 00	
8. 00	Revenues from telephone and other miscellaneous communication	sarvi cas		0	8.00	
9. 00	Revenue from television and radio service	i sei vi ces		0	9. 00	
10.00	Purchase di scounts			0	10.00	
11. 00	Rebates and refunds of expenses			0	11.00	
12. 00	Parking lot receipts			0	12.00	
13. 00	Revenue from Laundry and Linen service			0	13.00	
14. 00	Revenue from meals sold to employees and guests			0	14. 00	
15. 00	Revenue from rental of living quarters			0	15. 00	
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00	
17. 00	Revenue from sale of drugs to other than patients	nan patronto		0	17. 00	
18. 00	Revenue from sale of medical records and abstracts			0	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			o	20. 00	
21. 00	Rental of vending machines			o	21.00	
22. 00	Rental of hospital space			0	22. 00	
23. 00	Governmental appropriations			ol	23. 00	
24.00	OTHER OPERATING INCOME			248, 610		
24. 01	PUBLIC SUPPORT			4, 284, 061		
24. 02	GAIN/LOSS - DISPOSAL OF PROPERTY			9, 368		
24. 03	INTEREST / DIVIDENDS			12, 139	24. 03	
24. 04	UNREALI ZED GAI N/LOSS			506, 298	24.04	
24. 50	COVI D-19 PHE Fundi ng			2, 946, 037	24.50	
25.00	Total other income (sum of lines 6-24)			8, 006, 513	25.00	
26.00	Total (line 5 plus line 25)			4, 533, 176	26.00	
27 00	OTHER EXPENSES (SPECIEY)			0,	27 00	

27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27.00

0 28.00 4,533,176 29.00